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Dear Readers:

Thank you for your patience in receiving this issue as I faced some difficult issues. The recent months have been a time when healthcare and humanities took on new meaning for me as doctors, nurses, chaplains, and a variety of other providers emphasized just what the caring professions are all about and how big the gifts they give to patients are.

The images you see on the right are from my recent class on Creativity, Arts, and Healing, which I believe conveyed a similar message to them. One wrote this about a photography exhibit of patients in our hospital: “It just seems to bring to life how each of our patients are ‘real’ people with ‘real’ lives….We so often forget that we are treating fathers, mothers, daughters….someone’s loved one. When I come across a doctor who never forgets that fact, they always stand out in my mind as some of the best.”

The stories of patients emerge in different ways, as this issue portrays: narrative photographs, poetry, and from caregivers. Who owns these stories is an interesting ethical issue examined in our opening pages, and crafted storyteller figures by Courtney Fall Tomchik offer messages of hope and inspiration.

We look forward to hearing back from you with submissions, letters, and stories of your own.

Editor’s Column

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Three Stories

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It was quite a fall.
   No one could tell
   how he climbed
   into the top loft of the barn.
   Hit the open door on the way down.
But here he is,
   improbably crying,
awake, looking
   for mom and dad.
We’ll keep him the night
   just because
we can’t believe that he survived.

But down the hall
   there is
   a child,
pushed on the sidewalk
by his older sister, angry
   not having
her turn
   with the toy.
A hairline fracture,
   plus some blood,
the wrong place,
   it’s enough.
Grandma keeps saying “Why?
   Tell me why
he’s got to die.”
We talk of intracranial pressure,
irreversible cell death,
the closed box of the skull.
   Her eyes fill up
with questions, not for us.
“Who is going to tell it? Who is going to tell the story so that we can feel it? That’s important, man, because once you feel it, then it’s yours.”


**Introduction**

We conduct our daily business in stories, and physicians, by the nature of their profession, regularly have stories told to them whether from the patient with an illness, the colleague who questions a therapeutic decision, a resident or medical student who asks for career advice or who comes with a personal problem. As Wayne Booth states, “We all live a great proportion of our lives in a surrender to stories about our lives, and about possible other lives; we live more or less in stories, depending on how strongly we resist surrendering to what is ‘only’ imagined.”

In his 1988 book, *The Company We Keep: An Ethics of Fiction*, Booth asks, “Are there limits to the author's freedom to expose, in the service of art or self, the most delicate secrets of those whose lives provide material?” Unfortunately, he goes on to say that “the question is generally ignored in current criticism” and then fails to examine this particular issue in any further detail. However, he does identify three overriding concepts for contemplation in considering this question: the reader should not assume that the events and details that the author has chosen to write come from real life, this question may not even be important to the reader who does not have information about the author's life, and the question may not have relevance if one believes that “art justifies all.”

As best as this author can determine, an ethical analysis of “who owns the story?” has not been performed within the realm of creative literature. Physicians, probably because of the intimate nature of the physician-patient relationship, seem willing to not only ask the question but also to make an effort to provide an answer. In a 2001 paper, Charon examined aspects of the ethics of narrative medicine and concluded that if the heath care professional seeks to publish a patient's story in medical journals or in the lay press, then permission must be obtained from the patient. The main issue, as Charon sees it, is one of privacy and confidentiality and that despite changing the usual identifying-type of information, “the highly singular clinical details of illness make patients recognizable, even if only to themselves, their families, and those who work in the author's institution.” Second, because the patient might come upon what was written, whether or not what was written was thought to be favorable by the patient, the issue then becomes one of informed consent.
third ethical issue for consideration is that of fidelity, or trust, between the physician and the patient. Finally, Charon raises the ethical issue of justice, because of the possibility that the physician-writer might exploit patients for their stories.

In a subsequent essay, Coulehan and Hawkins, take a less dogmatic approach as compared to Charon, and indicate that although there is an ethical obligation to obtain informed consent from patients before publishing stories about them, “there is no bright line between fact and fiction” and the duty to obtain consent is dependent upon whether the story is more fact than inspired fiction. Furthermore, Coulehan and Hawkins feel that “keeping faith,” or maintaining trust with patients, readers, and editors also demands that the physician-writer add definition to the fuzzy border that exists between fact and fiction by “striving for transparency.” Or, similar to an idea raised by Brown (in the context of cultural anthropology), if the story has the “look and feel” of a patient’s true story, does the patient still maintain “ownership” rights for purposes of confidentiality, informed consent, and justice?

In this paper, I will examine the ethics of fiction in the context of ownership of the story, and the obligation (if any) that exists on the part of the author to obtain informed consent from those “whose lives provide material.” I will primarily use the terms “story” or “narrative” interchangeably, but I also include poetry, the essay, and the fictional novel in this group – that is, any fictionalized or creative writing. In addition, while I will focus on the physician-writer, my ethical analysis will, of necessity, also be applicable to creative literature that falls outside of the area of narrative medicine.

Ways of perceiving narrative knowledge and stories

In his examination of how we perceive knowledge (in the context of social inquiry), Barnes highlights three ways that characterize knowledge that also have applicability to creative writing and narrative medicine: enlightenment, power, and private property. The publication (or oral transmission) of a story or poem could be motivated by a desire to enlighten the author and/or the reader. In essence, the story or poem provides insight into learning, knowing, and seeing the world around us. Octavio Paz—a poet, essayist, and Nobel Prize winner in literature—makes this clear when he talks about poetry as “the other voice,” the “voice of passions,” that “exercis[es] our imagination [and] teaches us to recognize differences and discover similarities.” Paz’s assessment could be applicable to any author of stories who strives for such enlightenment. For the physician-writer, narrative medicine helps enlighten those daily experiences (stories) with patients, illnesses, colleagues, and our inner selves. Likewise, patients seek enlightenment when they tell their story to their physician, to a friend or relative, or to their religious leader.

The author who “controls” the story gains a certain amount of power over how the story is told, how the story is distributed and disseminated, and how the story is used for self-promotion or other personal benefit. Obviously, there are many levels of possible power. For example, the author of a story or poem detailing a secret religious practice has the potential to exert power over the culture surrounding that religion. Likewise, a physician-writer who provides identifying details of a prominent local politician’s illness in a narrative story exerts a certain amount of power over that patient. Power can also work in the obverse. A patient who tells the story surrounding his or her illness wields a certain amount of power over the physician-listener to the extent that critical or important information is forthcoming or withheld. A publisher or journal editor holds power over the physician-writer author by determining which stories or poems will or will not be published, or what words will be edited in or out.
Finally, a story or poem can be thought of as property. Does the teller of the story own the story? Or, does the creative writer who selects the words, thus creating the specific language, and reforms the details into a different story, hold primary ownership? When does a story lose its “identity” and become another story? Can a story, as some claim for social and cultural data and knowledge (e.g., religious ceremonies, customs, symbols, beliefs, etc.), be thought of as intellectual property that can be copyrighted? Certainly, authors of a written work, or a piece of music, can legally copyright their creation (at least for a defined period of time) but can the stories that make up our daily lives be “copyrighted” or claimed for ownership? As noted by Severi, “Since images are made to be seen and words are made to be exchanged, it is difficult to decide what images or what words must become someone’s exclusive property.”

If creative literature (and narrative medicine) is power, to paraphrase Barnes, then it will be used; if it is property, it will demand protection. When stories and poems serve as a source of enlightenment, then the benefits are more universal and the concerns about property and power dissipate.

Fact versus Fiction in Poetry and Narrative Medicine

If I should write a narrative about a child with leukemia that sounds like a note out of the medical record:

John Smith was an eight-year-old whom I first saw in my office in Hershey, Pennsylvania in 1982 because of general fatigue, loss of appetite, and easy bruisability…

I think there would be little disagreement that such a story contains factual information that potentially jeopardizes the confidentiality of the patient, and as everyone can appreciate, the medical record is protected by legal and ethical constraints on privacy and confidentiality; and, to a certain extent, the patient (or legal surrogate) controls (through informed consent) what can or cannot be made public about the medical facts. However, if I should write a poem entitled “Leukemia” that begins:

At first I didn’t know what it meant to have bad blood cells and that I would have to go to the hospital. Last year another boy in my school had leukemia and he got real sick. No one saw him for a long time then someone said he had died and we never saw him again.

The first stanza of this poem begins to tell the story of how a boy might feel about having leukemia, but it is not necessarily about a boy named John Smith (who actually does have leukemia) or, for that matter, about any specific patient in Hershey, Pennsylvania. In actuality, my poem “Leukemia” contains a mixture of fact and mostly fiction.

Booth suggests that we tend to “read differently when we believe that a story claims to be true than we do when we take it as ‘made up.’” He goes on to make the point, however, that fiction is actually less misleading because it is something formed creatively by an individual rather than something that the creator tries to duplicate from “life” or the “real world.” If I simply pull “facts” from the medical record and write them down I have not necessarily created a story or poem. Much more is needed to turn the medical jargon about a patient into narrative medicine. The “facts” become a story only when the author has added the creative “fiction.” The above poem could be about any patient or about a conglomerate of all
In the fictional novel *East of Eden*, John Steinbeck presents the story of several families over a number of decades. Several of the characters in the novel carry actual family names from Steinbeck's ancestry (including a child character named John Steinbeck who makes minor "cameo" appearances). One family patriarch in the story, Samuel Hamilton, is the actual name of Steinbeck's grandfather, but as noted in a biography of Steinbeck, "Like the other Hamiltons who are featured in the novel, Samuel is a semifictional character made up of various component parts from various models...than of the real grandfather as others remember him." To quote one small example from *East of Eden*, "'I can't tell you how to live your life,' Samuel said, 'although I do be telling you how to live it. I know that it might be better for you to come out from under your might-have-beens, into the winds of the world. And while I tell you, I am myself sifting my memories, the way men pan the dirt under a barroom floor for bits of gold dust that fall between the cracks. It's small mining – small mining.'" Who owns the story of Samuel Hamilton as told in *East of Eden*?

An example taken from narrative medicine makes some interesting points in the relationship between fact and fiction. In 2000, two narrative medicine pieces appeared in the literature by Jack Coulehan. Both stories, as told by Coulehan, concerned the same patient dying from metastatic cancer who, in his last days in the hospital, was involved with constructing a model of a beach house that he had designed and dreamed of actually building someday. In both stories, Coulehan recounts dialogue and thoughts attributed to the patient and to his colleagues. We assume that each story is true, because they sound true, and we have no reason to doubt the author's voice. In reality, both stories contain a mixture of fact and fiction created by the author. In both stories Coulehan notes that his patient "was woodenly opposed to discussing his feelings, or to any other verbal preparation for death" yet, there are a number of instances where the author presumes to "think" thoughts for his protagonist patient. For example, the author notes, "The model embodied a dream that had slipped through Bob's fingers during life. He had never realized his goal of living in an upscale beach house, yet in facing death he poured his energy and creativity into modeling the dream. In this, Bob was practicing the art of dying. He put everything into that house – the feelings, the yearning, perhaps even a vision of transcendence. Like artists and craftsmen throughout history, this Long Island carpenter used his own materials and symbols as allies in preparing to confront the unknown." The essence of this same sentiment is also noted in the other story, although in a somewhat different context, and the actual words vary somewhat. How does the physician-writer know these are the thoughts and feelings of his patient, particularly since his patient, as noted in the articles, apparently never had such conversations about death with anyone? While the author may have some intuitive insight into what his patient is thinking, the fact is that Coulehan is speculating about the patient's motives, his mental state, and whether he was "practicing the art of dying." Speculation and fiction most likely based on knowing intimate details about his patient, but fiction nevertheless. Likewise, Coulehan is producing fiction to add meaning to the motivations of all Long Island artists and craftsmen when he writes about their work as a spiritual quest to "confront the unknown." This is narrative medicine as fiction. As LaRue notes, "...we fill in gaps in our evidence, we build bridges between facts in order to interpret human conduct. A story is told to lend meaning to events. Most events have more than one meaning, all simultaneously both partially true and partially false." Coulehan has constructed a fiction—it is a good narrative fiction—and it is written to support his interpretation of the facts, his patient's struggle with terminal cancer, and to support his and the patient's moral and
emotional perspectives on death and dying. An interpretation that belongs to Coulehan and not necessarily to the patient, Bob Alexander. It is also an interpretation not necessarily shared by other characters in the story who, for the most part, viewed the patient as “too simple-minded or obtuse to understand” that he was dying.12,13 Whose version of the “facts,” of the story, is true? The version as told by Coulehan is true because it sounds true and thus it could be true; even though we can appreciate that it contains fiction. The story belongs to Jack Coulehan, and not to Bob Alexander. Nor does the story belong to the oncologist, or to the nurses who took care of him, because as portrayed in the two articles by Coulehan they might tell very different stories about Bob Alexander.

One final example will serve to illustrate my point. Philip Dacey's poem “The Deathbed Playboy” begins:

My old man, dying, motioned I should lean
down close to him to catch his whispered wish:
“I want to see a Playboy magazine.”
It was enough to make a grown son blush.
He was ninety-one. Retired from farming.
Iowa Republican and Catholic.14

Dacey goes on to talk about the father, and an interaction with a nurse who comes into the room. In reality, although Dacey received a number of condolences on the death of his father after this poem was published, the poem was actually based on a friend's brief remark and the majority of it was an invention and was not about his father at all.15 Who owns the story in this poem? The friend whose remark initiated Dacey's creativity, or Dacey who took the remark/story and made it into another story, or Dacey's father since the story is “about” him? As the poet Hayden Carruth has noted, “[The poem] is authentic because I know the place and time I am writing about, and I know myself…Intensity is what counts…intensity of perception, intensity of experience. To see, to hear, to feel.”16 Philip Dacey owns the poem and the story.

Along this train of thought, Booth notes that the author's voice can take several different forms.17 The narrator of the story “may be more or less distant from the”17

- “implied author” (morally, intellectually, or physically/temporally);
- “characters in the story he tells” (morally, intellectually, or temporally);
- “reader's own norms” (emotionally, morally, or physically).

Likewise, the implied author may have intellectual, moral, or aesthetic distance from the reader and/or the other characters.17 In a recent article in The New Yorker the writer Gabriel García Márquez said – in reference to his early beginnings as a writer – that, “They [books] showed me that it was not necessary to demonstrate facts: it was enough for the author to have written something for it to be true, with no proof other than the power of his talent and the authority of his voice.”18

When a physician-writer publishes a story from his/her practice, a medical autobiography, or some other form of medical fiction that purports to provide details of some patient, how do we know what voice the author is using and what parts of the story are fact and what parts are fiction? We don’t, and we can’t. We, the readers, believe the story is true if the author's voice makes it sound and feel true. As LaRue notes, “Can we produce stories without using the imagination? Most discourse is in part fictional…Every story will have some of both.”12 Thus, when a physician-writer creates a written piece about a patient with an illness or disease it is unlikely that simply one patient's factual account is portrayed. We, the readers, only know the voice as it rings true or false in a literary, moral, or emotional
sense. Does the story/poem enlighten the reader because the writer has factually detailed a single patient encounter, or does it enlighten because the author has creatively manipulated the language to give voice to universal feelings and experiences to achieve a deeper level of understanding that did not exist before? I contend that the created narrative enlightens because of the latter. Physician-writers put pen to paper because “the other voice” demands it and, as William Stafford said, “the possibility exists that a whole unseen human dimension will be opened up.” I further propose that if the latter is true (i.e., if the writer has created something “new” out of the medical jargon given to him/her) then the story/poem no longer belongs to the original teller (e.g., a patient), but it now belongs to the author who has given it a new voice. Dacey’s friend who made the remark that stimulated the writing of “The Deathbed Playboy” cannot rightfully claim ownership of the poem. And Steinbeck’s characters in East of Eden cannot claim ownership of that story. The patient who imparts a medical story cannot claim ownership of a reorganized, rewritten jumble of fact and fiction created by the physician-writer.

Words and patients, and thus stories and poems, do not exist in a vacuum and are constantly being nurtured by other stories and poems, and by contact with other patients and other people. Although it is convenient to think of a patient’s illness or disease as existing in a vacuum (i.e., an internal construct), illness and disease do not exist in such a distinct unidirectional flow, but exists, in the wider external construct of the whole of medicine. If the border between fact and fiction is fuzzy under the best of circumstances, then the boundaries that define the patient’s story as unique are even less clear. Thus, stories with the “look and feel” of belonging to the patient, to a colleague, or to a friend defy ownership, except by the writer who has created a new story.

Will a strict policy of obtaining informed consent impoverish narrative medicine?

The stories, poems, and essays that physicians write about their experiences are felt to be important for enriching the soul of medicine and for providing enlightenment in the practice of medicine. Several medical and literary journals regularly publish creative works by the physician-writer, and a number of books have been published that contain these writings. As discussed, an important issue in narrative medicine is whether patients “own” the information – the stories – that they have shared with physicians and other health care professionals. Charon and Coulehan and Hawkins advocate a policy of obtaining informed consent from the patient for the inspired stories (and poems) that physicians write thus implying some level of ownership by the patients.3,4

Stories change over time, and are constantly influenced and nurtured by contact with other characters and other stories. Thus, new stories are always being created and the story told today may, at some point, even be abandoned by the storyteller. From a legal perspective, patients do not “own” the medical record where their medical information – and the factual bits and pieces of their stories – reside. As anyone who has tried to claim ownership of their actual medical record will attest, the hospital or the physician’s office actually maintains ownership of the progress notes, reports, informed consent documents, etc. With increasing storage of the medical record in electronic format the issues of access and ownership are becoming even more complicated. However, because of legal and ethical constraints, the patients do maintain some semblance of control over who has access to their medical record.

From a creative literature perspective, I believe that a strict policy of obtaining informed consent from the patient before a physician seeks to publish a story or poem inspired by that patient will only serve to blunt the creative edge and will impede the free flow of information. Information in the form of creative stories and poems that many feel enrich
medicine, ultimately enhances the physician-patient relationship, and that probably also has historical value (the historical value of narrative medicine has not been critically examined, and deserves further investigation, but is beyond the scope of this paper).

An additional, and as yet unexamined, imperative against a policy of informed consent in narrative medicine is the potential wider social and cultural importance that potentially exists beyond the patient. For example, a patient’s story detailing a specific medical error could have profound impact on bringing this issue to the public, medical, and political fronts. In such a case, should a patient’s refusal to grant consent for publication override the potential wider cultural good that could result from dissemination of the story to a wider audience? Stories detailing patients’ experiences with death and dying, access to healthcare services, medical errors, etc., appear in the popular press on an almost daily basis. In such cases, patient refusals to be identified when the “story” is earmarked for publication in the mass media (e.g., newspapers) might still be published without personal identifying information in an effort to protect the individual. Thus, ownership of such stories is a complex relationship tied to the political, the moral, and the emotional, and the aspect of narrative voice, and whose voice is speaking, is no less complicated. However, my contention is that the story is owned by the writer who commits the created story to paper. And, although I agree with the necessity for informed consent in the normal context of the practice of medicine, I disagree with the ethical necessity to obtain informed consent from patients for the stories, poems, essays, and novels that inspire their physician-writers to creatively write and ultimately publish.

Concluding Thoughts

I believe that current efforts advocating for a policy of informed consent directed towards the physician-writer of narrative medicine are restrictive and will only serve to impoverish the genre of creative medical writing. The ethical concepts of confidentiality and informed consent are critical when handling purely factual medical information, but constant attention by the creative writer to these principles will only serve to blunt the creative edge. In addition, it is unlikely that “new forms” will somehow be forthcoming to replace what would be lost to narrative medicine. More likely, the physician-writer will seek publication in venues outside of the medical literature (where informed consent is not required for creative fiction) or, worse, cease publication all together.

John Steinbeck, in his novel, *The Winter of Our Discontent* says: “A man who tells secrets or stories must think of who is hearing or reading, for a story has as many versions as it has readers. Everyone takes what he wants or can from it and thus changes it to his measure.” Likewise, LaRue says: “…that a story will give us a particular sort of knowledge…the storyteller must search out the missing parts and fill in the gaps. Sentimentality and fantasy are judged to be inadequate; we must seek out the truth…. Each type of story has its own time and place…we should tell the story that we have the talent to tell.” Patients bring their stories along with their interpretation to the physician-listener who then creates another possible story to fit or agree with the facts. Thus, the imagination of the physician-writer “takes what he wants or can” from the patient’s story and creates a new story that is perhaps based on fact, but which now is changed and contains fiction, to seek out a particular interpretation of knowledge or truth. The oncologist in Coulehan’s story, for example, might tell a very different story about “Bob Alexander” compared to Coulehan’s published version; and both stories might be considered true. The new story is no longer owned by the original storyteller (i.e., the patient), but is now owned by the creative writer (i.e., the physician-writer).
References

Although the chief industry in San Pablo, Ecuador is fishing, most of the boats sit empty and unused due to the profound lack of fish. In years past, nearly every male in town would have been involved in harvesting fish to supply the shrimp farms and tuna canning factories down the road. These empty boats underscore the astronomically high unemployment rate and stagnant economy.

The simply-furnished boats also lack an engine, radio, rudder, GPS, or any other basic amenity that the even the average recreational bass fishing boat in the developed world might have, meaning all on-board functions are completed by manual labor in an often extremely hot and unprotected environment. This difficult work undoubtedly affects the health of the populace and leads to the prevalence of joint and back pain we came across on our interviews.

*The Global Health Scholars Program (GHSP) is a program that allows a select group of medical students who have interest in global health to work closely with faculty, other medical students in the program, and the Penn State University School of Nursing.*
This stark scene shows an empty fish-slicing structure. At the peak of the fishing season, buildings like these are packed with locals chopping up the day’s catch for canning at the local factory. Now, most of these facilities are completely empty with the exception of the haphazard lines of flimsy looking tables, concrete, and wooden pallets. The emptiness underscores the profound unemployment of the town. When the canning factories are open and the fish are abundant, nearly every able-bodied person works in places like this, markets, the shrimp larva labs, or the canning operation. When business is not booming, these places become ghost towns like the oil towns of the American West after the fields dried up.
A group of fishermen struggle to manually roll their wooden fishing boat down to the sea 30 feet away using a pair of crudely fashioned round wooden cylinders. This was one of the few boats that we ever saw leaving the beach during our stay; in this case, it was almost certainly to gather fish for their families rather than to sell for profit.

A short distance beyond the fishermen, a small cluster of lavish beach houses of Punta Blanca can be seen. During the week, the sand on this stretch of beach is left nearly untouched, as the individuals inhabiting those sprawling resort-like houses tend to only make the hour-long drive from Guayaquil on the weekends. The contrast between the rich and powerful of Ecuador's largest city and the impoverished fishermen of San Pablo could not be more stark.
On the beaches of Montañita are a small number of vendors who push, pull, or ride their carts of wares up and down the sand selling sodas, beer, and jewelry to the throngs of foreigners and Guayaquileños flood the shore every day of the week. This image is reminiscent of Sisyphus, the mythical king who was sentenced by the gods to continuously roll a boulder up a hill for all of eternity. He is selling snow cones from a rusty cart on a day that called more for windbreakers than sunscreen.

He is joined in the frame by a pair of beach-goers frolicking in the comfortably warm Pacific Ocean. This beach is exceedingly popular for young people from the United States and Europe visiting Ecuador. Walking down the short stretch of sand will undoubtedly expose you to more non-native Spanish speakers than almost any other place in the large country. The eccentric place is constantly frozen in a state somewhere between a frat party, Woodstock, and Margaritaville. All the while, a small group of local Ecuadorians move up and down the beach striving to keep the sunbathers happy, satisfied, and always spending money.
At the Catholic Church in San Pablo, there is a nursery school for preschool-aged children. The youngest children attend the school accompanied by their mothers. While the mothers could be out trying to earn some extra money caretaking at one of the massive houses in nearby Punta Blanca, they were personally involved in making sure their children get the education they were never offered.

This photograph underscores the commitment each mother has to her children’s avoidance of the hardships they dealt with. Virtually no individual over the age of 30 who we interviewed had any education past elementary school.
Walking down one of the few paved roads in San Pablo is a small family with one of the town’s many stray dogs coming along. The main street is also the road that the hourly buses meander down. This image probably depicts a young married couple out to purchase food and clothing for their extended family back at home. Like nearly everybody in town, their only means of transportation is walking. They are strolling toward the main thoroughfare of San Pablo, where most of the stores and the street vendors operate.

This seemingly small, nuclear family is a rare sight in San Pablo. The average household in any one of the simply-built houses in the image is quite large, with many children and relatives from both sides of the family. The younger family members take care of their older counterparts as they get older. Additionally, there is also a limited amount of housing and few can afford to pay for their own place to live.
This image shows a street vendor, selling beverages that claim to heal everything from liver problems to inflammation. The cart is covered in clear bottles full of liquid the color and consistency of olive oil, as well as powders and herbs for mixing into the aguitas. Folk medicine such as this is exceedingly popular in the country. While medicine is socialized and is theoretically provided to all at no cost, the price of care can still be a significant financial burden. For example, a hip surgery might be free, but all of the sutures, scalpels, and anesthesia must be purchased at the pharmacy and brought to the operating room by the patient. Therefore, many people rely on alternative medicinal relief, either from stands such as this or from indigenous healers, or curanderos.
While walking through one of San Pablo’s dusty streets, we came across a few men working on a utility line. The danger of climbing up a ladder that is resting on the line you are climbing to fix approaches the absurd. In our country, we are used to observing utility company workers in bucket trucks and cranes with modern safety equipment swooping in to mend power and telephone cables. Such modern technology is often taken for granted here; but for many Ecuadorians, it would be seen as an unnecessary luxury when the same line could be fixed with a long ladder and a fearless climber.

The amount each individual life is valued seems much lower than in more developed nations. While we require employers to give safety course and carry worker’s compensation insurance, Ecuador does not. While we mandate wearing seatbelts in cars and helmets on bikes, they do not. In short, life is more dangerous in Ecuador. It is a danger that many come to accept and not even notice. It is a necessary way to live when work is so hard to come by and resources are so scarce.
Mother was gone to the hospital,  
her gall bladder, brought on by nerves, she said.  
An ancient white-haired lady came to stay.  
She made pudding for dessert,  
but ruined it with red gumdrops,  
their color bleeding  
onto the cold vanilla skin.  
None of us would eat it.  
My sister flicked the gumdrops  
at my head. By Wednesday I was out  
of socks. On Thursday I felt ill.  
My face was hot, my body cold.  
The white-haired lady made my stay  
where sick children belonged.  
Upstairs, the walls of my room bent  
like stick-man arms where the rafters  
slid away. I stared up  
at the plateau of ceiling,  
connecting water spots dot to dot.  
At noon, she brought me broth.  
I thought about the holy water  
in the plastic font nailed to my door.  
The ceiling was a floating off-white net  
looming close to my face.  
When I looked again, it was back in place.  
All afternoon it came and went,  
a ceiling then a net. Calling home,  
mother told me of her hospital dream,  
how father, with a new growth of beard,  
draped in linens, begged her to join him  
in heaven. That night in my bed  
the sheets were damp,  
the ceiling dropped again.
The radiologist rolls the word like music from her lips. It is likely just that, a benign tumor in the right, the remaining breast. She recommends a biopsy since the left breast, a memory, had nurtured the invasive, ductal carcinoma. More music. Wife, mother, caretaker, giver of milk, of life to our children, is easily shaken by this.

The female breast, center of the universe, source of the river of life, is taken from within, brought down by its own hormonal asteroids. How can a woman marvel again at her body, its allure, its galactic symmetry, its planetary pull, when the not knowing has replaced the expected rising and setting of the sun, the every-day firmness of her warm breasts?

We schedule a biopsy for the following week. The wait will be a terror of imaginings, part of her new life where, even for the most devout, women review the percentage of recurrence, how effective the chemo is, chances of survival for the different stages. You hear clichés, like “gun shy,” or “waiting for the other shoe to drop.” I am here, but this is hers to ingest.

Fibroadenoma

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The radiologist rolls the word like music from her lips. It is likely just that, a benign tumor in the right, the remaining breast. She recommends a biopsy since the left breast, a memory, had nurtured the invasive, ductal carcinoma. More music. Wife, mother, caretaker, giver of milk, of life to our children, is easily shaken by this.

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Courtney Tomchik lives in Clemmons, NC with her husband and son and has a degree in ceramics from Appalachian State University. Her artwork reflects the beautiful colors and textures that are a part of life in the Appalachian mountains as well as pieces and parts of her past, present and future.

She says: “My current work is spiritual in that it has a southwestern flair. I am working with colors that are reflected in nature and are referred to as earth tones. Each creation is a one-of-a-kind part of my soul.”

She begins by creating many different textures and forms in the clay, then dries it to a bone-dry state and bisque fires it. In a process particular to raku firing, she glazes each work with a variety of low fire glazes, a trial and error process that is when the magic happens. A range of colors and finishes enhances the glaze. After a 24-hour drying period, Courtney adds pieces that are either man-made or handmade, such as glass beads from local shops or from her travels, bits of clay or gold leaf. Each piece is individual and unique.
A Doctor’s Ode

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I call them my girls
but they’re not, really
They belong to ED—
their eating disorder
They run until bones break
They stuff vacant, aching holes
until stomachs ache and heave
They deny themselves
food, and the freedom
to make mistakes
But isn’t that the biggest mistake?
Perfection is a myth, a fairy tale
that even they don’t believe.

I want to remind them
when they use words
always, never, everyone, that
those are black and white words.
I want them to remember
that the world is filled with countless
colors and even gray is beautiful!
Gray is fog, swirling among trees,
a Persian cat’s silky fur, a wolf’s
lush coat, rain clouds nourishing
the Earth, the churn of ocean waves
the sleek, slippery skin of dolphins in
those dark waters who chatter and leap
and aren’t afraid of monsters hiding
in murky depths, or, at least, not so afraid
that they don’t eat and leap and live.

Come, I want to tell them, dance like the dolphins
Stretch like that Persian cat and purr in contentment
Tip your heads back and howl with the wolves
Let your black and white judgments out into the night.
Let them out because they are shredding your souls.
Once released, those criticisms will swirl as a magical fog.
to the moon whose craters were formed by other women

giving up their aching wounds. Fling out your hurt, your anger, your pain.

It will craft stars in the night. Suddenly you’ll be painting with colors instead of just black and white.

You’ll fashion monarch butterflies who will soar to Mexico; robins who will herald the coming of spring.

Imagine a world without color, that’s what you’re living now—come grab a handful of sunshine.

It might burn for a moment, but the pain won’t last, and it won’t be more intense than what you’re living now. Come, find beauty in the jagged cracks of a sidewalk, the lightning gash of a tree where moss grows, the sparkling center of a geode whose true beauty wouldn’t be seen if it stayed locked away.

Don’t keep your beauty from yourself or from the world.

Tucked inside is your true voice.

Listen, listen. It’s the sound of a river, a raindrop, a humming bird wing. Listen, listen.

Come, now is your turn to sing.

Author’s Comment

A Doctor’s Ode was inspired by my role in the Penn State Eating Disorders Clinic. Through my work as a psychiatrist in the Partial Hospitalization and Intensive Outpatient Programs, I am humbled by my patients’ stories. Their eating disorder symptoms are often used either consciously or unconsciously to deal with emotional pain. This pain relates to past traumatic experiences, ongoing negativity within areas of their lives or an inability to live up to the goal of perfection that they or others set for them.

In addition to individual sessions, I also lead a weekly journaling group with these young women. Many use the distance of writing to express their fears and struggles. Even so, they are often apologetic as they read their words. They worry that they haven’t followed the prompt correctly, even though the instruction is to just write whatever is on their minds. Often they read in soft, whispery voices as if expecting one of us to pounce on their words, ideas or their own inner selves.

I wrote this poem to help others understand the pain of these young women. Their vulnerability and turmoil is present in young girls (and boys) who do not struggle with eating disorders. Today’s world has such onslaught of pictures, pressures and expectations. People often compare themselves to impossible images and come up lacking in their minds. I wanted to remind my patients and, really, everyone that we need to appreciate the variety around us. So many times we see things as good and bad, success or failure. Things are not that clear cut. When we appreciate the subtleties of the world and ourselves, we become more accepting of our own quirks and flaws.

A goal of this poem was to inspire my patients and other readers. I want them to go after their dreams. We all need to follow our passions in life. We need to be creative. We need to put ourselves out there, even though there is the risk of disappointment and failure. To not try is an even bigger failure. I always like the quote—“Aim for the moon. If you miss, you’ll still be among the stars.” Writing has pushed me to aim for the moon. I hope with this poem that I can inspire others to join me on that journey. We can all end up dancing among the glittering stars.
Gnawed Bones

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If language is bones, hard parts of speech, what do skulls of pack rats crushed into owl pellets have to tell us?

If this delicate pelvis once balanced a gravid javelina, what word passes on to her shoats?

If cicada shells hang on like single mothers starved for touch, what does hot wind whisper through them?

If every day re-enacts creation, if we live here, now in the first world and the last, let us speak in our bones languages of water from all skies, from deep underground. Let our bones quench the thirst of history, thirst for all we yearn to sip, marrow of each dry tongue.

Author’s Comment

“Gnawed Bones” began during an in-class writing activity during the Fairbanks Summer Arts Festival. We were asked to think of a metaphor and then qualify it with the word “if.” I began with the notion that language is our scaffolding, our bones.
No Sign

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One generation passeth away, and another generation cometh.
~Ecclesiastes 1:4

Just moments after your death,
a young woman, very young, knocks
then peeks
around the hospital door
I’d closed.
“I clean now?” She smiles,
ready to make our world
better. I blurt
“My father has died.”
Deep wells, her eyes,
water she doesn’t hide.
“Mi padre también.”
And we’re in each other’s
worlds right then, in each other’s
arms, found in this translation.

Perky, used to coaxing
half-conscious or deeply ill
folks without appetites,
the dietitian
breezes in.
“Ready to choose
your dinner,
Mister...
...And then she sees.

His wife’s daughters arrive,
take their turns
kissing his forehead,

the only father
they’ve known
lo these many years.

Then two strapping
young men swagger in,
snapping on latex gloves

and start to touch him.

“Why are you here?” I whisper.

“To turn him,”

they declare, confident,
reaching. “You’re aware
my father has died?”

Both recoil
as if they hadn’t suspected
such a thing existed

within their realm,
back out
filling the still air

with their young
men’s stuttered
apologies.

**Author’s Comments:**

“No Sign” grew from the surreal moments just after my father’s death.
Global Health Scholars Program*
Penn State College of Medicine

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*The Global Health Scholars Program (GHSP) is a program that allows a select group of medical students who have interest in global health to work closely with faculty, other medical students in the program, and the Penn State University School of Nursing.

The following thirteen excerpts from my journal express most accurately and thoroughly my reflections from our month in Ecuador in May and June of 2009.

Day One: May 23, 2009
Hard to believe we left only yesterday. Today turned out to be a long day of sight-seeing. We first dropped our stuff at the finca and then went up to Otavalo, stopping along the way in Cayambe for bizchotes (a local type of bread/biscuit eaten with dulce de leche) and at the Lago de San Pedro. The Otavalo Market was rich with exquisite textiles and I had to hold myself back from buying too much on our first day here. After the market we went a bit further up the road to visit a curandero. After haggling over the price a bit, the group was ushered into a low-ceilinged dimly-lit room with benches along one wall and a table off to one side. On it were a variety of rocks, candles, eggs and other unidentifiable objects. The curandero was an apparently very old man, short, and oddly appareled. Todd, our subject, was instructed to remove his shirt and shoes and, as chit-chat continued with the shaman's daughter, he abruptly began. Much of the ceremony consisted of him sucking an unknown alcoholic substance into his mouth and then spitting an even spray of it in Todd's direction. (We all got a bit showered during the process.) We were expecting him to read the eggs that he ceremoniously passed all over Todd's body but were disappointed to find out his vision was too poor to read the insides, so he just sat them on the floor and moved on. Eventually he retreated to his table of mysterious objects, lit several candles, and chanted into the flame. Then, lit candles in hand, he returned to his mystery-alcohol. We quickly caught on to what was happening next. Holding the lit candles in front of his mouth, the spray of alcohol caught the flame and filled the space between the two men with fire for one long, dramatic instant. The flame-throwing continued rather alarmingly for some time, resulting in many breathless stares and singed hairs. There was a pause after that as they discussed whether to continue. The daughter/interpreter went outside and returned with an ominous-looking bundle of nettles in her hand. As Todd was whipped with the stinging nettles his skin welted up in big red blotches and he laughed nervously. Then he was instructed to rub a special oil all over his body to ease the inflammation and finished it all off with a final spitting routine. On the way home we stopped at La Mitad del Mundo – the official touristy site of the equator – and enjoyed comida tipica for dinner.
Day Two: May 26, 2009

Monday morning came and we were escorted by our invaluable Jose Pedro to the hospital. It's hard now to remember my first impression but one of the most startling things was the absolute mob that filled the sidewalk outside the hospital and the halls inside, waiting in roughly-organized fashion. We loitered awkwardly for a while until the docs pulled up in a taxi. Once inside, we were led through the mob in the outpatient clinic area, through a set of double doors and back through the inpatient ward to the administrative office where we were introduced to the hospital directors. After introductions, we were haphazardly divided up for the morning. The pediatrician, Dr. Vaca, came by and said she'd take two of us so Sean and I followed her for morning rounds. As one of the residents was giving report, she stopped him to ask him to speak more slowly so we could understand. I breathed an internal sigh of relief that maybe I could follow the day's proceedings fairly well. My hopes were ill-founded and short-lived. Once in her office seeing patients she took off talking at an unbelievable pace. I caught enough to know what was going on, but I missed many of the specifics. It was fun to see how they did well-child visits. Though the facility was notably dingy, the public health system allows and encourages frequent well-child check-ups. They also provide most basic meds at no cost and baby cereal called “patilla” for kids 6 months to 3 years old. After lunch next door at a sketchy establishment that made almost everyone sick, we returned to do peds visits with Dr. Groh.

The plan made early in the day was for Todd and Shana to do overnight call that night and I was to do it the next night with Sean. Somewhere along the way Todd started to feel poorly so Shana asked me to stay with her. So, as it turned out, my first shift at Yaruqui lasted about 27 hours – we stayed all night and into the next morning. By the time we waved goodbye to the rest of the team who were heading home for dinner, I was already physically and mentally exhausted, but excited for what we would see. The first patient we happened upon back in the ER was a victim of domestic violence whose husband had cut her repeatedly with a broken bottle and given her quite a black eye. Apparently this had all happened the night before, so even the deep cut in her arm, which should have been stitched up immediately, could only be cleaned and stitched at the edges. The new government has adamantly expressed its intolerance of domestic violence, but many women still choose not to follow through with the lengthy paperwork necessary for the police to get involved. Thankfully, this woman was brave enough to get the whole process started. I wondered, though, as she was sent away with instructions to keep the bandage dry and return the next day to have it re-dressed, what awaited her at home. Was he sorry? Or mad that he had been reported? Did she cower in fear every day? Or only when he was drunk? My heart bled for her, in her world that I do not understand….

We had a number of pregnant women come in, in the early stages of labor. I was super excited to see a delivery. Having never been pregnant myself and not having any OB experience, I was startled by the way they were handled. Woman after woman was directed to the gyn exam room, told to remove her clothes from the waist down and then lie on the table and wait. Eventually one of the residents would stroll in, ask a few questions, listen for fetal heart tones, check the cervical dilation, and then tell the woman to get dressed and come back in some number of hours (depending on her dilation). The first time this happened I was totally startled. The woman is in labor! I didn't see why they couldn't just stay there. After all, the ER was empty at that hour. Some came and went two or three times before they were dilated far enough to stay. Their instructions were always the same – don't drink any medicinal waters (apparently a very common indigenous practice), don't eat anything, keep walking, and come straight back if you can't feel the baby moving, if you have more than
three contractions in 10 minutes, if your water breaks, or if you start bleeding. There turned out to be fewer partos (deliveries) than I had hoped. Two women were told to come back the next morning (after we were done for the night); one was diagnosed with preeclampsia, treated with mag sulfate and transferred to Quito; and the last finally did deliver that night. She was an older woman, 37, and her husband paced the waiting room worriedly the whole time. She was checked and sent away several times before they finally let her stay in the labor room until her water broke. From there she was haphazardly and hurriedly shuffled next door to the delivery table. Shana and I were sent to put on boots, hats, and gowns and by the time we returned there was a little baby being held between her legs. Each step was awesome to witness – cutting the cord, birthing the placenta, stimulating the baby to fill her tiny lungs, dressing her up in too-big newborn clothes, and giving her to her mom for the first time. As much as I was personally enchanted by all this, the delivery room lacked the air of excitement that I had always supposed. The new mother looked worn out and downright miserable and showed little interest in seeing or holding her newborn. Obviously, the miracle of birth was less miraculous for her, in that moment, than it was for me.

Towards morning a boy came in through the front door and blurted out a jumbled, distressed story, out of which I gathered only that his mom was pregnant and there was some sort of complication. I told him quite clearly, I thought, to bring her around to the ER entrance. He wasn’t taking my answer for a minute and started in again. I repeated myself, in case I hadn’t said what I intended to. Still dissatisfied, he turned and went back the way he came. Some time later I saw him pacing the emergency waiting area so I went into the ER to see what was going on with his mom. I soon realized why he was so distraught. In the gyn exam room I found a middle-aged woman (probably no older than forty, though she looked at least a decade more than that), lying on the table with thick red blood all over the table and her legs. A pair of blood-soaked underwear lay carelessly tossed on the floor among a fresh red trail. I tried not to let my horror show and turned to the resident for an explanation – an “aborto en curso” (a miscarriage in progress). She continued to lie there, bleeding and groaning, in that same embarrassing, uncomfortable position, for what seemed like forever. No one seemed to be doing a thing. Every time I went to see another patient and came back, she was just as I’d left her, with a slowly growing lake of blood on the table beneath her. For once the language barrier was almost a blessing, for I would not have known what to say to her in any case, and as it was I just stroked her hair, held her hand, and offered a tentative, (hopefully) sympathetic smile. For a while there was discussion of transferring her to Quito because she’d lost so much blood, but someone must’ve decided against it, because hours later I saw her being wheeled on a stretcher into the OR for a D & C.

Morning came, after we’d caught a few hours sleep in an empty patient room, and since we felt okay, Shana and I decided to stay for the morning. The gynecologist that Sean and I were assigned to had a harsh cough and kept joking that he had swine flu. We learned from him that any form of birth control is free at the public health hospitals in Ecuador. Finally, Shana and I slipped away back to the finca for a few hours’ rest before the rest of the crew came back for dinner.

Day 3: May 28, 2009

Wednesday morning Sean and I spent with the traumatologist, who showed us each x-ray with a thorough explanation, and taught us to do joint injections. In the afternoon we went to Cumbaya to visit Sean’s brother’s in-laws. Then in the evening I decided to do another overnight shift in hopes of seeing more deliveries. Those hopes were disappointed, but there were a few other interesting cases. Shortly after I got there, a woman was carried in having epileptic seizures. The family was questioned as to what she was taking for it and the husband
seemed unsure but said he didn’t think she was taking anything. In the harsh fashion that I’d come to expect, the doctor chided him, then had the family wait outside while he left the patient to lay there while it passed. When she was more coherent he rebuked her, too, for not taking anti-seizure meds.

Later we had another true emergency (as in the US, true emergencies are the exception rather than the rule in the emergency room) – a woman came in carrying a small boy, both of them sobbing uncontrollably. It was a bit hard to tell what was wrong, but I soon guessed (rightly) that he was a burn patient. When we pulled the gauze off his arm and back, there were a few small blistered areas but most of it just looked a little pale. (I later recalled that third degree burns turn white rather than red, which is why it didn't look very alarming at first.) It was obviously a very recent incident, because even as we were cleaning the area the blisters were growing until most of the skin on his back and some on his shoulder and arm had lifted off his body. Carefully, the doctor took a sterile needle and popped and drained each blister, gently poured sterile saline over the whole thing to rinse it, and then dressed it with silver cream and gauze. The whole thing was very dramatic and moving. He was crying; his mom was crying; his dad buzzed in and out buying supplies as the doctor ordered them; and the little girl with them (I assumed she was his sister but later learned she was his aunt) ignored her own minor burns while she blew on his back to ease his pain. His mom, too, was blowing on him, and when she would stop for her breath he’d start whimpering, “Sopleme, Mami!” In his tear-choked little boy voice he asked his mom, in all seriousness, “Voy a morir?” Eventually they got him all set to head home for the night. The next day when he came back to be checked, they determined the affected area to be extensive enough that they sent him to the children’s hospital in Quito for skin grafts.

Morning came, and I was just about to head back to the finca for some rest when a med student came to get me to say that the pregnant woman who’d been in and out for check-ups all night was finally ready to deliver. I scrambled back to the delivery room as fast as I could so I didn’t miss the little one’s grand entrance into the world. This time I was not too late. I got to help dress this little guy, carry him around, hand him to his mom, and generally pretend to be useful.

That afternoon Shana and I went with Drs. Groh and Boley to the Rotary clinic in Cumbaya. The contrast was dramatic. The clinic there was lovely and immaculately stocked with excellent equipment. For a minimal fee - $3, I think it was – anyone could make use of the health care there. We surmised that it was probably utilized most by what middle class existed in the area – those too poor for the expensive private hospitals but not destitute. The Norwegian director of the place claimed that the place was self-sufficient on that tiny fee. Pretty hard to believe.

**Day 4: May 30, 2009**

Friday morning Shana and I watched the much-talked of bone graft surgery. I was blown away. Here we were in this bare-bones operating room, with hardly any supplies, watching a very complicated procedure, after which a boy who’d cut off three fingers would again have almost full use of his hand. Wow.

Friday wrapped up with a visit to Cumbaya where Dr. Groh showed us the university where he had taught and the private hospital it’s associated with. And then this morning we waved goodbye to our beloved finca as we pulled away in the back of a truck with all our things to head westward to the coast....
Day 5: June 2, 2009

A couple of days here in San Pablo have been interesting, to say the least. We arrived uneventfully here Saturday evening, other than the fact that a resident from the Rotary group had a fever and was whisked away from the airport to a shady hospital to verify that he did not, in fact, have swine flu.

Sunday morning we were given a tour of San Pablo, hitting the high spots. We were introduced to the famed and highly acclaimed Ciudadela Rotaria – Río Guayas. As we had been told, the houses were all in a neat line, comparatively new, and pretty decent looking. Inside we saw a variety of interiors – some were impressively nice while other looked more typical for the area. After lunch we went to the clinic. I started out by dipping urine and taking blood sugars, but was soon ushered into the pap room to translate and assist Dr. Tricia in there. I was relieved to see that they offered greater privacy here than what I had witnessed in Yaruquí. The role of translator became more comfortable as the afternoon went on, especially for such a repetitious exam.

Monday I started out translating and assisting with pap smears, this time with Gabe, then translated for Tricia, and later for Claire, the dentist. It didn’t take long to catch on that trying to stick to any sort of pre-determined schedule was useless; I just went where I was needed.

This morning (Tuesday), I went with Dr. Fredrick, Patrick, Shana, and Aleida to interview the mayor. The meeting was thought-provoking, to be sure. According to him, there are about 800 families in San Pablo; domestic violence and alcoholism are huge problems; most people use Western medicine; and unemployment and poverty are almost universal. Interestingly, we followed a lead to visit a midwife and got a very different story. She not only assists with deliveries but also performs many healing rituals, including mixing of herbal drinks and giving massages. The most common that she mentioned were prenatal massages, a healing ritual for mal de ojo; and cleansing from susto espanto, a fearful or anxious feeling. The last condition she mentioned was called padrejón which is sometimes confused with gastritis but is not, she assured us, the same thing. A painful, raised area above the belly button is treated with a brew of wine, raisins, cinnamon and allspice that is left to sit 15 days and then dosed in 2 tbsp every evening. Her local remedy for diarrhea is, interestingly, pomegranate juice with lemon and salt in it.

After that stop, Shana and I interviewed the pharmacist at Farmacia San Pablo. He was a very pleasant man, patient with the lengthy survey, and eager to help. It took quite a while but we both felt satisfied with the result. He seemed surprised that we mentioned cipro as a treatment for diarrhea – he gives it mostly for flesh wounds and skin infections – and was pressing us for advice on how and when to recommend it. I felt more than a little uncomfortable advising someone who obviously doles out medical advice in the community.

We ended up back at the clinic after unsuccessfully trying to review charts at the Catholic med center (Nuestra Señora de la Consolación). I was in the pharmacy most of the time, but just as we were packing up, someone came looking for a Polaroid camera with which to take pictures and have instant copies of them. While I didn’t have that to offer, I was able to take my pictures straight to the Internet café and print them off with my card reader, so I was ushered back to the gyn exam room on a mysterious mission. As I soon discovered, Shana and Tricia had stumbled upon a case of domestic violence while doing a pap on a local San Pablo woman. She wasn’t sure yet if she was willing to go to the police, but they wanted me to photograph her bruises so that they could be easily printed and used as evidence if she decided to.
Day 6: June 3, 2009
Miraculously I was freed of translating responsibilities for the morning so I could finally do a little bit of actual patient care with Glen. The abuse victim came by and we exchanged hugs and a few words. And then the comadrona (midwife) brought her kids in to be seen. Amazing how fast you can feel like you know half the town!
The afternoon was spent surveying. It went well, though I found it very draining – a combination of the heat and the repetitious questions in Spanish. The largest household we found today had 15 – mom and dad, their five kids, two grandkids, another abandoned woman whom they’d taken in, and her five kids. This once again highlighted the hopeless place in society of abandoned and abused women. They are entirely dependent on the kindness of family or friends for daily survival. It’s little wonder that many refuse to leave their abusive situations, in spite of the government’s promise to prosecute the abusive men. Most surprising, I think, was the high level of unemployment. Most of the men and all but one of the women that we talked to today have no regular job. Even their cheap living expenses quickly become impossible to pay for with virtually no income. Many children only get to finish primary school because they can’t afford the private secondary school.

Day 7: June 4, 2009
Tonight I stood in the ocean with my chin in the water and looked out to the horizon as the last rays of sunset danced on the rippling surface. It was surreal. We played in the water until the light had faded and then I walked the beach and watched the stars pop out one by one. The rest of the day was full and exhausting, which is, perhaps, why the loveliness of the sunset was especially poignant. After breakfast we visited the nursery school. All the kids appeared well-nourished, according to our cursory mid-upper-arm-circumference survey. Shana and I then went to interview the pharmacist at the Catholic mission. This time went much quicker than the last. The funny thing is, we kept getting conflicting information. One person told us there hadn’t been any cases of diarrhea this week, but then the pharmacist said she’d treated a case that morning. Surveying all afternoon in the heat was tedious. We spent most of the time trying to figure out how to count houses in the remote and unorganized edges of town.

Day 8: June 5, 2009
Today Shana and I interviewed the doctors at Our Lady. They were a bit unsatisfactorily rushed, but a few interesting points surfaced. One of the doctors cited dengue as a major health issue. I’d never even heard mention of its existence in this area before. The pharmacist the day before said HIV was most critical. She gave us an interesting take on how testing and status were confidential and had to be done in Santa Elena. But the doc today said she had seen only three confirmed cases in the last four years – which seemed to disagree both with its prevalence and its confidentiality. Most healthcare workers have said they think diarrhea is a major problem in San Pablo, yet it hasn’t shown up in our surveys as much as we expected. Not sure what to think at the moment…
We made it back to the clinic in time to catch the group going to Montañita for the afternoon. The town was much as I expected from reports. Very touristy. After dinner back at the Mejias’ we went to the Ciudadela for their goodbye party for the Rotary crew. The program included many dances by the kids – falteringly executed but still adorable.

Day 9: June 8, 2009
Upon our return to Punta Blanca last night from a quick weekend trip to Montañita, we greeted the newly-arrived Drs. Lengerich and Iriana. This morning a woman from town brought her two-year-old boy over for Dr. Iriana to see. Then we went to the school to
measure heights and weights for the morning and surveyed all afternoon. The first house we went to after lunch was just to make more copies of the survey sheets. To our surprise, we found a makeshift art studio in one half of the living room, and some sort of furniture-finishing operation going on in the other half. Vibrant paintings of various things – mostly flowers – were propped along the walls and on easels. If I had a way to get them home I’d have bought several. While waiting for our copies, he also produced a pile of photo prints of various locations along the coast. We were all dumb-founded. When asked how much he sells the prints for, he shrugged and said he didn’t have much experience with selling them. There’s no market for art in San Pablo, he explained; nor did he seem interested in going elsewhere to sell. The outskirts of sector 4 seemed by far the poorest. People had to haul water into their houses from faucets along the road, and most had only a crude outhouse to use – sometimes shared among families.

Day 10: June 9, 2009
More school measurements this morning. Then Shana and I went to the social security clinic to interview the docs there. Medina had already left but we caught Triviño, who turned out to be quite a talker. Unfortunately, I found him hard to understand, and he found it hard to stay on track, so the interview was less productive than it might have been. We then finished up our pharmacist interviews at Mini Farmacia Sylvia.

Day 11: June 10, 2009
Field trip to Santa Elena today! At least that’s what it felt like was we all piled in the back of the limo to head south and visit the local hospitals. We had a very successful interview, I thought, with the director of Cristo Redentor, followed by slightly less convincing discussion at the public health hospital in Libertad. The director there could hardly have been more enthusiastic about the excellent state of healthcare in Ecuador. He kept talking about how everything is free, and everyone uses the system, and how there were hardly any issues to deal with or improve on. We were all a bit skeptical of his answers, but he was nice enough to talk to us for a while. We didn’t get much of a tour of the facility but it seems comparable to Yaruquí.

Day 12: June 12, 2009
Finally caught up with Medina today. He was much more informative than Triviño – ironically, because he had less to say. He answered questions without so many wordy rabbit trails. In the evening we had a town meeting at Rio Guayas. Seemed a bit strained but went fairly well. Since I was translating, someone else took notes on the proceedings, but as I recall we mostly fielded general inquiries about health-related issues. At least the people who showed up were interested, involved, motivated community members.

Day 13: June 14, 2009
Yesterday was our day of departure from Punta Blanca and San Pablo. In the morning I went with Roberto to buy our bus tickets to Baños. It was a fun outing. He helped me find the bus station and told me what to tell the taxi driver when we needed to get back there the next day, then showed me around Libertad a bit. After lunch we packed up and managed to make a pretty undramatic getaway. Only Daniella’s insistent waves made it momentarily painful. These things are never quite so hard when there’s the promise of a return, even if it is a few years off.
The rhetorical strategies of pregnancy support centers including the visual rhetoric of fetal ultrasound technology


Abstract (Summary)
This study examined the rhetorical strategies, including verbal and visual rhetoric, of pregnancy support centers that provide clients with fetal ultrasounds to persuade those who may be considering abortion as a means of resolving their unplanned pregnancy to carry to term. Qualitative data were gathered from 12 interviews of directors and ultrasound personnel from 7 states as well as from television advertisements and printed material. Eighteen research questions investigating the rhetorical transactions between centers and clients were answered. Rhetorical analyses were performed on the verbal and visual messages used in client interactions.

The grounded theory approach of inquiry resulted in the discovery of 10 major themes. First, centers offer holistic Christian ministry to clients. Second, centers provide professional health services. Third, a quest for uncertainty reduction and information brings clients to the centers. Fourth, centers maintain safe supportive environments. Fifth, personnel are trained to demonstrate sensitivity in sharing information. Sixth, staff exercise care in their deliberate choice of terms. Seventh, members recognize the importance of interpersonal communication in building relationships with and mentoring clients. Eighth, centers use persuasive arguments and artifacts. Ninth, ultrasound serves to reify the pregnancy for clients. Tenth, empowering clients to make their own decisions is a center goal.

A rhetorical critique was performed using three approaches. First, the rhetorical functions communicated by the visual artifacts were explored. Second, the individual elements of the visuals were examined for persuasive potential. Third, the possibility that the visual of the ultrasound image fills the eye of the beholder with a single dominant meaning was considered. The conclusion is that the apparent persuasive success of the ultrasound can be partially explained by the client's recognition of baby schema characteristics present in the fetus, recognition of the fetal heartbeat, and recognition of the beating heart as a symbol of life. The persuasive potential of the fetal position and fetal movement were also discussed. The role of storytelling was examined. The possibility of client self-persuasion was also evaluated.

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Adapting beauty shops to include a health internet station: An online feasibility study and needs assessment of clients


Abstract (Summary)
Black women are hit hardest by STDs and HIV. Even though some programs specifically focusing on this population have been successful, there has not been a significant decline in the overall prevalence rates of STDs for this group. No published study has sought to tailor and combine the venue, delivery mode and content of sexual health education to meet the needs of black women. As such, researchers of this study utilized a website of STD/HIV information for black women to view in beauty shops. The reviewed website was www.DIVAhealth.org.

The aims of this study were to determine the feasibility of adapting beauty shops to include a health internet station and to conduct a needs assessment of beauty shop clients in order to determine their need and readiness for a new delivery mode and venue to learn about STD/HIV prevention. Clients were recruited through beauty shops, e-mail and text messages to answer a questionnaire on STD/HIV knowledge, sources of health information, beauty shop dynamics, opinions about the website, self efficacy, stages of change and sexual risk behavior. Univariate, bivariate and regression analyses were performed to answer 13 research questions of interest.

Respondents included 78 beauty salon clients with an average age of 39, 63% were college graduates with a moderate income. For this group, STD/HIV knowledge and self efficacy for condom use was high, while most women were in the contemplation phase for stages of change for their sexual behavior. Women also did not report high risk behaviors, defined by number of sexual partners and condom use. Forty-two percent of those surveyed agreed or strongly agreed that there is a need or interest to equip beauty shops in their community with internet access; 59% agreed or strongly agreed that they would go online to use the www.DIVAhealth.org website while they waited for services and 80.7% agreed or strongly agreed that the website would be an effective way to disseminate sexual health information in beauty shops. This suggests that introducing a sexual health internet station in beauty shops may be a feasible strategy in which to promote positive sexual health and wellbeing.

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Story as a weapon in colonized America: Native American women’s transrhetorical fight for land rights


Abstract (Summary)

The violent collision between Native American and Euro-American politics, spirituality, economy, and community appears most prominently in each culture’s attitude toward land, which connects intimately with the position women held in each society. The social construction of land and a woman’s “place”—and the interconnectedness between the two as viewed through a Euro-American lens—conflicted so wholly with that of many Native American cultures that what resulted were wars, many fought physically on battlefields, but many others with rhetoric in speeches, books, petitions, and reports. The idea that the two cultures might fight bloody battles over land rights does not need much explanation; however, that they might come to blows as a result of how women acted in each society requires more attention.

Synthesizing the heterogeneous methodologies and insights of American Indian literature, nineteenth-century women’s writing, and the history and theory of rhetoric, this dissertation articulates the transrhetorical power of Native American women: their ability to cross cultural and gendered boundaries of rhetoric. I argue that while white middle-class women such as Lydia Maria Child, Catharine Maria Sedgwick, and Margaret Fuller sought to empower themselves by speaking through Native women’s voices, indigenous writers Nancy Ward, Narcissa Owen, Sarah Winnemucca, and Gertrude Bonnin, fluidly negotiating white definitions of gender and culture, used their roles as transrhetors in order to protest land theft and to fight to reclaim territories unjustly taken by the United States government, using rhetoric as a weapon in the war over land.

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Nurses are writing in legions about their sacred work. They paint the heaven and hell of being at the bedside. Painfully honest, their stories become drums speaking to each other through the long halls of midnight. Here is a world where nobody sleeps, certainly not the nurse. Where the sound of a bedpan hitting the floor makes a person laugh and cry at the same time. Nurses’ days are filled with rapid-fire decisions, eaves dropping, delegation, and enough frustration to knot a hangman’s rope. In this fine collection of 23 essays, editors Paula Sergi and Geraldine Gorman chose a choir of voices that brings the reader to a campfire of earned attention.

Most people have preconceived ideas of care-giving facilities, even nurses. Just say the term nursing home, and it conjures up images of people slobbering on themselves strapped in chairs. It makes foul odors rise to our memory bank. It makes a person want to turn away, but to one nurse it became a challenge, a mission. And in her essay, “Flying By the Seat of My Scrub Pants” Angela Posey-Arnold becomes a vessel for change in a long-term facility. She admits what so many nurses never say out loud: many times we don’t have enough knowledge to realize we should be afraid, especially in the beginning of our careers or after a transfer in areas of specialty.

Hired in a poorly managed long-term care facility, Arnold was window dressing her first day on the job. State inspection peels the dressing of a place to look closely at its wounds, and there were open sores in her facility. Arnold goes ever deeper in her honesty: “Some of the nurses were just bad nurses, lazy and mean.” What? Did she say bad nurses? You bet she did, and it’s high time we admit nursing has its share of those who want others to carry their load. Arnold prays for guidance to become a vessel for change, and it happens in stages. Her insignificant knowledge was a canoe in misery’s ocean, but in time “the expectation that change was occurring created optimism in the staff.” Arnold stresses it was a team effort and her acronym for HOPE is an idea we can take to any workplace.

Confluence is the world of nursing. We are seldom meeting our patients on their best days. Sometimes the footbridge a nurse walks is really a tightrope and most of the time, there’s no net. Begging ignorance will not grant pardon. Too much to do without enough hands? Too bad. A precious moment of professional veil dropping occurs in Elizabeth Tibbetts’ poignant essay “Intersection,” which addresses a question that has no right answer: should a high school girl keep her baby or allow it to be adopted. Tibbetts allows us to hear the young mother’s story so well we become an active listener. We feel the tug, the Solomon war of the nurses as they secretly cast ballets on who has the right to raise this child. This is a righteous bird that rises in us all.
Backlit by her own past, obstetric-nurse Tibbetts steps forth and admits she was a young unwed mother herself and faced such a decision. By opening her human door, even a crack, her young patient connects and asks many questions. “The nurse I was taught to be listened,” Tibbetts admits. Youth knocks on our doors. Are we to stand mute on the other side or answer? Will the young have ears to hear the whole of it? And later, which will the jury name guilty? Questions circle us forever, and Tibbetts says, “I wasn’t sure if I should have spoken those few words.”

We and will always need ever-increasing amounts of hope, but more than even this, we need each other. It’s easy to clap for the muscled swimmer glistening near the pool. It’s easy to stand and sing the anthem of wellness, but the body is a house and more than the roof will leak. Barbara Gordon Sauvage’s memorable essay of checks and balances, the unwritten rules of behavior, reminds us to be steadfast, especially in rough seas, especially when one of our colleagues becomes the patient.

Illness isolates. We know this. We have witnessed it year after year, but what happens when one of our tribe falls? Do we kneel to help or step over her? Sauvage kneels. Like Christ, she lotions the feet of her nurse friend who is stricken with a brain tumor. She talks to her colleague and listens to her friend’s fuzzy response. Hands busy rubbing her nurse friend’s feet, Sauvage tells her friend’s husband a story about a patient they’d once care for, how his organs were visible, “when he drank a glass of water, the water poured out of a hole in his stomach . . .” “She’s a good nurse,” Sauvage says. The husband replies, “she always likes going to work. But she didn’t like getting up in the morning.” As Sauvage shows us how to grow as humans, she says, “Don’t feel bad about it, that’s all.”

This rare and precious book shares the gift of a thank you note to flight nurse, Emily J. McGee. Nurses press such notes into the book of moments and will not part with them. This collection of essays brings us all closer to the world beyond our knowing. Like the catatonic patient in Eileen Valinot’s “A Silent Woman,” we say thank you to these nurses and editors for the days have been well spent, and with these stories, we are not afraid of night.

Jeanne Bryner, R.N., B.A., C.E.N.
Seeking Submissions

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

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

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

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

Artist Guidelines

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

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

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