Content

Letter from the Editor .......................................................... iii

Graphic Storytelling and Medical Narratives .................. 1
Green, Michael, M.D., M.S.

A Quiet Night ................................................................. 2
McCormick Goetz, Lindsey

The Humanities Interface of Nursing and Medicine ........ 7
Dellasega, Cheryl, C.R.N.P., Ph.D.

Positive Exposure ............................................................. 16
Guidotti, Rick

I’m Not Your Son, I Am No One You Know ................. 21
Oates, Joyce Carol

Night Therapy ................................................................. 27
Studer, Constance

Storm Song ................................................................. 28
Cox, Desiree, M.D., Ph.D.

Absolution ................................................................. 29
Coyulehan, Jack

Albert Camus L’Etranger, Thirty-Five Years Later ........... 30
Atkins, Priscilla

Sand and Water ........................................................... 32
Nigliazzo, R.N.

A Drop of Blood ........................................................... 34
Murch, Murial, A.

Cardiac Arrest .............................................................. 36
Bowe, Geoffrey, R.N.

You Can Make a Difference .......................................... 38
Singh, Harbir

Book Review:
The Heart’s Truth: Essays on the Art of Nursing ........... 40
Graybill, Marie, R.N. reviewer
Greetings Readers:

We are thrilled with our latest issue and the addition of a new editor, Ms. Judith Schaefer, a renown poet, nurse, and author. You can learn more about Judy's work at www.judyschaefer.biz. As we continue to explore the interface between health and humanities, our contributors find new and exciting venues to challenge you. Dr. Michael Green's class in graphic storytelling provides a magnifying glass into the lives of novice medical students, anxious patients, and savvy attendings. A scholarly look at the relationship between nursing and medicine reveals the humanities as a logical domain of shared interests. One example of using art to teach is the stunning photography of Rick Guidotti, a fashion photographer who put his talents to work on both our cover art and the pictures of individuals living with genetic differences. We at the Penn State College of Medicine were privileged to share the buzz of excitement when Mr. Guidotti's work came to our institution, conveying the message that beauty is not just a physical trait. Author Joyce Carol Oates graciously (and within twenty-four hours) gave permission for the reprint of her story about two brothers visiting their father in a nursing home. Again, the lens of words gives a glimpse into the world of health care some of us may not have seen. We thank Ms. Oates for sharing her gift of story. Our poetry section is truly stellar in this issue, especially with the inclusion of Jack Coulehan's work, “Absolution.” For me, the Author's Comments at the end of each work are an added bonus. We end with a short story, a book review by nurse Courtney Davis, and a final commentary on the physician-patient relationship. I hope you are interested, intrigued, and invigorated by the contents of this volume—and challenged to share work of your own!
Since I was a young boy, I’ve always loved comics. I grew up reading the Fantastic Four and Superman, the Sunday funnies, and cartoons in the New Yorker Magazine. As an adult, I became interested in comics as a serious medium for communicating complex and mature themes: as topics of scholarly inquiry and graduate school seminars, winners of prestigious book awards and prizes, and inspiration for Hollywood movies. In the arena of health care, I watched comics emerge as an innovative and engaging medium for depicting the experience of illness, and as an especially effective way to invite readers into a world they might not know personally.

These observations inspired me to teach a course on comics in medicine at Penn State College of Medicine, where fourth-year medical students are required to take an elective in Humanities. In 2009, I posted a course titled “Graphic Storytelling and Medical Narratives,” hoping the intriguing title and content would attract a group of students who were secret artists, writers, and life-long lovers of comics like me. On the first day of class, I asked the students about their reasons for taking this course. To my chagrin, fourteen of the sixteen students said they enrolled because it “fit in with their schedule,” and almost no one was aware of (let alone interested in) the comics medium.

Nevertheless, I persevered with the course, introducing students to contemporary examples of comics: Pulitzer prize-winning *Maus*, by Art Spiegelman; *Cancer Vixen*, by Marisa Acocella Marchetto; *Understanding Comics*, by Scott McCloud, to name a few. During an intense one-month period, we studied how comics work, what they accomplish, and why they are relevant to medical education. And it succeeded.

The students enthusiastically embraced the background readings and in-class exercises, and with only mild trepidation, plunged into their final assignment-- to create their own comic (or “graphic story,” as I called it). Students were given wide latitude to be creative, with the instructions that they were to tell a story about a meaningful experience they had during medical school, using pictures and words in a sequential manner. The only other requirement was that they were to help each other be as successful as time and talent permitted. The students not only enjoyed the class (it received rave reviews and high evaluation scores), but they produced wonderfully creative comics covering a wide range of topics. Even students who complained “I can’t draw” (the majority) proved to be effective artists and communicators whose work revealed deep insights into personal and professional experiences that challenged them during their medical school education. I noticed that they seldom spoke as freely as they drew. In the following pages, one student’s story illustrates what can be produced when smart, motivated, and creative individuals are given an outlet for their expression. The story is not only subtly drawn, but also funny. I hope you enjoy it as much as I did.
My graphic story, “A Quiet Night,” depicts the events that happened one night when I was a third-year medical student rotating through the OB/GYN Labor and Delivery Night Float service. It was only the second clinical rotation of my medical school career and I still felt out of place and uneasy in the clinical side of medicine. I chose to tell this story not only because it was one of my most compelling and memorable patient encounters, but also because I believe that the feelings of anxiety and inadequacy I felt during the ordeal were ones with which other medical students could identify and empathize. The memory of the happy outcome has also provided me with hope during some heartbreaking patient encounters with less fortunate endings. Re-experiencing the events as I created the comic, particularly the characters of the story, was an interesting journey that provided a rewarding retrospective glance at how far I have come in my emotional and professional development. I look forward to revisiting my work during the years to come as I enter residency and begin my career as a new physician.
Have a good night! Stay on your toes, Lindsey—tonight may be exciting after all!

It was my 3rd night on OB night float. My attending gave Carrie (R3) and another ‘quiet’ sign-out. I prepared for another exciting night of studying for the shelf exam and sleeping in the call room.

Well! I’m going to go lay down. I’ll page you if I need you.

It only took an hour to check in on the patients upstairs who had already delivered. No patients were in active labor.

Would you mind starting the H&P for me? I need a minute to wake up. Let me tell you what I know so far...

One of our patients had shown up in the ER concerned about decreased fetal movement. I wrote down her info.

Beep—beep! Beep—beep!

Just as I had nearly had enough of studying and was about to go to sleep...

11:45 PM

37 years old at 32 weeks gestation... only one prenatal visit, hasn’t felt the baby move since yesterday...

Her story had some ‘red flags’...

12:05 AM

She looks older than 37...

Well, I’ve cut back to one pack a day... I know I missed appointments but things came up.

Any pregnancy with a mother over 35 (advanced maternal age, AMA) is high-risk, but she had additional ‘risky’ behavior in her history...
AMA, tobacco use, no prenatal care, history of STDs, no fetal movement for 24 hours, questionable leakage of fluid...

...and she's measuring small for 32 weeks. Maybe the MFM attending will do an ultrasound for us tonight.

Did I mention her partner speaks very little English?

Maternal-fetal-medicine (MFM) doctors are trained to handle high risk pregnancies - like this case.

1:15 AM

SPECIALIST?!

Your exam looks fine, but to be sure we're going to have a specialist do a special ultrasound.

This could get ugly.

The MFM attending on call was doing a C-section that night. She agreed to help us out when she was done. Until then we monitored our patient closely.

The MFM attending on call was doing a C-section that night. She agreed to help us out when she was done. Until then we monitored our patient closely.

The baby was measuring very small and there was hardly any amniotic fluid. Then, just as she was about to document the fetal heart rate...

2:30 AM

Alright, let's make this fast - talk to me.

Uh... no contractions, no vaginal bleeding, some loss of fluid.

2:30 AM and her hair and makeup look perfect...

Finally the MFM attending was ready. Carrie filled her in on the patient's story.

2:40 AM

The fetal heart rate went to ZERO. Time stood still. The patient and her partner were clueless as we all held our breath in shock.

PREP THE OR NOW!

The heart beat started again, but VERY slowly.
Suddenly I was aware that I was in the room too, not just watching this drama unfold from afar.

I was so afraid that somehow I would make a mistake.

Don't worry, everything is going to be alright.

In the calmest voice I could muster I tried to put her at ease.

It still amazes me how quickly a Cesarean can be done if need be.

WAAAHHH!

It's a GIRL!

She's so tiny!

She's looking good!

Il mio dio!

A new life begins.

A minute later the patient's partner was "escorted" out to the hallway.
Your daughter is just fine. We'll meet you in the recovery room.

The baby was doing very well but they took her to the NICU for precaution.

Whew! I'm beat and my back is killing me. I'll meet you upstairs to round at 5. Good job.

I'm so glad it went well.

Carrie and I went to rest until it was time to round on our patients who had delivered the previous day.

But I couldn't sleep. I thought about how rarely things go better than expected in medicine. I wanted to remember the details of this night.

The delivery note counts for a note from today. We'll let them rest.

I glanced in briefly. There seemed to be a sense of peace in the room.

Another quiet one, ladies?

Not exactly...
The Humanities Interface of Nursing and Medicine

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Abstract

In the 1970s, the field of medical humanities developed and included ethics, literature, history, integrative medicine, and other topics, most often described from a physician’s perspective. During this same period of revolutionary changes in healthcare, nursing curricula did not seek to emphasize content in humanities, perhaps because stereotypical views of nursing as the “caring profession” made such coursework seem redundant.

In 2001, as a result of the Institute of Medicine’s call for all health professionals to be educated in interdisciplinary teams, there was a new focus on the importance of interdisciplinary education. Collaborative experiences in the humanities can foster professional relationships that lead to professional growth, promote collaboration, and enhance patient-centered care.

The purpose of this paper is to describe the relevance of humanities to the interdisciplinary education and practice of healthcare providers. This paper extends the thinking about the value of interdisciplinary education beyond the traditional dimensions of evidence-based practice, quality improvement and informatics to humanities. Ways to provide nurses and physicians with interdisciplinary humanistic experiences are illustrated through an overview of projects jointly developed by the School of Nursing and the College of Medicine at The Pennsylvania State University.

Introduction

Humanities and Healthcare

In the 1960s, as medical technology expanded, a paradigm shift in the delivery of healthcare occurred. No longer was the physician-patient or nurse-patient relationship central to the healing process as sub-specialized experts and layers of equipment and documentation came between professionals and those for whom they cared. As healthcare became more procedure oriented and driven by technology and specialization, hospital costs increased. Rogers (1975) referred to this problem of reconciling the concern for the welfare of people with the scientific and technologic requirements of medicine as the challenge of the century for young healthcare providers.

The term “humanistic medicine” was formulated to remind physicians that they needed to be compassionate and empathic, perhaps as a consequence of changes in the 1970s that revolutionized the practice of medicine (Little, 2002). While the practice of nursing was also profoundly affected by those same changes in the healthcare delivery system, little,
if any, discussion of the need for “humanistic nursing” occurred. While nursing curricula of the 1970s included experiences in the humanistic care of patients, content specific to the humanities was clearly that which comprised the general education requirements of the degree. Consequently, the early focus of medical humanities was largely shaped by physician education.

A traditional definition of humanities is: studies intended to provide general knowledge and intellectual skills (rather than occupational or professional skills) (Farlex Inc., 2005). Pelligrino (1979) offers a more specific definition of humanism as it relates to patient care:

*Humanism encompasses a spirit of sincere concern for the centrality of human values in every aspect of professional activity. This concern focuses on the respect for freedom, dignity, worth and belief systems of the individual person; and it implies a sensitive, non-humiliating, and empathetic way of helping with some problem or need.* (p.118)

**Interdisciplinary Health Education**

There has never been another time in healthcare that has seen the rapid growth in knowledge and technology that we have witnessed over the last 50 years (Kohn, Corrigan, & Donaldson, 2000). However, the system as it is today falls short of translating that knowledge into clinical practice and applying it safely and appropriately (Kohn et al.). “If the health care system cannot consistently deliver today’s science and technology, we may conclude that it is even less prepared to respond to the extraordinary scientific advances that will surely emerge during the first half of the 21st century (Committee on Quality of Health Care in America Institute of Medicine, 2001, p. 3)

The Institute of Medicine’s report titled Health Professions Education: A Bridge to Quality (2001) calls for changes in the traditional way healthcare providers are educated. These changes are important to the long-term goals of improved quality, decreased costs, and decreased error rates. The Institute of Medicine’s vision statement from the report, *Health Professions Education: A Bridge to Quality* (Committee on the Health Professions Education Summit Board on Health Care Services, 2003, hereafter CHPE) is “All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidenced-based practice, quality improvement approaches, and informatics” (p.3). Incorporation of “teamwork” into the delivery of healthcare is one facet of a multifaceted approach to decreasing error rates and costs as well as improving the quality of healthcare (CHPE, 2003). With the increasing complexity of patients and the increased chronicity of disease, the need to rely on interdisciplinary teams to provide care will grow (CHPE, 2003).

**Humanities in the Nursing Curricula**

The inclusion of humanities in nursing curricula goes back to the early days of nursing education. Humanities were included so that graduates of nursing programs could respond to and change in a competitive health care delivery system. In order to prepare truly educated, compassionate and socially conscious nurses, a foundations in the liberal arts was essential. A focus solely in the scientific and technical aspects of nursing education was necessary but insufficient to prepare the kind of nurse who focuses on complexity of the human experience. Donaldson (1983) suggests that without the humanistic perspective of nursing, the uniqueness and justification of the existence of the nursing discipline is lost. The nursing curricula needs to emphasize the broad interrelationships between nursing aesthetics and caring attitudes and empirical knowledge required to practice quality healthcare and human care (Hermann & Wright, 2002). In short, it’s the appreciation of the art of nursing woven together with the application of the science that prepares the practitioner for the challenges and rewards of nursing practice.
Once labeled the “caring profession” (Boykin & Schoenhofer, 1993; Dyson, 1997; Morse, Solberg, Neander, Bottorff, & Johnson, 1990), some nurses now complain they are little more than paper pushers. With the shift away from the bedside and toward the computer monitor, burnout among nurses has skyrocketed (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Bruderle and Valiga (2001) suggest that new approaches are needed to educate nurses to avoid burnout and to function effectively in the current healthcare environment. They advocate inclusion of the arts and humanities to both encourage creativity and move nursing students away from dualistic, black and white thinking.

Given the importance of humanities in the nursing curricula and the long history of its integration into nursing educational programs, why now, has there been an erosion of humanities education in current nursing programs? The most significant reason for the reduction of humanities content in nursing curricula has been an explosion of knowledge in the science of healthcare. Curriculum directors of undergraduate programs have to decide how to spend the student credit hours in their programs. If we just look at the information we know about genetics and its impact on health and illness today compared with ten years ago, the amount of time needed to spend on this content area has increased dramatically. And genetics is just one area in which there have been huge scientific advances. Add to this the advances made in the technology that supports healthcare delivery or the pharmacological advances that impact health and illness.

Given that the undergraduate curriculum is limited in number of credits in most universities, curriculum directors have focused on the science of nursing while sacrificing the content in the humanities.

In the 1980s, nursing curricula moved from a block curriculum to an integrated curriculum approach. In the integrated curriculum, students were exposed to concepts and principles of nursing rather than a focused setting or population for practice. At times, this resulted in difficulty identifying where elements of the curriculum were being taught without an extensive and exhaustive content analysis of the curriculum. During the integrated curriculum phase of nursing education, there may have been humanities concepts included in the curriculum, but it was not obvious from an external review.

A final reason why humanities education has eroded in the curriculum might be found in the perspective of humanities education by some nursing faculty. In an editorial by Cortney Davis (2003) entitled, “Nursing Humanities: The Time has Come,” she recounts a conversation with a nursing instructor about her contributions to humanities education in the medical school.

Ms. Davis asked why she does not teach a similar course for nurses in the nursing school. The nursing faculty responded “Medical students need to be sensitized; nursing students are already empathetic. Wouldn’t studying the softer aspects of nursing reverse the hard won gain in respect that nursing has made in the eyes of physicians and patients” (p. 13).

Humanities in the nursing curriculum has never been more important than it is today. As healthcare becomes more and more complex and the allocation of resources becomes more challenging, the need to have a full appreciation of the human existence is paramount. Nurses need to find ways to preserve caring connections with patients and other professionals in a work climate that is increasingly complex and impersonal.

Medical Humanities and Education of Physicians

In 1967, George T. Harrell, MD, founding dean of the Pennsylvania State College of Medicine, developed an innovative medical school curriculum that was the first in the country to include a Department of Humanities. Dean Harrell wrote:
Diagnosis, medical care and clinical judgment function in a cultural context that embraces the complexity of man’s world, his values, and his historical legacy….Our primary objective is to help educate physicians who see medical practice in a context that is comprehensive—that emphasizes and enlightens, rather than avoids, the rich complexities of man, his society, and his heritage (Harrell, 1974).

An early discussion of how humanities apply to medicine was provided in the introduction to the first medical humanities course offered at The Pennsylvania State University College of Medicine. Barnard and colleagues (Barnard, Dayringer, & Cassel, 1995) wrote:

Over the years, the humanities at Hershey have consisted of the disciplines of history, literature, religious studies, philosophy, anthropology, ethics, and law. The methodologies of these disciplines are complementary to those of the biomedical sciences—different, but equally relevant to the work of the practicing physician. The medical humanities explore questions of value and meaning in and around medicine.

They address, for example, the patient’s experience of illness; social and cultural contexts of sickness and healing; the development of the medical profession and its relationship to society; and moral dimensions of the physician-patient relationship. (p 807)

Throughout the 1970s, the number of medical schools with course content devoted to human values grew from 11 in 1972 to 65 in 1976 (Pellegrino, 1979). Many of those having a slant toward bioethics incorporated a wider range of humanities-based topics in their curricula over time (Mcelhinney & Pellegrino, 1981). In 1976, Human Values Teaching Programs for the Health Professions was published for the third time by the Institute on Human Values in Medicine. This document described 29 medical schools where some aspect of human values or the humanities were taught (McElhinney & Pellegrino, 1981). During this same time, The Society for Health and Human Values was founded to look at the integration of human values in medical education.

In 1988, The Arnold P. Gold Foundation was founded with a focus on: Fostering the values and behaviors that reflect humanism: traits such as empathy, respect, caring, integrity and service. We concentrated on changing behaviors. Our intention was to collaborate with medical schools in order to foster humanism in the medical culture (transform the culture of medical education) and help to educate humanistic physicians (Arnold P. Gold Foundation, 1988).

Initially, medical ethics was the dominant focus of medical humanities but gradually other foci such as medical narratives (Charon, 2004), arts and healing (Malchiodi, 1999), spirituality (Fortin & Barnett, 2004) were included. In 2003, the interest in medical humanities had expanded so greatly that the journal Academic Medicine devoted an entire issue to descriptions of selected programs from around the world. Those featured articles provided a snapshot of how medical humanities has grown in recent years. They described use literature, music, dance, religion, philosophy, drama, ethics, history, law, communications, culture, complementary and alternative medicine, palliative care, international medicine, and other topics to provide humanistic education for medical students (Association of American Medical Colleges, 2003). Some programs required credits in the humanities while others offered different options. All recognized that: “The study of the humanities can illuminate human interactions and concerns in a way the genome map or nanomedicine cannot” (Dittrich, 2003 p. 952).

Model for Interdisciplinary Education in the Humanities

By broadening the education of medical and nursing students to include interdisciplinary experiences in the humanities, nurses can become aware of the values that shape their
actions and those of the physicians and patients with whom they work. In turn, physicians can come to appreciate a hidden side of medicine that incorporates softer sciences traditionally thought to be reserved for nurses. This blending of medical and nursing perspectives in areas such as literature, ethics, history and spirituality can lead to patient and provider empowerment, mutuality among health professionals, and professional growth, as depicted in Figure 1.

While the literature has been replete with discussions about the benefit of interdisciplinary education, most authors address issues related to evidence-based practice, quality improvement approaches, and informatics. This model extends the thinking beyond the traditional area of interdisciplinary education to address the importance of developing a shared culture on which to base healthcare practice. Learning together using the humanities allows nurses and medical students to break down the power differentials inherent in the health science disciplines and to begin to reconcile their world views based on shared values (Shaver, 2005). In this context, each profession can learn from the other.

Opportunities for Mutual Learning

For physicians and nurses, ethical decision making and a focus on patient-centered care in an era of technological advances are difficult skills to learn from scientific content in textbooks. Often, literature or the arts can offer both disciplines the opportunity for a fuller exploration of the whole experience, sometimes from varied or conflicting viewpoints. Valiga and Bruderle (1997) suggest that education in the humanities can help health professionals think more critically and move toward “synthesis rather than reductionism” (p.14).

The humanities also offer an ideal neutral territory where professionals can dialogue. For example, no discipline can claim ownership of literature or art. Therefore physicians, nurses, and other members of the healthcare team can use writing and art as a springboard to discuss key issues related to their practice from a shared rather than territorial perspective. For example, reading One True Thing, a novel by Anna Quindlen (1995) (or viewing the movie based on the book), can prompt an exchange on end-of-life care that is free from the traditional role constraints a healthcare provider might feel when talking in a team meeting about pain management, palliative care, or life-prolonging therapies.

The absence of educational experiences that emphasize similarities rather than differences in professional roles can lead to conflicts between nurses and physicians in various healthcare settings. In hospitals where there are poor communication and collaboration
between nurses and physicians, there is reduced productivity, increased error (Rosenstein & O’Daniel, 2005), and reduced job satisfaction (AACN, 2002). Recently, there has been renewed attention to the nurse-physician relationship (Kramer & Schmalenberg, 2003; Rosenstein, 2002) and a belief that these two professions must come together and work collaboratively and humanistically to truly affect the lives of patients and to improve the healthcare delivery system.

Yet few universities or healthcare institutions promote humanities content in their educational programs for health professionals, either independently or from an interdisciplinary perspective. The authors conducted an external curricula review of graduate nursing and medical education programs from the Big Ten University system. Course titles from the Internet were reviewed for inclusion of content related to the humanities. While course title is not wholly indicative of course content, few courses that reflect humanities content were offered by graduate nursing programs and medical schools.

The mission of The Pennsylvania State University College of Medicine’s Department of Humanities is to engender a critical awareness of the values, presuppositions, and methods that undergird medical education and practice (Hawkins, Ballard, & Hufford, 2003), a goal equally relevant to the School of Nursing. Until recently there were few, if any, shared educational experiences between the two disciplines on our campus. Using the model described above, over the last two years we have piloted several programs designed to promote interdisciplinary experiences for graduate and undergraduate nurses, medical students, residents, and faculty from both the College of Medicine and School of Nursing in an effort to enhance the development of a shared perspective on healthcare and healthcare education. Each involves a creative, humanistic component.

**Humanities Coursework**

All medical students are required to take a fourth-year humanities elective offered by the Department of Humanities. Some examples of past classes include: Medicine and Madness, Death and Dying in Literature, Bioethics in Mass Media, Religion and Health. The realization that none of these courses contain content exclusive to medicine led to a dialogue between nursing and medical faculty on the possibility of an interdisciplinary option.

In 2004, a humanities elective on Arts and Healing was opened to both nursing and medical students. Taught by a doctorally prepared nurse from the College of Medicine, the focus of the course was the use of artistic modalities such as writing, music, movement, and visual media for therapeutic purposes. One nursing student participated, using the course to fill her elective credits. Evaluations from this course spoke to the importance of the opportunity to hear the perspective of another discipline.

In 2005, a second elective on Physicians and Nurses invited participation from both disciplines. This time, three nursing students enrolled. The focus of the course was to explore differences and similarities in how physicians and nurses are educated and practice. One of the key assignments was to shadow a nurse and physician practicing in a similar clinical area, and to observe similarities and differences in their care.

Commentaries on the degree and quality of nurse/physician collaboration were presented in class and as a final paper, along with an action plan. In the evaluations, one medical student wrote:

“I have become more aware of the training and experiences of nurses and how there are many overlaps with medicine. It hopefully will make collaboration with nurses easier in my future training and practice,…and I will certainly be more conscious about my attitudes toward nurses and respect their ideas and input while practicing medicine, as well as try to develop relationships with nurses modeled after some of our physician-nurse visitors.”
A nursing student wrote:

“Invaluable information was shared about the medical profession that will definitely improve my career as a nurse. To be able to see and hear what the medical students go through increased my appreciation and understanding.”

Residents Retreat

For many years, a two-day spring retreat has been held as a capstone event where chief medical residents can take time away from clinical practice to discuss relevant humanistic issues. Seminars are presented by faculty on issues such as ethics, burnout, stress, and power; and leisure activities promote casual discussions on healthcare practice.

During the retreat held in spring 2004, graduate nursing students were invited to attend for the first time. Two accepted, participating in the same discussions and activities as the 18 medical residents. In the written evaluations of the retreat, there were several comments on the benefits of the interdisciplinary approach. When asked about the strengths of the retreat, comments included “building relationships with other professions and the input of other disciplines.” It was also suggested that more nursing students should be included in future retreats.

Orientation of Incoming Students

At the Medical Center, each incoming class of medical students is met by the Director of the School of Nursing, and each cohort of nursing students is welcomed personally by the Dean of the College of Medicine. Their presentations stress the humanistic side of clinical care and shared professional values. A picnic for both groups of students and faculty is held early in the semester to promote ongoing collaborations between students, and activity groups focused on special interests such as arts and healing, international care, and alternative therapies are open to all students. A joint medical and nursing student affairs group has been established to facilitate collaborative problem solving on student issues.

Nursing Coursework

Communication skills that include the ability to listen effectively are essential to the delivery of humanistic healthcare. Recognizing that this process begins with respect across disciplines, faculty of the College of Medicine and the School of Nursing are developing an interdisciplinary course entitled “Dialogue: Building a Foundation for Communication In Health Care.” In the spring of 2006, this course will be offered as an elective to graduate nursing students and medical students with a goal of teaching the dialogic skills of listening, respecting, suspending, and speaking one’s voice (Finch, 2000). Development of these skills will help students incorporate humanistic values in communication with colleagues, other professionals, and patients. Faculty from both disciplines will co-teach so as to model the dialogic processes for students.

Conclusions

The preliminary efforts made at our University to promote an interdisciplinary model of humanities suggest that both nurses and physicians are motivated to collaborate more, rather than less. Future efforts will involve inclusion of other healthcare professionals and evaluation of short- and long-term outcomes of such activities.

The humanities provide an ideal common ground for nurses and physicians because there are no domain issues. As a neutral discipline not owned by either medicine or nursing, both groups can discuss shared values and concerns and can learn to approach health care as a true team. Potential for other cooperative ventures for nurses and physicians exists throughout clinical practice settings and research endeavors.
The world of healthcare is increasingly complex, technologically intensive, and subspecialized. This has created the need for medicine, nursing, and other health professions to come together as an effective team with exceptionally high levels of mutual respect and effective communication. The humanities provide a platform especially well suited to foster these qualities.

References


Little, J. M. (2002). Humanistic medicine or values-based medicine. What’s in a name? *Medical Journal of*


POSITIVE EXPOSURE is a highly innovative arts, education and advocacy organization working with individuals living with genetic difference. Through vigorous cross-sector partnerships with health advocacy organizations, governmental agencies and educational institutions, Positive Exposure utilizes the visual arts to significantly impact the fields of genetics, mental health and human rights. Our programs support and promote human dignity through Positive Exposure’s Spirit of Difference photographic image data bank and video interviews of persons, particularly children, living with genetic conditions. To develop these resources Positive Exposure conducts Self-Esteem/Self-Advocacy photographic and interview workshops in collaboration with people living with genetic conditions. Positive Exposure also presents diversity workshops and portable, sustainable educational and human rights programs and multi media exhibitions for physicians, nurses, genetic counselors, health care professionals-in-training, elementary and secondary schools, legislators and the general public. (www.positiveexposure.org)

Rick Guidotti is an award-winning former fashion photographer who has spent the past ten years working nationally and internationally with more than sixty advocacy organizations/NGOs and nineteen medical schools, colleges and other educational institutions to effect a sea-change in societal attitudes towards individuals living with genetic difference; his work has been published in newspapers, magazines and journals as diverse as People Magazine, the American Journal of Medical Genetics, The Lancet, Spirituality and Health, the Washington Post, Atlantic Monthly and Life Magazine.

Positive Exposure:
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Positive Exposure

Myotubular Myopathy  Ben  Hermansky-Pudlak Syndrome  Chelsea

Moebius Syndrome  Jessica
Albinism, Australia

Roz

Albinism, India

Keke
Don’t make eye contact my brother warned. They’ll be waiting just inside. Don’t look at them. Deftly my brother punched in the code. Knew the code by heart. I had to be impressed, this was my younger brother and seemed possessed of a grim knowledge of which I was ignorant.

A hefty double door with inset wire-lattice windows. Overhead, a video monitor. As soon as my brother punched in the code, the doors slid open and we stepped inside and at once the doors slid shut behind us. Two, three seconds you were granted, no more. Like the sliding doors of airport trains. Like a maximum-security prison. For already the figures waiting just inside pressed forward. There were three of them. Dad won’t be among them, my brother had promised. Yet my heart began to clamor, I felt sweat breaking out in all the pores of my clumsy body.

Hel-lo? Hel-lo?
Son? Son? Son? Son?

Sidelong my brother regarded me gauging how I was taking this, knowing me for a risk. His hand on my arm guiding me. He’d warned me not to look yet I could not not look. For the voices were calling to us, pleading. My instinct was to stop, to stare. An elderly woman with white hair lifting from her skull like electrified wire filings, a sunken-chested elderly man with a singed-looking face, a gnome-sized individual of no evident sex leaning on a walker and piping like an eager parrot, Hel-lo? Hel-lo? While the elderly woman began to scold, Dear? Dear? Here I am, dear! And the sunken-chested elderly man teetered forward on a cane managing to position himself in front of the others, blocking their entreaties pleading, Take me? Take me? Boys? Sons? I’m ready now. My things are ready. Take me with you? On his bony skull-thick-lensed glasses were secured by an elastic band. The smell of them was acrid as goats. The befouled wettish-rotting straw in which goats well.

My brother yanked at me. Jesus! I told you come on.

Yet somehow in that instant I stood stone-still, unmoving. For these elderly strangers seemed to know me – how? They were pleading, scolding, bleating. Their faces were familiar to me in some way I could not comprehend. The white-haired woman had a fattish fallen body soft as pudding but hee eyes were vigilant, alert to insult. Here was a mother’s voice.
– Dear? Dear? Come back here! Don’t you walk away while I’m talking to you! Don’t you walk away while I’m talking to you! – you could not ignore. And the others were crying to me, calling me Son. Son!

My brother pulled me away. Blindly we walked along the corridor. Even now I wanted badly to look back. I wanted to explain, apologize. I’m not your son, I am no one you know. My face burned, I was ashamed of myself. A deep visceral shame. To turn away unheeding from another who begs you. Those strangers with weirdly familiar faces. Ruins of faces. Desperation in those faces. It seemed to me that I did know, I’d once known, the sunken-chested old man with the singed face, but my brother was muttering in my ear, keep moving. They won’t follow us. They do this with everybody, I told you. It shook me up the first time, too. But you get used to it. They won’t remember, see. They won’t remember five minutes from now. When we leave it will happen again, for them it will happen for the first time because they won’t remember us. Just don’t make eye contact with them and you’ll be fine.

I pushed my brother’s fingers from my arm. Coldly I said, I don’t like to be rude to old people.

We’re not being rude for Christ’s sake! It’s what you have to do.

I was pissed, my brother had put his hand on my arm.

I asked if the old people were anyone we know.

My brother bared his teeth in a savage smile. Not really. Come on.

THE VISIT WITH Dad. My first at the Manor.

I’d stayed away for as long as I could but now I was here. Hadn’t prepared for the visit beforehand and now it was too late, I was here. Of Dad I will not speak. Of Dad I refuse to speak. Of the visit I can say, yes it happened. On our way driving to the Manor my brother remarked casually that Dad had tried to escape, at first. This remark was met with silence. It might have been a sad, or a stunned, or a confused silence. It was not an indifferent silence and yet I didn’t inquire how many times Dad had tried to escape nor did I ask what tried to escape literally meant. How much effort, with what emotion, cunning, desperation, force. Nor did I inquire with what force tried to escape was met by the staff.

Dad, hi! H’lo Dad.

Hi Dad! Hey. Looking good Dad…

Dad this is Norm, I’m Vince. You know…

Your sons. Hi Dad.

Your sons, Dad. Hey this is quite a place. Quite a …

In this way the visit with Dad began with ebullient spirits and raised smiling voices. Within seconds my mind detached itself from the scene. I was damned impressed: my brother who’d always been three years younger than me was now at least three years older. His eyes were older. The terror between us was This isn’t Dad. This elderly man. Not Dad any longer. We could not look at each other, our eyes could not meet out of dread of then we are not brothers, either. For we have no father any longer.

I went to the window to open it. Having trouble breathing suddenly. Like trying to suck oxygen through clots of greeny phlegm not your own. Help! Sweated through my fresh-laundered white cotton shirt, underwear stuck in the crack of my ass. The smell of wettish goat wasn’t so powerful in Dad’s room but there were other smells. Only one window, and it
was stuck. My brother said, Hey: that window doesn’t open. Grinning at me like it’s a joke. I looked down and saw for Christ’s sake the window is inset in the sill like concrete. You could rupture your guts trying to shove it open.

Where my brother and I were, we were in the E-wing. Visiting Dad in the E-wing of Meadowbrook Manor. From the two-lane country highway out front Meadowbrook Manor more resembled the campus of a well-financed community college that the brochures call an assisted-care facility. Seeing the Manor from the highway you wouldn’t guess how certain of its wings were under tight security and guarded as a prison. You wouldn’t guess how if any patient in these wings tried to escape confinement or through mental confusion appeared to be trying to escape alarm bells were triggered. E-wing patients like Dad were outfitted with unremovable bracelets around their left wrists with metal tags that, if brought through electronic detectors without clearance, set off alarms through the facility.

My brother had told me he’d heard the alarm once. Ear-splitting it was.

My brother had told me that Meadowbrook Manor was the best assisted-care facility within one hundred miles.

In fact, my brother was saying now, Dad is a favorite here. All the nurses say, what do the nurses say Dad, the nurses say every time I come to visit what a sweet old gentleman your dad is.

What I was noticing was the Manor was brightly lighted as a stage set. Furniture in bright pastel vinyl. Nurses and nurses’ aides mostly black women in dazzling white uniforms smiling often at us who were visitors. My brother spoke of doctors, too. Of course my brother had met with doctors. This is the best place for Dad my brother said. His smile was a brave smile and infectious.

In my vinyl chair as we visited with Dad I was wondering how many times Dad had tried to escape, and when had been his last, or his most recent attempt. I was wondering how far the old man had gotten before the alarms went off. Before he was restrained. And how exactly was he restrained. Were physical restraints involved. Did strait jackets still exist. In a loud voice my brother spoke of the nursing staff. Very nice they were. Very sincere. Genuinely attached to their parents my brother said, then laughed at himself saying I mean patients: genuinely attached to their patients.

In his loud voice my brother asked me if he’d told me Dad is a favorite here.

At the highway beyond the wall, the unmovable window, the lawn greenly svelte as a golf course, a diesel truck thundered past.

I would not ask where Dad believed he was escaping to. The old house was gone. The past in which Dad had lived was gone. Nothing remained. An elderly doomed man might wish to escape to the years in which he was neither elderly nor doomed but those years are gone. You wake up one morning, those years are gone. There’s a comfort in this fact perhaps. I want to think that there must be comfort in all facts we can’t alter.

Shit, said the man with Dad’s voice. Bullshit.

TIME FOR A walk?

My brother was on his feet. I saw that his jaws were stubble and that the stubble glinted gray. My younger brother no longer young! My own jaws were clean-shaven. Out of anxiety I shaved twice a day. I wasn’t certain if Dad had spoken as I’d seemed to hear him. I wasn’t certain if Dad had spoken aloud. In the Manor, voices tended to be louder and higher-pitched than normal. There were mirage voices, that possibly didn’t exist, like upside-down
and reversed images at desert horizons. And beneath these voices the murmurous quietly laughing TV voices. When I spoke, which had not been often in dad’s room, my voice cut the air like an awkwardly brandished blade, a machete perhaps. I was remembering who the sunken-chested man was I thought.

Who the sunken-chested man had been.

Three of us on our feet. My brother led the way. We walked slowly. There was no hurry in the E-wing. In Meadowbrook Manor there was no visible hurry. My brother who knew the way led us past the TV lounge and the upright piano and the resident fat dog sprawled in sleep. My brother led us past a nurses’ aide putting soiled diapers into a black plastic bag on a cart. The double door to the garden was unlocked. The garden was a secure place though you could not see the seven-foot chainlink fence through the dense hedge of wisteria. If there were video cameras trained upon every square inch of the garden you could not see them. My brother was saying in his loud cheerful voice, Dad is one of the best gardeners here. Dad, show us your tomatoes.

The tomatoes were indeed lush, staked to a height of four or five feet. There was really no need for Dad to show us, we were looking at them already.

Dad, show us which flowers are yours. Zinnias?

The word zinnias confused. The word zinnias met with no visible response.

We were circling the garden slowly. A graveled path, which we took counter-clockwise. Though we were on a more or less level plane it felt as if we were struggling against gravity on this path. For in this place time had virtually ceased. Perhaps between one heartbeat and the next time had in fact ceased. There was the danger of falling sideways in time, as when you pedal a bicycle too slowly, you fall sideways. In my right hand, somehow related to this strange cessation of time, was an elderly man’s hand. It was a bony hand, unresisting. My brother gripped the elderly man’s other hand in his left hand. A strange word, zinnias! I seemed to be hearing it for the first time. A combination of sounds like hot coiled wires that might spring suddenly out, and sting. Zinnias. There was a sound here too of wasps. I wished my brother wouldn’t repeat in his unnervingly loud and buoyant voice zinnias! See the giant zinnias these are Dad’s zinnias! Almost as if you were wearing an electrically sensitive bracelet, you might think that zinnias was a code word or a means of torment.

Dad’s hand trembled yet remained unresisting, like a hand made of slightly crumbling clay.

We were not alone in the garden. Other grown children were visiting with elderly adults. There were visitors, usually women, or couples. Never more than three individuals in a party, for too many visitors confuses the elderly residents of the E-wing. By chance we were all walking in a counter-clockwise movement on the graveled path. We did not glance at one another. An instinctive dread of glancing into a mirror. We don’t see you, you don’t see us. We really have no idea what we look like. Before my brother had punched in the code to open the E-wing doors, he’d told me that Dad no longer recognized himself in mirrors, so don’t expect him to recognize you.

I had that expectation.

I took cue from my brother, I smiled. I had no expectations to be thwarted or mocked.

The season was fall. Yet hot as August. Air quivered in a sinister tangle of near-invisible filaments like those in a gigantic lightbulb. My eyes blinked, blinded. Yet I was calm recalling:
the sunken-chested man with the signed face, Mr. M__ who’d taught junior high math. He’d taught me, he’d taught my younger brother. More than thirty years ago he’d taught us. Mr. M__ was not a name I wished to recall. Nor would my brother wish to recall Mr. M__. For Mr. M__ had graded my brother more harshly than he’d graded me who had been an honors student even in math which became my hated subject under Mr. M__’s instruction. Mr. M__ had taught at Yewville Junior High for a long time before they made him retire. That was the local story, Mr. M__ had been made finally to retire. Under threat of a law-suit, or an arrest. He’d touched a boy too intimately, you had to surmise. Too lingeringly, he’d teased a boy to tears. He’d pinched, tickled, slapped a boy. He’d twisted the tender earlobe of a boy just a little too hard and left reddened prints in the flesh for an astonished parent to discover. Or he’d playfully locked a boy in his homeroom after school. Or not so playfully: “for discipline.” The color rising in his face that had been fattish then, a moon face in which veins and capillaries glowed with an interior pulsing heat. During class you sat very still in your seat trying not to be seen by ever-vigilant Mr. M__. His eyes behind the black plastic teacher-glasses prowling the rows of desks. Eyes that were faintly bloodshot yet shone with a youthful vigor at such times. If you started blinking down at your desk top Mr. M__ would see and know you were hoping to escape his scrutiny. If you dared to gaze at him guileless and unblinking Mr. M__ would see and know you were hoping to escape his scrutiny. For there was no escaping Mr. M__.

Certain boys were Mr. M__’s targets. You could see why certain boys were not Mr. M__’s targets for he never dared single out any strong-willed or defiant boy, or any boy from a prominent family, and boys of limited intelligence he ignored; but you could not always predict which boys, out of a number of possibilities, he would choose to torment. Vulnerable boys, shy boys. Shyly stubborn boys. Smart boys. Small-boned boys. Boys with girls’ faces. Rarely homely boys. Never handicapped boys. Never Italian or Negro boys. First he’d call on you in class and if you gave the right answer he’d call on you repeatedly until at last you gave a wrong answer. You stood at the blackboard trying to solve a problem, chalk trembling in your fingers. Mr. M__’s scorn was so playful, his mockery so comical, you weren’t always certain why you were being laughed at by even your friends. Your face burned, your eyes stung with moisture. You felt your bladed pinch with the need to pee. Once summoning me forward to his teacher’s desk at the front of the room. Making of me a witness to his red-inked pen darting and swooping over my math test like a miniature deranged hawk. I had the mis-numbered questions! I was a careless boy! Might’ve had a grade of ninety-eight but now had a grade of forty-eight and this would be duly noted on my midterm report card to be sent home for my mother’s signature. Tears welled in my eyes. My nose ran. Disgusted Mr. M__ tossed a tissue at me. It might have been a used tissue, out of his baggy pants pocket. Wipe your nose, Mr. M__ said. Stand up straight, Mr. M__ said. What a careless boy you are, I’ve got your number. For it was so, there were boys (but never girls, and we never wondered why) of whom Mr. M__ could boast I’ve got your number.

Almost time for dinner, Dad. My brother spoke brightly as if he’d made a new discovery, and it pleased him.

Dad? It’s that time.

We re-entered the E-wing. We’d circled the garden not once but twice, slowly. The tomatoes had been admired, and the mysterious zinnias. I had forgotten that time wasn’t fixed like concrete but in fact was fluid as sand, or water. I had forgotten that even misery can end.

Got your number, got your number. Just ahead the sunken-chested old man with the singed
face, the thick-lensed glasses taped to his head, was leaning on his cane. Again we must pass close by him. For he would not give way. For he wished to block our way. The white-haired old woman was gone. The gnome-sized individual was sitting, back against the wall. Here was Mr. M__ wizened as a scrawny child. His face had lost its fat, his cheeks were papery thin and flushed as if with fever. I saw how, as his lighted upon us, Mr. M__’s expression turned hopeful, shrewd. For the first time I saw how his dentures glared like cheap porcelain. Boys? Take me with you? Take me with you? He lurched near me, his palsied hand groped for my arm, and I shoved him from me. Mr. M__’s fetid breath in my face, that made me gag. Don’t touch me, I said.

Shoving him from me I said, You’re not going anywhere with anyone, you old bastard. Your place is here, you get to die here.

My brother turned an incredulous face to me. Yanking at my arm to pull me away from the tottering old man who gaped at me as if he hadn’t heard a syllable of what I’d said.

Norm! For Christ’s sake.

My brother was so rattled, he had trouble punching in the code to unlock the doors.

Second time, he got it. There was a bleating and pleading behind us we ignored. As soon as the doors opened we stepped through. We walked swiftly along the corridor to the lobby not looking back. My brother was cursing me under his breath. I’d never heard him so angry at anyone. God damn, God damn you, are you crazy, God damn you.

Why didn’t you warn me, I asked my brother. You knew who he was.

Who who was? What? That pathetic old guy? He’s nobody.

You knew. You know. God damn you.

We burst through the lobby doors. We walked to my brother’s car in the parking lot without speaking. Without glancing at each other. Not a backward glance at the Manor. Inside the car it would be hotter than hell. My brother had insisted the windows be shut, the doors locked. At Meadowbrook Manor! Disgusted my brother threw himself behind the driver’s wheel not looking at me and I had a choice, to climb inside that car beside him or to walk back to his house which was at least three miles and along the country highway in the sun.

It wasn’t much of a choice.
Wavering light hits plaster walls
while brains spin behind closed doors
trying to heal their failures. The hospital at night
is a Hopper painting with its solitary figures
somber colors, undulating forms.

Someone moans and moves, a hump
rises in the sheets
and I know how a mother feels
finding daughter and boyfriend in bed.
No one talks about sex in a hospital
but, like oxygen, it’s always here
egoes, hormones locked together
months at a time. Mary, with the ebullience
of a Renoir nude, stretches and yawns
while Pete, sprung from isolation, slowly pulls on his jeans.

While the hierarchy tries to rewrite emotions
and histories, rebalance chemicals
on brass scales, lovers’ aches have grown arms, legs, breasts
as they whisper sweet messages into receptive ears.
Love weaves bodies together
creates new wrinkles in the brain as nerve
endings salute, hair follicles explode. Perhaps for Pete
and Mary there’s one cell that recognizes
each other’s face, voice, walk
and they’re home because love is here.

Author’s Comment
I wrote a short story, “The Isolation Room,” (published in Crucible, Barton College, Wilson, NC, 2004) which told the story of a writer who spent time in a psychiatric institution after an accident. She was accused of being a surrealistic writer even though the incident she wrote about proved to be historically accurate. “Night Therapy” arose from my work on this short story.
Storm Song

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Artist’s Comments
Joseph Campbell once said: “‘reality’ is comprised of those myths we haven’t quite seen through.”
My paintings are portals to the mythical realms of life. My paintings are an invitation to see beyond
the illusions of everyday reality so that we can dream new realities into being. This kind of healing
through art draws on the concepts from the sciences, medicine and the arts in the ordinary sense of
the word.
When they aren’t sick, I schedule them back in a few months to refurbish their pills for pressure and sugar and water. I check their labs and urines, but minimize frills—in media res. For most of the visit we talk about bosses; bosses’ vengeance; prancing office scum who make illicit screwball passes; big shots; the innocents who get shot down; their gardens; the old timers who shoot-off about managing their wives but manage to loose them; and the whiners, the rumbas, the Jesus-is-my-Savior lives—I sit there behind my screen and listen. Ego te absolvo doesn’t hurt them.

Author’s Comments:
“As a primary care physician, I see many patients for ‘routine’ follow-up of their chronic medical conditions. The ostensible reason for these visits is to monitor their diabetes, hypertension, or heart disease by checking lab work and adjusting (or not adjusting) their medications. However, at a deeper level, such encounters serve as opportunities for patients to tell their stories and be listened to in a non-judgmental and supportive way. I wrote ‘Absolution’ because it struck me that there were parallels, at least in some cases, between my patient encounters and the Catholic rite of confession, which I’ve evoked in the poem by using the Latin formula, Ego te absolvo (I absolve you). Because of the ritualistic nature of this process, I decided to employ a traditional poetic form, the Shakespearian sonnet.”
These days, for no reason, I slide back
to my thirteenth summer, summer a surgeon
slit open my spine, fused it, wrapped me
in a shoulder-to-hip cast. I spent two months
in a second-floor bedroom, and relied on my mother
to select my weekly library: one batch included

The Stranger, The Spy Who Came in From the Cold
and All Quiet on the Western Front. As with every-
thing else: I did not question, I read them. I do not
think Mom had ever read them, but she knew
the titles, knew to choose them over romances
or all of the Victorian novels I had already finished.

At first, Camus’ novel struck me as strange,
I had no hooks on which to hang the spare
landscape: the beach that, due to the circumstances,
did not sound so pleasant, or the protagonist
Meursault’s continuous air of detachment.
Yet the simple language seduced me.

What a funny fellow, this Meursault,
vague as to the exact day (today? yesterday?)
of his mother’s death. But, very soon,
from my prone, pillow-less perspective,
it did not seem strange at all,
this calm man who did not shed tears on the coffin—
even though he bore his maman no malice—
or that days later, it was the sun glancing off a knife
as much as anything
that caused him to unload a revolver
into the body of a virtual stranger
on the beach.
Yesterday, or today, my mother is suffering hours of relentless sciatic pain.
Now, when it is time to think about the things I’ve never liked to think about, my taste is for the simple, the spare, like Monsieur Camus’ storytelling:
these days, when I sense a distant wind blowing towards me, I long to shed my layers, lie down in the sun, aware of sky, the occasional cloud; to forget who I am.

Author’s Comments:
This poem emerged from the convergence of several strands: the fact of the speaker’s elderly mother’s decline—a fact which quietly overwhelms the speaker; the speaker’s memory of her own “extreme” physical condition following spinal surgery as a young adolescent; and, finally, her memory of the books her mother checked out of the public library for her to read the summer of her recovery. Now an adult looking back, she sees these books, specifically one French novel, in a different light.
Sand and Water

Stacey Nigliazzo, R.N.
College Station, TX

Startled
EMS radio
Someone forgot to adjust the volume
Twentysomething female, Anorexic
Possible suicide attempt
Awake and alert, crying
ETA 5 minutes

MD, RN at bedside
Each knows his task
Assessment, oxygen, IV, labs,
D-stick, possible EKG and charcoal
Nasogastric tube on standby, just in case
Unit clerk pages the social worker

Automatic double doors part widely
Paramedics barrel inside
Screeching tear floods and panic
Pouring in beside them
Big bag full of little bottles
Empty

What did you take?
NOTHING!
And everything, by implication

Soft white cup holding black earthen sand
Steady streams of water pour inside
Bubbles popping in a Styrofoam cauldron
Gurgling and belching with Sorbitol
Plastic lid on top

Pleading words
This is charcoal. You need to drink it.
She will not hold the cup
Frenzied, unyielding
No reasoning
Just the toxic swill swimming inside her belly
I can smell the calories!
She yelps, a wounded beast
Arms wild, cup hurls across the room
Banishing poison from white walls

The order is given
Reluctant restraints on wrists and ankles
High fowlers position
Gloves, gowns and masks
Nasogastric tube dripping water-soluble lubricant
Tinged with blood
Searching for the back of her throat

Stinging in the stomach
Raging torrents of sand and water
Chasing through the tubing
Quenching pink folds all aflame
Done

Vitals signs stable
No apparent distress
Normal sinus rhythm
Security at bedside
Silence

**Author's Comments:**
This poem was inspired by my experiences caring for young women in crisis, particularly those ravaged by eating disorders and attempted suicide. It is a harrowing testament to the striking nature of the illness—the fact that even to save one’s life, an antidote would not be allowed because it might contain calories. It is also a graphic tribute to the often unforgiving nature of charcoal administration in an emergency setting. It is never a pleasant experience, but always one that is memorable, and above all, life saving.
He notices the blood as he steps out of the shower onto the white marble bathroom floor. Tony Beal and his wife Sarah are in Rome on one of the working trips that now double for them as a vacation. Sarah has long ago given up on real holidays. These working trips come their way frequently as Tony's reputation as a speaker has grown to match his one as a gifted neurosurgeon.

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

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

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

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

But on this, the second morning of their week long stay in Rome, Tony was not thinking of his successes as he stepped out of the shower onto the warm bathroom floor of their elegant hotel. There was blood on the floor. He was always watchful. Blood on the floor
was something he knew about. On entering a fresh surgical suite his eyes took in the whole room, the gleaming clean steel, the bright lights, the trays of equipment laid out ready for his use, the crisp scrub uniforms of the surgical team, nurses, technicians, the anesthesiologist already attached to and caring for the patient and - the spotlessly clean floor. They all stood in a regimented order for his inspection and approval before he approached the patient. Like an old sea captain he needed to know everything was in its place and as it should be before setting sail into the skull and mind of a fellow human being. When he was satisfied he would then step forward, his registrars and interns following behind him as in a choral wave.

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

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

“Hum.” She replied.

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

“No, I haven’t.” Sarah replied absentmindedly. But she too began to think about the blood.

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

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

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

Sarah got up from the bed, went to the bathroom and closed the door. She sat down
on the wide marble edge of the bathtub and looked at the floor. She smiled. She wondered what Tony had been talking about. It never occurred to Tony to clean up, to wipe away the blood from the floor with his used towel. She picked up the used towel he had dropped on the floor. She looked down and then she saw them. Two spots of blood, small, dried and dark. Not much she thought, not really fresh either, but where did they come from? She ran her hands over her calves and looked down at her ankles. There were no nicks or red slashes showing. The angle of the razor had been true. So where had the blood come from?

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

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

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

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

**Author’s Comments:**

*A Drop of Blood; falls is spotted but not claimed. A couple circle this intrusion from one of their bodies and into both of their lives. But to whom does it belong to? One of them, or, as a couple, both of them. Maybe, as much as where does it come from, that is the question this story asks as the blood lies unclaimed - on the bathroom floor.*
In the summer of 2007, my brother and I traveled to West Bengal, India to experience and study the lifestyle of the underprivileged living in remote villages. These photos offer a brief and broad glimpse of the destitute conditions we encountered and what we learned about the health care system.

The residents pictured survive on roughly $40 per month – enough to barely feed four family members. They are the rickshaw drivers, fruit sellers, maids, farmers, and child laborers of the world. Here is a peek into their lives and the health care they receive.

In an attempt to alleviate the significant health care shortage in West Bengal, volunteer physicians from other parts of the state travel 6-8 hours to host free clinics. In a typical day, they see roughly 300 patients in four hours. With scarce tools, the doctors rely greatly on their clinical intuition to make diagnoses. Under such conditions, rapid development of doctor-patient rapport is essential.
How many books prompt one to pause and record a phrase or an author’s expression? As I read this book, almost every page got papered with a post-it note to rewrite and savor Davis’ words.

Her generous and eloquent language offers the reader a subtle gift of mutual recognition that sneaks into the gray matter connecting dots remembered somewhere in our own paths silent vibrations of sorrow; a radiant soul that was suddenly called away; to be there at that exact moment, the one we all think about, the one that can terrify, the one that can release.

Thirty years ago, I too ‘stumbled’ into nursing. Far from a calling for me, the free application to nursing school was the biggest selling point. In sharing her ambivalence and uncertainty about becoming a nurse, Davis’ masterfully described stories reveal and amplify our human interconnectedness and stunning vulnerabilities. Her understated backstory, which she deftly shares, illustrates her fortitude and success in balancing her personal life with a professional nursing practice. Davis hopes we hear, read, feel beyond her stories to “the universal truths about life, suffering, and death.”

Yes, thank you Cortney Davis-for reawakening and reminding me of all the holy moments and shy, simple miracles of our fragile humanity. Did I embrace all the opportunities “at the borders of our bodies...to connect, love, praise, and serve”? What did I miss?

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International Journal of Healthcare & Humanities

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