

Ars Medica

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Anatomical Heart

by Melissa Freund

Melissa Freund is a self-taught artist who is focused on the creation of digital art, coloring books, and NFTs (non-fungible tokens). She started drawing anatomical hearts when her daughter was born with a rare genetic disorder and complex congenital heart disease. Her daughter has had numerous surgeries, including three open heart surgeries in the first two years of life, and will need life-long monitoring. Drawing anatomical pieces has been

Melissa's way to process the intense medical experiences that their family has had to endure. Her drawings are an outpouring of the immeasurable love she has for her daughter. To find out more about her art, please visit theanatomicalproject.com.



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Editorial

Scars in Time—Healing, Memory, Medicine

We are able to find everything in our memory,
which is like a dispensary or chemical laboratory
in which chance steers our hand sometimes
to a soothing drug and sometimes to a
dangerous poison.

— Marcel Proust (2003)

Proust, the author of perhaps the most in-depth literary exploration of memory, was the son of a physician. Yet it is being a patient, not a physician, that becomes a conduit to his memory. Throughout *In Search of Lost Time*, Proust's semi-autobiographical work, Marcel is portrayed as more incapacitated and unwell than the author; it is this very sickness that provides the occasion to write. And writing provides a vantage for activating memory, twining sickness and memory, where memory is a laboratory that can soothe or sicken.

Many of the selections for this issue of *Ars Medica* touch the nerves of memory, and the pieces themselves become a kind of scar tissue that binds wounds caused by sickness and loss. The image of a scar recurred to me throughout my reading of these works. The fibrous tissue that replaces normal tissue after a wound is a site of both injury and healing, a physical site that can be returned to, worried beneath your fingers, marking the time of healing and regeneration. You can run your finger over the ridge of a scar, and be reminded of pain even while sensation is numbed by this nubby rind.

Several of the poets in this volume address memory, as they visit loss at the site of their poems. Dan Champion, in a series of poems, “Eidos,” “Progress Report,” and “Sinister, writes of the flare of painful remembering. In “Eidos,” memory sears: “Half a century on, this night scene burns, / sparked merely by a bike glimpsed as it turns.” While in “Progress Report,” writing and re-reading, in the form of letters, sustain the joy and comfort of memory against this harsh traumatic memory:

I’m grateful for these letters. Words don’t stay
with me. I need some medium to stay
them for me.

* * *

These letters stay your spirit from the blight.

Christine Kannapel, in her poem “Teacup of Roses,” links the narrator’s mother’s lost memory and dementia with the gardens and nature of the narrator’s childhood. The poem brings the sensory quality of these recollections—the “sap and watery notes/ of a forest in the neighborhood park” of the narrator’s childhood—to the reader, like the teacup to the mother, an invitation, a wish, a plea to partake, “to see the flowers and recall/ how she saw me once.”

In “Friday Thirteenth,” pediatrician Nick Fordham uses the poem not only as an occasion for memory, but as an injunction to remember: “I resolve never to forget.” Medicine can allow you to see into bodies and know the future before a patient: “I saw your blood before you arrived; / nasty cells, divulging / your Diagnosis.” In contrast to this almost omniscience, the poem is frag-

mented, with partial sentences, and haltingly placed capital letters. The writer addresses the deceased directly through the poem: “I will miss / your patient / nature” as if she were still alive, not only a patient, but patiently returning in “defiance” through the poem.

Ashley J. Choo, a Critical Care Fellow, also uses poetry to metabolize her experience with a failed attempt to resuscitate a patient, navigating the terrain between the anonymity of the patient and the leeching out of her own identity, “bleed[ing] my own name in debt onto each / death certificate ... until I have given my whole self away.” Within the poem, at least, she is able to “whisper anonymous death by / measures ...”.

The delightful translation of “Against a Wen,” an Anglo-Saxon charm, by Maryann Corbett, reminds us of this longstanding use of words to ward off ill and danger. Seeing and reading the original with the translation, the sing-song alliteration is retained, urging the reader to speed onward through the poem, to seek fortification and safety:

Original text

Ʒenne, Ʒenne, Ʒenchichenne,
her ne scealt þu timbrien, ne nenne tun habben,
ac þu scealt norþ eonene to þan nihgan berhge,
þer þu hauest, ermig, enne broþer.

Translation

Wen, wen, squat as a hen
here I forbid you to build or bide.
North must you go to a town that’s near
Where you’ve a brother, wretch that you are.

The measure of memory and pain in many of these poems had me thinking of writing within and from healthcare as a kind of collective memory of sickness and loss. But I was also stopped short by the poem “¡Fanon!” by physician-writer C.A. Rivera, playing with “old” and “new” to remind us that “Infectious colonialism persists, / genetically modified / and given the name / The New Colonialism.” And I was confronted with the limitations of Maurice Halbwach’s collective memory, which belies the fact of memory’s inconstancy, unevenness, and mess.

Many of the pieces within this volume of *Ars Medica* also complicate the idea of our ability to empathically witness the experience or memory of another. Maryam Golafshani, in her reflexive essay “Pumpkin, Penguin, and Pepper: Encounters Between a Mentally Ill Medical Student, a Psychiatry Patient, and a Psychiatrist,” recounts her experience as an outsider witness, “a third party who listens, acknowledges, and reflects upon stories the patient shares in therapy.” She experiences the complexity of this witnessing and, after Sara Ahmed, the stickiness of emotion, and the barriers to empathy. Golafshani redefines empathy “as generosity in allowing oneself to be surprised by all one does not understand about a patient’s experience.” In “Til Death Do Us Part — The Long Goodbye,” which details the difficult choices faced by a caregiver whose husband is losing his memory to dementia, physician writer Paul Rousseau is also confronted by the desire and persistence of his own interpretations. By the end of the story, he

must accept his patient's autonomy and recognize that "letting go is hard" for him as a physician.

Better than the term collective memory is what James E. Young calls "collected memory," which retains the fragmentation, and individuality of memory, and which allows for inclusive, diverse, and contradictory memories to exist alongside each other. It also allows us to see gaps in our collected memory where some experiences and memories were silenced or overwritten. My reading has left me with lingering questions that I will continue to address to the work. Are all of these contributions to *Ars Medica* a kind of collected memory where we can visit the sites of our hurt and of our healing? Can we create space for intersections where we can also engage in social memory within healthcare, to counter our social forgetting? Consider this issue of *Ars Medica* an invitation to visit the memories of others, and also an injunction to the act of remembrance.

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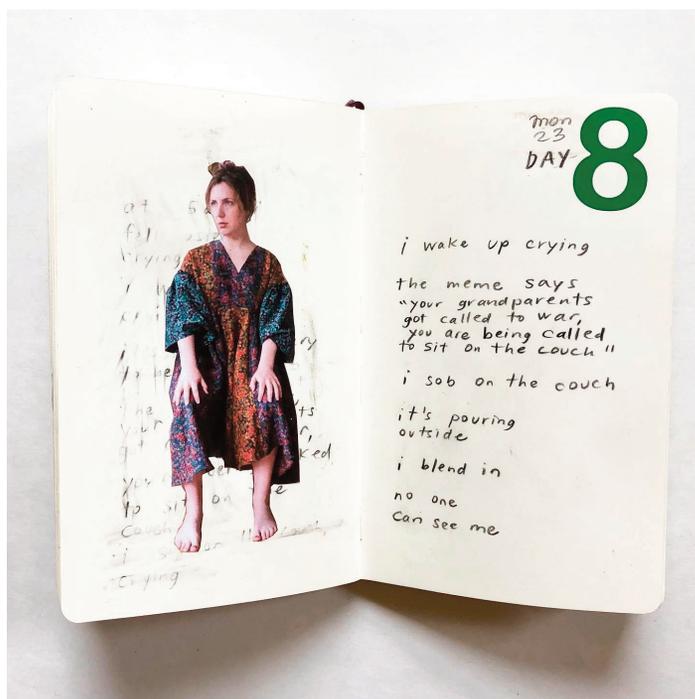
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Allison Crawford
Editor-in-Chief, *Ars Medica*

COVID Notebook Series

Laura Dawe

Pages from a notebook documenting the personal experience of a visual artist during the early days of the COVID-19.







About the Artist

Laura Dawe is an interdisciplinary artist who splits her time between Toronto and Newfoundland. Email: laura.dawe@gmail.com.



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Gyrations

Swati Joshi

This story is dedicated to mom and dad.

Clockwise and anti-clockwise! Usually, clockwise gave Seema more pleasure. However, this time she insisted on rubbing her clitoris anti-clockwise. Reverse masturbation helped calm down her intense stress and somehow, each reverse stroke spooled out everything that happened during the last ten days, as she said, *anti-climactically*. Ten days of frantic incessant calls at the hospitals where her parents were admitted to check on the availability of remdesivir, supply of oxygen, and food. The lung-racking present of hospitalization was gifted to her family by two unwelcome and uninvited guests—Corona Virus and Happy Hypoxia—while she continued staying at the campus hostel. The twin parasitic visitors seemed to enjoy outstaying their unsolicited visitation serving her parents with deteriorating oxygen levels, weakness, and cough. “Please, I don’t have the strength to speak to you.” This was the last complete sentence she had heard from her mother before her hospitalization, before her admission to the ICU, and before the beginning of her new life as a still photograph.

Ten strokes on the clitoris covered the journey of ten days, reminding her of her mother’s last ten

words before her father dialed the ten digits of her mobile phone to inform her at 3:00 am, “Darling, mamma’s no more with us!” Seema received the news after she had moaned for the tenth time, her left index finger still glued to her vulva that brimmed with tears before her eyes did! Moaning, mourning, in the early morning—she lay frozen in her room, where the air was heavy with the mixed aromas of fertility and death. The horizontal aluminum sheet pasted on the ceiling mirrored the image of her naked body. Her vision on the silvery surface appeared like a caramel stream. Her skin glistened with perspiration, her eyes transformed into a lachrymose fountain, her vagina debouched milky ejaculate, her mind discharged the fluid memories of her sucking at her mother’s breast. She stared at her hazy image dreamed up on the ceiling, and rubbed her eyes clockwise. This time it was more stressful. While the epithelial curtains blocked her vision, her mind staged the events from the day her parents were diagnosed with COVID-19.

12th April, 9:00 pm—that was the day her father didn’t speak with her on the phone. “He’s down with fever. I guess he is overwhelmed with office work.” Her mother’s voice carried a tint of fear along with exhaustion and Seema could sense that. “How about you, mamma? Are you ok?”

“Yes, I am fine. Just a little exhausted. How was your day?”

“Mine was great! Listen up, I am cooking dinner and am sort of running late for my online Narrative Medicine classes. I will call you guys tomorrow at 9:00 pm.”

“Stay safe!”

Every night Seema called her parents at 9:00 pm while cooking dinner half an hour before her evening classes. And every day their conversation ended on a note of safety and care.

Seema couldn't sleep that night after classes. She went for a walk and tried to drown her anxiety by plugging earphones in her ears and listening to the deafening bass beats. She avoided making eye-contact with people around her, pretending to be invisible. Something didn't seem right. She had talked to her parents the previous day on a video call and they seemed fine. Her mind continued building airy castles of possibilities. She returned to her room, and switched on her laptop to watch cooking shows on Netflix to distract her mind from thinking about the possibility of her parents being infected with COVID-19.

She didn't realize she had been asleep all night with eyes wide open and glued to the laptop screen showing the recipes of Modak, Aviyal, Suralichya Vadya, and Karimeen Pollichathu one after another. Each recipe brought back the taste of past memories, sweet kisses on the cheeks, pats on the back, and most importantly the satisfaction of seeing her confident reflection in their eyes.

The next day, 13th April, as soon as she woke up, she texted her mother asking if they were fine. Her mother instantly called, “Dad's gone to the office and I am busy with household chores.” The intonation and the information set Seema's mind at rest. Little did she know about her parents' secret of wearing masks at home and sleeping in different rooms

to save each other from being infected. In two days, her mother had perfected the art of camouflaging the truth lest her daughter become frazzled.

The second wave of COVID-19 hit her city hard in April. Hospitals were inundated with patients and there was a consistent paucity of ambulances, hospital beds, oxygen cylinders, and remdesivir. Seema followed the local news on Instagram and Facebook. Every night before going to bed she prayed for her family's health. Alas! Those prayers accumulated on the dust-stricken divine table like the ones piled on the desk of the government officers—visible to everyone except the one in-charge.

At 12:00 pm on 14th April, there was a call from home that made her convulsive, “We’re admitting ourselves. Mamma’s oxygen level has dropped to 52. Mine is fine at the moment. But we both are scared. I have booked an ambulance for us. Hopefully, it will arrive on time.” She didn’t say anything to her father except a repetitive “okay.” Her heart was palpitating fiercely making her nauseous and giddy. She plonked beside her single disheveled bed and retched up bitter, sour, sticky gobs of vomit. The air of the room felt rancid to her tongue, covered with remains of the spewed rice and daal. The semi-solid lumps of vomit were liquefied by the drops of sweat falling from her forehead and the cascades of tears rolling down her cheeks. She kept staring at the yellow, bitter, sour, lumpy barf, while the foul-smelling glaciers of undigested food kept melting, after their exposure to the torrents of bodily fluids.

She didn't cry, she didn't move, she didn't breathe. It felt as if her breath was entwined with her mother's and the invisible cord between the two conveyed to Seema her mother's concern to keep her daughter safe. For three hours, her father didn't respond to her calls or messages. And when he did he spoke assertively to her, "Don't call! When we reach the hospital, we'll update you."

"But why is it taking so long for the ambulance to arrive?"

"Didn't you hear what I just said? I will call you later."

Those words sent a chill down her spine. She imagined her home as a nuclear reactor ready to explode any minute. Digging her face in the pillow she kept crying, thinking of what she could have done. For the next nine hours, there was no news from home. She kept walking to and fro in her room, calling her friends, sharing her fear of losing her parents. Those 540 minutes seemed accursed to her. She had suffered from chronic bronchitis in the past. So, she knew what the experience of breathlessness could do to a person. She would hold her breath for a long time and then exhale, trying to put herself in her mother's shoes, attempting to experience the suffering from the low levels of oxygen in the body. And while she was making feeble efforts to sync her parents' experience of breathlessness with hers, she received her father's call at 11 pm. "It's all convoluted. The hospitals are permitted to admit only those patients who arrive in government ambulances and there is a shortage of government ambulances. I interacted with the po-

lice commissioner and he says he can do nothing. I am helpless. At the moment, everyone is. I don't know what more I can do for mamma. A good Samaritan has generously offered the spare oxygen cylinder reserved for his mother. So, she has the external oxygen support for now, but I don't know if she will make it to the hospital if the ambulance doesn't arrive in another six hours."

This was an earth-shattering phone call. She called her friends again and briefed them about her situation. At midnight they all gathered in the hostel courtyard, fondly named by students as Gossip Circle. They were all busy dialing A for Ambulance. Finally, it was Debbie's call that worked wonders for Seema. After 12 hours, a government ambulance was finally available.

Seema promptly called her father that the ambulance was on its way to take them to the hospital. Her father was relieved to know this. But his struggle didn't end there. The ambulance personnel knew the entire building was in the clutch of the life-threatening virus. They were not ready to climb the stairs and get the breathless COVID-19 positive middle-aged couple. So, they asked them to come downstairs by themselves. The moment Seema's father removed her mother's mask to take her downstairs, her head started buzzing and she gave him a swivel-eyed panicky smile, as if she was bidding him goodbye already. He quickly lifted her and descended three flights of stairs. He was really there for her all his life, all her life, in sickness and in health. In a matter of minutes, they were inside the ambulance and she was back

on external oxygen support. He was not, yet, the one who needed it.

All the city hospitals were packed owing to the surge in COVID-19 infections. There was just one government hospital that had 1200 beds for COVID-19 positive patients. The hospital was 30 kms away from home. The couple held each other's hands. Perhaps, they could see what was coming next. She asked him to come closer and whispered, "I had a great life with you. I am happy I decided to marry you." He tried to masquerade his fears and tears.

When they reached the hospital parking and realised that dying at home peacefully would have been a better option. More than a hundred ambulances had convened on the parking lot, and to the family, residing on the ninth floor of the staff quarters, they all appeared like toy trains (emitting blue and red lights) arranged in concentric circles. Seema's parents' ambulance was in the third circle. It took them three hours to get to the reception area, wherein there was no one to receive them except the cold glass desk. He lifted his wife in his arms and placed her on the stretcher. He was traumatized and exhausted. She pulled him to her and mumbled in raspy voice, "You, too, are infected with the virus. You, too, have the fever and cough. Don't overexert yourself." He kissed her sweaty forehead and held his breath and hopes.

Fortunately, a junior nurse quickly escorted them to the general ward. He was shocked to see every bed occupied. The worse was to imagine tak-

ing his breathless wife through the crevices, the cleft left by the ocean of the bodies lying on the floor. He saw two male nurses removing a body from a bed, so he quickly placed his wife there. The senior nurse who observed Seema's father's movements from a distance shouted at him, "Why should we give this bed to your dying wife?" He begged her with teary eyes, "Please! This is an emergency." The nurse was used to seeing death all around her. Seema's mother's case was just another brick in the wall. "Look Mr., all cases are emergency cases. What do I get if I assign this bed to your wife?" Seema's father was shocked and annoyed to see healthcare professionals take undue advantage of a patient's condition. He fished out a couple of grands and handed it over to the nurse. Feeling the warmth of the crispy, pink notes, the senior nurse was inebriated with happy greed. She said, "It seems she needs to be admitted to the ICU. I will quickly get the doctor for her. In the meantime, you must remove her gold bangles and diamond wedding ring. She doesn't need them there."

His hands shivered when he touched her bangles and wedding ring. The senior nurse could see him struggle. "Let me help you!" She removed the jewelry as if she were a salesman at a jewelry showroom asking for the ornaments to polish them. He could not bear the sight of the marital signs being taken from his wife. This signalled an augury for him. They were still holding each other's hands. A junior physician soon arrived at the scene and took Seema's mother's temperature and oxygen level. She called the ICU control room team and com-

manded the volunteers to escort the patient to the ICU. “Sorry Sir, you won’t be allowed to go with her.” Seema’s father looked at the anxious junior physician, who was filling out a form at lightning speed, and then at his wife. As the stretcher was being pushed towards the elevator, they continued to hold each other’s hands. The senior nurse applied all her strength to unclasp their interlaced, shivering, moist fingers. He felt as if the nurse was truncating their wedlock. The mouth of the elevators soon swallowed her and the team of ICU volunteers. That was the last he saw of her.

He called Seema and briefed her about everything, pretending to sound hopeful and confident of his wife’s return. He called the COVID-19 service cab and took one last look at the hospital building trying to take deep breaths before hopping in and placing the online instructions for his destination. Being a long-distance ride, the cab service offered him free headphones to listen to or watch songs, video clips, etc. He connected the headphones to his phone and watched all the videos of his wife singing and dancing at festivals. “She was an artist, my wife. The best at interior design, singing, dancing, cooking, and making me laugh.” The driver looked in his rear-view mirror and smiled at Seema’s father, “I am sorry Sir. I hope she rests in peace.” He was annoyed at listening to the driver’s caring response: “What do you mean “rest in peace?” She is alive. In the ICU battling COVID-19. But ALIVE!”

The driver was scared to see Seema’s father’s reaction, “I am sorry if I have offended you but you

just said that your wife was a great artist. So, I assumed. ...” Seema’s father didn’t realise he was already speaking of her in the past tense and sense.

He reached home, unlocked the door, and poured his heart out on the pillow where his wife’s head had previously rested. That noon he skipped lunch. Instead of pulling up their blanket, he wrapped himself with all her shawls, trying to embrace her aroma, her warmth, her love, her care, HER (if possible)! It was in his sleep, that he started feeling the discomfort. He walked to the kitchen to drink water, but he couldn’t swallow it. So, he called Seema, “Book an ambulance for me. I think I, too, need to be hospitalised.”

Seema dropped her mobile phone unable to believe what her father had just said. “Yes, daddy. Don’t worry.” This time she didn’t call her friends. She booked a private ambulance to take her father to her uncle’s clinic that had recently converted into a COVID-19 facility with basic amenities. She called her uncle and briefed him about her father’s condition. He assured Seema that her father had received a first dose of vaccine, so most probably his condition wouldn’t worsen like her mother’s.

The ambulance, she had booked for her father, didn’t have an oxygen mask. So, they stopped on their way to the hospital to get one. Once Seema’s father was admitted at her uncle’s hospital, she was somewhat relieved to know that her mother and father were receiving medical care. She felt helpless, but even she knew she could have done nothing more than what had been done.

For the next nine days, she kept receiving messages from her parents, which were mostly about their health updates. Her father would write very short messages; however, her mother's messages were a linguistic potpourri. She would mix the scripts of English, Gujarati, and Marathi and type long messages. She would send Seema photographs of her cardiogram and oximeter every alternate day. She would call junior physicians and ask them to speak on a video call during the less busy hours. The interactions with her parents made Seema hopeful of their speedy return home.

On the ninth day her father was discharged from his hospital. When Seema and her father texted her mother about his release she replied, "J now I can sleep happily." This message made Seema queasy. She felt suffocated in her hostel room, so she went to the campus grocery store to buy mineral water.

Her father was home but didn't quite feel it. Four hours later the hospital authorities informed him: "I am sorry. Your wife has passed." He kept staring at the rotating blades of the fan, reminiscing their anniversary celebrations, Seema's first birthday, their wedding day, the day when he first met her ... The cyclic movements of the fan brought him closer to the vortex of whirling memories.

About the Author

Swati Joshi is pursuing her PhD in Medical Humanities at the Indian Institute of Technology Gandhinagar. She was working as a Lecturer of English Language and Literature at St. Xavier's College, Ahmedabad, before starting her doctoral studies. Email: swati.joshi@iitgn.ac.in



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Against a Wen: An Anglo-Saxon Charm

Anonymous

Translated by Maryann Corbett

Wen, wen, squat as a hen
here I forbid you to build or bide.
North must you go to a town that's near
Where you've a brother, wretch that you are.

He'll lay for you a leaf at your head.
Under foot of wolf, under wing of eagle
or its sharp talon, ever may you shrivel.
Crumble away like coal on the hearth.
Dwindle down like a pat of dung

And be withered up like a puddle of water.
Become as little as a linseed grain
and less even than an earwig's hipbone.
Now grow so narrow you turn to nothing.

Original text

Þenne, Þenne, þenichienne,
her ne scealt þu timbrien, ne nenne tun habben,
ac þu scealt norþ eonene to þan nihgan berhge,
þer þu hauest, ermig, enne broþer.

He þe sceal legge leaf et heafde.
Under fot polues, under ueþer earnes,
under earnes clea, a þu geþeornie.
Clinge þu alsþa col on heorþe,
scing þu alsþa scerne apage,

and þeorne alsþa peter on anbre.
Spa litel þu geþurþe alsþa linsetcorn,
and miccli lesse alsþa anes handþurmes huþeban,
and alsþa litel þu geþurþe þet þu napiht geþurþe.

This anonymous metrical spell, inserted in a twelfth-century hand in the tenth-century British Library MS Royal 4A xiv, testifies that trust in pagan medical magic coexisted for a long time with Christian faith in early England. Twelve such charms in meter survive in various Old English manuscripts, often accompanied by instructions to use certain herbs, prayers, and rituals.

About the Translator

Maryann Corbett holds a doctorate in English language and literature from the University of Minnesota. She is the author of five books of poetry, most recently *In Code* from Able Muse Press. Her work has won the Willis Barnstone Translation Prize and the Richard Wilbur Award. Her poems appear in journals on both sides of the Atlantic and on the web pages of the Poetry Foundation and American Life in Poetry. Email: maryann@corbettdigital.net



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'Til Death Do Us Part
The Long Goodbye

Paul Rousseau

Robert has dementia. His wife Barbara provides his care, alone. He is eighty-six, she is eighty-three. They have no children, and all of their friends are dead or dying. She has no one to help her, other than a nurse's aide who comes every three days to bathe and groom Robert. I sit at the kitchen table as she prepares breakfast. Robert perches on the edge of his chair, body bent, hands slicing the air. She places a plate in front of him. "Who are you?" he bellows.

She caresses his arm. "I'm your wife Barbara; we've been married sixty-two years." A glint of tears appears in her eyes. She leans over to kiss his forehead; he grabs her arm and squeezes. She is unable to pry his fingers loose. I rush to her side to help. He clenches his hand into a fist and swings at my head. I dodge the punch and tumble to the floor. He glares at me, then releases Barbara's arm. She scrambles to my side, winded and pale-faced. She begins to cry; I cradle her shoulders. "I'll be fine," she sobs. "It just gets to me sometimes. He doesn't mean to hurt me."

Robert pivots toward me. “Are you the foreman?” I inform him I am his physician. He scrunches his brow. “I’m a forklift operator, aren’t I?” Barbara shifts to his side and reminds him he is retired. He sits, quite for a moment, then flails his arms in rage. “Where’s my goddamn beer?” He pounds the table, over and over. He has lost twenty pounds over the past year, but he is still brawny.

Barbara fetches a cup of coffee, blows a cool breath, and whispers, “He thinks this is beer.” She is a wisp of a woman, small and slight. Nevertheless, she continues to care for Robert, despite the mental and physical grind. I address nursing home placement, as I do each visit. Predictably, she declines. “A nursing home is a last resort. I can still care for him at home.”

“I think it’s time,” I implore. “His behavior is increasingly violent. I worry about your safety. I worry about his safety.”

She glances out the window, her eyes pinched narrow. “I took a wedding vow. I know it doesn’t mean much nowadays, but it does to me. I will continue as I am.” She grieves and she prostrates, yet she persists. She is of the generation that honours their vows, regardless of the situation.

Robert cocks his head like a bird listening for a worm. “Where’s the motor oil? I need the motor oil.”

Barbara plops into a chair and exhales a tired breath. “We’ll get the oil later, honey.” She ties a bib around his neck and portions bacon and eggs into small pieces. He takes only a few bites; she does not eat. I attempt to make conversation, but

she remains silent, nodding when appropriate. She is discomfited by the suggestion of a nursing home. I apologize if I slighted her. She half-smiles, then stands, anchors Robert in his wheelchair, and pushes him into the living room. She leads me to the door and bids a brief farewell. “Thank you for coming. I appreciate your concern and time.” Her words are sincere, her tone dismissive. I step onto the porch as the door closes. I glimpse in the window; she has collapsed on the couch, a pile of errant hair on her face. My shoulders slump. Letting go is hard.

About the Author

Paul Rousseau (he/him/his) is a semi-retired physician and writer published in sundry medical and literary journals.
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Volume 16
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**The Worried Well / Surgery /
Body Sounds at Night**

John Hart

The Worried Well

We are the worried well, whom illness will
Make prophets of, well before we die.

The arcs are several and slow.
The gains are laughable, the debits grow
And that great debt that will engross us all
Is being compounded yearly.

From now on we go on by letting go;
Not eagerly and no more than we must
But all the auscultations tell us so.

Now begins the fight in the stairwell: at every mossy turn
Some faculty or weapon clatters down
Some shimmer is ablated from the skin.
We go on by subtraction, from now on.

(Within the body's wiring did you dream
There was a spirit soldered crudely in?)

And suffering will leave us last of all,
The company
That ends and ables us,
The system that we are.

Surgery

Pry out the ribs and isolate the heart.
Possess it as a lamplit, hollow thing
Its machinations halted for an hour
And open to the gloved correcting hand.

Oh we are jackbuilt, built to breed and die.
What if we did not breed and will not die?
What if we all continue, stiffening?
Our wiring shoddy like a cottage's,
The tubes that we are built of, narrowing?

The body with its filters and its bags—
The flopping heart, the tramp and go of tide,
The hormones sneaking,
Ceaseless, sidelong, telling us the time;
The brain, that unrepeatable and golden braid
That in the skull is coiled . . .

And the self: strange compromise and shifting swarm
Of attitudes, tiny ignoble bargains,
Slant observations, and the sheer
Warm-bloodedness of things.

Have some affection for the excellent animal,
The edible portions slowly going bad,
The senses dimly leaping,
The remarkable meadow of sleep.

The risky organs continue to pump and bleed.

Body Sounds at Night

The noises that escape from sleep:
The processes imperfectly concealed
Of private factory and battlefield,
Great bellows, pumps where the dark liquids drive.
The night shift over, we return alive
And unembarrassed: we slept through it all.

About the Poet

John Hart is a poet living in San Rafael, California. First published in the Pitt Poetry Series, he edits the all-poetry journal Blue Unicorn.
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My Memory Returned to Me

Teri Szűcs

Three years ago, after a decade-long series of illnesses, my mother developed symptoms of dementia. They came with devastating severity, and we were not prepared for them. She almost completely lost her connection with the world of objects and with the everyday practices and procedures of life. That kind of knowledge evaporated out of her, and suddenly she had no answers to any questions. She was only sure of one thing: she knew who the people beside her were. She knew that she had her husband, my father; her daughter, me; and Maja, my partner.

Since then, we have been observing together what memory and knowledge can mean when it is no longer about growing and developing but about the shedding of layers and finding what foundations still remain. But of course, we don't know anything about these amazingly rich and complex structures.

We are still in my mother's most stable and—for now—unshakable memory, but every time we meet, even when we spend more time with each other, again and again I have to reassure her: you are my daughter, she says. Yes, and you are my

mother. Maybe it makes her happy to say this, happy that she still fully remembers one of the most important things about life, and she is happy that we can communicate with each other. It makes me happy, too.

The most incomprehensible complexity of memory presented itself to me when, for a few nights, her memory returned. Suddenly, in the dark of night, she began to remember and to speak. She needs twenty-four hour supervision, day and night, and I was next to her at that moment, listening, asking. Everything came back: who she was, how she lived, what she did and when, how she had felt, and what her plans had been. Her life story was not disfigured by self-censorship or self-blame, nor was it infiltrated by neurotic revision. With brilliant clarity, she remembered.

Later, I learned that many people who live with dementia experience something similar, and lucidity always comes at night. I don't know why—how the blood flows or how the inactive parts of the brain become reanimated—but what is clear is that in these tracts of time, when I thought that her memory was lost, the truth was that it still existed; it had only been paused. And then, for a few nights, it returned.

She was so happy to have her memories back. The timbre of her voice, the pace of her sentences all came back. It's because of her that I know that remembering is joy. I've always known that it is important, but that it is joy, a happiness tied to the very core of existence, that I know because of her.

“Ko mne vernulas pamyat.” “My Memory Returned to Me.” This will be the title of our book, she says. She chose this. And I must write about her, about her sickness, her life, and about all of us, she says. It’s important to her; she still remembers that she used to love books, and that I love them, too. She knows that it will give us both a purpose during this time. And so we cling to it, both of us.

My mother learns what is truly important: that her father’s grave has been found, that her best friend has had an accident, that her nephew’s son was born. She has learned to say that if her own mother were still alive, then she would be a great-grandmother by now. If we would tell her about important events, she would memorize most of them. But which verb should I use? It’s not right to say that she “memorizes.” We toss that word around, as if we expect her brain to be able to memorize. But it’s also not right to say that these things become “etched into her mind” because it’s not possible to etch something into that sporadically-functioning instrument from which anything and anyone can spill out at any given moment. Truly, she is learning these new pieces of information. She is working. And I am working with her, too. I am learning how to pass along information; I am teaching her new essential knowledge. Again and again I explain things, contextualizing with emotion. I repeat every piece of information until she herself begins repeating it. So that the information becomes ingrained, I’ll ask her it about several times over until we can be certain that she has mastered her own knowledge and learned these memories.

What else has she learned? That it's not okay to touch her stool. That she should not chew her medicine before swallowing it. In both situations, she had to fight her strongest instinctual compulsions. My father taught her both of these things. I don't know how he did it, but he didn't back down, and he didn't give up.

My mother learned, in her own manner of learning, how to navigate a completely new and complicated space: a new house and a new garden after she and my father moved. She quickly found her own places—her room, her bed, her chair at the dining table—in this new space. She could adapt, and she could delineate what was hers.

That kind of knowledge is the strongest because it is automatic: it becomes a feature of the body. But then again, what kind of knowledge isn't a thing of the body? It is not a retained knowledge; my mother can no longer retain information. What remains is the kind of knowledge that has permeated the body to such an extent that the knowledge, itself, becomes movement. It manifests in her compulsive repetitions, in the unconscious movement of her hands, and in the way her legs simply take her somewhere. Just as she knows what to do with a spoon and a fork, her hand and her mouth know, too.

Like many with dementia, she learns quickly what it is that she does not have to do and what her aides do instead. She herds us persistently. She would hand over all responsibilities for getting dressed just so that she wouldn't have to put on anything by herself. She would hand us every task

that becomes complicated and to which she can no longer adapt her movements. She hands over the spoon when it hits the bottom of the plate; that last dip is already insurmountable. We take the spoon, but we cling, resolutely and desperately, to her every shred of knowledge and to every functioning reflex. And she does, too. She does not want to give up on knowing and remembering, and she does not want to feel the all-pervading disappointment of becoming helpless.

A person living with dementia is like a poet. They have to be like poets, in the way they twist their words. Only now am I able to write about this, two and half years after my mother was diagnosed with moderately-severe stage dementia. Since then, we have all found a common language. But when dementia, with its wrung-out words, suddenly came crashing down on us like an avalanche, I wrote this about my mother:

She's forgotten the names of things; she's forgotten the times of day. But she wants to talk, to communicate, to be in constant contact. Over and over, she repeats the sentences that she forms on the nights when her memory returned to her, and she is stuck with them. Now, these have become her new memories: twenty sentences. The other repeated sentences are about her anxieties. If something is black, if it is afternoon now, if there is water, if there is toilet paper, and when are we eating already. She feels as though she cannot answer the question:

“why did you do this?” And we also repeat ourselves. Every day, two hundred times a day, we ask: Why did you pour out the water? Why didn’t you shut off the faucet? Why didn’t you put on your slippers? She feels as though there is a disconnect between the action and the question—that’s all. Even if she forgets her present embarrassment, the profound frustration she feels at herself is gathering inside her. So, too, is the anxiety. Sometimes she rebels, and she becomes sharply defiant. The only thing she repeats in Hungarian is *vállalom*. I admit it. Her second language, the one she learned as a wife and a parent—Hungarian—she has forgotten.

Now, she is like a poet, and once again a bilingual one. My father, who never let her lose her language skills, was right about this, too. Meeting the Hungarian-speaking helpers reawakened the language in my mother when we had thought that it was almost completely lost. The encounters stimulated her. She has difficulty recognizing when she is using Russian or Hungarian, but for the most part, she still chooses her words correctly.

She never spoke Hungarian flawlessly, but beyond accent and literal translations, her style was unmistakable. Already, then, she was playing with the language.

For us, Russian used to be the language of our home, and all three of us spoke it. My father flawlessly, and I with mistakes and falteringly, but

Russian, too, was mine. Meanwhile, Hungarian became the substance of and vehicle for my thoughts. With Maja, I speak English, though with mixed feelings. Would this be an impediment to intimacy? We hoped to compose our own private language. Instead, multilingualism is now our norm with English, Russian, and also Slovenian. Hungarian words flying through the air, with a few Serbian ones, too. And we know a little German. We speak in a carnival patchwork.

Maybe because by now we all have more or less found a common language with my mother, which she primarily creates and shapes; or maybe we've found common ground because, as she says, she got "used to this illness — but I hear her differently. I pay attention to how she switches words, when in place of an important word she cannot recall, she offers another. These changes can extend across entire turns of phrase and sentences. It's as if a strong and indelible word has dragged another into its forcefield because one resembles the other (perhaps in function or in sound). Nowadays, she feels as though her walking stick is necessary for every step, which is why a fork or a spoon will sometimes become a stick, too: "palka." Sometimes the word with which she replaces the other resembles its tone, its mood. For a time, she liked to take a molecule of perfume out of an old bottle, one of the last drops in the vial, and she would call it: "igrayu na skripke." Playing the violin. When I first heard this, I didn't understand. She had never been able to play the violin, but I was certain that the connection between the two would become clear. Maybe it was in the so-

phistication of using perfume. Neither in Hungarian nor Russian is there a good verb to describe this.

Maybe we've learned to hear her distress in the accumulating repetitions, and so we try to alleviate it. Maybe we've also learned how to repeat things well, more slowly and more loudly, if necessary, so that she can understand what we are saying. Our language has also evolved; we use simpler words, and we rely on figurative meaning and abstract metaphor less and less. Maybe we already better understand that we have to make eye contact when speaking—she has to see us. Conversation is situational, and we have to be present for her.

I've also adopted some of her new turns of phrase. For example, anything good is “delicious.” In Russian, as in Hungarian, that adjective applies to everything from tastes to smells. And it didn't stop there for her: “Mnye eto vkusno.” “It's delicious to me.” We say this about whatever brings us happiness and we enjoy. In Hungarian, too. In my mother's manner of speaking, it becomes *FI-nom*; the stress is on the first syllable, and the second collapses into the first, almost sliding away.

She had to relearn how to wash her hands, and even now, she is not always successful in completing the complicated series of steps: turn on the faucet, soap, rinse with water, turn off the faucet, dry with a towel. But sometimes, when she gets to the end of the sequence, she says triumphantly: “ya vit'erla kazhdiy pal'chik!” I dried off every little finger! And I say this to her, too, and we laugh. There is nothing better than this.

I can't describe how my mother speaks Russian. All I can say is that as it was before her illness, now too, her own style is evident in every word choice. But it's possible that the reason I describe it this way is because she is the Russian-speaker to whom I am closest. And because it's my mother's tongue, so it is my mother-tongue. When dementia suddenly came crashing down on us like an avalanche, for a long time after the jolt, we lived with the certainty of her impending death. At the time, I wrote:

How easily I talk about her death, but what will happen to me once she dies? With her will also die the soft consonants, the *nezhnost'*, the Russian, where "tenderness" is said so that three times your tongue touches your palate. I fear that what remains after will be rigid and prescriptive, and the language will run dry. I don't even want to finish writing this sentence, just as I do not want her to die.

About the Author

Teri Szűcs is a literary historian, critic and writer. Over the past decade she has been involved in homecare, and in the last few years, in dementia care. She has started her blog titled "Visszatért hozzám az emlékezet" — "My Memory Returned to Me" to collect and recount the experiences and adventures of caring for her mother who is living with dementia. Email: szucs.teri1@gmail.com

About the Translator

Alina Bessenyei Williams is a Hungarian-English translator and PhD student at the Religious Studies Department of Indiana University Bloomington. Email: williali@iu.edu



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**Who Knew Hemorrhoids Could Be Profound?
A Reflection on LGBTQ Healthcare
at the U.S.-Mexican Border**

Elena Hill, MD, MPH

For three years, I have worked as a physician with the Refugee Health Alliance, a non-governmental organization that provides healthcare to patients seeking asylum at the U.S.-Mexican border. The clinic serves women, children, families, and a considerable number of LGBTQ individuals. One such patient was Miss Lady, a transgendered woman from Cuba. In order to escape daily physical and sexual abuse in her own country, she had flown from Cuba to Guatemala, and then taken a series of buses to cross the border into Mexico, at which point she travelled north toward the U.S. border. All in all, the journey had taken her 14 months.

She was 5 feet and 2 inches tall, wore a padded bra over her broad flat chest, and always had brilliantly colored nail polish. She had terrible teeth from years without access to dental care, but the sweetest smile nonetheless. I wanted to ask more about her journey to Mexico which, like those of so many other refugees, had been harrowing.

She was not to be distracted, however. She looked at me desperately across the exam table.

“I’m very concerned about my problem,” she said. “When I have intercourse, my partners think I have an infection, and I can’t convince them otherwise.”

I did a quick exam and it was immediately clear that she had external hemorrhoids. I was happy to reassure her that hemorrhoids are benign, albeit annoying. She said she knew that—another doctor had already told her as much. He had also told her there was a surgery she could undergo to have them removed. “Please help me,” she pleaded. “I need them gone.”

I hesitated. Conducting such a procedure in this setting was somewhat unorthodox, as well as a little risky. Our clinic consists of three exam rooms, none of which were the most sterile of environments. What if she got an infection? What about pain control? She would probably be quite tender for a week or two after the procedure. Moreover, I was a family medicine doctor, and while I removed skin tags all the time, I wasn’t a surgeon. The anus is very vascular. What if she bled a lot? Would she be able to recover from the operation while living in a shelter for transgendered individuals? Would her new home be sanitary enough to keep her wound clean?

In medicine, we carefully consider the risks and benefits of each thing we do to a patient’s body. If I decided to proceed, I could cause her significant bleeding and pain. I could also leave her cosmetically worse off if I ended up with redundant scar tissue. Was this really the right thing to do?

“Doctora, listen,” she said. “I came all the way from Cuba. I have been beat up, abused, and

raped more times than I can count. Now this. Now I can't even be with a partner without them thinking I have some kind of disease. I want to feel comfortable when I am naked. I want to feel comfortable in my own skin."

Who would have thought that hemorrhoids could be such a profound problem? For me, as a doctor, they were simply an annoyance. For her, they represented much more. Having already endured a lifetime in the wrong body, she experienced this as just another thing that was "wrong" about her physical form, another aspect of her being that brought her shame instead of comfort. I couldn't give her the gender reaffirming surgery that she certainly wanted and deserved, but I could fix this one small thing for her.

In spite of my hesitancy, we decided to do it. The room was incredibly hot. Sweat dripped down my face. I asked her to lie down on the table. I anesthetized around her anus, then used clamps to cut off as much blood supply as possible to the tissue. Then, extremely carefully and holding my breath, I began to cut away the redundant tissue. I went slowly, taking care to ask her every few minutes if she was having any pain or discomfort. I wanted to make sure this experience would be as respectful to her as possible. After a lifetime of trauma, she deserved that much.

The procedure itself went smoothly. Miss Lady returned a few days later for a wound check and was pleased with how she was healing. "I feel so much more confident now with my partner. I know it's a small change, but to me it

makes all the difference in how confident I feel about my body.”

As humans, we cannot disconnect our physical form from our mental health. One informs the other. This much I have learned from her story. “Who knew a butthole could represent so much?” I asked her, maybe a bit unprofessionally.

In spite of ourselves, we giggled.

About the Author

Elena Hill, MD, MPH, is a family medicine physician who completed her training at Boston Medical Center and is now practicing in the Bronx, NY. Her clinical interests include underserved healthcare, immigrant healthcare, and chronic pain. She can be reached at EHill3047@gmail.com



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Friday Thirteenth

Nick Fordham

Dark winter's night.
I saw your blood before you arrived;
nasty cells, divulging
your Diagnosis.

You arrived. Sick,
yet smiling. Conversive.
Confident. Fiancée
hiding behind
your Courage.
Support vital
during difficult months.
I told you.

I told you.
Telling is routine,
yet novel. I have done this
a Lot.
Your resolve
steels me.
It Affects me.

I wish we could
have helped.
Helped more.
If only Chemotherapy
had worked.
I wish we could have
Cured you.

I will miss
your patient
nature, battling
Defiance.
We have become
Closer than
perhaps we
should have.

A year further, I
naively resolve
never to Forget.

About the Poet

Nick Fordham is a paediatric doctor who enjoys writing in his spare time. He aspires to be a writer who practises medicine in sparer time.
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Teacup of Roses

Christine Kannapel

My mother told me not to pick flowers
from the gardens of strangers. I never did,
but I couldn't resist the needles of fir
trees—the sap and watery notes
of a forest in the neighborhood park,
where my mother caught me climbing up
to the sky and embracing the sticky trunk.
Today I bring my mother a teacup
of roses from a stranger's garden. She cries,
smiles—sleep, or something, in her eyes.
I sit by her on her bed
and watch the rise of her gone breasts.
I want her to see the flowers and recall
how she saw me once, needles, furs.

About the Poet

Christine Kannapel received an M.A. in Creative Writing from University College Cork and a B.A. in English from the University of Utah. She currently resides in Utah. Email: christinekannapel@gmail.com



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¡Fanon!

C.A. Rivera

Infectious colonialism persists,
genetically modified
and given the name—
The New Colonialism.

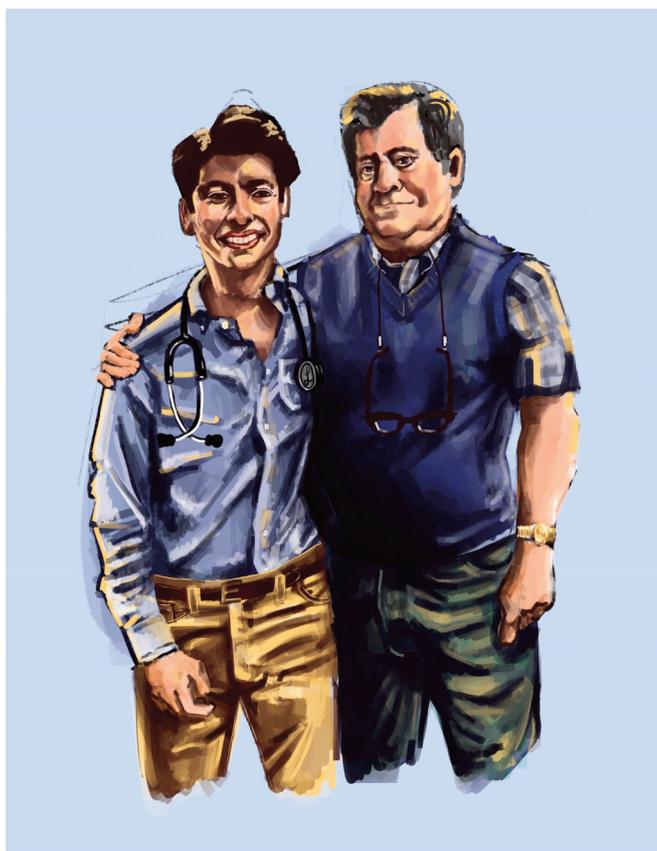
And, since
i was born a failed poet,
i must die a failed poet, a failed poet,
in the old sense
at least—
it is
a New War,
a new imperialism,
a new industrialism—The new virus
has found its host. One world,
a new resistance,
a new peace,
a new movement,
a new struggle,
a new born
poet—
genetically modified as well.

About the Poet

C.A. Rivera is a physician-writer based in Los Angeles. His writing has appeared or is forthcoming in *Garfield Lake Review*, *Pulse*, *SFWP Quarterly*, and the *Signs of life Anthology*. He is currently working on a novella. Email: carivera@berkeley.edu

Mentor / Rounds

Noah Weinstein



Mentor

This “painting” was done on an iPad and is of Noah Weinstein and his father’s mentor, who he has shadowed and continues to shadow.



“Rounds”

This second drawing is of Noah’s father, a Doctor. The drawing is cartoonish, but realistic, down to the ink stains on his every oxford and his ever-present ipods that are in place while he is making his rounds.

About the Artist

Noah Weinstein is a Senior at the University of Georgia, majoring in History and minoring in Biology. While his plan is to attend medical school to become a physician, he is also an artist.
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#isolationfashion

Casey Hinton & Layne Hinton

During the first Covid lockdown of 2020, Casey and Layne Hinton, Toronto artists and sisters, created a participatory art project to break up the monotony of pandemic isolation. They staged elaborate dress-up photo shoots shared via Instagram, using materials found within their living space and following weekly styling prompts, including Tiger King and Retro Futurism. Viewers were invited to participate; they offered themes and joined in by creating and sharing their own outlandish and innovative outfits. The result was an unexpected collaboration in an otherwise isolated time.



Theme announcement post for 'Retro Futurism' shared during early lockdown in April 2020.



Layne wearing an air duct hood and Casey with a megaphone stun-gun, stuck inside in Toronto.



laynemarley

Mom (@hardie.jennifer)
is wearing:
fascinator - sculpture
by Chris Hinton
silver rain coat - Ikea
black leggings and t-
neck - closet
bag - domino case
sunglasses - blue-
blockers and foil tape
necklace#1- recycled pop
bottles, necklace#2 by
@coreymoranis
boots - back of the
closet and foil tape



Submission from Jennifer Hardie,
sent from rural Ontario.



casehinton

And @jennie_suddick and @marilyn mansion killed it again. Check out their entire elaborate photoshoot for retro futurism #isolationfashion



@jennie_suddick

Submission from Jennie Suddick and Cam Lee, locked down together in Toronto's West End.



Submission from Christine Merrigan,
on Canada's East Coast.

About the Artists

Layne Hinton, an artist and curator, and Casey Hinton, a designer and strategist, often work at the intersection of art, culture and city-building. Email: lh@laynehinton.com



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A Refrain for Jane Doe

Ashley J. Choe

Her skin steals the heat from mine, and I
surrender it willingly. My hands pump
stale blood from her heart by way of her
chest with each staccato of her ribs before it
sucks back into its chambers.

Cacophony ensues. Then we listen in rest for the
harmony of a regular rhythm, breaths held.

Stay cool and calm. Don't show weakness.

But it never comes together in major chord.

Our twenty-minute *goodbye* has

my sweat and her blood
oozing uselessly to the floor. It
drips down and pools with my
emotions. They don't belong.

How could I have saved her? I think

about how I will tell her family
her heart is wholly in asystole, but theirs is
beating while broken.

They want to see your humanity.

I reach out for their hands and end up
collecting their heat—incidental payment for the
twenty-minute recital. Sans encore.

Cold hands, warm heart, I'm told.

Unless the hands are cold because the heart is.

“She was fine yesterday,” they reason. But the sun

sets and resets, a metronome, and sometimes that
step toward stepping down becomes
a free-falling trill without reason.

They just want answers.

My fingers played through her whole range of
skin temperatures with practiced memory, but her name is
barely familiar. My intimacy was with her
problems – the plan. And while I try
to pluck her name from
the puddle on the floor, I hear their hearts
belt out a cry. But my eyes cannot stand
to look because these hearts do not need
my help to strum their beat.

She was more than just a patient.

Discordant echoes follow me home. They become
mine—a crescendo waiting to be released
to nothing.

Cardiac arrest.

And there ends her refrain. But the
reverberations miss their cue
to cease.

You cannot share her life story.

So, instead, I whisper anonymous death by
measures – confining each complete minuet
to digest its theory. *Strong, but humanistic.*
Fed pieces until the whole is
lost. Nameless because her name sticks
to my lips while the melody escapes. Instead I
bleed my own name in debt onto each
death certificate.
Silently scripting their notes
to sound until I have given
my whole self away.

Dr. Jane Doe.

About the Poet

Ashley J. Choe is a combined Adult and Pediatric Critical Care fellow at the University of Rochester. She completed Med-Peds residency at East Carolina University. Email: Ashley_Choe@URMC.Rochester.edu



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Primum Non Nocere

JP Sutherland

Gabriela Sabatini was not only one of the top-tier tennis players of the 1990s, but she was blessed with a natural beauty that drew cameras to her like butterflies to wild bergamot. It was no surprise that her fame spread far beyond the tennis court to make her, for a while, one of the most recognized women in the world.

What was more surprising was hearing that she had secretly married one of my patients, a young man called Jacob, who suffered from schizophrenia. Since my informant was Jacob himself, I had the opportunity to comment.

“Surely not?” was my initial, and understandable, reaction.

“Yep,” he smiled. “Gabriela Sabatini.”

“The tennis star?”

“Yep. Want to see a picture?”

“Sure.” I was grateful for a moment to gather my thoughts, rather than trailing behind him in the unexpected direction that this interview was taking.

As he reached for his wallet, I took a fresh look at him. Tall and thin, Jacob had the characteristic poor grooming of someone afflicted with severe mental illness. His hair hadn’t seen a comb in some time, and his shirt could have used an iron-

ing, and probably a wash as well. I had first met him when he turned eighteen, and a child psychiatrist colleague had handed him over into my care. Jacob's schizophrenia had begun to manifest itself while he was still in high school, starting its slow and relentless erosion of the path he had wanted to take in life. Since I had known him, things had only worsened, as one treatment after another had failed to help. Now, at just twenty-three, he had already endured enough hospitalizations to add up to a couple of years of his short life spent within the limiting confines of a psychiatry ward.

Jacob's usual expression was puzzled and serious, as is normal for people who are struggling to understand their extraordinary experiences of delusions. But now it changed. As he brought out a magazine picture of Gabriela to show me, he beamed. I was struck by the thought that he looked even happier than she did.

"There," he said, pushing the photograph towards me. "Gabriela Sabatini. I told you."

"You certainly did. How did you two connect?"

He frowned.

"It's complicated."

"Did you go abroad to meet her, or did she come here?"

"It's not like that, but we are married."

Now he reverted to the Jacob I knew better, perplexed and unhappy at his inability to fully understand his reality and how it didn't align with anyone else's understanding of the world. He told me that he and Gabriela hadn't met, at least not according to the normal meaning of the word, nor

did he hear her talking to him, as I thought he would in a hallucinatory fashion. But he knew, and knew with the fixed certainty of a delusion, that she was with him, and he felt great comfort from that.

I decided that I didn't need to challenge his belief any further, since the diagnosis was already clear. In addition, we never advise anyone to endorse a psychotic patient's delusions, and so I ended our session with a comment that I hoped was sufficiently empathetic without actually agreeing with him.

"Gabriela Sabatini," I smiled, "who would have thought it?"

"I know." He smiled back. "I'm married!"

* * *

Delusions come in various forms, and if people think about psychosis at all, then they likely imagine someone with either a paranoid delusion, believing that they are being followed and threatened, or having a grandiose delusion such as believing that they are a reincarnation of a famous historical figure. However, delusions are uninvited guests that wear many other coats—nihilistic, somatic, jealous and, in Jacob's case, erotomaniac.

An erotomaniac delusion is defined as the belief that one is loved by someone who is physically distant and who has shown no interest in the individual, if they are even aware of them. It's not unusual for famous people to be the object of erotomaniac attraction, and so Jacob's choice of Gabriela as his bride wasn't really so surprising. It

also fitted and offset the sad reality of his disabled life. Schizophrenia had deprived him of his ability to work, or to live alone. He was still a young man, with all the usual longings and desires, though there was now little likelihood of him ever achieving a more conventional relationship. If he was going to be delusionally married, then why should it not be to the most beautiful woman of the moment? When Freud wrote about wish-fulfillment, he was initially talking about dreams, but since he elsewhere noted the many similarities between dreams and psychosis, I have no difficulty in picturing him nodding wisely at Jacob's choice of delusion.

"Jacob, we should talk about a treatment called clozapine."

"I've heard of that," he said. "Isn't it dangerous?"

"That's what I wanted to talk about. For someone like you, who has had such bad luck with treatments so far, it represents the best chance of recovering from your delusions, and it helps about one person in three who takes it."

"What delusions?" he asked.

"Things like owning that plane that you used to talk about, or actually being someone else called Timothy," I said, deliberately referencing his older symptoms rather than further challenging him about Gabriela.

"That plane thing was just a misunderstanding, but I really am Timothy Grenville."

“We disagree about some of these things, Jacob, and that’s OK,” I added, bravely avoiding an argument. “But schizophrenia is not only giving you delusions, it is getting you hospitalized repeatedly. If we can find a treatment that works for you, then you might be able to stay out of psychiatry wards in future.”

“I’d like that. But what’s the danger?”

“Right. Clozapine was first introduced years ago. It was found to be effective for people when nothing else worked, but in about one percent of those taking it, there was a serious problem with the white blood cells.”

“How serious?”

“Serious enough that some people died.”

“I don’t want that.”

“Me neither. The drug was taken off the market, and it’s only been allowed back again if everyone taking clozapine gets a weekly blood test. This picks up the white cell problem before it causes any harm. Then clozapine would have to be stopped, but the bone marrow would recover, and the blood count would return to normal. No one has died since they brought in this new system, and a third of people recover from their delusions.”

“I don’t know.”

“Fair enough. Let me get you some pamphlets about clozapine, and then we can talk again tomorrow. And if you ask around on the unit, you may find some other patients who know the drug and have benefitted from it.”

* * *

It took a while, but he finally gave consent. His parents were strongly in favour of anything that might finally release him from his psychosis, and pressured him to agree. That made little difference to Jacob, who couldn't see why anyone should worry about his name or his marriage. However, the thought of finding a treatment that would let him step off the carousel of repeated hospitalizations was a major factor in his final decision. As well, the support of other people on the unit helped persuade him that the dangers were controllable. At that time, there were a couple of inpatients who had benefited from this complicated treatment of last resort. Although my advice to take clozapine was sound, it carried little weight compared to the recommendations of those who had walked in Jacob's shoes, carrying their own burden of illness, to which he could instinctively relate. I thanked them for their help, set up the treatment protocol, and guided Jacob successfully through the startup period. Then, before we would expect clozapine to yield any positive results, my annual holiday arrived.

"Have a good trip," said Jacob, looking as though he was forcing out the polite words, after I had explained my forthcoming absence. "What's the doctor like, the one who is taking over?"

"Dr Wong? Oh, she's nice, and she's just going to proceed in the way we've already agreed. By the time I get back, we will be able to see how the clozapine is working."

"Okay. But I'd prefer if you stayed."

I somewhat guiltily swapped the stark, close confines of the inpatient unit for the sunlit alpine

meadows of the mountains. Restored by the long views and fresh air, I only occasionally thought of work, but when I did, I found myself worrying about Jacob. Clozapine represented his last and best opportunity for even the most limited recovery, and yet he was statistically more likely to fail this treatment trial than he was to actually improve. Then, after a while spent lamenting the blind unfairness of all medical suffering, I shouldered my pack again and headed off up the trail.

* * *

My first day back at work started with a long case conference before I got to see any of my patients. As we got closer to discussing Jacob, I felt myself tensing.

“He’s done well,” said Gladys Wong. “We had no problems titrating the dose to four hundred milligrams, and his delusions are definitely fading.”

“That’s great news.”

“Yes, but you better see him before you get too pleased. I think he’s depressed.”

As soon as the meeting was over, I headed out to look for him. Jacob usually sat in the open area of the ward, ready to talk to anyone who passed, though people often stayed only briefly because he tired listeners with his delusional conversation. Today, he was nowhere to be seen.

I found him in his room, lying motionless on his bed, and staring at the ceiling.

“Hi Jacob. I’m back. How are you doing?”

Silence followed, with not even a look in my direction.

“I’ve been told that clozapine has been helpful, but I want to hear all about it from you.”

Still he lay, immobile and mute, consistent with Dr Wong’s worries about depression. And then he finally stirred, sluggishly and so painfully. I would not have thought that someone could wail quietly and slowly, yet that’s what I heard.

“I want Gabriela!”

I sat down.

“Tell me what’s up.”

“She’s gone!”

“Well, yes,” I replied clumsily, “she was a delusion, Jacob.”

“No! She was my wife!”

Realizing my error in assuming his insight, I backtracked as fast as I could.

“I’m sorry. I remember how she made you so happy. Tell me what’s changed.”

“I always knew she was there. I know she never talked, but she guided my thinking, and helped me decide things. I wasn’t alone with her.”

“And now?”

“Nothing. It’s just like it was before she came.”

I sat a while longer, hearing more of his despair, while also quietly counting up enough symptoms of depression to make the diagnosis. He agreed to take an antidepressant. While I knew that would likely help him, I was troubled that his low mood was so obviously a reaction to the loss of his delusional marriage. Would mere pharmacotherapy be enough?

* * *

“Is treating someone’s delusions ever the wrong thing to do?” I asked our morning meeting. “I’m thinking about Jacob.”

“Of course it’s not wrong,” replied Gladys. “You’ve spent years trying to help him, and now we’re finally getting somewhere with clozapine.”

“But he seems so bereft after we removed his wife, even if she was a delusion.”

“He’s just depressed. That’s not so uncommon in the aftermath of psychosis. It will get better with treatment.”

“But will it? He’s already been unresponsive to all sorts of drugs. Anyway, if the cause of his depression is more psychosocial than biological, who says it will respond to medication?”

Gladys answered by referencing the studies that had shown antidepressants helping even depressions that were an obvious reaction to external stresses. Small and determined, she was an excellent psychiatrist, but she possessed a certainty about our profession that I knew I would never share. I had read the research findings that she mentioned, but had never thought that altering brain chemistry could be a full response to life’s misfortunes, even if it did make some difference. Psychotherapy would be my treatment of choice for individuals dealing with a relationship breakdown, even if I wasn’t quite sure how to proceed with that if the absent partner wasn’t actually real.

“Anyway,” added George, our most senior and pragmatic colleague, “if he consents to the treatment, then that’s all the answer you need. If he’s

determined to have his wife back, then he'll stop his medication at the first opportunity.”

Although this completely avoided my question, I knew that he was probably right. I was still young enough in my career, though, to be shaken by the discovery of unwanted consequences to well-intentioned acts. There was no doubt that in the short term we should continue his treatment, with the added antidepressant, and allow time and therapy to help him adjust to his new reality. Knowing how to proceed, however, didn't free me from my concern that Jacob might not respond, and withdrawing Gabriela from his internal life might yet prove to be more wrong than right.

* * *

A full treatment of someone's schizophrenia often involves a period of rehabilitation after psychotic symptoms have remitted. This is especially true in someone whose illness began in their teens, such as Jacob. Adolescence is a time of great development for social skills and the practical management of life's daily requirements, so if a patient spends their formative years fighting against severe illness, then they often emerge with a very limited ability to resume a normal life and engage with the world. Rehab programs address this, and the centers are often residential, and located outside major cities. We had booked a place at one such center for Jacob when his clozapine trial began. Now that a spot had become available, there was some debate about whether he was still appropriate for treatment, since he was so depressed, but eventually the

rehab team accepted him. His delusions had continued to diminish, but there was no letup in his mood or his grieving for Gabriela. I tried to encourage him with positive expectations for the benefits that this next treatment step would bring, but nothing appeared to touch him, and he left the unit with his head bowed low and without making eye contact.

I didn't see Jacob again for many months, because rehabilitation in psychiatry is such a slow and gradual process. The high mountain meadows were now cloaked in snow, and so I took my brief respites from the city on quiet ski trails in isolated valleys. On my summer visit to the mountains, I had worried about whether Jacob would respond to clozapine, but now I was second-guessing myself about whether we should have even tried, and whether it would have been better to leave him in psychosis, with the solace of his wife, even if she was a delusion.

* * *

When we next met, as another spring unfolded and he returned to the city, I had to look twice. Jacob jumped up quickly from his chair in the waiting room and shook my hand, smiling with apparent pleasure at the reunion. Once in my office, I stood back and looked anew. Gone were the crumpled clothes of last year, that looked dirty even when just laundered. He was dressed casually, in jeans and flannel shirt, but looked tidy and well-groomed. All too often, schizophrenia announces itself in someone's appearance, but no one would

now think that this young man carried such a severe diagnosis. He noted my inspection of him.

“Looking good, eh?”

“Jacob, you really are.”

“And I feel good, too.”

“Have a seat and tell me all about it.”

“I have a job.”

“That’s wonderful.”

“It’s with “Placido the Plantman.” We look after office plants. Do you know that a cactus only needs water once a month?”

I was so pleased, since I knew of the company he was describing, and how they welcomed people with disabilities. They only offered minimum wage positions, but the pay cheque that would leave him just above the poverty line also came with the priceless benefits of a sense of purpose and belonging, things that his schizophrenia had looked set to deny him. Seeing a recovery such as Jacob’s is pure balm for psychiatrists, and keeps us all going through the day-to-day difficulties of others’ treatments, and his improvement was all the more remarkable for having come after so many treatment failures. He told me how he no longer believed in a second identity for himself, and he appeared to have recovered more than I had ever allowed myself to hope for him.

There I should have left it, but prompted by his wellness in so many domains of life, I foolishly asked about relationships. His face fell, and he shook his head. As he spoke, suddenly holding back tears, all my ethical doubts about his treatment resurfaced.

“I can’t believe Gabriela is dating someone else.”
“Donald Trump, isn’t it?”
“Yes. I miss her so much. Why did she leave me?”

About the Author

J P Sutherland is a psychiatrist, writing nonfiction to try and help demystify that most misunderstood branch of medicine. All characters are composites from different patients he has cared for over many years. Identifying details have been changed to preserve patient confidentiality, and this includes the names of all individuals, as well as the author’s. Email: drjpsuth@gmail.com



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The Different Faces of Abortion

Samantha Liu

Introduction

Abortion is a medical procedure that can be employed to save lives or as an expression of bodily autonomy. In the minds of many, however, it is an issue rife with ethical controversy. Abortion sits at the intersection of race, gender, sexuality, (dis)ability, religion, and more in medicine: women and people who can become pregnant were and now, because of the United States Supreme Court's decision to overrule *Roe v. Wade*, are once again afforded few legislative rights. The doctor/trainee/patient experience is also impacted by the controversies surrounding abortion: providers unable to provide abortions legally may try to help in other ways, and patients without the guidance of health-care providers may seek dangerous options if they feel they have no other choice.

Images of the harm involved with using physical methods of self-induced abortion like knitting needles, clothes hangers, or throwing oneself down a flight of stairs are far more visually obvious than, for example, a flower. However, the use of herbal abortifacients also involves significant risk of severe morbidity and mortality. By juxtaposing these methods, the viewer is stimulated to think of the

history of abortion and the legal, social, and medical context of abortion.

Research Methods

I utilized Google Scholar to find herbal abortifacients and physical methods of self-induced abortion using the following search terms:

- Abortion
- Abortifacient
- Herbal
- Plant
- Self-induced
- Trauma
- Morbidity
- Mortality
- Medication
- Pill

To learn more about alternative herbal medicines used as abortifacients, I read a number of articles (see References) and compiled a table of the plants mentioned in each (Table 1). I then found the scientific names of the plants (sometimes only the common name was used in the article). In an effort to distinguish historical fact from contemporary misinformation, I focused on three plant species which were recorded in multiple articles and also native to the United States/America: pennyroyal (*Mentha pulegium*), sage (*Salvia officinalis*), and black cohosh (*Actaea/Cimicifuga racemosa*). I decided to paint these three plants in a classic triptych, with the intention of the viewer being “surrounded” by the art—straight on, right, and left.

Table 1. Cimicifuga/actaea racemose

Source, Country	Common Name	Scientific Name
Ciganda & Laborde, 2003 Uruguay	Ruda	Ruta chalepensis/graveolens
	Cola de quirquincho	Lycopodium saururus
	Parsley	Petroselinum hortense/crispum
	Pennyroyal/poleo	Mentha pulegium
	Yerba de la perdiz	Margiricarpus pinnatus
	Oregano	Origanum vulgare
	Guaycuru	Statice brasiliensis
	Celery	Apium graveolens
	Cedron	Simaba cedron
	Floripon	Brugmansia suaveolens/arborea
	Espina colorada	Solanum sisymbriifolium
	Arnica	Arnica montana
	Bardana	Arctium lappa
	Fennel	Foeniculum vulgare
Grossman et al., 2010 USA	Rue	Ruta chalepensis/graveolens
	Sage	Salvia officinalis
	St. John's wort	Hypericum perforatum
	Black/blue cohosh	Cimicifuga/actaea racemosa
	Black walnut	Juglans nigra
	Oak bark	Quercus (genus)
	Common ragweed	Ambrosia artemisiifolia
Kuo-Fen, 1982 China	Snakegourd root	Radix trichosanthis
	Tian hua fen	Trichosanthis kirilowii maxim
Gold & Cates, 1980 Mexico, India	Cottonroot bark (Mexico)	Gossypium herbaceum
	Pulsatilla (India)	Pulsatilla (genus)
	Rue	Ruta chalepensis/graveolens
	Parsley	Petroselinum hortense/crispum
	Cohosh	Cimicifuga/actaea racemosa
	Sage	Salvia officinalis
	Pennyroyal	Mentha pulegium

Table 1 (continued)

Source, Country	Common Name	Scientific Name
Nikolajsen et al., 2011 Tanzania	Black-jack	<i>Bidens pilosa</i>
	Benghal dayflower	<i>Commelina africana</i>
	Creeping tick trefoil	<i>Desmodium barbatum</i>
	Cassava	<i>Manihot esculenta</i>
	African basil	<i>Ocimum suave</i>
	Old world diamond-flower	<i>Oldenlandia corymbosa</i>
	None	<i>Sphaerogyne latifolia</i>
Zhang et al., 2021 China	Chinese herbal medicine	<i>Persiscaria orientalis</i>
	Cotton root	<i>Gossypium arboreum</i>
	Ergot	<i>Claviceps purpurea</i>
	Marjoram	<i>Origanum majorana</i>
	Peppermint	<i>Mentha piperita</i>
	Spearmint	<i>Mentha spicata</i>
	Pennyroyal	<i>Mentha pulegium</i>
	Rosemary	<i>Salvia rosmarinus</i>
	Rue	<i>Ruta chalepensis/graveolens</i>
	Savin Juniper	<i>Juniperus sabina</i>
	Wormwood	<i>Artemisia absinthium</i>
	Myrrh	<i>Commiphora myrrha</i>
	Fern	Polypodiopsida (class)
	Garlic	<i>Allium sativum</i>
	Asafetida	
	Asarum	<i>Asarum caudatum</i>
	Colocynth	<i>Citrullus colocynthis</i>
	Squirting cucumber	<i>Ecballium elaterium</i>
	Pomegranate	<i>Punica granatum</i>
	Jalapa	<i>Mirabilis jalapa</i>
Birthwort (Virginia)	snakeroot)	
Aristolochia (genus)		
Aloe	<i>Aloe vera</i>	

Artistic Methods

I used photographs and artistic representations of the three plants to pencil sketch a guide before I began painting using acrylic paint on 5" x 7" water-color paper and various paintbrushes. I wanted viewer to experience the botanical beauty of the plants “interrupted” by the harsher visual experience of knitting needles (paired with sage), clothes hangers (paired with pennyroyal), and misoprostol pills (paired with black cohosh).

The three methods of self-induced abortion I chose are well known to cause significant morbidity and mortality—knitting needles, clothes hangers, and pills (misoprostol). Knitting needles and clothes hangers can cause uterine perforation, predispose to infection, and cause other trauma to the female reproductive tract when they are used to try and induce abortion. Misoprostol can be used safely in medical abortions overseen by a medical professional, but it is also prescribed for stomach ulcers. It can be dangerous when it is used off-label and/or illegally as an abortifacient, potentially causing pain, bleeding, or sepsis, requiring hospitalization, or even causing death (Damalie et al., 2014).

Results

In my research, I wanted to determine the pharmacological mechanism of action of these alternative herbal medicines. My findings are as follows:

Pennyroyal

- Principal component of essential oil: pulegone
- Mechanism of action: unclear. It has been shown that pulegone inhibits myometrial con-

tractions, similar to the voltage-dependent calcium channel blocker nifedipine. This suggests a different method of action as an abortifacient such as relaxation of blood vessels and inadequate uterine-placental perfusion (Soares et al., 2005). Additionally, pulegone is metabolized to a hepatotoxin in mice (Gordon et al., 1987).

Sage

- Principal component of essential oil: thujone (diastereomers α -thujone, β -thujone) (Raal et al., 2007).
- Mechanism of action: GABA antagonist. Sage inhibits the inhibitory neurotransmitter GABA, causing neurological overactivity. Thujone is the active agent in absinthe and is considered a convulsant (Hold et al., 2000). It has been shown that sage essential oil (fed to pregnant mice) negatively influenced distribution of embryos according to nucleus number (Domaracky et al., 2007). Additionally, liver, vascular, and kidney damage were found in the fetuses of pregnant rats who were treated with sage leaf aqueous extract (El-Ghareeb et al., 2016).

Black Cohosh

- Principal component of essential oil: triterpene glycosides (including cimicifugoside M and cimifugin, which can serve as indicators for species identification) (He et al., 2000).
- Mechanism of action: unclear. It has been shown that black cohosh extract, which is sold as an over-the-counter medication called Remifemin, is suitable as a treatment of choice for menopausal symptoms. Black cohosh

preparations have been shown to inhibit luteinizing hormone (LH) secretion in menopausal women. (Foster, 1999).

Discussion

It could be that abortion is induced with pennyroyal use because of general stress on the pregnant person's body, but it may also increase the risk of serious medical outcomes secondary to abortion. This falls in line with general concerns about complementary/alternative medicine usage where there are unknown or unclear sequelae that may put the user at risk. As a GABA antagonist, sage exerts an effect on a pregnant person's body, but could also induce abortion via organ damage to the fetus itself. If abortion is incomplete, the fetus could be born with medical issues, further burdening the person who was seeking abortion. In the case of black cohosh, I suspect that it could be used as a contraceptive because in menstruating women, ovulation is caused by an LH surge, and black cohosh has been shown to inhibit LH secretion. However, LH plays less of a role in pregnancy, so its mechanism of action as an abortifacient remains unclear.

In my search for sources of morbidity and mortality surrounding self-induced abortion, several recurring themes began to appear. It was no surprise to me that the illegality and stigma of abortion worsen outcomes for people who are pregnant and wish not to be. Relatedly, the reasons for choosing to self-induce abortion can be more structural (barriers to access such as geographic distance from legal abortions, lack of health insurance), or more

personal (desire for privacy, avoidance of shame). One recent article by Moseson et al. (2022), suggests that a high proportion of transgender, nonbinary, and gender-expansive (TGE) people attempt abortion without clinical supervision. The lack of healthcare provider knowledge and discrimination TGE people experience compounds the barriers that may already be in place for others.

Conclusion

It is clear to me that as a future healthcare provider, it will take action beyond my scope of practice to ensure safe abortion access for my community and beyond. There is a multitude of research proving the safety and efficacy of medication abortion with misoprostol and mifepristone, for example, but what physicians may consider medical fact is tangled with political will, religious beliefs, and emotion. I hope to continue my work with the Medical Students for Choice organization and the American Medical Association to protect abortion as an act of bodily autonomy.

I recognize that abortion is a positive right in that it requires action from others (i.e., provision of medication or procedure by physicians, financial assistance from health insurance, etc.), but that does not render it invalid. I see arguments for and against abortion as arguments about autonomy butting heads—the pro-choice side wants to exercise bodily autonomy, the pro-life side wants to exercise their morals. The pro-choice side, however, is not expanding the boundary of their autonomy into paternalism.

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**Pumpkin, Penguin, and Pepper: Encounters
Between a Mentally Ill Medical Student,
a Psychiatry Patient, and a Psychiatrist**

Maryam Golafshani

Shame is an especially sticky emotion. Its grasp feels tenacious and unforgiving, and you're often unable to peel it off without losing a piece of yourself—a bit like bubble gum in your hair. Feminist theorist Sara Ahmed argues that emotions, like shame, are not just produced from within us, but rather from outside us: How and what we feel are shaped by social, cultural, and even political forces (*Emotions*). As such, emotions circulate amongst us all, but stick to some people more than others due to structures like racism, ableism, heteronormativity, and more. Understanding emotions in this way helps make sense of my own experience with shame as I navigate medical school with mental illness. I previously studied literature and critical theory, so I'm not surprised that I turned to thinkers like Ahmed to unpack how shame stuck to me during medical school. But I was surprised by how this shame finally began to peel off through working with a patient named Kate, a 30-year-old woman with OCD.¹

Shame first adhered itself to me a year before I met Kate. I was with my first-year clinical skills group discussing how to recognize and empathetically elicit psychiatric symptoms and conditions that patients may not feel comfortable disclosing to clinicians. Often, such patients avoid disclosure because of prior negative encounters, internalized stigma, and shame. I know those feelings and experiences all too well. Our group's discussion centred around one particular mental illness, and it happened to be one I live with. Medical students are repeatedly taught that one of a physician's most critical responsibilities is empathizing with patients. Along this vein, my well-intentioned classmates asked our tutor probing questions to understand the minds of patients with this—my—mental illness. "Why would someone ever act like that?" one asked. I whispered the answer to myself: "Because I just can't help it." I felt like an impostor, trapped in the gap between my classmates seeking to understand this illness through our tutor's clinical insight and already knowing it through my own lived experience. Flushing with shame, I wondered: am I really so odd that my bright classmates can't understand this crazy mind of mine while having no problem understanding the complex physiology of acute kidney injury? Even as I write this essay years later, that shame keeps me from disclosing what specific mental illness I live with.

My classmates' approach to empathy stems from how medical trainees are socialized to approach everything unknown: to pick it apart, understand it, and ultimately master it in order to

become a valued medical expert. But empathy is not necessarily about understanding the patient's experience. Yes, it can sometimes help us empathize, but fixating on understanding risks getting in the way of what else empathy is crucially about: acknowledging the differences between your experiences so you can compassionately and justly care for another's particular situation (Jamison, 2014).

I left class that day dressed in shame, performing as a visibly healthy medical student to disguise my identity as an invisibly ill patient. Feminist theorist Eve Sedgwick understands shame as performative: one is flooded by the negative feelings and judgements of a real or imagined audience towards oneself, internalizes this, and then responds outwardly through actions like averting the eyes, flushing, and/or turning inwards (2003). This helps me understand empathy also as a performance, but with a key difference: both shame and empathy begin by internalizing the feelings of another, but then empathy projects that back out by striving to connect with others, whereas shame pulls one away. As more medical school lectures and discussions implied that illness was something experienced by patients, but not physicians-to-be, I internalized that irreconcilability by further wrapping myself tightly in shame, feeling ever more alone in my experience. This shame didn't begin to unravel until I started shadowing psychiatry in my second year.

Months into the pandemic, I was invited by my psychiatry mentor, Dr. D, to participate in narrative therapy as an "outsider witness" with a patient

named Kate. An outsider witness is a third party who listens, acknowledges, and reflects upon stories the patient shares in therapy (Payne, 2006). One of the first things Kate shared is that she has a cat named Pumpkin whom she cares for deeply. I suspected we would get along well, as I also have a beloved cat named Pepper, and Dr. D has a cat named Penguin. This connection with our cats is a surprisingly instructive, albeit quirky, reflection of one of our strongest points of connection: the way Kate cares deeply for her cat, a mysterious creature she can never fully understand, reflects how she is teaching me to care for others without expecting or needing to fully understand their experience.

In one appointment, Kate described feeling “stuck” in the feelings, actions, and habits of both her mind and body due to mental illness. Although she was describing her own experience of mental illness, I was struck by how well her metaphor described mine. In response, I disclosed some of my own experience, inspired by Dr. D’s prior role modelling of the same. Navigating disclosure is especially tricky amidst the power dynamics of a clinical encounter. This shared feeling of “stuckness” could tempt me to want to further understand our experiences as the same, thereby risking appropriating Kate’s experiences for myself. However, I was surprised to find myself more curious about what made Kate’s “stuckness” different from mine, humbly hoping to help her better understand herself. Here, I circle back to Sayantani DasGupta’s call for “narrative humility” in medicine—a concept I first encountered as an

early undergraduate student, curious about how my learning in literature courses mattered beyond the classroom (2008).

Through our shared curiosity and care for each other's suffering and successes, Kate and I have helped each other in ways neither of us predicted. Kate has reduced time spent on rituals and, for the first time, spent time genuinely believing in her own worth. Similarly, I have spent less time dwelling in the shame of my mental illness and more time recognizing the value it brings to my role as a medical student. Through my new encounters with Kate and my renewed encounters with my humanities background, I am relating to my own mental illness in new, affirmative ways. I have also started to consider new ways to relate with patients beyond empathy-as-understanding.

One way I have begun to re-imagine empathy is through the concept of surprise. In her seminal essay "Paranoid Reading and Reparative Reading, Or You're so Paranoid You Probably think this Essay is about You," Sedgwick argues that paranoid inquiry has problematically become the *only* accepted way of approaching a text or even the world, when it is really only one of many approaches, including reparative inquiry (2003). Paranoid reading is to analyze with deep suspicion—a sense that something bad or nefarious is always going on beneath the surface, so it never catches you by surprise. In medicine, such paranoid anticipation is necessary for timely diagnosis, treatment, and prevention. But when paranoid inquiry is the only way one approaches patients, it

transforms them into objects who only have the potential for problems to be managed. To read reparatively, however, is to surrender to the possibility that one may be surprised by what is encountered and that those surprises can even be good.

Ahmed might call reparative reading a generous encounter between two elements—a reparative reader and a text, for example, or even a doctor and a patient (2000). Surprise is also foundational to this generous encounter: it is not a meeting of elements that already or indeed ever can know each other, but depends upon the surprising nature of acknowledging that “we may not be able to read the bodies of others” (*Strange Encounters* 8). This point crucially reminds me that my humanities education has not taught me to read the bodies of patients, but rather to recognize that I may not, cannot, and even sometimes should not.

In this way, I re-imagine empathy as generosity in allowing oneself to be surprised by all one does not understand about a patient’s experience. It is this kind of surprise that may get one closer to fostering a reparative (read: healing) relationship with patients.

I want to walk into the 1000th room with a patient with mental illness and still be surprised—to not fully know what mental illness is for that person, despite my wealth of medical knowledge, clinical-communication skills training, personal experience, and all the literary representations of mental illness I have read. Months into working together, I am still surprised by Kate’s experiences, her reflections on those experiences, and her trust

in sharing it all with me. After a decade working together, Kate and her psychiatrist also still find themselves surprised.

Most surprising of all to me is how shame's sticky grip is finally loosening as I begin to experience how my training in the humanities and my own illness experience are genuinely assets in caring for patients—not just in theory, but in practice. And I owe that largely to Kate, Dr. D, and, of course, Pumpkin, Penguin, and Pepper.

Note

1. Patient details have been changed for confidentiality, including cat names, but the true coincidence of all three cats' names beginning with the letter "P" has been preserved.

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Eidos / Progress Report / Sinister

Dan Campion

Eidos

A motorcycle headlamp swam, a moon
at full, across the avenue and smashed
a news kiosk in two. Lost in a swoon,
the driver and the passenger who'd crashed
lay, unaware that anything went wrong,
half-dead before an all-night Rexall store.
Somebody stumbled out and spied a prong
of bone protruding from the flesh it tore.
Mars lights and spotlights gathered, sirens groaned.
The fallen riders, spirited away,
bore in their wallets numbers to be phoned.
A nurse discharged that task without delay.
Half a century on, this night scene burns,
sparked merely by a bike glimpsed as it turns.

Progress Report

I've come across your letters from your stay
in Worcester, in that other century.
Though several weeks apart still weigh on me,
I'm grateful for these letters. Words don't stay
with me. I need some medium to stay
them for me. Here they are, by courtesy
of your affection. We could not foresee
they'd stand in for you now, who could not stay.
We loathed the cancer language and its tricks:

the euphemistic “journey” versus crabbed
and crippled military “battle,” “fight,”
“won,” “lost.” These letters came. When cancer grabbed
us later, words absorbed that cankered mix.
These letters stay your spirit from the blight.

Sinister

I stumbled and I fell, and broke my fall
with my left hand, and hurt it doing so.
Where palm meets wrist was bruised and swollen. Ball
of thumb, inflamed and sore, would heal up slow,
without a doubt. But scarcely two weeks in
I woke and pain was almost gone. The hand
could hold the kettle handle, give a spin
to dials, stretch just to show it could expand.
I couldn't help but find these welcome signs
mysterious. Would dexter hand have healed
so readily? Had left hand signed some lines
that compromised me? Challenged, would it yield,
or had hand sinister assumed a right
that put my mortal claims on it to flight?

About the Author

Dan Champion is the author of *Peter De Vries and Surrealism* and co-editor of *Walt Whitman: The Measure of His Song*. A selection of his poems, *A Playbill for Sunset*, was issued in July 2022. He lives in Iowa City, Iowa. Email: jecdr@earthlink.net