Lynn Koller
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A Resurrection of Love: Fictional Phalluses in a Material Age

I shall call it *medico penile theory*.

I proclaim it revolutionary.

Medical intervention feminizes the patient, men and women alike.

I have a short, completely true story to tell.

Dr. M photographs birds. He lives on the edge of a river and floats onto that river in a canoe most nights after work. The birds fly within view of his camera and he captures their images. They fly away unhindered by Dr. M or his camera. He emails the photographs to dozens of his friends. The sight of birds in nature brings him a certain amount of satisfaction. As a gastroenterologist, Dr. M concerns himself with his patients' digestive problems and ways in which he can reduce pain and extend life; these are not always compatible goals and so he must balance possible outcomes. Usually, his patients want to live.

On this particular day—and this day is not a compilation of many days, nor is the patient merely representative, but instead, it's a real day and a real patient—his silver-haired patient, whom we'll call N, reclines on a gurney in the hospital hallway, awake and alert, wearing glasses and a medical gown.

This leads to an aside: In an interview last week, Doris, a 92-year-old woman, described what her physician said to her a half-century ago, when she complained that she had taken all responsibility in her marriage for running the couple's appliance store, paying household bills, cleaning, cooking, and raising their two children, while her husband regularly drank himself into a stupor.

"… and today, I opened our shop and put all of the men to work," Doris said.

She had done the one task that her husband remained responsible for, but was unable to accomplish on that day, because he was in an alcohol-induced state of unconsciousness. Her physician looked at Doris and shook his head sadly.

"Do you know what you've done?" her doctor replied. "You've stolen your husband's pants."

N wears no pants on the gurney. His taunt face appears stern and shows slight signs of stress. Dr. M greets him and they talk.

"Any questions?" asks Dr. M.

The patient has none.

"We'll get you set up," Dr. M says and leaves N's side.

A smiling medical technician, a lovely woman with stylish hair, touches N's shoulder and asks if he needs to go to the bathroom. He declines. Acknowledging a need to void bladder or bowels may cause difficulties anyway, as he would have to climb off the gurney in a hospital gown that only nominally covers his *derriere*.

Assuming a certain level of modesty, the question seems moot. The restrictions of clothing designed for the needs of medical experts – easy access, one-size-fits-all, poly-cotton blend for repetitive washing – rather than the wearers of the clothes is often considered a feminine issue. Historically, women have endured the suffering and indignities of restrictive, uncomfortable, or revealing clothing – the necktie notwithstanding. (It's more of an accessory.) Judith McGaw highlights the brassiere as an example and points out that the design of this feminine technology "goes beyond issues of capitalist exploitation of the consumer or patriarchal disregard for women's concerns, to which analysis through social construction readily leads" (19). She believes that the bra exemplifies a way of standardizing the biological. The bra cannot fit because "breasts are living things" that change constantly, which may explain why the pants of Doris's husband failed to fit him any longer; he had changed, but his pants had not. It certainly goes a long way to explain N's hospital gown as a feminizing piece of technology that serves as a symbolic sort of bra or support system allowing entry into various bodily orifices. Of course, Dr. M is not at fault here, nor is the brassiere industry. It's a matter of situatedness; the patient situates himself in a position where he has no authority to determine what he wears. According to McGaw, brassieres don't fit because women "make the compromises and create the knowledge that permits a deeply flawed system to work" (19). And so, women situated themselves to be

constrained rather than uplifted, though in a cosmic irony, they are literally uplifted as a result.

N waits to feel uplifted. He had stones in his bile duct a year ago, which were endoscopically removed. The patient is a *recurrent stone former*, whereas Dr. M might be considered a *current restorer of men*, a perfect anagram of his patient. Once a year, the patient comes into the hospital for an endoscopic retrograde cholangiopancreatography (ERCP) as a preventative measure – that is, something that is not strictly necessary for immediate relief of a pathological condition, an important consideration here. N offers up his body willingly and without the duress. If something bad comes of it, he can only blame himself. Two medical assistants roll the patient's gurney into the procedure room. They transfer him to a supine position in another bed of sorts.

The patient lies nearest the back wall in the horizontal center of the small room. A large device called a fluoroscope hovers above him. That's a lie; it actually hangs from a big metal arm, but does appear to hover. Fluoroscopes transmit a radiographic image of, for example, the abdomen, on a video monitor for capture and storage. The procedure exposes the patient to radiation, a known carcinogen; new fluoroscopes use less radiation than older systems. Physicians often ask patients immediately before undergoing a procedure – gowned and prepped – if they understand the dangers and possible outcomes or consequences of invasive medical procedures, and whether they are willing to take the risk. Despite some fairly nasty possibilities, few physicians have

seen a patient jump off the machine and run for safety, though the process does firmly plant in the patient's mind as he drifts off into an ether-induced sleep that death is a side effect of life. The question seems moot.

The room contains four monitors, including one large video screen that stands above the other equipment and people. Five people move around the room now: the male anesthetist, Dr. M, two female medical assistants, and a non-gendered researcher. Later, a male radiology technician will enter.

"Have you had your cocktail?" Dr. M asks the patient, politely, as he might have asked a date in an effort to loosen her up.

The cocktail is Mylicon, a concoction that dissolves any air bubbles in the stomach and duodenum. The patient says that he has in fact consumed his cocktail and makes predictable yet still humorous alcoholic references. Small laughter ensues.

For the researcher's benefit, Dr. M demonstrates the endoscope, which is a black, flexible video unit the diameter of a pen with an opening at the end that allows the physician to insert tools into the patient's body. Dr. M blows air through the tube and exhibits its power to make bubbles in water. He knows that its power exceeds that displayed in the demonstration. Devices attached to the patient's body allow monitoring of his vital signs; if Dr. M. detects abnormalities, he can administer medications intravenously to correct deviations from the biological standard. Tools he inserts through the tube allow manipulation of the bile duct and its contents.

Technicians now help N into a prone position and turn his face outward, away from the wall. Everyone in the room can see N's face, but the technicians severely restrict his movement, as they seem to tie him up with tape and tubes, limiting his ability to see those who see him. His restraints render him defenseless against molestation, but there is no fear of that. They tie him up because they care about him.

"It looks like I'm not going anywhere," N says rather cheerfully.

"We're going to be putting a small piece of plastic in your mouth, sir," says the anesthetist. "And you're going to drift off to sleep."

"Good night then," the patient says.

The lights dim.

As she gestates in effluvia, Donna Haraway works tirelessly to erase the boundaries between "stodgy bipolar terms of hominids" (69) and the rest of nature, which of course is a contentious space or non-space, as the case may be. She sets about to reclaim an understanding of science as culture from the "technopornographers, those theorists of minds, bodies, and planets who insist effectively—i.e., in practice—that sight is the sense made to realize the fantasies of the phallocrats" (64). Goddess knows, this procedure room could have bloomed from a phallocrat's Petri dish with its phallic-visual interruptions of space, clearly framed digital boundaries, i.e., separate computer monitors serving as windows into phallo-fragments of the patient's body, and clear delineations between the patriarchal phallo-physician and feminized patient, who's

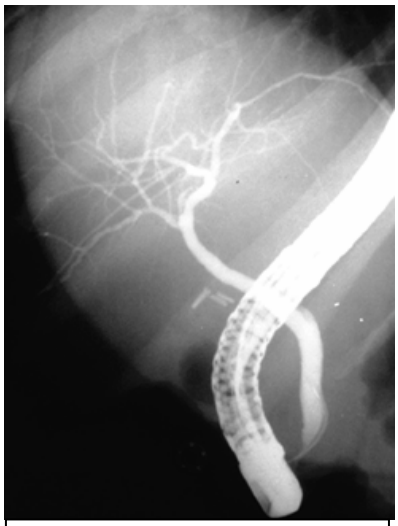
about to have an elongated tube inserted down his throat, the image of which will be projected on the screen for all to see. This might be problematic, but it does allow Dr. M to prevent little stones from growing too large inside N. For Dr. M to look into the nature of N's condition, he must look into the nature of N. Haraway finds nature unhidden and not in need of unveiling. She proposes that to experience nature or who we are in nature, we need rhetorical spirits. This leaves Dr. M in a bind. To create a rhetorical spirit – the light and shadows that make up the rhetorical artifacts containing the spirit of life – he must unveil nature. And, in any case, he would argue that he is no phallocrat; he simply likes to see things clearly, whether it be birds or intestines.

The big screen displays images projected from the endoscopic camera, currently in a cylinder of still water. As Dr. M demonstrates the tool's flexibility and nature again briefly, the screen shows flashes of the procedure room, fingers crossing the camera's lens, and the bowl of water again as the tube is dunked inside. Dr. M. will use video endoscope and video fluoroscope in this procedure. Images from both devices will be projected on monitors placed above the patient, some of which will be saved for later analysis.

"This productionism is about man the tool-maker and –user, whose highest technical production is himself; i.e., the story line of phallogoentrism … his reward is that he is self-born, an autotelic copy," Haraway states, firmly (67). This seems to be playing out somewhat in Dr. M's endoscopic theatre to the extent that the artifacts that

he creates serve as "autotelic" copies of himself, but mostly if the borders are removed. If we erase boundaries as Haraway would have, we might as well erase the line between patient and physician and allow the masculine and feminine representatives in this play to become one, and while we're at it, we might as well erase the line between human and techno-artifact, so that the reproduced image of N's esophagus (or whatever body part) becomes metonymical for All of Nature. Dr. M might even find it useful for the birds.

Between the patient and the wall near his knees, a monochromatic screen displays the numbers and lines showing whether the patient is alive, dead, or somewhere in between. These are the patient's vital signs. The monitor nearest the patient's head projects fluoroscopic images after the radiologic technician transmits x-rays through the patient's abdomen. These images are shadows and light and they are beautiful. On an electronic monitor, similar to x-ray films on a light board, the reflection looks like a glowing shadow – an impossibility in nature. The image appears not like a part of the human body, but more as a fractal where each part of the whole makes sense in its own right. Another monitor that sits haphazardly on the patient's opposite side is part of a computer on a rolling cart that contains a portion of the



N's scans being unavailable for publication, we have here an image from Harvard Medical School's teaching program. It's an ERCP scan that shows normal filling of the common bile duct, hepatic duct, cystic duct remnant and intrahepatic ducts. N's scan had more cachet.

patient's medical records – at least those that relate to this procedure. Dr. M explains that the patient's total records are not consolidated in this apparatus. Pieces of N's medical data stream reside elsewhere.

Dr. M inserts the camera into the mouth of the sleeping patient. The patient does not complain; he sleeps. The large monitor shows windows with two images: the larger, primary window on the left displays the moving image transmitted by the camera as it travels through the patient's esophagus and stomach and into his small intestine. While it's visual, projected on a screen, and seems a bit licentious – like a cautionary tale for young girls to avoid activities that lead to getting laid, splayed, or objectified unless they want to be physically violated – what we are watching could hardly be called pornography, though it's tempting; that would be an exceptionally convenient argument. Instead, the moving image offers an artistic rendering of the natural body. The physician's phallic prosthesis seems nothing like Haraway's cruel description of a "male's urinary and copulative organ" (72), which would deprive medicine of romance. Rather, it is a love tube with which Dr. M enters the patient orally.

The second window shows a still image from the camera. In the upper, left corner against a black background, the screen displays the patient's name, the date, and the type of procedure. Dr. M. pushes the tube further into N and comments that the patient shows erosions in his stomach, indicating the use of certain medications, such as

common pain relievers. Both medical assistants confirm that the patient has denied use of any medications. Everyone in the room watches the screen, except for the anesthetist, who watches the patient.

Investigating the body via endoscopy is like walking into a very dark, mysterious cave with a candle. The endoscope's light brightens the fleshy lumen it travels through revealing the shimmering, reddish glow of the gastrointestinal tract, but offers only the slightest hint of the inner body's brilliance. It's a medico peep show.

"Recurring common bile duct stones is the diagnosis," Dr. M informs me, the researcher. Everyone else in the room knows that.

Some confusion ensues, as one medical technician, R, comments that the patient may have a stent. A stent is a small device endoscopically implanted to keep the bile duct open. Dr. M seems to tense slightly, becoming alert to an unknown circumstance, and states that mention of a stent is not in his dictated notes. R remains uncertain and says that the patient may have mentioned it. While it remains unstated, they all know that patients cannot always be trusted. They are often fickle and unpredictable. Like a hysterical woman, the patient's inherent pathological state makes him subject to error and even delusion, though he cannot be totally ignored.

Dr. M assumes control. The ERCP, like most invasive medical procedures, follows a strict flow chart of actions, which even a non-expert might reasonably be expected to learn without a decade of training; the physician's expertise is that of

decisiveness and deviation. The body acts upon itself in unpredictable ways and does not accommodate the flow chart. In addition, the technology itself and the conditions surrounding it create unexpected scenarios. The physician must draw from his understanding of the human body and the technologies in his hands to face the unexpected.

Dr. M pulls the tube out through the patient's mouth.

"Fluoroscope," Dr. M. states, as he pulls the large, flat panel over the patient's back.

R picks up the phone to call for a radiology technician; Dr. M suggests that he should call to get the technician here quicker, but R makes the request anyway. Soon thereafter, a balding radiology technician enters the room and attends to the fluoroscope. He moves it over the patient more precisely and pushes more than one button. An image of the patient's abdominal cavity fills the smaller monitor.

Haraway describes "subjugated human adults" (she may be referring to N), who have been disengaged and relocated "in the authorial domain of the representative" (she may be referring to Dr. M), finding that this relegated position of the represented who is rendered speechless is the "representative's fondest dream" (87). Everything that might constitute a voice for the represented – the patient – is removed. That seems to be the case in this story, though both the patient and the physician would be hard pressed to see it that way. They would, however, see their relationship as one that

negotiates the biggest payoff or loss. "The power of life and death must be delegated to the epistemologically most disinterested ventriloquist, and it is crucial to remember that all of this *is* about the power of life and death," states Haraway.

Dr. M inserts a second endoscope, a duodenosope, in the patient's mouth, advances it to the duodenum, and calls for a balloon. No one in the room considers the balloon in anyway analogous to a prophylactic; that assertion never comes up anywhere but here, in the form of a denial. Dr. M inserts a deflated balloon in through the endoscope and injects the patient's bile duct with contrast agent. The endoscopic video screen shows bile pouring from the patient's bile duct into the small bowel. Both monitors show the elongated balloon being filled with air; the fluoroscope image shows a sort of transparency, while the endoscope image shows the balloon pressed against viscera.

"We're going to pull the balloon through and see if anything comes out," Dr. M says.

Everyone quietly watches the screen. Dr. M pulls out the endoscope.

"No stones," he says.

Not coincidentally, *phallus* refers not only to male generative power, but also to bird anatomy. Donna Haraway sees birds through a different lens. She understands their queerness and laments their position bound into an undeserved servitude. "Forced to live in our ethno-specific constructions of nature, the birds could ill afford

the luxury of getting embroiled in what counts as natural for the nearby community," states Haraway, about ducks she encounters on a lake (129). She knew the ducks were into queer communities and did not need bras or hospital gowns.

* * *

I shall call it the *fictional epistemological model.*

I proclaim it revolutionary.

Medical texts can only be decoded with fiction; fiction offers the only truth that matters.

I have a short, completely true story to tell.

If medical intervention feminizes the patient, then the relationship between patient and physician must be one of love; it is the open, sacrificial love of a woman offering herself on faith – in the medical credentialing process – to one who will make her whole. Some time ago, my daughter went to bed and began coughing. At midnight, I called her pediatrician.

"She can't seem to breathe," I said.

My daughter gasped for air; panicking made it worse. On her physician's instructions, we went to the Emergency Room, where two nice men took multiple x-rays of her chest. The ER physician had already administered medication that stemmed her coughing fits and the x-rays were to determine whether she had bronchitis or some other ailment of the lungs. That night, the hospital experienced a record number of

head traumas from motorcycle accidents, moving croup patients down the list of priorities for personal attention. My daughter and I spent several hours in a cold room watching videos of dancing bears on a very small television set. Nevertheless, she left the hospital calm and able to breathe, which fulfilled our goal.

I looked at my daughter's radiology consultation report recently and realized that the radiologist loved her. Reading his report, however, it seemed clear that he was hiding something, as lovers often do. The text – plainly a love note – that bonded he and my daughter did not clearly identify his feelings. I could not decipher his message very easily. His love remained hidden in a way that hurt. The medical record seemed stripped of meaning; it said nothing of my daughter's beauty or love of domesticated animals. The radiologist failed to comment on her blond hair, hazel eyes, and dancing ability, and said nothing at all about her penchant for practical jokes.

RADIOLOGY CONSULTATION REPORT

Ordered By:	Eric S. Csortan M.D.	**MR #:**	H0879673	**DOB:**	12/23/97
Copy To:		**Loc:**	HEPD	**Age:**	7

KOLLER, SYDNEY
Chest, PA & LAT **March 13, 2005**

INDICATIONS: Seven year old with difficulty breathing.

TECHNIQUE: Frontal and lateral views of the chest at 0219 hours.

COMPARISON: none

FINDINGS: Frontal and lateral views of the chest demonstrate the heart and mediastinum to be normal. The lungs are clear. The osseous structures are intact.

** **IMPRESSION:** No acute cardiopulmonary disease.

Scott D. Klioze, MD
Board Certified Radiologist
This report was verified electronically.

My daughter was more than a "seven year old with difficulty breathing." I found that I could not ask Dr. Klioze what he meant, because he did not exist. Neither my daughter nor I ever met him. He reportedly read the x-rays sometime after they were taken. It is apparent that, "This report was verified electronically." What kind of conversation could I have with an electronic verifier? I chose to address this situation as anyone would: with fiction. What better way to understand a love note verified by a fictional entity than to ask a fictional love story? What better love story could we use than Kundera's *The Unbearable Lightness of Being*, where the main characters, Tomas and Tereza, exist in an existential space moving between fiction and reality, and where the duality of body and soul is at the heart of the matter? To accomplish my mission, I need

to fragment the love note—tear it apart to be able to see it in a new way. The tearing process mimics how the radiologist fragmented my daughter to understand her pathology. He penetrated her with his gaze, though from afar, and exposed her "Frontal and lateral views of the chest," leaving the rest of her untouched by anything but traces of radioactivity. Bettyann Kevles points out that from the x-ray to the digital images produced by more sophisticated imaging technologies, such as CT, MRI, and PET, visual medical technologies have "increased the sense of fragmentation that comes from seeing parts of our inner selves as transitory patterns on video monitors" and focused on specific organs, similar to the move from general practitioners to specialists focusing on body part" (261-262). By isolating and dislocating, it is possible to create.

As a baby, my daughter's first words were *no* and *dada*, so it seems to make perfect sense now that Sydney was saying *no* to the *Dada* movement, and instead instructing me to look beyond at an offspring of Dada – surrealism in this case. Fortunately for us, the Surrealists practiced cut-up and collage wherein text is rearranged to understand each fragment and the reconstituted whole in a different way, which is highly instructive here. I refuse to slip into unconsciousness, however, and will search with intent to find the right fragments, the right language.

Fragmenting the medical record of the x-ray itself creates a new way of understanding Sydney's radiologist, the cryptic medical report, and even her own body. It might offer something like Barthes's "third meaning," as described by Robert Ray.

Barthes fragmented movie shots, in addition to written texts. "Both Barthes's 'third mearning' practice of reading movie stills and the Surrealist strategies of film watching amount to methods of extraction, fragmentation," Ray says (36). It isolates the detail from the narrative, so that its meaning becomes open for new interpretation. In this case, we can rearrange the fragments to reveal a different meaning of the medical text.

By searching through the Kundera novel, I filled in the blanks of the radiologist's love note; I decoded the white space and completed the communication between the electronic verifier and my daughter. This juxtaposition of the love note and love story offers a new way of addressing the puzzle of meaning in this ostensibly medical interaction.

> Seven year old with difficulty breathing. What fell to her lot was not the burden but the unbearable lightness of being. Technique: Frontal and lateral views of the chest at 0219 hours. God, it may be assumed, took murder into account; He did not take surgery into account. He never suspected that someone would dare to stick his hand into the mechanism He had invented, wrapped carefully in skin, and sealed away from human eyes. Comparison: none. The odd duality of body and soul has become shrouded in scientific terminology. Findings: Frontal and lateral views of the chest demonstrate the heart and mediastinum to be normal. The lungs are clear. The osseous structures are intact. A long time ago, man would listen in amazement to the sound of regular beats in his chest never suspecting what they were. He was unable to identify himself with so alien and unfamiliar an object as the body. Impression: No acute cardiopulmonary disease. The road there wound through some hills, and their pickup had crashed and hurtled down a steep incline. Their bodies had been crushed to a pulp.

What does this say? What questions does this conversation between medicine and literature answer? It's clear: "Seven year old with difficulty breathing. What fell to her lot was not the burden but the unbearable lightness of being." What fell to my young daughter's lot that night was not the burden of illness, of croup, or of lack of breath; it was the agonizing pain of living in a body that requires breath. The love note hints at it, but doesn't finish the thought. Her lightness – the lightness of childhood, innocence, and maybe my love – became unbearable for her that night. As she coughed spasmodically and screamed that she couldn't stop, she felt the pain of existence and the fear that it would be snatched from her.

We see from the text that God had no idea; the technique was ungodly. "Technique: Frontal and lateral views of the chest at 0219 hours." Two-nineteen refers to the two of us, waiting as one billing unit (for hospital purposes), at a moment in time when we were not dressed to the nines. This is significant. Our clothing was our own.

> God, it may be assumed, took murder into account; He did not take surgery into account. He never suspected that someone would dare to stick his hand into the mechanism He had invented, wrapped carefully in skin, and sealed away from human eyes.

God could not have envisioned x-rays; x-rays are God and he has no mirror. They penetrated Sydney's skin with a mysterious, invisible ray that produces – like murder – both dangerous and thrilling results: the exposure to radiation and the

spectacular artifact created by the radiation. "Comparison: none. The odd duality of body and soul has become shrouded in scientific terminology." As the new text states, there is no comparison. The duality between body and soul, between my daughter as female, patient, child, and her radiologist as male, physician, adult becomes more apparent. But wait! His love for her is becoming suspect.

"Findings: Frontal and lateral views of the chest demonstrate the heart and mediastinum to be normal," he states. How could he call her "normal," especially her heart? Normal signifies her as nothing. While normality is historically the ideal condition of a patient, as a person and one he loves, what could such a banal description of my daughter possibly mean? You cannot love someone who has a "normal" heart. It's insulting if not downright blasphemous. Love requires exceptionality. Normality is nothing but a sham that keeps us in a constant state of pathology. But things appear to improve; the explanation follows. We see that "scientific terminology" shrouds the truth. Amen, sister. Nothing appears clearer than a truth shrouded by language. Moving along, we learn through an interpretation of the x-ray image that my daughter's lungs are clear and her bony structures intact, but we are reminded that things were not always as they are.

> A long time ago, man would listen in amazement to the sound of regular beats in his chest never suspecting what they were. He was unable to identify himself with so alien and unfamiliar an object as the body.

The love story reminds us of a time when we romanced the body and were romanced by its ticks and murmurs, a time when they remained mysterious rhythms that might as well have emanated from the earth. The body, earth, sun, universe, God, and buttercups were all one conflated juggernaut. My daughter's love mate understood and grew impressed by my daughter. "Impression: No acute cardiopulmonary disease," he states. Thank Goddess. But, reading on, we learn that: "The road there wound through some hills, and their pickup had crashed and hurtled down a steep incline. Their bodies had been crushed to a pulp." What is this winding road and how can I stop my daughter from getting in the pickup before it's too late?! The road cannot be life; that's far too easy a metaphor. Is the road one day – the day of all days – when no matter how "normal" her heart and mediastinum, they will fail her and she will be crushed to a pulp? I need to know who rides with her, whether the radiologist sits there, a new lover, God, or maybe it's me. This says that despite all of her radiologist's efforts at seeing inside of her and no matter how she exposes herself to his gaze in an effort to endure her lightness of being, it is merely a prolongation of the inevitable outcome.

A year later, another physician visits our home and sees my daughter's chest x-ray in a frame. I have shrunken and revised it in a digital photo-editing program. She's mine, after all.

"It's backwards," he says. "The heart should be on the left."

How could he know her heart better than I do?

Works Cited

Haraway, Donna. "A regenerative politics for inappropriate/d others." *The Haraway Reader.* New York: Routledge, 2004. 63-124.

--. "Otherwordly conversations; terran topics; local terms." *The Haraway Reader.* New York: Routledge, 2004. 125-150.

"ERCP in radioscintigraphic detection of bile leak following elective laparoscopic cholecystectomy." 1995. Harvard Medical School Joint Program in Nuclear Medicine. 19 Apr 2006. <http://www.med.harvard.edu/jpnm/tf94_95/feb7/ercp.gif>.

Kevles, Bettyann. *Naked to the Bone: Medical Imaging in the Twentieth Century.* Sloan Technology Series. 1997. New York: Basic Books, 1998.

Kundera, Milan. *The Unbearable Lightness of Being.* Trans. Michael Henry Heim. New York: Harper & Row, 1984.

McGaw, Judith. "Why feminine technologies matter." 1996. Photocopy of republished edition.

Ray, Robert. *The Avant Garde Meets Andy Hardy*. Cambridge, Massachusetts: Harvard University Press, 1995.