

# Empathographies: Using body art related video approaches in the environment of an Austrian teaching hospital

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## ABSTRACT

*In this article, I introduce video as an ethnographic method of translating human experiences of illness and suffering into an aesthetic language. Interviewing physicians and patients in different clinical fields with the help of a video camera is embedded in the research project CORPOrealities (2004–2009), which I carry out together with a team of visual artists, curators, historians and caregivers at Medical University Vienna (MUV). I ask clinicians and patients to teach health professionals and medical students by using video as a tool of self-reflection. Selected video footage is regularly discussed among clinical personnel who are invited to participate in interdisciplinary workshops. These visual ethnographic interventions illuminate apparently opposed perceptible and expressible realities in the physician–patient relationship. With the application of such sensory and body art related methods we aim to enhance complex processes of translation and mediation and strengthen the empathy, sensitivity and emotional competence in health care work.*

**Keywords:** Experience, sensory ethnography, body art, reconstructive surgery, performance, socio- and psychosomatics, emotional competence.

## PROLOGUE

Imagine yourself sitting in a small, darkened room, a big screen in front of you, people next to you dressed in green and white hospital gowns, who, through moving images travel with their eyes through the inner bodies of cancer patients, discussing case histories, deciding about medical diagnosis and future treatment. In some ways the situation reminds one on watching a film at a movie theater. Although the issues at stake are serious and rather existential, the levels between an imaginative world with virtual bodies and the tough realities among the sick and their healers

are constantly blurred. In this contribution, I will confront the *diagnosable body* and how it is “staged” in the contemporary work of health professionals using personal narratives of patients’ and physicians’ corporeal experiences and embodied practices in the clinical environment. Hence, the texture of my considerations unfolds at the margins of the phenomenological distinction between *having* a body and the malleable lived perception of one’s flesh.

According to the historian Ivan Illich, in the course of the 18<sup>th</sup> century the relationship between physicians and patients fundamentally

changed from an interpersonal encounter to a mediated one (2006: 151). The patients' stories became increasingly irrelevant within the development of modern medicine. Sick bodies and individual modes of expression were progressively replaced by diagnostic tests and translated into an abstract scientific language. Before this upheaval medical doctors simply listened to the sick person's story and subsequently an anamnesis was put together, mirroring how people perceived themselves. Doctors treated the oral confessions their patients had told them. For instance, Gerard van Swieten (1700–1772) and Anton de Haen (1704–1776) who founded the first *Medical School* in Vienna, taught their students at the sickbed, where trainees had to examine the sick persons, whispering the results in the ear of their teacher.

The becoming of a cancer patient in contemporary times, however, includes complex procedures of staging. According to the sociologist Erving Goffman (1959) who suggested a theatrical metaphor to investigate and describe interactions among individuals: "We do not just live our 'real life' identities, we *perform* them" (Sandahl and Auslander 2005: 215). We all change our social roles on a daily basis. This paper reflects in the involvement of both the researcher and participants in the research process. The self is framed in a variety of clinical areas. An investigation of the framing procedures of the self in different fields at the hospital needs the elaboration of a theoretical and methodological concept that includes the opening of my emotional boundaries during fieldwork. Hence, the notion of *EMPATHOGRAPHY* which suggests a relatedness of *identification* (understanding), *pathos* (feeling) and the *narrative* or *pictorial* (writing or portraying). These categories are equally important for the approach, which I will introduce in the following preliminary report. I use the term *empathography* for the video interviews I conducted at the hospital between 2005 and 2008. I will summarize the video ethnographic and experimental works with clinicians and patients, which were realized within the *CORPOrealities*-project. All of my interview

partners gave me their written permission to use the video footage as research materials and presentations in academic contexts. All participant names used are pseudonyms. The multidisciplinary endeavor has been officially registered as a clinical study at the *Medical Ethic Commission* at *MUV*. The research framework consists of four parts, which are integrated in the following outline: methodology and the reflective researcher, reflective pieces associated with clinicians, experimental videoing with two breast cancer patients, and communicating and teaching emotional competence to physicians and medical students.

## CORPOREALITIES

Methodology and the reflective researcher: Methodologically I embed videoing in an art and body related reflective concept. My ethnographic work is informed by narrative medicine (Charon and Montello 2002; Frank 1997; Mattingly



FIGURE 1: GÜNTER BRUS 1999: NO. 8 OF THE SERIES *KLEINE NARBENLEHRE*, IN: C. LAMMER 2007, *GÜNTER BRUS. KLEINE NARBENLEHRE (GÜNTER BRUS' THEORY OF SCARS)*, VIENNA, LÖCKER VERLAG, P. 26.

2002; Stoller 2004), visual anthropology and sociology (MacDougall 2006; Pink 2001) and by an anthropological theory of visual art (Gell 1998). Particularly inspiring for my audiovisual work in the medical context was a case study I did with the *Vienna Actionist* Günter Brus about his poetic self-depictions of one of his hospital stays. The findings of our 24 month collaboration are published in *Günter Brus: Kleine Narbenlehre* (Lammer 2007). The project is developed in collaboration with clinicians at *MUV*, with Barbara Graf (visual artist and researcher), Catherine Rollier (visual artist and researcher), Cathrin Pichler (curator for visual art) and Christa Spatt (curator for contemporary dance and performance). My studies at the clinic are based on the use of video with both clinicians and patients, creating a laboratory situation where forty physicians of different medical fields told stories about how they perceive patients. The idea behind this investigation was influenced by what I have learned and understood about cultures within medicine during my participation as sociologist at interdisciplinary clinic rounds.

Reflective pieces associated with clinicians: In my audiovisual ethnography, I aim at showing how patient-doctor contact is shaped in the heterogeneous cultural disciplines at the hospital.<sup>1</sup> I invited clinicians to the TV-studio at the hospital where I video interviewed them. I first asked them to take a seat in front of a black background. I then pulled the floodlights in a good position and put myself and the camera rather close to my interview partners. In this unconventional setting, at least for health professionals, they performed and presented themselves, describing the relationships to their patients.

Experimental videoing with two breast cancer patients: I introduce video works with Monika, a breast cancer patient, and her daughter Angelika

as two of fourteen women who participate in an ethnographic study about the reconstruction of the body image(s) by sharing their illness stories with me.<sup>2</sup> At the time of the video interview (2006), Monika undergoes chemotherapy. Angelika, Monika's daughter, also develops (benign) lumps in her breasts. To date, she has had two operations. Angelika's and Monika's illness narratives form the core *empathography* of this article. This case study is inspired by the visual artist Jo Spence who "began to reverse the process of the way I had been constructed as a woman by deconstructing myself visually in an attempt to identify the process by which I had been 'put together'" (1986: 83). In the course of her work with photography she displayed "'new' visual selves to the camera" (173). She herself died of cancer.

Communicating and teaching emotional competence to physicians and medical students: The breast cancer patient Monika and her daughter Angelika put themselves in the picture. They express their vulnerabilities with the help of a video camera. Their modes of expressiveness and body languages are full of communicative power. Angelika portrays to the camcorder her ideas about the prophylactic removal and immediate reconstruction of breast tissue as it is discussed with her plastic surgeon shortly before her second surgery. She decides against the suggestions of her doctor, accepting the risk of falling seriously ill – the fate of her mother, grandmother and great-grandmother. In the eyes of her physicians, Angelika is at highest risk of developing cancerous cells. As an ethnographer I mediate during fieldwork between the sick and their healers. This is an important aim of my clinic projects – strengthening empathy and the interpersonal contact among patients and health professionals.

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<sup>1</sup> The research is similar to the invention of Richard Chalfen's and Michael Rich's *Video Intervention / Prevention Assessment (VIA)*-method that is successfully applied at a *Children's Hospital* in Boston (Chalfen and Rich 2007: 53-70). It also builds on Rick Iedema's qualitative sociological projects at Australian clinics and on Paul Bate's and Glenn Robert's study *Bringing User Experience to Healthcare Improvement* (Iedema 2007; Bate and Robert 2007).

<sup>2</sup> The project is realized together with Manfred Frey, head of the *Division of Plastic and Reconstructive Surgery*, and his team.

## ANAESTHETIZED AESTHETICS

Art historical background: As a unique example and a remarkable witness of the turn to the institutionalization of medicine taking place in the 18<sup>th</sup> century I introduce the sculptor Franz Xaver Messerschmidt (1736–1783). He revealed the existential nakedness of the human being in the form of portraits and *Character Heads*. His late sculptures were a revolutionary artisan contribution in times of Enlightenment. He posed the question of the soul with the creation of grimacing busts, studying his own mimic capabilities in front of the mirror. An exemplar of what it meant to become a *patient* in the 18<sup>th</sup> century is one of Messerschmidt's *Character Heads: Ein mit Verstopfung Behafteter / The Constipated One* (No. 30 in the series, after 1770). He created facial expressions of a young woman who suffered constipation (Krapf 2002: 234). It is reported that he was himself constipated and remolded his own mimic features during this uncomfortable condition.

Studying Messerschmidt's works in more detail can provide a corporeal vocabulary of human suffering. Franz Xaver Messerschmidt unfolds the sensory arts in the expressiveness of the face. His impressions and distress are articulated delicately, up to the grotesque, with the *Character Heads*. A particular haptic quality is significant for these busts. One can feel pain and other sensations by looking at them more closely. Messerschmidt's faces are extremely dynamical in their modes of utterance, appearing in constant flux. Some of them are inwardly withdrawn, resist any communication with the viewer, whereas others cause opposite reactions. They are molded selves, turning inner existential layers outward.

Techniques of the body: *The Wounded Storyteller* (Frank 1995) – combining Messerschmidt's plastic art with approaches in medical anthropology and sociology needs further explanation. Art works represent cultures and how they are associated with aesthetic fabrics. I consider Franz Xaver Messerschmidt as an influential figure “betwixt and between” the different movements within

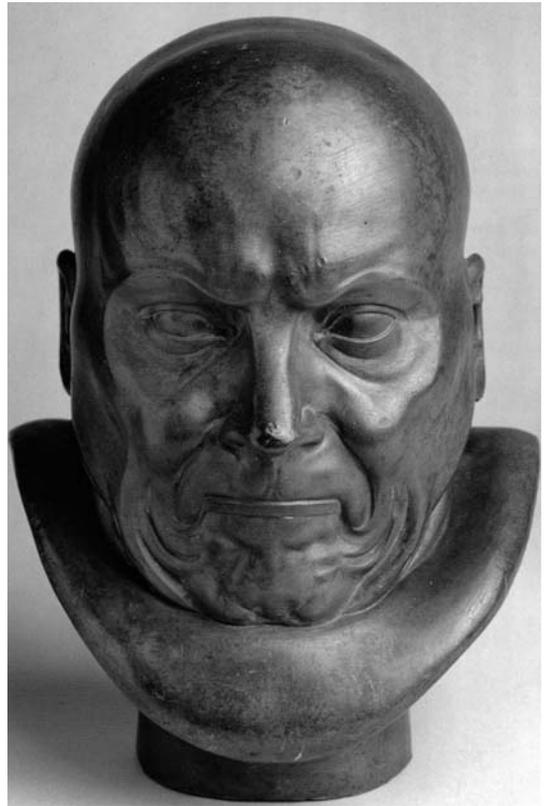


FIGURE 2: FRANZ XAVER MESSERSCHMIDT AFTER 1770: NO. 30 OF THE SERIES *CHARACTER HEADS, EIN MIT VERSTOPFUNG BEHAFTETER (THE CONSTIPATED ONE)*, IN: M. KRAPF 2002, *F. X. MESSERSCHMIDT 1736–1783*, OSTFILDERN-RUIT, HATJE CANTZ VERLAG, P. 235.

Vienna's medical cultures (Turner 1967: 93). In the words of Marcel Mauss in *Techniques of the Body* (1934), penetrating the “miscellaneous” is “where there are truths to be discovered” (1992: 455). I use the videos of forty physicians as one method of entering different cultural landscapes in the context of a university clinic and, thus, I describe and interpret the social interactions between clinicians and patients as bodily techniques. The clinicians were questioned in front of the video camera: “What is a patient for you?” They defined their contact with the people they treat in their fields of practice and commented on their own emotions and perceptions. In his videoed statement, a plastic surgeon connects *aesthetics* with suffering and *experience* with bodily sensations and feelings:

A patient is a suffering person. The suffering can have different causes – physical, painful or psychic reasons, from outside hardly understandable.<sup>3</sup>

I quickly noticed that this particular situation in the TV-studio puts the portrayed physicians themselves in a vulnerable position, almost comparable with the one of patients. Thus, I increasingly concentrated on aspects of the performances of my interview partners, assembling touching scenes, putting them together into movie collages. The technical eye of the camera is used to capture the body language and emotions of people.

The created video materials were presented to my colleagues at the hospital in (three) workshops. These screenings took place in the room where physicians of different medical disciplines usually discuss cases (*TumorBoard*-meetings is the name of the regularly held interdisciplinary cancer conferences at *MUV*; see figure 5). For one of these reflective rounds at the clinic, I prepared a video (35 minutes) with the title *Grenzen der Empfindung* (*Limits of Empathy*). This informal multi-

disciplinary conference took place in March 2006. Surgeons, radiologists, neurologists, oncologists, psychologists, plastic and reconstructive surgeons, artists, and a study nurse participated, altogether about 25 people. Some of the physicians present watched themselves talking and acting in the video montage. Some of the participants were uncomfortable watching their own recordings.

Videoed physicians: Although I carefully chose the statements for the movie, one surgeon felt particularly uncomfortable about the screened message of himself. I consciously include his reaction in my considerations because it is representative for the difficulties such a self-reflective audiovisual intervention can produce:

I believe, or it is definitely so, that physicians are not to blame for the malignant diseases of their patients. However, we are the ones who have to communicate this message. The [patients] simply have [to get] the chance to cope with it, and to take on that they need a big operation, and eventually further treatment. They need to win trust. Trust is very



FIGURE 3 A-F: CHRISTINA LAMMER 2005: STILL PHOTOGRAPHS OF VIDEO PORTRAITURES WITH PHYSICIANS.

<sup>3</sup> The ethnographic video materials are used within the clinical context. Only for screenings at international conferences and for publications such as this one, I needed to translate the documented conversations into English. Video interview: TV-studio at *MUV*, June 2005.

important in such a situation. Insofar one receives even in dramatically narrow situations, when we physicians really cannot do anything [other] than supporting the patient in making the rest of his life as tolerable as possible, particularly of these patients very much motivation and gratefulness. These are always deeply stirring situations. In order to [do] this, one cannot be other than empathetic. Especially with young patients, or those where one recognizes that they fight and need support because they go very consciously through this phase of life. I frequently thought about seeking psychological help. But I increasingly realized that the best [emotional] support in this situation is the conversation with the patient himself. And I find the feeling that one receives positive vibrations of patients in still as dreadful situations as [emotionally] supportive enough.<sup>4</sup>

I interpreted the words of the surgeon as an example of his emotional competence in the work with patients and, thus, as highly informative and instructive. His perception of how I put him in the picture was the opposite. He felt misinterpreted and did not quite understand why the way I present audiovisuals is *scientific*. Immediately after the workshop he wrote in an Email: "I thought you would use the interview for your research and not for public screenings." There are multiple epistemic cultures in the play, and actually his objection was rather important and helpful for the further development of a framework of mediation and translation.

Neutralizing the touching qualities of life: The surgeon's argument "emphasizes the neutrality of seeing. It is a vision which treats seeing as an event in the physiological eye focused on a physical world" (Romanyshyn 2001: 47). In this understanding, being moved by a *story* is not perceived as a *scientific* point of view. However, the

*touching quality* of reflection is a necessary ingredient of the applied ethnographic approach, which I suggest with my work at the clinic. Medical science fails "to affect us precisely because it lacks this disruption which awakens us from the sleepiness of our routines, from the numbing inertia of our habits, in order to mirror for us the stories and figures whom we live and who we are" (ibid.: 48). In the videos, patients and caregivers are framed as *figures* and as inhabitants of the psychological world. The empirically depicted *diagnosable body* is considered as the counterpart of the *refiguring* of the *person*. Within my study I asked, "How do, for instance, radiologists 'see' their patients"?

Patients are customers who seek our help and we try to support them with our activity. ... These are persons with whom one has to interactively communicate on a personal level.<sup>5</sup>

With many of the video-interviewed radiologists I get the impression that they perceive any direct and personal contact with sick persons as disturbing. Often they give rather short answers. Their body language represents hesitation. One (male) colleague at the radiology department characterizes patients as "working objects" and said:

Actually I don't have relationships with patients. Eventually there is a relationship, particularly with children, but this is extremely unpleasant.<sup>6</sup>

Patients who are examined with the help of medical imaging technologies are regarded in their material physicality as empirical entities. They become staged and mediated translucent body landscapes.

Illness portraiture: The *body image* is one of the fundamental points of life experience. According to the psychiatrist and neurologist Paul Schilder (1950), we live constantly with the knowledge of our body. Phenomenological approaches in medical anthropology and sociology

<sup>4</sup> Video interview: photo-studio at MUV, June 2005.

<sup>5</sup> Video interview with a radiologist: TV-studio at MUV, May 2005.

<sup>6</sup> Video interview with the same physician: TV-studio at MUV, May 2005.

make distinctions between notions of *illness* and *disease*. Illness is related to the sick person's experiences, whereas disease "is typified by complex patterns of dysfunction" (Leder 1990: 81). Thus, in "disease, one is actively disabled. Abilities that were previously in one's command and rightfully belong to the habitual body have been lost. ... When sick, I no longer can engage the world as once I could" (ibid.). The philosopher and physician Drew Leder refers to this phenomenon as a form of bodily disappearance, which goes hand in hand with a withdrawal from self-experience. In the *becoming* of a *patient* individuals move somewhere in a vulnerable sphere in between of being the sick body and having a sick body "that is distinct from self and that the person observes as if it were someone else" (Kleinman 1988: 26). The experimental creation of ethnographic videos of patients and physicians encounters the disappearance of the self and how it is perceived by giving the sufferers the opportunity of textually (verbally) as well as pictorially (nonverbally) "keying" their everyday lives and realities (Chalfen 1987: 124). What follows is a case study with a breast cancer patient and her daughter. Monika, 45 years old, clerk and mother of two young women, developed breast cancer. She had her mastectomy and immediate breast reconstruction in October 2005. I first met her on the day after this operation. She told me in an interview (without video):

You will be stigmatized forever. This is like a mark on you. There is an excuse for war injuries, being inflicted by someone else. For you it is a disease, which always signifies you. Of course everyone strives after making it invisible.<sup>7</sup>

In this statement, Monika points to issues of how the disease permanently altered her body image and influenced her self-awareness. Her thick descriptions she gave me in front of a video

camera and those I recorded as field notes provide a rich body of knowledge, which is communicated to health professionals on a regular basis. For example, selected video sequences are provided on the *CORPOrealities* homepage ([www.corporealities.org](http://www.corporealities.org)) and I still participate as a sociologist at the twice-monthly interdisciplinary clinic rounds where case histories of breast cancer patients are discussed<sup>8</sup>. These video materials and written reports of sick women provide an experiential understanding of what it means to live with this condition.

### MESMERIZED CORPOREALITY

Addressing patients and clinicians as equally framed actors through such experiential modes of being, forms the ethical framework of my research at the hospital. Accompanying women, who fall sick with cancer, during treatment and diagnosis, demands of me to put my own feelings and impressions into question, participating personally and empathetically in the processes of self-expression. My role as a researcher is constantly transcended during the work with patients and health professionals. I intuitively encounter this breaking and renewing of my emotional boundaries in opening my own private space, inviting patients to visit me at home, sharing parts of my everyday life with them. There are no prescriptions for behind- or in-front-of-camera routines. They are sensibly developed and negotiated, sitting around the kitchen table, drinking tea, coffee or a glass of wine, and spending a good time together.

Ethnographer as *operator* (camerawoman): The "conversation with patients" can serve as "emotional support" for physicians. At the beginning of this article, I quoted the argument of one of the video portrayed surgeons. He does not seek psychological help in his work with people who developed cancer because he finds talking with patients supportive enough. This was one of the

<sup>7</sup> The interview materials (with and without a video camera) have been collected between 2005 and 2007.

<sup>8</sup> The final results of this case study will be presented in the form of a book at the end of 2009.

statements which influenced my further use of ethnographic video at the clinic, elaborating research materials, which imply a strong focus on the emotional fabrics patients and physicians are made of. Assuming that we are all vulnerable individuals who live and express their feelings in manifold ways, opens a playground of multiple methodological options of how to capture these human modes of being together and, thus, of the patient-doctor relationship as one particular form of contact among persons.

Monika:

As soon one enters this whole scenario, this hospital loop, one is confronted with medical expressions, which one does not understand. They are so strange and actually give one the feeling of uncertainty. The finding reports are written in medical Latin. The non-invasive and the invasive, mastectomy, oh god, these expressions sound terrible. They are to be explained.<sup>9</sup>

It was Monika's idea to use a video camera. After spending hours together at the hospital, we needed a break and in the late afternoon we

went to my apartment to drink tea. I told Monika about one of the planned multidisciplinary clinic rounds. We talked about the video interviews with physicians, and I explained to her my hesitation of filming patients. Monika suggested using a video camera as an instrument, which can provide a tool for patients to speak up, creating footage particularly for the reflective work with health professionals. She wanted to perform in front of the camera, acting as representative for other women who suffer of breast cancer.

Home movie shooting event: Monika takes a comfortable position on my couch, in front of the white painted wall in my living room. Daylight falls through the windows to her right side, drawing shadows on her face. Since it was late in the afternoon, we needed to switch on an additional lamp. Monika asked me not to video her whole face but only parts of it. Respecting her wishes, I portrayed her with close-up adjustments. In the footage her face is plunged in warm lighting with a soft rose-colored touch. Her skin appears nearly unreal, like wax, smooth and almost without wrinkles. The cheeks are still red as a result of



FIGURE 4 A-F: CHRISTINA LAMMER 2006-07: STILL PHOTOGRAPHS OF VIDEO PORTRAITURES WITH PATIENTS. CHRISTINA LAMMER 2008: DRAWINGS AND STILL PHOTOGRAPHS OF VIDEO ANIMATIONS.

<sup>9</sup> Video interview: at my apartment, January 2006.

the medical treatment she had received a few hours earlier. Her dark eyes appear as brightly shining buttons. She does not use any makeup. Her hair is not identifiable as artificial. A self-conscious woman presents herself, vividly talking about her illness story and her experiences with doctors.

Monika:

Falling sick with breast cancer is nothing unusual today. One hears much through media, gets well informed, and should make precautionary diagnostic tests. For other people it is not difficult to associate something with the theme. Breast cancer is cancer, and has to do with the breast. That is the first what comes in one's mind. However, what effects it actually has for the single person, and how the concerned cope with the disease matters quite a lot.<sup>10</sup>

With the help of the video camera, Monika reconfigures herself in a way which includes "the contiguity between looking and grasping" (Connor 2001: 37). Perceiving the (projected) skin of another person creates alert sensitivity. "Whether this screen-creating capacity repeats the experience of the primal screen of the mother's breast, ... or whether the mother's skin is in fact hereby being retroactively cinematized, need not be in question here" (ibid.). What is developed is a form of sensory knowledge. One is viscerally affected by the images of Monika's face and the vibrant sound of her voice.

Comparing surgical operations with film- or video making, using Walter Benjamin's notion of the *operator*, leads to numerous ethical and theoretical considerations within my ethnographic research framework. Benjamin associates the *surgeon* with the *magician*. Whereas the magician keeps a "natural distance" to the sick person, the surgeon does without an interpersonal encounter in the "decisive moment"

(1977: 31 f.). Inspired by the Italian author Luigi Pirandello, Benjamin develops the figure of the *cameraman*. The central topic of Pirandello's novel *Quaderni di Serafino Gubbio operatore* (1929) is the dehumanization of mankind in modern industrial societies. According to Benjamin and Pirandello, the *operator* – either as surgeon or as cameraman – is by no means to be understood as politically neutral power. In my ethnographic works with a camera, the operator plays an important role as an analytic category. Monika, for instance, gave me instructions of how she wanted to be videoed. She switched from her role of a patient into one of a woman who medially reconfigures herself, with the target of teaching her doctors. The first video session took place in the living room of my apartment in January 2006. Monika had her chemotherapy at this time. Her body language was extremely sensitive. Pure vulnerability. She had lost her hair and performed in front of the camera with a wig.

According to Walter Benjamin, there is a distinction between the *operator* (surgeon, cameraman) who moves his hand beneath the organs, and the *magician* (general practitioner, painter) who keeps a natural distance between the treated person and him- or herself, reducing this space with his or her replaced hand only a little. "The hand is not a mere part of the body; rather it represents the body as such, like a homunculus, for it is the body's capacity to reach out beyond itself, as well as transformingly towards itself. ... This is to say that the hand (like the face) can be an alternative body, a second skin" (Connor 2004: 140-141). Videoing a mother and her daughter who are both at high risk, according to their physicians, of falling sick with cancer, carefully listening to their stories, reading the moving images, illuminates a deep gap between a diagnosable surgical body and the emotional and sensitive faculties of personal experience, fantasy and perception.

<sup>10</sup> Video interview: at my apartment, January 2006.

Being a(t) risk: Monika appreciates the factual behavior of her operator. Thus, two episodic models are brought face to face, the *nakedness* of the *Leib*<sup>11</sup>, and the disclosure of the body as object.

Monika:

He [plastic surgeon] does not look at me as a person but he measures my breast in lines and abstract categories. ... He does not need to become my friend. I rather want him to do a good job. That's what he is there for.<sup>12</sup>

Whereas diagnostic devices produce medical images with strong affective impacts for patients, the video portraiture of Monika and Angelika mirror what it means to *be* at risk or even terminal, *having* a (sick) body. Angelika, 22 years old, flight attendant, considered a prophylactic removal of both of her breasts and an immediate surgical reconstruction. Finally she decided against a radical operation, though her surgeons recommended getting it done.

Angelika:

They said that they would do it because it is so obvious. I thought, since I don't have it, since it is not in my body, this could be easier. Then I would be left in peace. That's what I thought. So powerful I encounter the breast cancer, these are still my breasts. These are my glands inside. If I had two artificial ones, the feeling would not be there anymore. One day I like to get children. I want to breastfeed them like other women do. Before nobody tells me that I need to do this now, because otherwise I would die, I would not do it.<sup>13</sup>

A few months after this video interview I accompanied Angelika and Monika to their

plastic surgeon. Both women planned further breast operations, Monika a corrective intervention and Angelika an additional removal of lumps. Angelika had a long conversation with her physician about a prophylactic immediate breast reconstruction. During the consultation she would talk about her body as if it were one of another person. Afterwards I had ten minutes with her alone. Tears shot out of her eyes. She could hardly speak and desperately fell into my arms. Fortunately her mother was away for a moment. She did not want to worry her. The young woman had no idea what to do and how to decide. She felt left alone with her anxieties. In my office I tried to calm her down. In February 2008 I presented the aforementioned video interview with Angelika to the aforementioned group of clinicians who regularly meet to discuss further treatment of breast cancer patients. One of the surgeons said after the screening session:

Well, what I have learned from the decision of this woman is that in the communication with her something went completely wrong. What she is doing is suicidal.<sup>14</sup>

Intuitively he ignored the attitude of his patient. Oncologists admitted that there is no "oncological safety" in the (prophylactic) treatment of cancer. I felt myself caught in an indistinct space of meanings and body conceptions. The reappearance of the patient as person in the videos leads to a confusion of different lived realities. The comparison of these opposite imaginary framing events – of an anatomized and, thus, abandoned body and of a person who tells her story – creates a potentiality in the understanding of what it means to live with a particularly vulnerable condition. The videoed *empathographies* unfold a sensory knowledge of human being.

<sup>11</sup> There is no English word for the expression of 'Leib'. 'Leib' as a phenomenological category means living and experiencing corporeality

<sup>12</sup> Video interview: at my apartment, October 2006.

<sup>13</sup> Video interview: at my apartment, June 2007.

<sup>14</sup> Invited screening session: at the MUV, 5 February 2008.

## EPILOGUE

Imagine yourself sitting in a small, darkened room, a big screen in front of you, people next to you dressed in green and white hospital gowns, who travel with their eyes through video animated and reconfigured bodies of breast cancer patients, attentively listening to the women's voices, identifying oneself with the projected persons who tell their illness stories. A few of the clinicians present are themselves portrayed in the video footage.

I conclude this article with some aesthetic-ethical considerations. Some of the cancer patients with whom I work together gave me the permission to include pictures of their breasts in my research. These photographs, which were produced in plastic and reconstructive surgery before and after the women got operated on, witness particularly framed wounded female bodies – a treasure of individual body history. The snapshots reveal painful statements of existence. I made breast drawings, collecting, scanning and animating them in combination with records of the

women's original voices. Thus, referring to the oral history of medicine, clinicians listened to the personal narratives and experiences of their patients. Additionally they grasped the experiences of their colleagues in other clinical fields, learning from them.

Scars are writings on the body. They tell intimate stories. Disease leaves traces in the flesh. With my particular use of video in health care, I aim at giving shape to notions of suffering as possible symptoms of health. Hence, in my writing, I have developed tactile and sensory qualities of the application of visual ethnography at the clinic. "One does not experience cancer," her radiologist said to Christa, one of the patients whom I accompanied during the course of treatment. Drawing her body from the photographs creates an intimate affective proximity to her story. Her voice resonates in the video animations.

## ACKNOWLEDGEMENT

I like to thank the patients and clinicians for giving me video interviews and for their permission



FIGURE 5: CHRISTINA LAMMER 2009: STILL PHOTOGRAPH OF VIDEO DOCUMENTATION AT ONE OF THE TUMORBOARD-CONFERENCES AT THE MUV IN JANUARY 2009.

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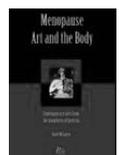
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### Menopause Art and the Body: Contemporary Tales from the Daughters of Hysteria

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The visual and textual experiences of menopause in the work and words of twelve artists. Artwork, visual diaries, journals, creative writing and poetry depict the lived experience of menopause, as artists re-imagine the memories and experiences which informed their changing sense of self and the lived body. In this meaning-making collaboration, the ways in which contemporary cultural meanings of femininity, sexuality and identity have influenced their artistic modes of self-representation are explored.



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