Christina Lammer

EMPATHOGRAPHY
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This little catalogue book is about my work. Yes and No. EMPATHOGRAPHY is more of a collaborative endeavour and I am very grateful to the authors Kim Sawchuk, Lisa Cartwright and Tamar Tembeck for accepting my invitation and contributing wonderful essays to this art publication. For me, their contributions are a big gift – encouraging in many ways what I am doing and what I tried to develop in the past years. Tamar’s, Lisa’s and Kim’s support helped me to stay motivated during a challenging time and goes far beyond what I can put in words. Thanks for being there – as inspiring colleagues and good friends.

Thanks to all the patients – I do not mention you by name to protect your privacy – and doctors for their wonderful assistance, great trust and friendship. I am aware that working together with me can be rather intense and time consuming – all the more reason for me to appreciate your patience and your sharing your thoughts with me on a regular basis. I cannot thank you enough: Birgit Grünberger, Manfred Frey, Brigitte Happel, Thomas Helbich, Friedrich Längle, Fritz Leutmezer, Gudrun Mancusi, Markus Peck and Elisabeth Stögmann. Thanks to Manfred Frey whose thoughtful input – in his double role as plastic surgeon and connoisseur of contemporary visual art – generated much debate among the two of us, from which I continue to benefit greatly.
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Christina Lammer
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NOTES ON CONTRIBUTORS

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CHRISTINA LAMMER
is a research sociologist, collaborative multimedia artist and lecturer based in Vienna. Her work combines sensory ethnography with video, performance and body art in hospitals and clinics to focus on embodied emotion and sensory interaction between patients and physicians during the course of medical treatment. In Features: Vienna Face Project (2009-2014), Lammer investigates the place of portraiture and the aesthetics of the smile in facial plastic and reconstructive surgery. Surgical Wrappings (2009-2014) explores the
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material culture of surgery. Works in the series CORPOrealities (2004-2009) considered empathy, somatic perception, and the role of touch and the hands in the use of techniques such as image-guided vascular surgery at the Medical University Vienna (MUV). Her most recent book is CORPOrealities (Vienna, Löcker Verlag, 2010). Lammer holds a Ph.D. in sociology from the University of Vienna. http://www.corporealities.org

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Kim Sawchuk is Professor of Communication Studies at Concordia University, Montreal, Québec. She is the co-director of the Mobile Media Lab at Concordia, and a co-foudner of studioXX, a Montreal-based feminist digital media arts centre. Her writings on embodiment and technology have appeared in Body and Society, Visual Communication, The Canadian Journal of Communication, as well as numerous anthologies.

TAMAR TEMBECK
Tamar Tembeck is a Montreal-based performing artist, art historian, lecturer and curator. She holds a Ph.D. in Art History from McGill University and is trained in physical theatre and dance. Her current research interests include both investigating and participating in contemporary cultural practices that engage with
the field of medicine. She has received grants from various institutions, including the Canada Council for the Arts, Conseil des Arts et Lettres du Québec, FQRSC, CBIE, and Künstlerhaus Büchsenhausen. Her curatorial work has been presented at Eikones (Basel), Kunstpavillon (Innsbruck), and Oboro (Montreal). Her recent writings can be read in the journals Jeu and RACAR, and in the anthologies Bild und Stimme (Fink), An den Grenzen der Sprache (Innsbruck University Press), Narben: Kunstprojekt zu sexueller Gewalt (Studienverlag), and Danse et Santé (PUQ).
For Cathrin Pichler
1946 – 2012
For over ten years Christina Lammer has infiltrated the mysterious corridors, meeting rooms and operating theatres of Viennese hospitals and clinics. With patient care Lammer has engaged in intensive fieldwork, as artist and sociologist, dialoguing, documenting and collaborating with patients and health care workers. Her painstaking attention to detail and nuance vitalizes her aesthetic practice at the same time as it nourishes her research. Rather than offering a generalized condemnation or uncritical glorification of western biomedicine her formal training in the social sciences and humanities and her informal, yet rigorous, apprenticeship in video art unravel its systemic machinations. These explorations with the camera, her preferred tool and companion, offer insight into the deeply corporeal dimensions of subjectivity. Medical anthropologists Byron J Good and Mary-Jo DelVecchio Good, who have written on the training of medical students, contend that a “general analysis of biomedicine” and the “biomedical model” serves us poorly. They argue that it is crucial to avoid analysis that produce “glib characterizations” which indicate “more about the analyst and his or her social theory than that which is being
analysed.” As they suggest, at this stage in the development of medical anthropology, “little can be expected of studies of the nature of medical knowledge unless they are situated, contextualized and ethnographically rich”. (Good and DelVecchio Good, 1993: 83).
Attention to contextual richness is embedded in each and every one of Lammer’s finely crafted projects and collaborations, collaborations that I have been following since we first met at a conference on skin well over ten years ago. Since then, our research interests on the nature of embodiment, the subtle impacts of the technologization, and the intersections of art and science have nurtured our intellectual friendship. I have learned much from Christina in these years. We have lived parallel lives on different continents.
Lammer’s collaborations within her milieu, a major hospital and medical research centre in Vienna, have allowed her to explore and expose the complex intertwining of three simultaneous processes – how the body of the patient is medicalized, how patient bodies are mediated within these systems of care and how patients may use media to explore their own subjectivities. It is a legacy of care-filled research to apprehend the complexities of the biomedical from the inside, whilst never completely becoming an insider. Her artistry is nurtured in this liminal tension of access to the lives of those whose bodies are in crisis, a situation in which the borders of
confidentiality, privacy and ethics are primordial. So is care. This caring is integral when dealing with subjects with breast cancer or facial paralysis, subjects who choose to work with her to tell their stories, offer their perspective and point of view, and to participate in a process of creative media and artistic production.

It is here that Christina Lammer’s dual status and accumulated years of experience as artist and researcher must be understood as part of a movement in the 1990’s to explore the intersection of art and medicine, and a commitment to a form of body-analysis, documented in her CORPOrealities website. The intersections between art and medicine have been covered by a number of critical writers, including Barbara Maria Stafford, Lisa Cartwright, José van Djick, and Jonathan Sawday. While writing on art and biomedicine has become implicated in the bio-art movement, in which artists often explore viral and microscopic processes from within a post-humanist framework, Lammer’s work is distinct and intersects with artists concerned with the body at the level of the anatomical, felt body, the body we live with everyday and whose contours are known to us (Lederer, 1993).

In this respect, Lammer’s research and artworks resonates with other artists who have traversed this terrain, from Max Aguilera-Hellweg to Andreas Serrano, two artists who have been employed in
Kim Sawchuk

clinical settings and developed their own visual languages to explore surgical procedures in the case of Aguilera-Hellweg, and mortality in the mortuary, in the case of Serrano.
Lammer’s contributions are both to the art world and to the fields of communications and sociology, the disciplines in which she was trained. However her contributions go beyond this with her growing stature as an artist as well as the intersection of her research and writing with anthropology, particularly its more experimental methodological aspects. We share a mutual fascination, and commitment, to experimenting with modes of expression and analysis other than the written text.
Although Lammer began her career as a social scientist using video, as she has said in interview, to simply document what was happening in front of her meant learning to pay attention to the multilayered processes that oft-times escaped the normal descriptions that one might have as field notes. At first, she explains, the camera was conceived of as a tool. However, through successive projects conducted under the aegis of the term CORPorealities this relationship to the aesthetics of the visual, documented by the camera, began to compel her. She came to realize that the medium had greater potential than as device for data collection.
The camera as a means of aesthetic expression has assumed an increasingly prominent role in her investigations allowing her to visualize and represent surgical procedures, the movements of
a surgeon’s hands, the bandaging of a subject in preparation for an operation. Deploying the lens knowingly, Lammer’s thoughtful insertion into this universe, closed to most of us even when we are its object, instigates new sets of relations between subjects. It is deeply relational and motivated by a keen ethical sensibility that pays attention to situation and milieu, or the localized space in which events and actions unfold. In this sense, the video camera becomes an expressive means to reflect upon transformations in medical treatment and their impacts upon bodies and lives: those of the patients, for sure. But it also is a key element in her method of engaging with the staff involved in very strict sets of procedures and protocols. It is an integral element of within situations that are of life and death consequence.

In the process, Lammer has come to play a mediating role between the world of art and biomedical science, where much of her research has been concerned with the aesthetic dimensions of surgery. This is done in two ways: she has been exploring in detail, and with nuance, the gestural language of surgical practice in her astonishingly beautiful trilogy of *Hand Movies* (2012). Drawing inspiration from the work of dancer Yvonne Rainer, her *Hand Movies* bring out the interplay and movement repertoire of surgical practice. They also assert the ongoing centrality of the hand-drawn in modern surgical procedures that are often characterized, falsely, as only *high-tech*. 
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In a recent interview, included in this catalogue, she tells the story of the three ways that surgeons “draw” a picture of the procedure on the body, the day before surgery, and then again during surgery with both marker and ink a discussion of process.

In clinical practice there are different forms of drawing. For instance, drawings are made for the patient to explain what the surgeon will do during surgery. That’s the first step. The second step is that the surgeon draws directly on the body of the patient on the day before surgery. One of the women allowed me to video the surgeon drawing on her body and that’s very touching and very, very sensory material. Then there are also different forms of drawing during surgery. First, they draw it again with a marker. They do more drawings in the operating room if the lines are not so clear. They copy the lines. Before the surgeon cuts into the body, he does another line with ink: not with a marker, but with a wooden instrument that is very fine. He works with ink from a little pot. It’s a very beautiful procedure. You see the surgeon putting these very, very fine wooden sticks into the ink pot and then drawing these fine, fine, fine lines on the body of the patient just before he’s starting the first cut. (Interview with author, June 5, 2012)
In *The Work of Art in the Age of Mechanical Reproduction* (1936), Walter Benjamin famously compared the cameraman to the surgeon, for both “penetrate” deeply into the body’s recesses, at the same time as they maintain a distance from this body, and this person. For Benjamin, this paradoxical connection was largely metaphorical. Not so in our own era. Cameras and surgical procedures are inseparable from the use of miniature cameras on the end of a laparoscope by surgical incision to cameras that one can swallow like a pill, which emit a series of images. The eye of the camera literally travels through the body (Benjamin, 1969: 233).

While Lammer’s early work, both documents and reflects on these practices, her more recent work with the camera has given her the capacity to go “deeper and deeper” into these questions to untangle their intricacies. To be succinct, Benjamin wasn’t quite right: the surgeon can be compared to the illustrator and not just to the photographer. The hand-drawn lives on in surgical practice in these very vital ways.

The camera, in her hands, her eye looking through the lens, her voice asking her questions produces in the process, brings forth the performative dimensions and ritualistic aspects of surgery, and diagnostic techniques as practiced in Vienna. An openness to learning from the site, listening to others, and seeing through the lens of the camera, reveals a commitment to hands-on experiential and experimental
Kim Sawchuk

ways of proceeding, aesthetically and ethically. Her sensitivity to situation guide her major questions: how do patients experience the penetration of their bodies by miniature cameras that reveal their inside? Why undergo plastic surgery? How do teams of medical researchers work? The camera is used by Lammer not only to produce media, but accomplishes what we might call a mediation, following Raymond Williams: it is an intermediary way of negotiating between parties; it connects or builds a bridge between disparate people or things; it renders into material form that which is otherwise indiscernible (Williams, 1976, 204-207). It is never hidden. Her camera-work is often accompanied by thoughtful written reflections on the surgical cut and the entire operation as a kind of collaborative performance. In short, in Lammer’s hands, the video camera has assumed a more prominent role, as a kind of expressive “actant” working in collaboration with her (Latour, 2005). As she said, she has begun to develop a visual language as a result of these dialogues in, through and with the lens of the camera. In Empthography I it allows her to see and to stage the performance of doctors. As an integral part of her play and creative affirmative and life-giving process with patients the camera is another sort of witness and performer. As a scholar it is a way to communicate the results of her research. In this sense, Lammer’s investigations into the modes of representation within these settings is also an engagement with that modality of practice that in Canada is known as research-creation, and what in
other contexts is known as practice-lead research (Chapman and Sawchuk, 2010). Combining formal interviews, casual conversations, on-site observations Lammer’s work engages with all four aspects of research-creation: research for creation; research from creation; as the creative presentation of research and creation as research. The camera is used to collect information; the research is presented as video installation in a variety of venues; the camera is used to provide an analysis, in writing that reflects on these processes, but it is also an integral intertwined act of coming to know deeply, affectively all aspects of the research and of the practice of surgeons in a way that allows for no other substitution. The camera plays a performative role in the research.

These more general concerns surface, more specifically in Empathography I, which highlights the patient role as understood by an array of doctors: radiologists, neurologists, surgeons, oncologists, specialists in internal medicine, ear, nose and throat specialists and plastic surgeons. Her manner of working with the video camera, and with patients and clinicians all demonstrates Lammer’s openness and commitment to new modes of methodological inquiry and the use of digital media forms and formats to represent the results of her efforts with patient care. This mode of proceeding foregrounds a sensitivity to situation and context. It takes time to build relations of trust that often continue beyond the official timeline of a project.
And here it is important to return to the question of the patient.

Patients are not born, they are produced within these systems. Once a subject hands over a health card in a hospital they open themselves up to examination and put their lives in the hands of a myriad of caregivers. It is an act of faith and trust. Seeking a diagnosis for an ailment, formally, they undergo a transformation in their very being. As information is gathered through a process of triages, physical probes, and laboratory tests the person-as-patient becomes inseparable from a large dossier – an avatar – that will make the rounds at meetings and discussions, which may be passed on to insurance companies, or government agencies, and that lives in a system of electronic record-keeping with a potentially infinite shelf-life.

Doctor and patient are in a relation from the moment that a particular person walks through the door of the clinic, have a sense that something is wrong. They may walk through the door because they feel something in their body: a pain, a lump, a loss of energies. These sensations are then part of a diagnosis and conversation between doctor and patient that then results. Our identities and sense of self-change with a diagnosis; what it means to become a part of this complex apparatus of medical procedures in which it may seem as if we are not patients, but specimens. And depending
on our disease, or condition, and role doctor and patient will have a longer or shorter amount of
time together. Good and DelVecchio Good (1993) discuss the dilemma and tension of physicians who
must demonstrate both competence and caring. In posing the question “What is a patient?” what
emerges are multiple facets of a relationship. The patient is there in the worlds of the doctor, who
does not see the problem as an isolated one but a contextual one. A person is not their tumour says
another; the patient must be understood in terms of immigration. People come to you with all sorts
of problems. Physicians have authority, power and prestige in the hospital. And while we often see
nurses as those who must deal directly, so too does the doctor, who in providing both a cure and care
is charged with making the right diagnosis and coming up with an appropriate course of treatment.
What is significant about this version of *Empathography* is its reversal of relations of power. Sitting in
this formal setting, in front of the camera, the doctors are put in the role of the patient at the same
time as they offer their reflection on the meaning of the word *patient*. Likewise, we who sit and listen
to them explicate their concept of the patient occupy this role of patient-listener. *Empathography* is
not just a display of a discourse but the playful rotation of positions for all concerned.
The care that Lammer has taken building a long relationship to the institution means that she is able
to offer an immanent critique of the complex ways we are transformed as subjects in these settings; a
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critique that in the best sense of the critique exposes the paradoxes and contradictions and limits of the current system and approach of medicine in the era of very high technologies. Conducted with loving enthusiasm, it has produced another body, a corpus of images from raw footage of surgical procedures to carefully staged sets of formal interviews in controlled settings. These images, or research data, speak to these concerns allowing both patient and doctor another voice. But they also instigate a powerful dialogue between protagonists, in which we are invited to participate.

REFERENCES


Kim Sawchuk
TACTILE ENGAGEMENTS
An interview with Christina Lammer

Kim: Let us start with Empathography I. Where and when did the Empathography I project start. How did you select the doctors?

Christina: I started this project many, many years ago when I did the CORPOrealities\textsuperscript{1} study. When you visited me in Vienna in 2005 I had just begun the video interviews with physicians. I think that was exactly the time when I started to do these 40 video interviews. And then some time passed. I always had the idea to show this material at a gallery or at an exhibition space as a big video installation, but of course no gallery would have the money to show 40 video interviews. The idea for the project developed when I was involved in interdisciplinary work with physicians who held meetings on a very regular basis. I realized that physicians of different medical disciplines apparently have very different contact with the patients and talk in a completely different way about the people that they treat. This inspired this project. It was the first project that I really conceptualized...
Kim Sawchuk/Christina Lammer

as an art piece. Before this, I used video, or the camera, as an instrument to observe what’s going on at a clinic during interventional radiology, as you know. When we met first time in London, I was busy with this research in interventional radiology.

Kim: I remember this very well.

Christina: At that point I was not working with surgeons, radiologists or medical personnel from different disciplines. I also was not working very closely with patients. It started with the CORPOrealities research and then I also developed many follow-up projects, like the one with breast cancer patients. The title, Empathography came much later when Tamar Tembeck invited me to participate in an Auto/Pathographies exhibition in Innsbruck three years ago. Empathography was inspired by her title Auto/Pathographies. I realised that this title fits very well with all of the projects I had been doing at the clinic. That’s exactly what I’m doing. I’m working on the issue of empathy. At the same time I am producing visual materials, video materials. I really try to visualize and to develop ways that show this very, very complex relation between physicians, patients and other clinical personnel. My question, for instance, is how to build dialogue between visual artists and clinicians. It’s also an important part of the work I’m doing.
Interview

Kim: Can you elaborate on this idea? Why empathy? Why the shift to a more dialogic situation and a turn to more artistic means of expression?

Christina: It started with a study with breast cancer patients who decided to have reconstruction in the plastic surgery department, in particular in my collaboration with breast cancer patients. I was working on the photographs that the plastic surgeons do of the patients. The patients allowed me to use these photographs for more artistic work. I did projections. I projected the photographs in my studio on a sheet on the wall. I then painted the contours of the women’s bodies and of their scars on this material and filmed everything. I put a very monochrome video installation together on the painted contours of the women’s bodies. And the sound is the interviews I did with these women. So it’s very much about voice and emotionality. This work has the title Empathography II. Actually, that’s the first work. In Empathography I, I also worked with the physicians and collaborated with the surgeons, radiologists, and pathologists who are involved in the interdisciplinary breast cancer group. These two pieces all belong together. There are two parts to the Empathography work that has developed over the years.
Kim Sawchuk/Christina Lammer

Kim: It’s fantastic. Actually, that helps a lot because it gives the context and history.

Christina: The contours of the women’s bodies are light and of course, it’s moving images. You would also see me in the picture in a white lab coat. You can see how I’m working with the paintbrush. And the colour is of light shade of skin-tone. It’s very sensor. When I started to work on the computer and to edit the material, it was like I was with the women and this was very helpful because I found it difficult and moving to work with these women. I was anxious about collaborating with breast cancer patients but actually, it worked out quite well even though it was very exhausting and to a certain extent, it was painful.

Kim: How long did that piece take you to realize and how long did you work with those patients?

Christina: Oh, I still work with some of the women. A few months ago I did a piece for a surgical congress together with one of the women who underwent more surgical reconstruction. I accompanied her during surgery and one of the Hand Movies, the first one you’ve seen, is of her surgery, actually.
Interview

Kim: Can you speak more about the Hand Movies?

Christina: In the first Hand Movie I worked on the question of drawing and how surgeons use drawing. What drawings do they make? How is drawing meaningful in surgery and in their work together with patients. What I tried with this Hand Movie was to show the parallel between drawing and cutting into the body because there is a very, very similar cultural technique that they share.

Kim: In what way? Tell us more about the drawings.

Christina: In clinical practice there are different forms of drawing. For instance, drawings are made for the patient to explain what the surgeon will do during surgery. That’s the first step. The second step is that the surgeon draws directly on the body of the patient on the day before surgery. One of the women allowed me to video the surgeon drawing on her body and that’s very touching and sensory material. Then there are also different forms of drawing during surgery. First, they draw it again with a marker. They do more drawings in the operating room if the lines are not so clear. They copy the lines. Before the surgeon cuts into the body, he does another line with ink: not
with a marker, but with a wooden instrument that is very fine. He works with ink from a little pot. It’s a beautiful procedure. You see the surgeon putting these thin wooden sticks into the ink pot and then drawing these fine lines on the body of the patient just before he’s starting the first cut.

Kim: I had no idea.

Christina: Yes, and then he cuts – and the operation starts. Sometimes he does these drawings inbetween.

Kim: You mentioned that surgeons use other artistic techniques.

Christina: Yes, sculptural ones. He formed, for instance, this mould as a nipple and set it on the other reconstructed breast. There you can really see that drawing has a lot to do with cutting in surgery. You see in this Hand Movie how he’s drawing with the knife what looks like an eye. That’s when he’s cutting the mould and preparing it to form the nipple. I don’t know if you recognize this little scene. I find it very beautiful and impressive because the knife drawing has the exact form of an eye.
Kim: Tell me more about the *Hand Movies*: it sounds like they were made for a more recent exhibit and demonstration. Could you tell us more about the context?

Christina: Yes, exactly. I exhibited the first two parts of this installation when I was in New York in the spring at this presentation at EMPAC\(^2\) together with Lisa Cartwright\(^3\). I finished the third part only ten days ago\(^4\).

Kim: I want you to go back to a couple of things you said, Christina, about your use of the camera. You mentioned that *Empathography* marks a shift in your use of the video camera. In prior work you thought of it as just “a thing” that you used to document procedures that you then rendered into artistic works. In *Empathography* the camera is used as an artistic tool from the very beginning. Would you talk a little bit more about that shift? It seems quite significant. It also indicates a shift in your identity as a researcher and as an artist, and in your understanding of your process.

Christina: You know when I started to use video I was looking for a tool to observe these very complex procedures at the clinic. Interventional radiology was so overwhelming for me at first. I found myself...
with patients who were fully conscious and with radiologists in these operating rooms. I really didn’t know what would I write down. Actually, there was nothing I could write down. I was interested in the question of the body and not so much in the question of what people would talk about. I wanted to understand these embodied elements of communication. I was always very interested in what’s happening on the more sensory and material level: the touching, the use of cloth and the draping of fabric, the wires, the hands working, and so on and so on. I can only capture that when I use a camera, either photography or video, and video is much better. At this time, I also read a lot about visual ethnography and anthropology. My background, as you know, is neither video nor anthropology. And I really never had a video camera in my hand before I entered to work with it at the clinic.

Kim: Let’s go back to this question. You were describing a transition from the use of conventional note taking and photography, as well as your desire to use the camera – and particularly video – as a means of recording processes that are difficult to write about.

Christina: In my first years in using the camera, I still was in a test phase so to speak. Everything was very experimental in terms of method. I wasn’t sure if I could even work with a video camera because
I never had a camera in my hand. At a certain moment, I included the materials at conferences and I realized that I intuitionally was never just using the camera as a tool to document things. Even from the very beginning (laughs), I started to use the camera to produce more artistic and interpretive pieces. But at the beginning, I didn’t know that I was doing this.

It was the reactions of other people that made me aware that I had been doing something else different from what a visual anthropologist or a visual ethnographer would do. Later, I started working with facially paralyzed patients and in the surgical rooms or operating theatres of plastic surgery. It was then that I became conscious of the material components of the mise-en-scene, for example, how the body is wrapped in sterile cloth during surgery. The cloth is important for hygienic reasons and for social reasons. You can see the hierarchies in the operating theatre and how they use all of these the materials and instruments.

At a certain point people started to invite me to more artistic spaces and to contribute to exhibitions. It was then that I realized that I was evolving a visual language, a language that makes it easy to talk about the videos that I produce as artistic pieces. That shifted something in how I thought about what I’m doing. Actually, that’s not so long ago that this happened.
Kim Sawchuk/Christina Lammer

Kim: And what about the editing? Obviously a key part of your work is making decisions, not only what to include but what to exclude and how to construct a sequence of images, a narrative. As you are using the camera, are you making decisions about what you think is going to be interesting material? Does it help you think of it?

Christina: That also changed with the surgical project. I had a very hard time selecting materials for the Hand Movies or even to decide that the Hand Movies are the right concept. I was asking: how can I deal with these materials? How can I show what happens during plastic surgery? I had observed many, many surgeries and kept tons of video materials. For a long time I had no idea how to use the footage. And then I read an article about Yvonne Rainer, the contemporary dancer.

Kim: Yes, I know, Rainer’s work as a dancer but also as a choreographer, feminist video artist and activist who has been working since the 1960s.

Christina: I read about her Hand Movie\textsuperscript{5} and I thought “wow” that’s so good. Maybe it could be adapted for what I’m trying to do in the operating room. So when I started these pieces I had the idea
in my head and I knew before the surgeries what material I would need. Thus, the editing was very easy because I took the most beautiful shots and scenes I had gathered during surgery and put them together. I also did something with the light. I took a bit of the light away from the background and so the hands give an impression of being three-dimensional.

Kim: Could you speak a bit more about the idea of the Hand Movie as a method?

Christina: It’s a very simple concept: do close-ups of hands. On the other hand (laughs), it’s not such a simple concept because the outcome is rather complex. I think it was really important for me because what I’m doing took another direction. I started to think in terms of a visual language that wasn’t only ethnographic or documentary. It’s an aesthetic language comparable with how an artist would develop it. That’s the difference. I never stopped seeing myself as a sociologist working with a video camera. Instead I started to think like an artist. Maybe that’s also the outcome of my collaboration with people like Artur Zmijewski. He’s a Polish video artist that I have been working with now for two and a half years. He is now curator of the 7th Berlin Biennale 2012.
Kim Sawchuk/Christina Lammer

Kim: I want to get back to the Hand Movies and the language of the close-up to convey expression with the voice-overs. Could you speak about the intimacy of the close-up?

Christina: The Hand Movies have a lot to do with what I understand under the notion of Empathography because what the surgeons are doing with their hands includes so much sensitivity and so much care also in their work with the body, on the body, and in the body. Empathy in a very embodied sense – I think Hand Movies are the logical consequence and the next big step.

Kim: Sensuality is there in the Hand Movies for sure. The lighting is gorgeous, very Caravaggio. Yet the pieces you are showing in Montréal are mostly medium-range shots, not close-ups. They are not long shots. Your participants are not located in a landscape or a context. In fact, you’ve put them in a very neutral and formal setting. So in terms of the goals of Empathography, why did you decide to use a formal setting and a medium-shot – basically heads, shoulders and upper body?

Christina: It’s a very good question. The Empathography installation that I will show in Montreal, is only one part of a larger project and process. It was a methodological, staged situation that evolved
over time. I invited the physicians to come to the TV studio and I positioned them in front of the camera. I set up the whole scenario for them and I posed the question, “What is a patient for you?”. When I did, something really crucial happened. It reversed the situation. The physicians were put in the position of the patient.

Kim: Now I understand. They were being interrogated, and at the same time as they were talking about patients, they were suddenly positioned in a very formal, yet embodied way, as patients.

Christina: I think of it from within a framework of power relations. Normally, physicians work with people and with patients asking the questions. This structures a complete reversal of this relation of power. Their reactions were really interesting because they realized that something was going on. It caused a lot of confusion. They tried to pose for the camera, to show themselves from their best sides and to talk about patients in a very, very nice way.

The other part of it is the way the installation is set up. There is another monitor where you have a kind of direct dialogue with each of the nine physicians. You see them answering the question and you are sitting in a chair with your earphones on your head, listening to what they are saying. This set-up puts
Kim Sawchuk/Christina Lammer

you, the viewer, in a situation where you are sitting in front of a physician who is talking with you. Only that he or she is not talking with you...

Kim: ...they are talking about the generalized you, a patient in general. You then become the patient. It’s a kind of musical chairs where we each play the role of patient.

Christina: Yes, exactly. So it’s a rather funny situation. That’s how I see it and that’s how I think of this work. It is quite a nice piece to show in the context of an exhibition about Auto/Pathographies because it exposes the pathographies of the physicians themselves.

Kim: I want to go back to what you just said about reversing the relations of power and your transformation of identity to a more artistic persona. Obviously you are still asking questions about relations of power if you’re noticing when you set up the situation that you’re making them uncomfortable because you’re creating a reversal. Has your adoption of this more aesthetic process transformed the critical questions you might have about health care, embodiment, the medicalization of the body, or physicians? How has it changed your notion of scholarship?
Interview

Christina: As I have worked with the camera, I have come closer and closer and deeper and deeper into these topics. The deeper I have gone, the more some questions became obsolete for me. I am now busy with different questions. I think that this was the case with the first *Empathography* work. I had already answered some of the very first questions that I had at the hospital. I am now more interested and fascinated by the handwork of physicians and by the very embodiment of these clinical processes. There is, subsequently, a shift from verbal communication and interviewing people, the methodologies that sociologists are trained in, towards something else. I want to show these things more directly and also to be more body-oriented. I think that’s what it is. So I started from a methodology where I was secure and safe and I knew and then, yeah, I entered different areas. My questions have changed with the development of my own methodological approach, I believe.

Kim: That is very clear. Could you speak a bit more about methods or methodology?

Christina: The method is dependant, of course, on the actual research question. But it’s also the parallel story. I try to find the appropriate means to the end. I had questions about methodology and I wanted to find answers. In the first moment, I could answer them for myself and in the second
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moment, I have tried to find ways to answer the questions posed by other people. I want to think about how to present what I’ve learned now.

Kim: Fantastic. Yet you are still influenced by your disciplinary past, I assume?

Christina: Let’s think about fieldwork for a moment. I’m still doing interviews but I don’t need to show these materials anymore. I mean, when I’m invited to show a piece at an art gallery, then I go through my external disk drives and try to think of video materials I already have. It’s not the first thing that comes in my mind, to show an interview yet it was there at the very beginning when I started. I’ve tried to use video interviewing as my medium and to develop methods to do video interviews, for instance, with patients, including with breast cancer patients. This was particularly tough. I was very hesitant to put these women in the picture, to have any woman who is doing chemotherapy to come to my studio later in the day and to pose questions to her and to position her in front of cameras. I needed to conceptualise this and to define ethical guidelines for these situations. I think it worked because I involved the women in a very collaborative way. The women told me how they want to be filmed. They also told me how they wanted me to edit the materials. They were clear with what they
want to tell other women who are in a similar situation, what they want to tell me, and what they want to tell the physicians. And so it was not only interviews I did with them but it was the development of methods of collaborative video interviewing and editing.

Kim: It sounds like this collaborative method of working with people has been a crucial step in your process.

Christina: Yes, exactly. I was working on particular questions but I continually tried to bring my methodology forward. I think that’s a process that’s still going on and it’s a very step-by-step process.

Kim: It’s a very hands-on process.

Christina: Very much so.

Kim: What do you think the impact of your work has been in the hospital? Why do surgeons and physicians keep inviting you back? Why is this collaboration so successful? What do they get from it? Why are they interested in having you participate?
Christina: That doesn’t happen so often. There are many people at the clinic who do not want to have anything to do with me because they cannot take it when I, for instance, make a video interview with them and then they see themselves on the screen and discuss the materials with other colleagues. For some of the people, that was very, very hard and tough. They now try to avoid these situations. But there are some, including the head of the plastic surgery department, Manfred Frey, who are very much interested and involved. I’ve been working with breast cancer patients and with all disciplines at the clinic, which are concerned in treating breast cancer patients. They can see the benefits of the participation of some patients in these projects.

Kim: In other words, rather than working with a whole bunch of surgeons or teams now, you’re working with one or two with whom you’ve developed close relations? And you’re also working in relationship to their patients?

Christina: Yes. At the moment, I frequently work with Manfred Frey, the head of the plastic surgery unit and with his patients. And I mean, as a one-woman show, as you say, I have only a limited amount of time. I’ve been working with twelve breast cancer patients and their families and most of the
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women I still meet. Well, I stay in touch with them. And now, I am working with about ten facially paralyzed patients, four of them are small children, and with their families. The majority of these patients come from abroad. There’s a girl from Switzerland, a girl from Germany, a boy from Germany, and there’s a boy from Salzburg. Not everyone is based in Vienna so that’s already enough when you are collaborating with people. It’s rather time consuming, and emotionally, it’s not always easy.

Kim: I understand the demands and commitment much better now. And so you have scaled back to experience greater intensity with your key collaborators?

Christina: At a certain point, I thought, okay, I cannot go to the clinic on a daily basis. I cannot work in several departments at the hospital and at the same time with all these patients. My day only has up to 14 hours and not more. I need to do my writing and the video editing, and I have a private life, hopefully (laugh). So I needed to restrict myself and to make the research at the clinic a little bit smaller so that I can do the work like I want to do it.
NOTES
1  www.corporealities.org
2  http://empac.rpi.edu/
3  See Lisa Cartwright’s essay in this volume.
4  May 2012
5  1966
Tamar Tembeck
PATHOGRAPHY IN RELATION
On the mutual inflection of doctor and patient identities in *Empathography I*

In 2009, I asked Christina Lammer to participate in a group exhibition I curated on the topic of illness and (self-)representation. At the time, Lammer had been working as an artist and visual ethnographer in Viennese hospitals for almost a decade. She occupied a singular position in her field, on the one hand because her work broke disciplinary boundaries, combining artistic practice with research-based sensory ethnography, and on the other, because of the privileged access she was increasingly granted to witness medical procedures. Currently, her artistic and research activities continue to involve regular interaction with patients, doctors, and medical staff, both within and beyond healthcare facilities.

One of Lammer’s contributions to the *Auto/Pathographies* exhibition offers clinicians’ interpretations of what it means to be a patient. As such, her work participates in the exhibition’s broader explorations on the functions of relationality, or interpersonal exchange, in the act of recounting an experience of illness. The term *pathography*, around which the exhibition *Auto/Pathographies* is conceived, is borrowed from the field of literature, and typically refers to a narrative account of illness. In the
context of this exhibition, however, its meaning is expanded to include both visual and performative portraits of the experience of disease. The photographic and video works presented in the exhibition are for the most part produced from either an autobiographical perspective (autopathographies), or an exchange between sick and healthy individuals (relational pathographies). Only Lammer’s work offers the perspectives of medical practitioners on patients’ experiences of disease. Lammer contributed two pieces to the exhibition, including the work *Empathography I*. This two-screen video installation provides viewers with multiple accounts of the patient role, as defined by nine Austrian doctors. Central to the grouping of the various image-based projects that are included in the exhibition is the notion that autopathography, like autobiography, is an inherently dialogical endeavor. As Judith Butler explains in her writings on autobiography and performance, any account of the self is necessarily directed towards a possible receiver, and furthermore, the self in question is performatively constituted in its very movement towards someone else (Butler, 2005). As with autobiography, the relational impulse that lies at the foundation of autopathographic practice becomes all the more evident when the artwork itself is the product of a collaborative process. Though Lammer’s *Empathography I* is not produced from a patient’s perspective, it is directly derived from an explicitly dialogical process.
Lammer invited 40 doctors from Vienna’s Medical University Hospital to individually respond to the question “What is a patient?”. She filmed the interviews that were conducted within the hospital’s television studio, and built *Empathography I* from nine out of the 40 responses she received. The installation, as seen in the *Auto/Pathographies* exhibition shown in Innsbruck (Kunstpavillon, 2009) and Montreal (Oboro, 2012), is presented on two screens. The first screen generates a cacophony of voices: nine doctors’ responses blare over the loudspeakers simultaneously, while videos of their individual interviews are distributed across the image in rows of three by three. As soon as the doctors reach the first pause in their responses to Lammer’s question, their images and voices disappear one by one, until the screen is left empty and black, and the video loops back to the beginning. The viewer, meanwhile, is invited to sit before a second screen – as one might sit in a doctor’s office or hospital waiting room, perhaps – and to watch the doctors’ interviews one after the other, while listening to their responses over a headset.

Lammer’s staging of *Empathography I* on two distinct screens reflects the play of proximity and distance that patients may sense in their therapeutic interactions with medical personnel. While a clinical setting might encourage the contact between doctors and patients to remain formal and distant, medical staff must nonetheless gain quick access to intimate knowledge about their patients.
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(i.e., information about their physical and emotional states of health) in order to adequately treat them. This duality between proximity and distance, or formality and intimacy in the doctor-patient exchange, is mirrored, and thereby reversed, in the *mise-en-scène* of Lammer’s installation. Although the doctors interviewed are asked to talk about “What is a patient?”, they become the visual objects of focus in Lammer’s work. The first screen allows viewers to compare the doctors’ body language and appearance, as well as the length of their individual responses to Lammer’s question, without however being able to discern much verbal content. The second screen, in contrast, provides viewers with a frontal, one-on-one contact with each of the specialists, almost as though the viewers were conducting the interviews themselves. While the doctors on the first screen may seem to be leveled by their common professional identifications, and by the white lab coats that they wear, on the second screen they become individuals, and viewers are permitted to see passed their professional roles by listening to their testimonials. The passage from a professional to a more personal contact with the doctors in Lammer’s video installation parallels the shift in the nature of the contact that can develop between doctor and patient over time. When seen within the broader context of the *Auto/Pathographies* exhibition, Lammer’s video installation reveals the extent to which doctors’ empathy – their capacity to understand and even
identify with the patient’s plight – significantly impacts the ways in which patients experience their illnesses. In her videos, the degree to which doctors appear to be inclined towards empathy comes across in their verbal responses to Lammer’s question, and in the quality of their physical presence. When looking at the first screen, it is difficult not to compare each of the doctors’ gestures, and the degree of openness that can be perceived in their bodily language. One is tempted to equate their ease in responding to Lammer’s question with their level of comfort in interacting with patients directly. Since the doctors are only identified by their genders and medical specialties in these videos, further associations – and quite possibly rash judgments – spring to the viewer’s mind: just as the doctors are invited to submit their generalizations about the patient, so can the viewer, in witnessing their responses, draw different conclusions about various doctor types.

The nine responses Lammer retained from her interviews strikingly correspond to what medical sociologists refer to as a patient’s “sick role.” First identified by Talcott Parsons in the 1950s, the “sick role” characterizes patients in terms of both their medical and existential needs in the face of illness, and describes the attendant behaviours that come to be expected of them (Parsons, 1951). Whereas until then, the biomedical model had addressed disease primarily in biological terms, Parsons’ identification of the sick role allowed for the inclusion of human behaviour into the equation of what
constitutes health and illness. Primary characteristics of Parsons’ sick role include the “exemption from normal role obligations,” the “lack of responsibility for illness,” the “desire to get well, and the seeking of technically competent help” (Williams, 2003: 182). These last two items – the desire for a return to health and the seeking of specialized assistance in the form of a doctor – are identified by eight out of Lammer’s nine interviewees.

Of the many answers Lammer received in response to her pointed question, all doctors seem to agree that a patient is anyone who comes in seeking help, an observation that is consistent with Parsons’ definition. Perceptions on the patient’s status as being exempt from normal duties, however, as well as views on the moral/existential dimensions of experiencing disease (what some of the doctors interviewed refer to as the question of responsibility), are varied. In some cases, the doctors do not even address such issues in their responses. Ultimately, what transpires from each of these interviews is not just a portrait of the typical patient, but equally, an account of the doctor’s own sense of purpose in conducting his or her work.

In reading the transcripts of Lammer’s interviews in Empathography I, it becomes clear that any generic account of the social category patient turns into a corresponding reflection of the category doctor: judging by the responses included in the work, one role seems to be defined by the other.
Lammer’s installation shows how doctors’ personal investment in their patients’ experiences has a hand in shaping their individual narratives of illness or *pathographies*; and conversely, their responses reveal the extent to which patients’ experiences can also have an impact on doctors’ lives. While the doctor-patient relationship is generally defined along strict professional parameters, it is no surprise that in practice, such boundaries are to a certain extent transgressed. To wit, many of the doctors interviewed (the female oncologist, the male neurologist, and the male surgeon, in particular) slip into accounts of their own life stories, talking about their personal religious beliefs, or describing what motivated them to become doctors in the first place. We are thus lead to believe that such self-revelations are considered to be relevant, perhaps even integral to these doctors’ definitions of a patient’s identity. The doctor’s own biography appears to be imbricated with his or her expectations of what constitutes a patient.

The tendency to somehow ally the doctor’s personal narrative to a patient’s narrative of illness corresponds to the French physician Gérard Danou’s observations of the doctor-patient relationship. In his studies on medicine and literature, Danou portrays the healing process as a partnership between doctor and patient, one that generally occurs through verbal exchanges during medical consultations (Danou, 1994: 101). Similarly, the literary and disability studies scholar G. Thomas Couser describes
the treatment of illness as a “narrative collaboration between doctor and patient—the creation of a
new ‘life text’” (1997: 10). While the patient seeks out a doctor because he or she possesses a certain
required expertise, both Danou’s study and Lammer’s installation reveal that patients, too, have a
certain form of privileged knowledge to impart in return.

A number of the doctors Lammer interviewed describe a relationship developing over time with
some of their patients: in particular those whom they encounter for a first diagnosis, and whom they
continue to meet in the course of lengthy treatments, sometimes up to their deaths. It is perhaps no
surprise that the doctor who came up with the shortest answer to Lammer’s question, and whose
image first disappears from the screen, is that of a radiologist, who typically has no such extended
contact with patients.

The radiologist answers Lammer’s question as follows: “Male and female patients are sick persons,”
he states. “I cannot say more. Yes, that is the definition for me. Yeah? Not healthy. Someone healthy
is something else.” The definition he provides is strictly functional and pragmatic: a patient is a sick
person, and a sick person is not healthy. There is no consideration of what a patient might be above
and beyond their biomedical condition in this definition, beyond the *mechanics* of their ill health –
no consideration of the sociological *sick role*, in other words. Of the many specialists interviewed,
this radiologist is one of the few doctors who do not come into direct contact with patients over an extended period of time. His relational interaction with patients is thus limited. He probably shares his interpretations of the patient’s X-ray images with his colleagues, but that is likely to be the extent of his direct contribution to the patient’s experience.

At the other extreme, an oncologist’s image lingers longest on the first screen of Lammer’s video installation, well after all the other doctors have finished answering her question. Since the oncologist faces patients with life-threatening diseases on a daily basis, and must also communicate with them directly in order to decide upon their course of treatment, it is clear that she has put much thought into the patient’s plight. This oncologist also acknowledges the fact that her sense of responsibility towards the patient’s well-being goes far beyond her biomedical expertise and attendant professional obligations: she talks about seeing “the whole picture,” for instance, and “not reducing the patient to his 3.2 cm metastasis.”

The oncologist also notes that, unlike patients who suffer from heart attacks, cancer patients are forced into long-term relationships with their medical caregivers: they undergo therapies over an extended period of time, and generally have to go back to the doctor for regular follow-ups, even when they are in remission. Thus, unlike some other doctor-patient relationships that may be more tightly bound in
time, many of the relationships between this oncologist and her patients are durational. Based on her own testimonial, one can assume that doctor and patient develop an increased familiarity with one another over time, and that consequently, the nature of their exchanges progressively becomes better adapted to each other’s needs. In a similar vein, both this oncologist and other doctors interviewed attest that they have built quality relationships with some of their patients, developing particular bonds with them all the while maintaining a necessary professional distance.

It is of note that a similar dynamic installs itself in Lammer’s unusual exchanges with both medical personnel and participating patients in the course of her work; not just in the making of this particular video installation, but in the broader context of her extensive ethnographic and artistic research within the medical sphere (Lammer, 2012: 173-190). While *Empathography I* concentrates on doctors’ personal implications in their descriptions of a patient’s role, it also provides significant insight into the influence of patients’ experiences on doctors’ own self-definitions. As Danou has observed, any broader therapeutic effect that might be derived from the practice of medicine is the product of such an encounter (Danou, 1994: 162). *Empathography I* reminds us that the practice of medicine depends upon the intersubjective exchange that takes place not only between the social category of *doctor* to that of *patient*, but in the meeting of one individual with another.
Through their daily professional practices, doctors are immersed in a world of illness and death. Such regular reminders of human frailty undoubtedly affect their interpersonal exchanges, particularly with patients. As Danou points out in his aforementioned study, doctors tend to respond to these reminders of mortality by either closing themselves off in an instinct of self-preservation, or by allowing themselves to be implicated, perhaps even challenged as subjects, in their contacts with people who are dying (Danou, 1994: 9). It is precisely such a perspective on the level of doctors’ implication in the definition, and by extension, experience, of being a patient – their willingness or not to engage, even to challenge their own stability as subjects – that Lammer’s installation adds to the discourse of relationality explored in Auto/Pathographies. The experience of illness is of course first and foremost a challenge for the one who bears it, yet the ramifications of disease are also borne by those who surround the patient, be they medical caregivers or loved ones. Empathography I provides the viewer with a perhaps less familiar perspective on the interpersonal dimensions of illness, but one that is significantly constitutive of the patient role. The empathy at stake here is not the one that is felt by friends, relatives or loved ones; it is the kind of empathy – borne out of a mutual recognition of human finitude, perhaps – that is exchanged between strangers.
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Doctor and patient meet each other on a purely fortuitous basis, other than the fact that they are matched by their respective medical specialties and ailments. But they are often forced into long-term relationships, in which what is at stake is the survival of one of the parties. If we consider, as Danou has noted, that every death we witness is ultimately a foreshadowing of our own, then how doctors respond to the life-threatening illnesses of their patients undoubtedly has some bearing on the choices they make in their own lives (Danou, 1994: 185). Like the other video and photographic works addressing disease and mortality in Auto/Pathographies, Lammer’s video installation is a testament to the fact that even illness is experienced in relation, and that not unsurprisingly, medical personnel can have a significant impact in shaping individual pathographies.

NOTE
1 This brief account of Parsons’ contribution to the field of medical sociology is drawn from my doctoral research (Tembeck, 2009: 38).
REFERENCES
EMPATHOGRAPHY I

Interviews with physicians
A patient is, as soon as someone comes through the door, or whereever he looks for help - never mind, if through talking, through ... via medication ... whatever. That is why someone relatively quickly becomes a patient.
ONCOLOGIST
A patient is, as soon as someone comes through the door, or wherever he looks for help – never mind, if through talking, through ... via medication ... whatever. That is why someone relatively quickly becomes a patient. Also at home, on the phone, if someone, I believe, looks for advice on a medical issue, he becomes a patient. Yes, that is a bit how I differentiate it, what we expect from a patient. Because I find that we can do that.

And I have, or I wanted to be a doctor ever since, and at the age of eighteen I decided to specialise in oncology. It was my aim not to let any patient through the door without having smiled at least once. Yeah? Although that is very, very difficult in our field and I know that, too. But I believe that they especially need a lot of love, you know? But they sometimes do not make it very easy, I have to say. Then occasionally I find my intention a bit more difficult, when patients only try to find somebody to blame for their illness, which I can understand, yes. I say that to my patients, if they, if that makes them feel better, if they want to yell or hurl abuse at me that nothing is working out. Then I am willing and I take that, if afterwards they feel a little better. So one always has to look at it like this and I let them yell at me, I let them torment me for hours, and I also let them take their time because I believe this is what we owe the patient. I can’t be blamed for going there and adding a chemotherapy session, that is clear. I only treat oncology patients, so that they feel a bit secure during the time and generally find
Oncologist

help. Yeah? So that he can really tell me that the cat was annoying this morning or that the neighbour was noisy, because I find this is all part of patient care that we have to provide. Every time you can see that patients really look for that. So when they speak to me and they were in a different department before, then they know the difference, yes.

I am not really sure that you can learn that. I believe you have to develop the love for that. We have, or that is my opinion, the advantage that our patients always return. Yes, somebody who suffered a heart attack, you cure him and then he goes and is never to be seen again. Our patients come to every chemotherapy session and even if we then cure them, they have to stay on until the follow-ups and we always see them again. That way you can track them a little, which I find very nice and I believe the patient also seeks, he looks for a fixed point, yes, someone to whom he can go, in whom he can confide, and whom he can tell that the nephew is nine and has passed the school grade. These are all things, I believe, we owe. So that we see the whole picture and do not reduce him to his 3.2 centimeter metastasis. That we see him as a whole and as a person. But what I expect from the patient is that he also gives me the chance. Yes ... just like me, as I said, I can take unfriendliness, it is no problem at all, but it makes it a bit more difficult, yes. I expect from a patient that he also brings patience, that I cannot know everything in a second, because it simply takes a bit here until I have the results and
sometimes things that should not happen even occur to us, that sometimes we forget to order the chemotherapy session for whatever reason. This is what I expect in response, but when somebody starts, I believe the next steps are relatively easy and it is great fun to work in this field. You find joy with your patients, who ... where the chemotherapy is of good help. Yes, you are happy with the patients and these patients are a compensation for those with whom it simply does not work so well. You still try to help them and also if you have known them for longer and in the meanwhile can have a personal conversation with them, you can ask whether or not to stop the sessions, yeah? And I believe that is a very interesting point you need to bear in mind. Yes, and that only works if the doctor and patient form a symbiosis, as stupid as this may sound. But they have to come to a point where they just stop and say... our therapies have not had the effect we wanted, which is to ensure his quality of life, instead of using therapies until he dies. And that only happens if that is good, also in a good sense, talking to a patient you have to be in unity. It is not easy but it is my job that every patient smiles before he walks through the door and I have until now always achieved that, yes.

I can remember, and this was one of the few good things about the practical side of the university course, back then I did my psychology traineeship in the Wilheminenspital on the child psychology ward. We must have had a very good teacher there. I cannot even remember what his name was,
but he told us that it is very horrible when children have tumours. There is ... you can always draw something positive out of every part of life. In this case it does not apply. I don’t know what I should say to somebody who has a tumour, but look ... and he said that there is only a very small thing, and that is that patients with a tumour know that the end is near. Somebody who dies of a heart attack tomorrow does not know that. The tumour patient has the chance to say farewell to life and to do so in his own way. He can go on a world tour. He can talk to the father-in-law with whom he is at odds. He can experience the sun every day with greater awareness. We cannot do that, yes. We get up every day and it is terrible, if there are rainy clouds. Simply because we are annoyed. We are not aware of it consciously. And back then I found that very interesting and it is something of a small truth.

Yes, everyone is very courageous in the beginning, even if they are a bit afraid. But everybody deals with it in his own way. Everybody says, they want to go on a holiday, the other wants to do that and how beautifully the flowers blossom. We are not aware of it and it is very, very nice to see how a patient does it all in his own way. My fear was, because I have this close relation to the patient, what it will be like if the first patient who is close to me dies. I experienced that very quickly on the ward – at the beginning of my nightshifts, a patient, who was really close to me, whom I knew as a student, died. It was in a room that he had to himself. The woman was next to him and she had already been told that
day that the end was near. And she was present all the time and stroke his hand all the time. It was such togetherness and he closed his eyes peacefully and that was not horrible. I have seen death for the first time not as something horrible, but as something liberating and for her it was like, “I let him go now” and “He has managed it”. And there was such a strength. They both showed that this strength, although her husband had died, you can draw on it – that becomes not so difficult, but rather he has managed it. It was very silent. He did not die alone. I have seldom seen anybody dying alone. There are always people there. If not, the nurse holds the hand and it is always peaceful. That is, you do not see death as something acutely horrible. The person is not suddenly losing his life, but step-by-step he has bidden his farewell and the people have step-by-step said goodbye. That makes it a bit easier. For me it is obviously a bit easier, because my husband is a surgeon. We have the same patients or the same patient population. Yeah, you take it back home. And to me it is of advantage, even if some do not see it like this. We can talk through everything in the evening when having dinner. We tell each other what happened and you talk everything through and seemingly you process it then.
For me the definition of a patient in comparison to normal acquaintances, friends, colleagues is as soon as somebody shows to me his symptoms, questions, ailments and other things I should have a look at, by confiding in me or asking for something, then he is a patient.
EAR, NOSE AND THROAT SPECIALIST
Interview

For me the definition of a patient in comparison to normal acquaintances, friends, colleagues is as soon as somebody shows me his symptoms, questions, ailments and other things I should have a look at, by confiding in me or asking for something, then he is a patient. A human being who approaches me with his problems or symptoms and says: “Have a look at this”, “What shall I do?” … “What helps?”. This is especially striking within the family, when family members suddenly suffer, have aches and pains and the medical knowledge of the mother, the daughter, or the sister-in-law is needed and suddenly the family member becomes a patient.

Yes, as soon as somebody says: “I have this problem”, “This hurts me”, he becomes a patient. He is no longer fully self-reliant but I need to have a look at him with my medical eye, treat him accordingly and ask questions. And this interference is sometimes a problem, especially at home. The people in hospital, yes, these are patients because they come. They are on some registers, there are some indices. You associate some pictures from the body with a specific procedure. It is very clear that they mainly come because of that, yes? That is, so to speak, the patient, whom I otherwise do not know. But as far as I am concerned, it becomes problematic and interesting if there is somebody you know, and they suddenly see you in the role of a doctor. There are many very different ways to enter. I myself sit in a specialist clinic. That is a voice and language clinic where people occasionally wait three to four
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months for an appointment and have a medical condition that has possibly been examined by various doctors, institutions and they want to have another opinion.
This is an extreme case. These patients have a specific psychological strain but are fairly defined. If you go to a specialist clinic during the nightshift, then patients are those who have suffered something oh-so-horrible, something particular acute, which at the moment is very oppressing. You have to say that because often that is not the case. That is yet again another view.
For the patients, yes, a lump, which they have discovered in the throat, was probably there weeks ago and was only noticed because of some event, and they now have the need to have it looked at because it unsettles them. Well, for us this is obviously nothing of an emergency and sometimes it can lead to corresponding comments, where you say that the nightshift is not there to treat something like this. And then, there are people who say at five o’clock in the morning: “And I did not dare to breathe and I was afraid” and then there is some kind of swelling in the throat, which according to us in specific situations can be dangerous and you treat it immediately and you then say: “No, it does not matter that you woke me up. That is what I am here for.” Or somebody who has a nosebleed, and after half an hour, does not know what to do. More or less, in the acute ear, nose and throat patient sector – i.e., shortness of breath, swelling and pain, fever, yes – these are rather accessed with surgery. Access to a
Interview

voice and language clinic has more to do with psychosomatics. There it is a function-oriented technique of clinical examination and approach. There it is rather, yes, rather psychosomatics. Especially with patients with voice disorders, you have to take everything into account, the life situation, habits, the psychological state, but also the bodily state, fitness and so on. All that comes into play.

Yes, patients who even come to the clinic as well as the general clinic, and also to our specialised clinic, you possibly see them again and again. It depends on the medical condition. At first, maybe five to six times. Then you say, okay now one case has been dealt with, and the voice is satisfactory again. That can take roughly one year all in all, with interruption. And you can also have the same patient for years, because they may, for example, suffer from a tumour in a specific state and should be checked repeatedly. The patients in the ENT, with whom I obviously deal with as well, those you see until they die. That is, from the carcinoma diagnosis with all the educational measures, then we operate on them; in-patient stays including surgery, intensive care, then home discharge; reintegration with a changed voice, with the inability to eat or drink, with being mutilated in some way. Then you see them during radiotherapy, for example, always with problems, and then eventually after a recurrence, possibly with disfiguring tumours and metastases. Sometimes you see them dying on the ward. Yes, there are patients who have been here since I started. Ten years.
Ear, Nose and Throat Specialist

Yes, the Phoniatrie deals with vocal functioning in particular. A central issue with us is the swallowing function and there are many neurological patients, who after a heart attack have several paralyses or coordination disorders and problems with talking and also swallowing, so that you possibly see them for a long time. They need probes and only slowly can come close to normal swallowing. Or you see neurological patients, who have no further defects but it starts with a … with a speech impairment, yes, with, for example, a tongue movement disorder. There are very specific disease patterns, from the amyotrophic lateral sclerosis, which can become manifest proximally, where the first symptoms of a disturbed speech or eating behaviour are, and who possibly come to us first for a diagnosis. Yes, so those patients who do not come in the night, you ask them some questions and then, but … regarding the voice anyway. As soon somebody has troubles that preoccupy him for a time, even, for example, noise in the ear and such stuff – it is important.

No, specialist problems are, outside of any appointment, yes, continuously discussed. That is also the nice thing with the General Hospital in Vienna or other institutions that I do not know, that you are in constant dialogue with the colleagues and not only discuss specialist issues, but also deal with the consternation in some way. That is very important. Getting specialist advice but also to be consoled, if you have the feeling that you have done something wrong. You do not necessarily have to take it
home. If that does not work then you have to, you have to take it home on occasions, but which I very consciously avoid. I also heard the plea at home: “Please, don’t tell everything at home about what happens with the patients and, even worse, what happens with the doctors.” It is really the case with me that I brood over something the whole day, because I took this or that action with somebody and I wonder whether that is the right thing and whether they understand it correctly, what I can do and what I cannot do. Yes, that does happen.
In principle a patient for me is a person that comes to me to have my medical advice for a medical problem. These can be very different problems. These can be all sorts of problems from very simple rules of behaviour to information or degree of abnormality in laboratory tests or serious life-threatening situations, yes?
INTERNAL SPECIALIST
In principle a patient for me is a person that comes to me to have my medical advice for a medical problem. These can be very different problems. These can be all sorts of problems from very simple rules of behaviour to information or degree of abnormality in laboratory tests or serious life-threatening situations, yes? All the persons have in common that they have a question that in some way, at least to their subjective perception, has to do with their health condition, yes? In the extreme case it is, as I said, only laboratory findings. This is, they feel that they are not really ill. They have laboratory findings that are outside the norm, for example, during a routine check-up. That is not rarely the case. Then they can have illnesses of different severities up to life-threatening conditions where they partially are not approachable and need an intervention.

Yes, that is probably stronger in all non-operative areas than in the operative areas, whereby it surely is of importance for them. But especially in those conditions, so in particular with liver disease, which with patients that do not have an acutely life-threatening problem, a very important aspect always is the conversation with the patient, whereby the conversation has various functions. On the one hand it has a mere information function. The patient wants to find out about his illness, although I believe that is not necessarily the main issue at this point, when the patient comes to me. Because my colleagues and I are often asked as experts, thus the patient already has some previous
Internal Specialist

information. Often it has to do with reassurance that the condition, which possibly has been classified as non-dramatic by a colleague, is indeed so. And the conversation is a very important factor and during the conversation not only the information components come into play, but also the effect the doctor has on the patient, right? Whether he... how he can explain, whether he can really reassure, for example.

Trust is clearly very decisive in the doctor-patient relation. Yes, also partly with the patients where you know that they will die because of their illness. Well, I believe there are generally no rules. Everybody does it a little differently, yes? I do not even know whether strategies are developed with time. For me, personally, it is more of an overall attitude, which I believe has not changed massively since I started this job. That is the attitude towards life and death and also the aspect that death is an integral part of life, just the last. But just as birth belongs to it, it happens to be the case that one part is viewed very positively and the other part very negatively, but this would not always need to be the case. Yes?

The fact that death is perceived as something negative is probably a philosophical issue, but I believe that Socrates has already put it nicely in the face of his own death by saying he does not know why he has to see death as something very negative. It simply is something he does not know. It could be that death is something great. Right? From this point of view ... and obviously also from the view of an
extensive catholic attitude in Austria, irrespective of whether or not you believe in God, you are in a way nevertheless indoctrinated by these matters.

I, in particular in my personal case, have to say because I went to a convent school for many years and there death was not regarded as, as ...a particularly negative event. And now coming back to the question: empathy. I believe I have a lot of empathy with the patients and try to solve their problems. But it is not hard for me that the patient has to die, yes? And in the end I do not take it home. That is to say, I do not perceive it as a burden. Yes? That is ...the way of life. Yes, which I obviously try to influence with my help to the advantage of the patient, which always means that he wants to live longer and not only longer, but he wants to live with a possibly good quality of life. But on the other hand with a specific realistic attitude and that I need to communicate to the patient, because the patient has to prepare himself for his situation and it is very important for him that he knows that he will die with this illness, so that he can make his prearrangements for this situation.
INTERNAL SPECIALIST
Well. In principle we have two sides. The patient is a human being, who - from the radiologist's perspective, I can only speak for the radiologists first of all - comes because he has a problem. He has pain or he notices that something is different and wants from us a confirmation or a diagnosis as to what the matter is.
Well. In principle we have two sides. The patient is a human being, who – from the radiologist’s perspective, I can only speak for the radiologists first of all – comes because he has a problem. He has pain or he notices that something is different and wants from us a confirmation or a diagnosis as to what the matter is. So in principle the patient is someone who comes here already with fear or worries and that you have to take into consideration, I believe, as a doctor.

I myself, I believe I have a pretty good way of dealing with the patients, because I like to talk and generally in a friendly conversation I quiz the patients. I always ask, “How are you?” or “What is up?” and then obviously the personal things come. But by doing so you get a good anamnesis of the patient which I believe is an important aspect, especially for the diagnosis ... if doctors speak too little with the patients many details are simply lost.

We have different wards where maybe we are not directly in contact with the patient, where lung X-rays or bone X-rays are made. There some things are lost, but especially in the mammography ... the patients come with a psychological strain because they have been told so from others and possibly have cancer. That is obviously the worst imagination. One therefore wants to be as detailed in the diagnosis as possible and one does so and one has to obviously consider the psychology, because if you storm into the room and say: “Hi, what is up?” and you do your diagnosis and that is it, then maybe many patients
Radiologist

are shocked or will be shocked. You notice very often that when the diagnosis happened, and there is nothing, everything’s okay, that it is a relief. You can tell pretty well from the patients. Yes, that is my approach towards the patients. In principle, I am now in the mammography and I like it a lot, because it is an important aspect of radiology. Every woman should go to these examinations, but far too few make use of it and breast cancer is one of the most common diseases or cancer diseases for women. Scientifically I am mainly involved in kidney or adrenal gland changes and there it has more to do with computer tomography and magnetic resonance, where you do not necessarily have direct contact with the patient. It is still left open, I have to say, but now in the department where I am now, that interests me a lot and there are already specialists that have only the mammography or the breast area or the women’s department and it will show. I also have this feeling that women prefer to be examined by women, because men then do not have the ... perhaps they cannot put themselves in the shoes of somebody else or they do not understand what it means for a woman.

I also do the examinations for the hysterosalpingography. That is an examination when a woman is pregnant and you have a look whether the tube is not permeable and that is actually more the gynaecological aspect and only three to four people do that with us and is, I believe, more pleasant if a woman does that for example. I experienced that if a colleague comes along to have a look it is obviously embarrassing
and unpleasant and everything. Very unpleasant, just like with the gynaecologist where you sit on the gynaecologist chair. Then a catheter is inserted into the uterus and there a contrast agent is applied and then you do X-rays and see whether the tubes are permeable. That can obviously be painful if they are clotted, because the contrast agent cannot go further and then there is the pressure and it does not open. There, being a woman, you can possibly better imagine that it is very painful and unpleasant.

Yes. I often imagine that. Do I have that or does my mother have it or how do you feel then? That for me is ... I always imagine that then, because that was why I studied medicine, because it interests me, on the whole, the human being. What is with me, what can I have, what is that, what does it consist of and so I imagine that with the patients. They are obviously different in terms of their psychology. Just as we just had a patient who denies the cancer and but ... that is how I imagine it. I also try to – does this hurt or how does it feel. Maybe I am socially inclined. I do not know how you call that.

Perhaps I do not take that much home except if it was now, except if it is just at the end of the day the last case that does move you and you think about it in your head, but actually I can draw a line pretty well, I have to say. I never thought about it, because seemingly it is not such a strain on me. But overall I feel a lot of empathy for the patient, because it just is horrible what they have to go through. But myself I do not think too much about it at home. Maybe that is better.
RADIOLOGIST
Yes, generally is that someone suffering, banally translated – for what reason ever, whether it is the body, the pain or the psyche, due to something discernable from the outside and that is also my understanding of this discipline.
Yes, generally that is someone suffering, banally translated – for whatever reason ever, whether it is
the body, the pain or the psyche, due to something not discernible from the outside and that is also
my understanding of this discipline.
Yes ... First of all we do not want to distance ourselves from cosmetic surgery. But cosmetic surgery is
also a part of it. People suffer from aesthetic problems. Otherwise they would not voluntarily undergo
this treatment. The other thing is more of a question, which possibly blends in nicely with the theme of
the surgeon conference. What is doable – from the most different perspectives? I have by chance, not
by chance, held a keynote lecture about this, about the topic of reconstructive surgery and aesthetic
surgery. And there it once nearly led to understanding that the patient-doctor relation is only one side
of the coin. This view and the point of view regarding the criteria determining what, referring to your
question, a patient is, are defined by the patient himself on the one hand, and the treating doctor on
the other.
This again is heavily influenced by other authorities – referrer, cooperating institutions, the society,
the image aesthetics, for example, or plastic surgery within society. It’s not without reason that this
field is continuously in the media. So this level or position has a very important, significant, influential
role, and also in the immediate area, environment. And that is probably – and this I also pointed out
Plastic Surgeon

accordingly – particularly important for plastic surgery. Therefore in the other departments that have
also had presentations on such specialist issues, there has been very little input in this respect. They
only spoke about what the patient maybe wants or means, and what the surgeon can imagine and
believes to be doable. But why they believe this to be sensible has hardly come across. With us, it is
obviously the same question as yours: how can you compare this with aesthetic surgery, with each
patient? ... That is exactly the same question, even if it is reconstructive, right? That always forms one
unit, the aesthetics and the reconstruction. That is also our claim, right?
That is just the question of the definition of the illness and the evaluation. Not in the very concrete
individual situation and the question of balance between what one could do and what one should do,
and what the cost is. When you are subsumed in the incision of the body, is that the right indication? Is
it balanced? Otherwise it is a wrong indication. It has got nothing to do with “I have the feeling I should
be doing this,” and so on. Instead, it has to be completely clear.
No, it is not all easy, but I believe, a human being who comes to me in the end and has a need or who is preoccupied about something or who maybe has noticed a change that is worrying him or a strain, where he only wants clarity.
No, it is not all easy, but I believe a human being who comes to me in the end and has a need or who is preoccupied about something or who maybe has noticed a change that is worrying him or a strain, where he only wants clarity, who comes to me with this need and expects that I can bring clarity into the matter – clarity to tell him what it is he has, how to assess it. Because the world, so to speak, I believe, is something ... well, the patient perceives what is happening to him as a threat. He thus wants to know from an outsider how he has to evaluate it, or what it is and how he has to evaluate it, and whether it continues or whether it stops again. And he wants clarity and in the end wants his mind put at rest. He already wants to have reassurance from me and also consolation. It is for me somebody who not only challenges my intellectual capacities, but also, yes, my emotions. To give him that depending on what he needs. Some patients come and only want clarification, the matter of fact, and others come also with completely different issues, where maybe somebody else would not even walk anymore. You sense that above all they want reassurance, emotional reassurance. I think you can see that, for example, people with very different issues come. There are many individual aspects as to who goes to hospital with what. Yeah? One comes with a hemiplegia three days later and only enquires that he had thought this was strange or something and he then really has a stroke or something serious. The other comes because every now and again there is a piercing pain in the right
side of the head and that unsettles him now. In terms of their needs they are all almost similar. Yes? For me then it is completely different how I classify them, where are the objective criteria, so to speak. What it is for one ... it has a lot to do with the individual personality, I believe, what you perceive as an illness or what is a psychological strain. Yes? Depending on that, you need to deal with your patients accordingly. The one that only has the piercing pain also has a need or wants something. Otherwise he would not come. And I believe that it is important that one does ... or at least I feel responsible to absorb this. Yes? So that it just goes out and he wants to get rid of it and afterwards he wants to be at ease.

Actually yes, obviously on an objective level, but in the end they want the objective level so that they can be reassured, which is often possible, especially with ailments that are not classified as serious, where you just have the feeling that something is a burden. Maybe these are completely different things, which he lets out like this. Yes? In the end patients want clarity about what they currently have or what they newly detected and they want this to be assessed objectively, but also emotionally. So they want consolation or be in some way consoled.

Generally, that is true, I find the job consuming overall and it is also at times the case that I am astonished to what extent it does not put a strain on me. I believe that obviously you find a routine
with different things or you can put things in order for yourself, what is to what extent difficult for me now and how sorry do I feel for this person with that issue. If it is a disc hernia I think, well, that is a disc hernia. If it is a brain tumour I classify it completely differently, and by doing so my empathy is also influenced.

I believe that individuals can always have a very touching effect, yes? Individuals can touch you and often you do not know why. It is also very different. It can be an old man or a young woman. I do not know. There is something very personal that affects you, which you probably cannot really classify at first. Maybe it is only the eyes or something, which remind you a person you liked very much and you take this person on board. I know that especially if I am not in a good mood or if I am tired – so more likely in nightshift situations or when it is already evening – that personal fates really affect me. Just so, there are many immigrants in the emergency ward who have many psychogenetic disorders where you simply have the feeling it is useless what one is doing, because that, that is the problem ...

Actually you would need to take the person home, give him a flat and a job and you know that what one does – maybe hand out some aspirin or something like that – does not do any good at all. I believe that especially then, people can have an effect, and the more exhausted I am and the softer I get, the harder I find it to solve. For example, I still think about a patient from ten days ago whom I saw in the
Neurologist

emergency service, and I think to myself, that was so horrible, and it has a strain on me. You know? I just cannot classify it. I do not know, previously I thought this is maybe because when one gets as old as you are, or if you simply identify with the personal history, but actually, that is not the case. Sometimes I really feel for the elderly. The elderly that live alone and then come and have so many expectations and are actually pushed off in a way. These just are fates that have more effect or are more touching. That probably has got to do with a very personal history. Yes, it somehow also lies in my family, or has got to do with my life, or probably also with my memories, or with my idea of life. Yes? And that is a strain somehow and I carry it with me.

More and more I also notice that the more exhausted I am, the softer I get. Then I cannot differentiate... my boundaries start to blur. I cannot be hard anymore on the outside. Otherwise I can distance myself pretty well in day-to-day business. Or I can take it on an objective level and think to myself, ok, that is her condition, but actually, this and this is the case, and probably the development is not too bad and so on, and this is probably how you have to evaluate it and communicate it. So I have to place it somewhere in my system, yes? Accordingly I try to mirror my evaluations and my empathy is often the same. What can be a burden is often the social situation. These are often social indications, that have a strain on me, you know? Not necessarily the medical condition that leads them to me, but
when I shortly listen to them, what is the appearance and what happened in the last days you often hear a lot that is burdensome. I find. In the end I will go into supervision. I say to myself you have to find something, because it is not offered and I started with supervision a couple of years ago when a patient really affected me. That was a boy with a carcinoma and then I always dreamt about it and from then on I started to go into supervision. Now for three and a half years once a week, but a lot of it has already become self-awareness. The whole supervision has a lot to do with oneself. Yes, alone but I also go to a group. That is right, for half a year now I have attended a group where only doctors go and it is actually about supervision.
PLASTIC SURGEON
That is not an easy question to answer. A patient is a person whom I regard as someone who goes to another person because of a problem, in this case a doctor, to find an answer to or to get help with this problem. This might be a physical or a mental problem that he wants treated or cured.
That is not an easy question to answer. A patient is a person whom I regard as someone who goes to another person because of a problem, in this case a doctor, to find an answer to or to get help with his problem. This might be a physical or a mental problem that he wants treated or cured, so that afterwards he has regained his so-called normal healthy condition, which he had before becoming ill, regardless of the nature of the illness. If it is appendicitis then it is a relatively clear, isolated matter that is to be treated and one knows... Or you can say one goes to a dentist because of toothache and he is also a patient. Either the dentist extracts the tooth or does a filling. It’s important, I think, to distinguish between illnesses and also between... For the patient the crucial factor is that the illness comes to an end and after the appendicitis and the operation he can go home cured. Or it’s a chronic illness.

I think there are completely different types of patients or people or problems that make or turn a person into a patient. It could be a tumour, which of course is an enormous problem for many patients. Because the idea of death is something which people today do not bother too much about, especially not in the big cities, don’t you think? Then there are people in rural areas who die and that is seen as God’s will. For example, when the grandmother suddenly has a tumour or becomes seriously ill and the tumour is in a relatively advanced stage and cannot be cured and she dies and that is it. That is
what is expected. And in the cities, when a patient comes in and dies, the relatives ask if the doctor has not made a mistake. You can see the different attitude towards death and how people in the country areas prefer patients to die at home. In the towns they are pushed into hospices or hospitals. For sure, that is just a group of chronically ill patients. Whether they are tumour or dialysis patients, both chronic, those are patients who have suddenly been torn out of their normal life and have a problem that limits and determines their quality of life and their normal life. Compared with patients where it is just a one-off matter like a broken leg, one gets a plaster cast and after three months everything has been forgotten. One can go skiing again. A patient for me is a person looking for help, who sometimes... yes, a patient looking for help who demands too much from the doctors and often demands recovery which the doctor cannot do and nor can medicine. Some patients accept their illness and others absolutely do not and here there are also different aspects.

The most important thing is communicating with the patient. A patient comes to a doctor full of fear and in the conversation between the doctor and the patient it is extremely important that the patient is put at ease and is given as much information as the doctor thinks the patient can take, as much information as the patient asks for. What does he want to know? That needs to be comprehensively answered, because I think only when the patient has sufficient information is he satisfied and feels
informed, because he is moving into a terrain that is completely new to him, when he suddenly develops an illness which he has never read anything about. Here the communication and conversation are key aspects for a basis of trust between these two people. There are also situations where the chemistry is not right and it is best to change. At least that is what I think if things do not work. I think the doctor always just accompanies the patient and is not the dominating person who says, “Do this, do that”. I see myself as a doctor accompanying a person who is looking for help – whom one can help with hands or words or with medication. In other words, communication is the most important thing and one certainly needs very much time and one has to take this time. Of course we usually do not have it. Yes, there is a great deal of pressure on us because lots of people go to the doctor and you have to take time. That is really very, very important – the communication.

I did not learn that while I was training. If it is already in the new curriculum or not, I do not know. But I do not think so. I could not tell you if communication is now a subject on its own. I did not have it and it was not part of my course and it is what you learn when you are actually dealing with patients. You see the result when you talk to people. Or you are suddenly confronted with a situation, where a patient asks a question and you have to answer and then through practical experience or observation of how other people or other doctors or colleagues talk, you see the feedback and how it functions. And then
there are people who are reticent and do not like talking and the patient goes home dissatisfied. And then the other group who speaks a lot and explains things and builds up a basis of trust or at least tries to do so. You find a way of talking to patients or strangers in order to build up a relationship. Often it is just a short relationship and sometimes it is an extremely long one, which can last until death.

Empathy – well, it is a bit difficult to say how you do that because everyone does it differently. There are patients to whom one is very, very close. Then the question does not apply, because with them you establish an intimate, personal... yes, a personal contact when you like these patients and have the same interests. It often hits young people with children and a family and all of a sudden they are torn out of their lives.

For me personally when it gets on top of me I just try to escape hospital life, in other words I try to get away by doing sports or going out into the countryside. I just shut the door and think about something else. I have to think of my own family. I have got four children and with them I try to find another kind of life and I am very grateful that my children, thank heaven, are healthy and do not get ill and that we only have minor problems in the family. I am also religious and I go to church on Sundays and try to work off the pressure a bit, but it is extremely stressful and I can only bear it for a certain amount of time and then I have to escape. There is no other way – when there is just too much stress or when
complications occur or when the patient dies or needs to be attended to over a longer period. On the one hand, we surgeons are a bit better off because these patients often end up in a hospice or in the general ward or then die at home, but of course on the surgical ward we experience the fates of such patients more and more.

Do I want to say anymore? I do not know if I have answered the question about what makes a patient, because it is rather difficult to say that in one sentence. A patient is, um... That at least gives you an idea how I see patients and how I feel responsible towards them.
That is a very difficult question, because for me there is no single patient. For me there are three groups of patients and that is also how I would divide it. For me there is the patient who is very distant to me, and he comes to me and expects some service from me and is willing to pay for it.
That is a very difficult question, because for me there is no single patient. For me there are three groups of patients and that is also how I would divide it. For me there is the patient who is very distant to me, and he comes to me and expects some service from me and is willing to pay for it. He secures my existence financially, if you will. He leaves again and that is it. Just like I go to Billa [supermarket] and leave again once I paid. These are the most common, but if you like, the least interesting, to put it frankly.

Then there is the second group. These are very rare. I would say they are interesting from an academic point of view or intellectually challenging, so that you think about it. But they are mostly unsuccessful because nobody knows within medicine. They show you your own limitations in the end, because they are difficult patients. They come and offer you the possibility to somehow show your own grandeur and then you actually see your own limitations. But they just are interesting or also a challenge and you can maybe rise with them, if you are lucky. They also are very unlikely.

And the third group, the third group probably is, I would say, why I have become a doctor myself, if I think about it. And these are finally the patients that are of interest in terms of your expertise, but in the end – actually they are more so – somebody comes and you look for parts of yourself in the person, you know? And these are those, as I have just said, they are so ... Once, this thirty-year old
Neurologist

patient came after a seizure, he had a brain tumour, yes? Then it is actually over already. He gets his therapy. He gets his operation or medication. The most interesting is to look in him for characteristic traits of yourself. I try to understand. What would happen if I had this tumour? How would my life change, and would I manage to walk to the toilet? These are extreme – actually existential – questions and that is like ... and that is probably why I studied medicine, because it is like a religion, isn’t it? Before, I studied theology and actually always wanted to be a professor of theology. But then, somehow it always... my belief was not strong enough and then I changed to medical science and actually there is no difference, I have to say, yeah. You are always searching for yourself or the essence of the world. And these are exactly these patients where you can look for it – for these roots and for your own identity and also, so to speak, for your own weaknesses. And for me that is probably also a ... Well, when I speak to patients, with those that really affect me, then I always have the feeling that I try myself, by either relaxing them or by trying to find a concept for their life, I also try to find a concept for my own life. I think to myself then – I could sit here and it affects me a lot and that is also the, probably the best thing about the job, or so. You can probably only find this within theology.

No, I believe that the distance ... – you can either keep distance or not keep it. But there is nothing where I say I am here empathically and then when I walk through the door I am distant again. That
does not work, I believe. Or is it then not, it is then a faked empathy or a faked distance, isn’t it? I believe either you are in it or you are not and I manage pretty well, because I somehow – I am aware I could sit tomorrow also on the other side with some kind of tumour or with epilepsy or whatever. Yeah? I have in these six years, in which I did my training, learnt how to cope with it somehow. Sure, I am afraid, but it is in the balance, probably it is because I always talk about it with the patients so that I can cope with it. Yeah. From my view, so I find it a brilliant job – also with the disadvantages and so on. From that point of view the patient for me actually is – it almost is, that goes two ways somehow. The patient does not come to me and gets something, instead I sometimes think – there are these other two groups where I do not really gain anything – with these, where I look at myself and I can get involved I profit from them more than they do from my therapies or whatever.

If, so to speak, I take a cross-section and take the files out and say – or I could at least in most cases say the names or describe the face. Well, that is just a – it occurs in waves because if the patients are well, then there is more distance on their behalf and you are less involved. Then they come back, especially the MS patients. They have a surge, and then they become more needy. There are hundreds of them. When they phone and say their name and I hear their voice, then I have the most important information. Not necessarily the facts, but their way to deal with the medical condition. I can often
Neurologist say with these patients, they call and say that this or that is the case again, and with many of them, I can figure out whether or not they have a surge, or if they are only worrying or whatever. I also have (patients), I do not know how many hundred, where that is not the case. They really are there in a way for the survival of the species of my profession.
NEUROLOGIST
Male and female patients are sick persons.
RADIOLOGIST
Male and female patients are sick persons. I cannot say more. Yes, that is the definition for me. Yeah?
Not healthy. Someone healthy is something else.
ONCOLOGIST
The term *empathography* can be understood in at least two ways: Most obviously, it brings together the word empathy with videography. The camera enacts an empathetic gaze through the hands of the videographer, Christina Lammer, who enacts through her instrument of the hand an empathetic relationship of looking closely and with care.

*Empathography* also involves documenting the subtle, almost imperceptible ways that surgeons and others in the operating room work together not only with obvious empathetic feeling for their patient, but also with an empathic connection among themselves. The hand of the surgeon is not simply a precision tool for getting things right mechanically. It is also an empathetic and creative extension of the feelings – the hand of the surgeon feels for the body of the patient. There is a tremendous tenderness in this relationship.

*Hand Movie 1* opens with an extreme close-up on a pair of hands folded contemplatively as if in prayer, except they are covered in sterile gloves tucked into the arms of a surgical gown. The two thumbs support one another, bouncing together in rhythm as if performing in dialog the inner thoughts of the
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surgeon as he plots his first steps (we take from the action of the feet, and not the hand). It is as if the surgeon is limbering up for the performance ahead, stretching the fingers as a pianist might do before an important performance. But there is never the opportunity for a surgeon to rehearse on a living body. All cuts are live.

Before *Hand Movie 1* breaks into action, a single hand reaches into the frame and places itself steadily and firmly, gently, on the breast of the unconscious patient. It is a strange and moving gesture – strange because such a gesture would never be made by a medical professional toward the breast of a conscious female subject; even in clinical exam, the hand of the clinician would never be made to rest, even in reassurance, on the breast. But in this context, with the patient unconscious and her breast about to undergo surgery, there is no mistaking that the gesture is an expression of tenderness and concern. The image is touching because it gives us a strong sense of the caring hands that receive this woman in her unconscious, anesthetized vulnerability. At this close range, the reassuring hand works almost like a point of view shot. In this close-up of the gentle touch, we are invited to feel, as if for the woman undergoing surgery, a sense of reassurance, a confidence in the many-handed body that will now perform a surgery on her in concert.
We might also sense what this hand feels as it places itself on the woman’s breast – the cool, soft tension of the flesh where the cut will be made, the warmth that radiates from the body, and the pulse that will remain so despite the reparative violence that will ensue. This reassuring hand seems to speak: it suggests respect for the body, care, and also a message of reassurance through the flesh to the unconscious body.

The gloves that are so predominant in this movie conceal – but they also reveal. We can see the outline of the surgeon’s thumbnail, but too the glove draws our attention to the paradoxical role of the glove as mediating tool: thin and supple yet impermeable, the glove makes possible a kind of intimacy and direct contact by touch while shielding from any potential exchange of physical matter. The surgeon can feel through his or her instruments the release of the tension of the skin as an incision is made. The gloves mediate the soft wet warmth of organs while preventing the passage of traces of infectious matter from the outside world into the vulnerable tissue of the patient’s body. The gloves also keep the fluids of the patient’s body from seeping into the surgeon’s pores. The gloves allow sensory intimacy, and yet they preclude the mixing of matter between bodies. At this micro-analytic scale of seeing, we can almost feel the difference between the tissue of the living body and the gel of the implant in its sealed plastic membrane, and the steel of instruments as they must feel against the
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skin of the gloves, or the tension of the thread as the needle pushes through the skin and is pulled, that faint sensation of friction as the thread is pulled through two thin layers of fabric in a reparative movement that brings closure.

What I am trying to emphasize in this descriptive account is how Lammer’s sensory film draws out for us not simply what can be seen with this kind of gaze up close, but also the duration and points of interaction between the surgeons’ body and that of the patient. _Hand Movie 1_ tells a close and personal story about intersubjectivity, but its _body_ is a body multiple – a body of multiple surgeons, assistants, and a patient, and all of the communicating within this body is performed not through speech but through the subtle, quiet micro-actions of the hands together – the small motor actions that perform in a field that requires a high level of awareness in eye-hand coordination not only about what one does individually, but also about what one’s partners are doing and probably intend to do, moment to moment. The success of an operation hinges on this intense awareness and anticipation of what one’s hands will do, and what one’s partners hands can be expected to do in concert with one’s own.

Accounts about surgery and subjectivity tend to emphasize the interaction between two subjects, as in narratives about the doctor-patient relationship. I’m sure we can all think of accounts we have read of the subjective experience of a medical encounter written or filmed from the standpoint of one
subject – the personal standpoint of a doctor or a patient, for example. These accounts almost always rely on words, either for the documentation itself, or for the retelling. When the work of the hands of the surgeon is the focus, there is a tendency to fetishize them as the skilled tools that make the surgery a success. We tend to speak of the brilliant hands of a concert pianist or a painter, for example. Yet the surgery involves not just two but many hands. The closeness of the shots, in *Hand Movies 1* and 2, no sooner do we see this ritual of the two hands begin than the frame is filled with not just two but many hands, at times as many as eight, all working in the same field as one creative body. These hands reach into the field of the tight shot around the surgical site with collaborative gestures and movements that complete one another as tools pass hands and as hands belonging to different bodies perform tasks in concert with one another. In rhythm and pace, the shots takes on the dimensions of a concert, in that these hands work their instruments together with astonishing precision and beauty. Never do we see them two hands getting in one another’s way. Often it is impossible to tell which two hands belong to the same body, such is their practiced skill in working together as one many-handed body. One could say the team has come together as if all of one mind – and this without having to pre-think any one gesture. The routine of work with the hand of another has become internalized, so that the hand performs apart form the conscious thought-process of the surgeon or nurse. In this way, we
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might say that the patient is not the only one whose unconscious is actively on display in the operating room. Think, for example, about the shot in which the surgeon uses his dominant hand to pass off an instrument to the hand that waits to receive it from the other side of the patient’s body. The hand that receives the instrument waits in readiness, as if listening for its other, the hand of the surgeon. That hand to which the tool has been passed remains poised, holding the instrument delicately but firmly and still in exactly the right position so that the surgeon can retrieve it again with no loss of time and no need to speak. It is as if the two hands were of one body and one mind.

The hand and the face are the two places we tend to look when we turn to the body to read its surface for expression and feeling. Emotions are understood to be written on our face — and it is the work of the hand that we associate with the crafting of meaning through gesture and through the crafting of work, from the handwork of painting to the handwork of surgery. In a selection of four of Christina Lammer’s recent films, she draws together the expressive dimensions of the face, and invites you to be face to face with a child whose facial differences are something from which we might be compelled to turn away out of respect, or in shame about our own interest in looking. By inviting you to look at the face with its transformations of physical difference, and by asking you to consider the empathetic and concerted work of the hand in transforming the meaning and experience of bodies, Lammer opens
up a different way of understanding the creative and the affective dimensions of medical practice. Rather than providing you with images of medicine that demonstrate knowledge in its relationship to visuality, and rather than showing images that demonstrate the wonderment of images in medicine, she emphasises instead the role of the image as a tool for the contemplation of the multisensorial, intuitive, and affective dimensions of surgical experience as an intersubjective domain.
Christina Lammer
SELECTED VIDEO WORKS

2012

HAND MOVIES (1-3)
DVD, Master: HD 3 channels video installation
Duration: à 5’

MAKING FACES
DVD, Master: HD 1 channel video installation
Projection on 10 x 1 m medical gauze
Duration: à 15’

SURGERY LESSONS
DVD, Master: HD 4 channels video installation
Duration: à 5’
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2012  EMPATHOGRAPHY I
      DVD, Master: HD 2 channels video installation
      Duration: à 5’, à 20’

2011  PLASTER BED
      DVD, Master: HD 1 channel video loop
      Duration: à 5’

2010  EMPATHOGRAPHY II
      DVD, Master: HD 9 channels video installation
      Duration: à 9’

      BRED + ROSES
      DVD, Master: mixed media 1 channel video loop
      Duration: à 7’

Vienna, June 2012