Biomedical Discourse and the Discourse of the Lifeworld in Contemporary New Zealand Poetry on a Medical Theme

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Abstract

The critical component of this thesis investigates autobiographical medical poetry written from the perspective of doctor, patient and parent in the context of a growing global interest in the relationship between medicine and poetry, and in the medical humanities. Its focus is the poets' use of medical discourse and the discourse of the personal, social world, and the ways in which their poems often echo the work of sociologists, revealing an inequity in doctor-patient relationships. The research also reveals a bias among some reviewers towards the poetry of doctors, and a contrasting tendency to accuse the patient-poets of solipsism, or the inability to go beyond self-referential anecdote. In response to such reviews, the critical component analyses the ways in which the poems have been carefully crafted, with attention to the blending or juxtaposition of biomedical and lifeworld discourses to a polemical end, moving the personal to the universal, and calling for more individualised patient care. In this way, the poetry of all three groups is found to be reflective of the contemporary socio-cultural backdrop of narrative medicine and medical humanities programmes around the world. The creative component, a book-length manuscript of poems called "Family History," explores the relationship between biomedical and lifeworld discourses in the light of the study undertaken in the critical component and also in response to the personal medical experience of the author and her family.

Preface

In order to explore the discourse of the biomedical world and the discourse of the lifeworld[1] in contemporary New Zealand poetry on a medical theme, two methods of investigation are employed in this thesis. The critical component is an essay on autobiographical medical poetry published between 2003 and 2010. The creative component is a manuscript of poems about my mother's illness, medical treatment and death, titled "Family History."

This thesis responds to the large number of medically-based poetry collections published in this country since the beginning of the new millennium. Texts by nine representative poets are studied in the critical portion.

Two main research avenues are pursued in the critical component. Firstly, I note that the recent proliferation of autobiographical medical poetry runs parallel to the increase in tertiary medical humanities programmes worldwide. I investigate the extent to which the poetry echoes the sociological and sociolinguistic research underpinning such courses.

Secondly, I observe that, regardless of whether they are writing as doctor, patient or parent of an ill child, these poets all appear to be using language in a multi-voiced way, and with a degree of polemical intent, employing a mixture of clinical and personal discourse in what can be argued to be a heteroglossic[2] mode.

Narrative position also appears to be associated with authorial intention, aiding the poet in communicating ideas about the objective and the subjective, the clinical and the personal. Therefore, in three chapters demarcated by narrative position ("The Doctor-poets," "The Patient-poets" and "The Parent-poets"), I consider not only narrative perspective, but also the interplay of biomedical and lifeworld discourses in order to examine the ways in which the poets draw attention

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[1] "[T]he 'voice of medicine' and the 'voice of the lifeworld,' representing, respectively, the technical-scientific assumptions of medicine and the natural attitude of daily life" (Mishler 14).

[2] Put at its simplest, "a diversity of voices, styles of discourse, or points of view in a literary work" ("Heteroglossia").

to the dehumanising effects of clinical language, and to the need for lifeworld language and imagery to communicate personal medical experience.

To accomplish this, I employ the lenses of current sociological and sociolinguistic study, as well as those of Foucauldian and Bakhtinian criticism, in an effort to prove that these poems are often the sites of conflict between the authoritarian biomedical world and its intrinsically clinical language, and the marginalised lifeworld and its essentially personal, vernacular language. I analyse the ways in which a heteroglossic mode is used by the poets, combining not only the languages of biomedicine and the lifeworld, but also, often, the language of religion, in order, it seems, to bring notice to the spiritual aspect of holistic patient care.

The creative component, "Family History," has been informed by the critical essay. This series of poems is divided into three sections. The first introduces the mother: her status as an adoptee, her diagnosis of and treatment for breast cancer, the daughter's (and father's) reactions; the second section describes the family's dread of the disease's recurrence and the cancer's return; the last section deals with the daughter's grief following the mother's unexpected death in a car accident.

The "voice of medicine" (Mishler 14) and the "voice of the lifeworld" (Mishler 14) are frequently employed by different characters in the same poem (a physician and the mother's daughter, for example), both voices refracted through the medium of the speaker. Just as frequently, the speaker, as the only 'voice' in the poem, uses both discourses exploiting the layers of meaning created by the blending of medical and personal languages. The amalgam of biomedical and lifeworld discourses often evokes a sense of disharmony in these poems, the Latinate formality of the former clashing with the relaxed, innocuous vernacular of the latter in a way that highlights the formidable otherness typical of the medicalisation process. It is at this juncture that spiritual diction is sometimes called upon by a poem's troubled speaker. The language of religion represents a secondary lifeworld language whose esotericism offers an alternative (or missing) hope in a time of crisis.

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Introduction to the Critical Component

The Modern Marriage of Medicine and Poetry

International symposia, prizes, publications and university programmes are now according the marriage of medicine and poetry our modern measures of approval: monetary value, media focus and academic recognition. Medical poetry has developed into a thriving literary sub-genre, with many contemporary poets publishing whole collections based on personal medical experience.

The United States and the United Kingdom are at the forefront of medical poetry symposia, as evidenced by the sheer number and magnitude of such events in the past decade. For example, in 2004, Duke University's inaugural poetry and medicine conference, *Vital Lines: Vital Signs*, welcomed seventy speakers from both medical and literary specialisms. Their May 2010 conference *Life Lines*: *Poetry for Our Patients, Our Communities, Our Selves*, featured talks and workshops combining the talents of leading American poets, creative writing teachers, oncologists and family doctors. In October of the same year, a symposium at the University of California, Berkeley, hosted by the Program for the Medical Humanities, was held to examine the use of narrative and metaphor in medicine. In England, every May since 2010, an International Symposium on Poetry and Medicine takes place at the University of Warwick, with themes such as the history of interactions between medicine and poetry, and the impact of health and disease on the writings of professional poets.

An international award with a £15,000 prize fund for poetry on medical subjects, The Hippocrates Poetry Prize, is also associated with the University of Warwick . This annual prize, first awarded in 2010, by nature of its monetary value and media coverage, eclipses other prizes for medical poetry, such as those sponsored by the *Annals of Internal Medicine* (since 1997) and Yale UCL (since 2011). The presence of these prizes signals the growth of medical poetry as a significant sub-genre worldwide.

Well-known medical journals such as the *Journal of the American Medical*

Association,[3] the *Medical Journal of Australia*[4] and *The British Journal of Psychiatry,*[5] which were for many years publications for scholarly reviews and research-based articles, now publish poetry by physicians on a regular basis. Moreover, "[n]ew literary journals have sprung up at medical schools" (Thernstrom 44) and elsewhere—for example, the journal *Medical Humanties,* co-owned by the Institute of Medical Ethics (IME) and BMJ. There is also the extensive "Literature, Arts and Medicine Database" maintained by the New York University School of Medicine: a rich online source of annotated poetry, prose, art and film for use in teaching in the medical humanities.

The Medical Humanities

The growth of resources in the area of medical humanities runs parallel to the increase in narrative medicine and medical humanities programmes at universities. According to some scholars, the medical humanities were incorporated into medical training as a countermeasure to "the emergence of seemingly miraculous but morally troubling medical and technological advances" of the 1970s (Jones, Wear and Friedman Introduction 1). To others, the narrowness of the "new criticism" dominating the literature curriculum drove many educators to seek out the socio-political, cross-curricular opportunities offered by the study of literature and medicine. Kathryn Montgomery Hunter, Professor of Medicine, Medical Ethics and Humanities at Northwestern University Medical School, explains this view in greater detail:

> Much as medical ethics was occupied with the patient-physician relationship, literary criticism was occupied with the intricacies of the reader-writer dyad, a terminal formalism that excluded social issues. Literary scholars interested in the social contexts of literature, in history or culture, in the author's relation to the text, or in the work's political force or

[3] *JAMA* started to publish poetry regularly in the 90s although a search through the archive will pick up the occasional unindexed poem as 'filler' from the mid-1970s.
[4] The *MJA*'s first poem was published in 2005.
[5] The *BJP* started to publish poetry in 2008.

> societal reception were intellectually underemployed, even if they held academic positions. In the late 1970s and early 1980s, the field of literature and medicine put a spin on customary teaching by opening up interesting questions about literature and culture, literature and the lives of human beings. (5)

At present, thriving medical humanities programmes are taught in tertiary institutions all over the world and referred to as "part of the mainstream in medical education" (Gordon 6) in North America and in the United Kingdom. In 2003, the journal *Academic Medicine* reported that there were over 40 programmes in medical humanities internationally (Gordon 6), including countries such as Hong Kong, India, Nepal, Israel, Qatar, The Netherlands, Switzerland and Australia.

With regard to New Zealand, our two medical schools now make humanities subjects compulsory. Since 1996, Otago University's students have had to choose one option from 18 humanities selectives which run for six weeks from April to mid-May in their third year. An expert humanities tutor in each selective takes the students for six two-hour sessions over this period.

A comprehensive medical humanities course exists in Auckland. The Auckland University Medical School (now The Faculty of Health and Medical Sciences) introduced it to their curriculum in 2000, an interfaculty committee having been set up to implement this in 1995 (Grant 1072). In the comparative literature topic of the FHMS' course as it is currently offered, students are encouraged to read and write medically-relevant poetry and prose in order to perceive the place of narrative and metaphor in their future profession. The FHMS' course blends concepts from what is probably the most well-known medical humanities course, Rita Charon's "pioneering Program in Narrative Medicine at Columbia University," (Thernstrom 44), with its focus on co-constructed doctor-patient narrative, and the commensurately important study of image or metaphor in writing by doctors and patients. As course lecturer Michael Hanne posits in his introduction to the *Binocular Vision Project* presented at the 2010 University of California symposium,

"Metaphor plays an equally crucial role[to narrative] in our attempts to make sense of the experience of illness" (225).

It is no coincidence that the medical story-telling courses taught at Columbia, Harvard and Pennsylvania State universities, and the feasibility of increasing the number of such courses here, were the subject of New Zealand doctor-poet Glenn Colquhoun's 2010 Fulbright scholarship research (Yeats par. 42).

Having explored the relationship between writing and medical practice extensively in his 2003 collection *Playing God*, Colquhoun then chose to study beside recognised leaders in medical humanities teaching, such as the poet and physician Rafael Campo, whose writing programme for medical students at Harvard seeks to redress "the occasional disconnect between medical facts and human truths" (Brown and Woodruff).

Medical Poetry

Written during his medical training at Auckland University (now FHMS), Colquhoun's *Playing God* is New Zealand's best-selling and most nationally-renowned book of medical poetry. (Yeats par. 27). It was the first poetry collection to win a Readers' Choice Montana Award (as well as winning the 2003 Montana Award for Poetry). In October 2006, it climbed the Booksellers New Zealand list and became the only poetry collection in New Zealand to have gained Platinum status.[6] By September 2009, it had sold over 10,000 copies world-wide, gaining Double-Platinum status (Yeats par. 27).

In addition to Colquhoun's *Playing God*, in the past decade several New Zealand poetry collections on a medical theme, both from doctors' and patients' perspectives, have won awards and plaudits, proving demonstrably popular with readers and ranking highly on best-seller lists. Haematologist Rae Varcoe's medically-based *Tributary* was published in 2007, the same year as C.K. Stead's *The Black River* (Auckland University Press). Stead won first place (£5,000) in the inaugural Hippocrates competition with his poem, "Ischaemia," and Varcoe won

[6] This indicates that more than 5,000 copies of the book have been sold nationally.

first and second place in the *Annals of Internal Medicine*'s Poetry Prize in 2004.

Assisted by a grant from the Mental Health Foundation of New Zealand, Jessica Le Bas' *Walking to Africa* was the best-selling New Zealand "book of fiction"[7] a week after its launch on 9th October 2009. The series of poems, told from the point of view of a mother whose daughter is being treated for depression, looks at the provision for mental healthcare for adolescents in our country.

Other medically-themed poetry collections published in New Zealand this millennium, which will be discussed in this thesis' critical component, include Anne Kennedy's *Sing-song* (2003) hospital doctor Angela Andrews' *Echolocation* (2007), past poet laureate Jenny Bornholdt's *Mrs Winter's Jump* (2007) and *The Rocky Shore* (2009), the late Sarah Broom's *Tigers at Awhitu* (2010), and Ingrid Horrocks' *Mapping the Distance* (2010). Many of these collections have an autobiographical basis—indeed, a number of the works under discussion evolved from authors' journal entries that were later developed into poetic sequences or whole collections. For example, the subject matter of C.K. Stead's poem "Ischaemia," written especially for the Hippocrates Prize, is directly related to the stroke he suffered in 2005 (Stead, "2010 Hippocrates Award Podcasts"). The poem is narrated, in dictated-letter form, by Catullus, Stead's poetic alter-ego, but the experience is Stead's own, down to the details documented in the poet's other writings and interviews—the transient dyslexia, the distortions of vision that persisted even months after the ischaemic attack (Stead, "S-T-R-O-K-E" 76–77). Stead's first post-stroke collection *The Black River* (2007) features a number of poems that grew from a notebook kept at his bedside while he recovered (Stead, "S-T-R-O-K-E" 80).

In addition to those books which I shall discuss in detail in this thesis, other notable collections have been published between 2003 and the present date. Paula Green's *Slipstream* (2010) is a series of poems about the poet's diagnosis of and treatment for breast cancer. Throughout the book, cross-word clues and song titles are woven into the story, reminding the reader of the patient's everyday life and interests while she goes through surgery and radiotherapy, humanising and giving

[7] According to Nielsen Weekly Bestsellers Lists.

character to the nameless "she" persona, caught in the slipstream of illness and recovery.

Leigh Davis' posthumously published *Stunning Debut of the Repairing of a Life* (also 2010) follows the author's struggle to write again after brain surgery. This book won the Kathleen Grattan Award. The first half of the collection is the facsimile of a handwritten notebook. The second is a month's worth of printed poems informed by *The Odyssey*. Davis' poetry is transcendent, personal; it looks at illness, faith and death from the position of an unflinching "I". Another posthumous collection is *Gleam by* Sarah Broom, which was published in 2013. This second volume of the poet's work focused on terminal illness and the family and was linked to her premature death from secondary lung cancer.

In 2014, Zarah Butcher-McGunnigle's *Autobiography of a Marguerite* was published. Told by an "I," suffering from an undisclosed autoimmune disease and enmeshed with her mother/carer, the book explores the themes of identity and language from the inside of illness. The first section of the collection is a series of connected prose poems, linking daughter, mother and grandmother. The second section features poems punctuated by footnotes taken from books by Marguerite Duras and Marguerite Yourcenar. The last section uses photographs as well as prose poems to return to the story of the mother, daughter and grandmother, and the effects of illness on family and identity.

Cloudboy by Siobhan Harvey was also published in 2014. Told in the third person, but very much from the viewpoint of "Cloudmother" ("Cloudmother" 2) to an autistic and gifted child called "Cloudboy" ("Cloudmother" 28), it is searing in its criticism of the educational, psychological and paediatric healthcare provisions for children on the autism spectrum.

These collections are all fascinating in terms of the narrative positions taken by the poets and the ideas they express about identity and family life in the face of illness and medical treatment. If the scope and timing of my project had been more expansive, I would have been pleased to have included them in my research.

Differing Critical Reactions

While I cannot go as far as Eleanor Catton and describe New Zealand as having "no reviewing culture at all" (in Cochrane par.7), it is perhaps true to say that there is a dearth of critical material written about the collections that feature in the critical component of this thesis. Conducting a balanced and far-reaching survey of academic reviews was therefore challenging. However, this was not my aim, and there was enough material in the form of reviews from *The New Zealand Poetry Society*, *The Lumiere Reader*, and magazines such as the *New Zealand Listener*, *New Zealand Books,* regional newspapers and longstanding literary publications such as *Landfall* to make and illustrate the following remarks regarding differing critical receptions of doctor-poets and patient-poets. In short, I found that the critical reception of the work by doctor-poets and patient-poets was in some ways schismatic, the former most often viewed as brave and heroic in their revelations, the latter as solipsistic. Furthermore, it was evident that when parents made their sick children the subjects of their poems, reviewers could interpret their narrative position as exploitative or sermonising.

To expand just a little, consider *Playing God*. Colquhoun's book has been called "revealing" by reviewers (Bieder par. 2); the content, largely autobiographical, insofar as it discusses his work with patients and his own family's experience of illness, has been said to reflect Colquhoun's "intense, almost fragile self-awareness," a quality that makes his poetry "heartbreaking and beautiful" (Bieder par. 3). *Southland Times* reviewer Margaret Hunter similarly praises the work's "personal appeal and the sense that the author is near you and talking to you" (35), a comment that aligns with Colquhoun's recent classification as one of three New Zealand "poets of the people" (Green, in Green and Ricketts 398), alongside Hone Tuwhare and Sam Hunt.

As Colquhoun's title *Playing God* suggests, his doctor-speakers' perspective apprehends the doctor's place as authority figure and object of faith and trust. However, it also articulates the difficulties and pressures associated with such perceptions, the poems voicing what Colquhoun calls "a long conversation with my

doubt" (*Playing God* Introduction 8).

Angela Andrews is another doctor-poet, whose collection *Echolocation* (2007) takes as its subject her personal and professional concerns. In an interview with Linley Boniface for an article in the *New Zealand Listener*, Andrews explains the emotional catalyst to her writing:

> The hardest thing to deal with as a doctor … is not the drugs or the mechanics of illness but the human stuff—birth, death and suffering. Poetry helps you to acknowledge what you're going through, and to accept the uncertainty of it all. (par. 9)

In keeping with this tone of the doctor-poet's inner conflict, as in *Playing God*, *Echolocation* has poems which explore the topic of familial illness, and reviewers have admired Andrews' ability to present a speaker in whom: "the concerned eyes of a loving granddaughter combine with the precise observation of a doctor" (Liang par. 4).

Similarly, in Simon Sweetman's review of *Tributary*, haematologist Rae Varcoe is commended for her "honest" approach as she unflinchingly describes her work on the hospital ward: "her written word/world is very much the real world according to her, a world she is moving through" (Sweetman par. 6). Sweetman is taken with the fact that "[s]he stops off to offer advice from time to time ("A Wish List For Melissa At 21") but mostly ("Signs") she assures us that she's no surer than anyone else" (par. 6)

What the reviewers have in common is their praise for the apparent honesty of the work and the appearance of a dichotomous biomedical/personal self on show in the writing. That the doctor-poets are writing about their own experience is understood, and it is seen by these critics to enhance their poetry.

By contrast to the almost unanimous admiration of reviewers for the doctor-poets' work, poems written from the point of view of patient-poets have occasionally met with less favourable appraisals. Some reviewers have perceived the

poets as resorting to "the gut-spilling impulse of the 'confessional' mode" as Hugh Roberts said in a review of Stead's poetry ("The Book of the Dead" par. 6). Or, as Joanne Preston suggested in a review of Jenny Bornholdt's *The Rocky Shore*, "Why pretend these are poems? There is a genre that they fit into much better—the memoir" ("Stubbing my Toes on Jenny Bornholdt's The Rocky Shore" par. 5).

These negative comments regarding poetry-as-memoir or poetry-as-confession raise a pertinent issue. Despite the fact that contemporary medical poetry collections have proved popular with the reading public and have sold widely, and despite the fact that the point of attraction for many readers seems to be the very closeness of the material to the medical life experience of the poets, be they doctors or patients, there is a notable schism between reviews of the work of the doctor-poets and the work of the patient-poets.

Perhaps it is the case that, as Marilyn Chandler McEntyre proposes in *Patient Poets; Illness from Inside Out* (2012), despite our society's increased awareness of disability and illness, and our purported acceptance of sufferers whom once we might have feared or scorned through ignorance, "some conditions are still spoken of only behind closed doors, or with an edge of unease and an eye on the privacy clause" (40). She makes the point that approaching and engaging with autobiographical work that involves mental health or sexual health, for example "remains emotionally, politically, or theologically complicated" (40). Is the critical divide with regard to these poets, then, the line between the clean, healthful doctors giving us an insight into their lives on the wards versus the struggling patients and parents of sick children, revealing more than we wish to see of potentially taboo-raising, embarrassing or fear-inspiring illnesses? McEntyre sees it thus:

> Poets who set themselves the task of writing past that tacit social barrier know their words may give offense. Their disclosures are a kind of "coming out" that locates them in a geography of controversy. (40)

In a similar vein, in her recent doctoral thesis (now a published book) *How*

Does it Hurt, New Zealand poet and chronic pelvic pain sufferer Stephanie de Montalk "acknowledges the possibility that for reasons of self-protection … we are conditioned or 'hard-wired' not to accept the pain of others" (Abstract, 6). She sees our non-acceptance as a self-protection mechanism. The pain of other people is not to be admitted, lest it infiltrate our own armoury.

But if social discomfort could explain part of the reaction to these patient-poems and parent-poems, aesthetic concerns also play a role. For Hugh Roberts, the autobiographical basis of Stead's post-stroke poems is not only unpalatably "gut-spilling" ("The Book of the Dead" par. 6), it also contradicts the octogenarian author's career-long adherence to modernist impersonality. Roberts sees *The Black River*'s new mode as an unsuccessful stylistic experiment:

> It might seem a paradox that the writer who nailed his colours so definitively to the mast of Pound and Eliot's "impersonal" modernism in *The New Poetic* back in 1964 should have produced a literary oeuvre that so obsessively mines his own autobiography.
> ("The Book of the Dead" par.4)

For Roberts and some other critics, the stylistics of the patient-poems is tied to, and perhaps inextricable from, their theme and their content: that is, the poems' nascence in the authors' recent medical experience is associated with a raw, diaristic quality to the writing that precludes sophistication and craft. As Roberts remarks with regard to Stead's stroke-related poems, they are "most remarkable for being unremarkable" ("The Book of the Dead" par.10).

In another review, this time of Sarah Broom's *Tigers at Awhitu* (2010), Roberts goes so far as to suggest that medical confessional collections are in fact part of a current trend in New Zealand poetry: "a new genre that could be described as exercises in Higher Blogging: free-verse ruminations on Stuff That Has Happened To Me Lately" ("Is it a poem or a blog?" par. 1). Broom's first collection, concurrently published by Auckland University Press and Faber, features many

poems on the subject of her diagnosis of lung cancer and her subsequent treatment. Roberts concedes that the subject matter of some of Broom's poems is "riveting" ("Is it a poem or a blog?" par. 14); the implication is that interest in this collection would rely on *schadenfreude* or voyeurism, the content being more compelling than the craft. Roberts suggests that the poems themselves are not masterfully or completely rendered; they are overshadowed by the very emotion of the experience they are trying to express. He explains that "there is in these works what Wordsworth called an 'overflow of powerful feelings' but not quite, yet, that transformation by reflective 'tranquillity' that would sublimate these feelings into a fully realised work of art" ("Is it a poem or a blog?" par.14).

What Roberts perceives to be lacking here seems to hinge on craft—the technical mastery of the poet used to subdue and express the most volatile feelings in a felicitous manner, enabling the reader not only to comprehend the feelings expressed, but also to derive pleasure from the mode of expression. Wordsworth's description of subduing those feelings may serve to describe what Roberts finds wanting:

> . . . whatever passions [the poet] communicates to his Reader, those passions, if his Reader's mind be sound and vigorous, should always be accompanied with an overbalance of pleasure. Now the music of harmonious metrical language, the sense of difficulty overcome, and the blind association of pleasure which has been previously received from works of rhyme or metre of the same or similar construction, an indistinct perception perpetually renewed of language closely resembling that of real life, and yet, in the circumstance of metre, differing from it so widely—all these imperceptibly make up a complex feeling of delight, which is of the most important use in tempering the painful feeling always found intermingled with powerful descriptions of the deeper passions. (Wordsworth par. 26)

Although Roberts does not go this far, perhaps it is also the case that underlying his critique (implicit in his review's title "Is it a poem or a blog?") is the long-standing argument that poetry should reach towards the universal, to something that the personal touches upon that is more than just individual in its significance, for as poet Kate Sontag argues, it is important that "first-person lyrics can embrace a larger social vision, achieving revelation over narcissism, universal resonance over self-referential anecdote" (Sontag, Interview par. 31).

The Autobiographical Lyric in the Context of Confessionalism

In the 2001 anthology *After Confession: Poetry as Autobiography*, Sontag and Graham David have collected essays that explore the ways in which the modern self-revelatory poem may be judged narcissistic or memoir-ish at the expense of aesthetics, or the ways in which it may break the silence of a family secret or a taboo subject in order to make a larger political or social point—or, simply to free the individual from the secret's hold. To Sontag there is nothing amiss with a true, personal story catalysing poetry. In an interview with David Algers, she explains how the act of making the poem, the selection of language, the shaping of form, can lift a poem out of personal memory and far from its inciting experience:

> A poem may be initiated by an actual event, but a poem also takes on a life and a truth of its own—through attention to line, imagery, music, and overall lyric structure. A poem based on autobiographical material combines memory and imagination, and memory is always selective and subjective, just as the shaping of a poem is. Many times the farther you allow yourself to travel from the fact, the closer you get to the truth. The truth is in the creation, not in the actual event. (par.15)

"[S]elf-referential anecdote" (Sontag par. 31) that cannot transcend its associated sentiment is precisely what Roberts deems to be driving 2005 poet laureate Jenny Bornholdt's poems that chronicle a period of illness. He states that

"given autobiographical material only too laden with emotional resonance, it all seems to be too hot for Bornholdt's techniques to handle" ("Holding the Light Quietly" par. 10). Again, his point appears to be that emotion related to personal experience overpowers the poetry and evades stylistic control.

When Bornholdt's autobiographically-based collection *The Rocky Shore* (VUP, 2008) was first published, the self-consciously and provocatively titled poem "Confessional" incurred disdain from some literary commentators and reviewers for being too personal and not crafted enough, as did the collection as a whole, despite the fact that it won the Montana Poetry Prize in 2009—a prize awarded in recognition of the poet's aesthetic and technical prowess.

Poet and critic Joanne Preston, for example, saw *The Rocky Shore* as more memoir than poetry and therefore somehow inferior to poetry on other, more impersonal or fictionalised subjects:

> Her subject matter is almost exclusively personal: her father dies; she builds a shed; her kid gets sick; she gets sick; other people get sick; she moves plants around her garden; she makes bread; she wears pants. (Her own words): "I was thinking about personal poetry and how it's not given much time of day anymore," (from "Confessional")—why is that, I wonder?
> (Preston "Stubbing my Toes on Jenny Bornholdt's *The Rocky Shore*")

It is interesting to note that Preston is concerned not just about Bornholdt's focus on her own illness, but about *The Rocky Shore*'s focus on other people's illness and death. For this, too, is a point of critical attention among reviewers of medical poetry. Indeed, the poets who write from the perspective of carer or parent (in particular, Le Bas and Kennedy) have been accused of producing poetry that is too close to the life of the person about whom the medical poems have been written, exploiting them or exposing their private lives to public scrutiny or voyeurism. To

call Bornholdt's poems about her children and her father merely "personal" is to call them banal, commensurately so with the poems about plants, bread and wearing pants. Preston's tone is deliberately dismissive.

It follows that Bornholdt resists being called a "confessional" poet, perhaps in part because of what some critics acknowledge to be "the negative value judgement adhering to the term" (Horváth 12), its reputation as "a dirty word" (Sontag, Interview, par. 11). Bornholdt explained in an interview with Harry Ricketts:

> 'Confessional' sounds as though it's just blurting on to the page, but I like to think my poems are more carefully crafted than that. Probably most poetry can be described in these terms. It just depends on the ratio of crafting to blurting. (in Harvey 57)

It is relevant at this point to note that when the term "confessional"(coined, it is claimed, by M.L.Rosenthal[8] *and* by A.A. Alvarez[9]) was applied to the poetry of Eberhart, Roethke and Lowell (Boyden 178), it reflected the self-revelatory nature of the new American poets' work as opposed to the more reserved and inhibited voice of poetry of the time—what Lowell referred to as "the tranquillized Fifties" (in Beach 155). The poets of the so-called Confessional Movement placed the speaker closer to the reader; the reflections of the I-speaker were overtly autobiographical and emotional, eschewing "modernist difficulty and New Critical complexity in favour of a more relaxed or personal voice" (Beach 155) that could connect with the reader in a democratic and accessible manner, unafraid of difficult or traumatic subjects.

Some critics of the time preferred impersonality in poetry, distance from the poet's own emotion, or, as T.S. Eliot famously put it, "an escape from emotion" (par.

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[8] M.L. Rosenthal is commonly held to be the originator of the term 'confessional,' in an unfavourable review of Lowell's *Life Studies* in 1959.

[9] See Michael Boyden's "Predicting the Past: the Paradoxes of American Literary History." This text attributes the first use of the word 'confessional' to Alvarez in 1958, used in a positive sense.

17). They subscribed to what Alvarez derisively called "the cult of rigid impersonality" (28). However, the "new generation" of poets who arose in the United States during the forties (Alvarez 28) was also praised by some commentators who saw their work as "poetry of immense skill and intelligence," albeit work "which coped openly with the quick of their experience, experience sometimes on the edge of disintegration and breakdown" (Alvarez 29). Its refusal to obey cultural censorship and its focus upon topics such as divorce, mental illness, alcoholism and suicide were what Alvarez termed the "new direction" (29).

Such a critical divide persists today with regard to poetry that is deemed confessional and autobiographical. Otherwise, how could Jenny Bornholdt's writing be disparaged by Preston and Roberts, and yet win the Montana Poetry Award, for, among other things, "disobey[ing] the rules that poetry should be compressed rather than sprawling, that it should avoid the personal" ("*The Rocky Shore* Rides Wave To Win Montana Poetry Prize"). Convenor of judges for the award, Mark Williams, also praised Bornholdt's use of "speech as we know it in everyday life, not lifted into the poetic, but made poetry by all that it is allowed to contain." ("*The Rocky Shore* Rides Wave To Win Montana Poetry Prize").

One has only to read the work and critical reception of New York poet Frank O'Hara (one of Bornholdt's influences[10])—who won plaudits for his casual "dailiness" (Aleshire 35), and for his vernacular disregard for the constraints of regular rhythms and prescriptive line breaks, from some; and drew disdain for the same diaristic chattiness from others—in order to understand the critical divide that persists in the literary world today, labelling the same poet both genius and talentless. In her essay, "Breaking the Code of Silence: Ideology and Women's Confessional Poetry," American poet and critic Judith Harris posits an explanation for the derisory attitude of some academics to contemporary confessional-style poets—they view modern confessional poetry as solipsistic, and heir to a multitude of self-dramatising, self-interested stars:

[10] "… at university I discovered Frank O'Hara's 'lunch poems,' which were a revelation – that someone could write about such ordinary things in such a casual way. I've taken a lot from him, I think." (in Johnston and Marsack 130)

> In recent years, critics have given the term "confessionalism" negative connotations. Poets who have found their way by the constellation of Sylvia Plath, Anne Sexton, John Berryman, and Robert Lowell—to name but a few of the original representatives of the confessional school—have been belittled for writing poems deemed as private, exhibitionistic, self-indulgent, narcissistic, or melodramatic." (254)

On the other hand, in support of Alvarez's comments made in the early 60s, contemporary poet and New Confessionalism advocate Clare Pollard, suggests that "the confessional movement needs to be revalued as an important progression in twentieth century poetry—one that was not just outpoured emotion, but emotion transformed into art by often ignored technical mastery" (Pollard 44). Pollard is of the opinion that poetry close to the experience of the poet does not mean poetry that is accordingly unschooled or unrestrained. Furthermore, the personal aspect of the work is often the point at which it is most universal and most potent—as Judith Harris asserts—"confessionalism seeks to break the silences that encode, censure and censor private and public truths" (254).

Harris' essay arose in part as a defence of confessional-style poetry by Sharon Olds and Linda McCarriston—American poets whose collections, *The Father* and *Eva-Mary*, respectively, were disparaged in a review by Louise Glück. Glück, an acclaimed poet and academic, judged that both poets cultivated what they "intended to be the heroic voice of the survivor" (21), and that the books, both dealing with incestuous parent-child relationships, relied on "the prestige of tragedy" (Glück 20) to carry their collections and buffer them against criticism. Gluck says, "We cannot, as readers, dispute what must have been genuine suffering. The question is, why are we involved at all?" (20)

To those charges, Harris responds, "Confessionalism contains the positive belief in expression as liberation from the powers who would disarm the truth" (256). Harris sees the lyric poem and the confessional "I" as enacting a deliberate vocalisation of the verboten:

> the poem cannot be severed from its maker: it is asking too much from the poet to permit the reader to exclude certain material on the basis of its taboo or shocking subjects. When we begin to do that, we join the 'conspiracy of silence. (259)

Broaching the topic of inappropriate subject matters for poetry, in 2010, Sharon Olds gave a guest lecture at Columbia University Medical Centre for the series known as Narrative Poetry and Narrative Medicine Rounds. She read from one of the poems from *The Father*, which told graphically of his struggles to swallow as he approached death. She commented:

> I remember when I first read this poem, around 1982 or 1983, some people in the audience left in the middle of the poem. I guess it was just too gross, felt as if it harmed their hearts, or harmed their idea of what poetry should be.
>
> And when I would submit to magazines poems which had children in them, I would get back these rejection slips which said, "If you wish to write about children, may we suggest the *Ladies Home Journal*? We are a *literary* magazine." (230)

Jessica Le Bas' *Walking to Africa* is a book of poems about suffering and bearing witness to suffering, described unflinchingly; it is also a collection about mental illness and a child—Le Bas' daughter, Genevieve (Arnold 14). The mother character witnesses her daughter's descent into depression, her self-harm, the physical changes that come with the medications she tries and the process and aftermath of her electric shock treatments. New Zealand's best-selling book one week after its launch, *Walking to Africa* received a number of popular reviews based on the poet's sharing of her and her daughter's personal experiences, but the collection's subject matter also confounded some commentators. Jack Ross, for example, finds Le Bas' focus on her depressive daughter an uneasy choice: "It's an odd decision, to say the least, to make someone else's suffering the subject of such a set of confessional poems" (185). Even though the daughter, "she," is kept

anonymous , as is the mother (referred to as "you" throughout), Ross perceives the work to be too "confessional", too close to familial experience, and, by extension, of dubious origin and quality, as if some themes and subjects are still taboo in contemporary poetry. On the whole, his review is equivocal, undecided as to how the reader should receive not only Le Bas' telling of her daughter's story, but the poet's self-exposure, too:

> … it's honest. That's what gets me about it. She's not saintly,
> not all-knowing, wise, patient—she's human, flawed, peevish.
> Maybe that's worth saying at such length. And maybe not.
> Who knows? (Ross 189)

It is not that Ross condemns Le Bas' "you" speaker; it is more that he is confused by the character, and perhaps the honesty of the writing is the aspect that makes the character and the collection uncomfortable.

Anne Kennedy's *Sing-song*—again, family-focused and based on actual medical experiences—has been subject to similar critical ambivalence. *Sing-song* won the 2004 Montana New Zealand Book Award for Poetry, and it was reviewed largely positively. Yet, like Le Bas' *Walking to Africa*, it received some negative reviews connected with the autobiographical/familial nature of the poems. Some commentators also viewed the high emotional content of the poems as inhibitive to stylistic consistency. Indeed, New Zealand poet and critic Peter Bland suggested that Kennedy's poems are little more than therapeutic jottings used to string along a story: "She uses poetry as a sort of emotional shorthand. It works in terms of pushing through the narrative (always her primary consideration), but the poetry itself is very on/off …" (par. 10).

Bland's concern seems to be that Kennedy is more interested in the "story" than in the craft of the poem. Given that the whole collection tells a single story, a series of linked poems that function together to tell the quest narrative of an "eczema-mother" ("The Bells of Westminster" 21) searching for a cure for her daughter's painful skin condition, why should the poet's focus *not* be on the

unfolding of the story and enacting its performance from a particular perspective (that of the mother—the role which she held in real life)? His answer is that "[t]hese poems read like a novel" (par. 11). Kennedy's "focus on story-telling would be better achieved by prose" (par.11).

Narrative Perspective

What seems to be most problematic to Bland is *Sing-song*'s narrator and her confiding, diarising tone (par.9). As Ross noted with regard to Le Bas' "peevish" speaker (189), Bland also claims to be confounded by the attitude of the speaker in *Sing-song*—a speaker who does not dress herself up to appear in public:

> I'm totally confused by this book. I admire its sustained narrative energy and was moved by the mother's struggle, but a sort of chip-on-the-shoulder attitude kept getting in the way. Understandable in terms of the author's real-life situation, but unsettling when allied to a persistently grudging quality in the fiction. (par. 13)

As it was for Ross in his assessment of Le Bas' collection, the narrative perspective of the mother is a key point of ambivalence for the reviewer. Having criticised the "pushing through" (par. 10) of the narrative, Bland now applauds it, but what he cannot accept is the "attitude" (par. 13) of the speaker. The persona's closeness to the author, despite the use of the third person, seems to be what is most "unsettling" (par. 13).

It appears, then, that narrative point of view is one technique worth examining in appraising all of these personal medical poems—the perspective chosen by the poet as a conduit for the narrative and the importance of this to the act of poiesis. Like the "I" point of view often assumed by Colquhoun, Andrews and Varcoe and their doctor personae, the first person is not a default mode in the these poems dealing with the mother/daughter stories, but a conscious choice. As Bornholdt explains with regard to the autobiographical medical poems in The Rocky Shore, "I wanted to tell things in a very straightforward kind of way. I

wanted it to be clear that it was me as a writer talking" (Interview with Kathryn Ryan).

However, as we have seen with Le Bas' and Kennedy's work, some poets eschew "I" when describing medical encounters that are demonstrably autobiographical. Perhaps poets who write about familial medical encounters using a more distancing perspective are reacting to what Bornholdt identifies as the pejorative associations of the "confessional" label that she aims to avoid. If "all poems with a high emotional content in which the speaker can be identified as the poet are being labelled confessional, as if all were, willy-nilly, overly subjective" (Aleshire 14), where is the incentive to overtly own the story with an "I" narrative voice?

In *Walking to Africa*, the generic "you" persona distances the poet from the experience but brings readers closer to it, inviting them to take the journey beside the speaker, asking them to position themselves as the mother of a depressed daughter stuck in the limbo-land of adolescence, between national mental health provisions for children and adults.

Like the retrospective writing from a journal that became "S-T-R-O-K-E" in *The Black River* by Stead, Le Bas recorded details of her experiences during the time of her daughter's illness. Many of those details were poems from the outset, however, and subsequently shaped into the collection as it stands.[11] In this way, Le Bas imposed some distance upon the relationship between the experience and the poet at work. The equation of authenticity with a sense of detachment from the work is an idea to which Le Bas attests. For Le Bas, credibility became even more important when the Mental Health Foundation became one of the sponsors of *Walking to Africa* (Message to the author, E-mail), imbuing the collection with a more-than-implicitly social voice:

> … from day 1, wrote it in 2nd person … the only POV with

[11] "I was encouraged to put it together as a narrative when I heard on the radio one afternoon how some guy had climbed Everest under extreme conditions—and it struck me that my child had done that too, except no one knew, and she wasn't at the top." (Message to the author, E-mail)

> which I could deal with the material at all. It gave me a distance, a detachment that kept me perhaps away from being sentimental, or indulgent - Even editing I found myself often in tears, and still do. And I wanted the poetry to be good, and strong, to give the 'story' a respectability, a seriousness in the public arena.
> (Message to the author, E-mail)

Le Bas was clear that although the story was a personal and painful one, the lyric poem's job was to universalise the family's experience and draw attention to a common problem. The poetry loses its polemical power if a reviewer decides that its closeness to the author's personal life precludes it from being anything more than a pathography or memoir of an illness. Such is the case with the criticism of paediatric medicine at the heart of Kennedy's *Sing-song*. This aspect of the text becomes another target for Peter Bland, who believes that the collection's narrative "rarely slows down long enough to be more than a vehicle for personal complaints and bitter social comment" (par.13). It is unclear as to whether Bland's concern is that the poems are merely asserting social commentary (rather than performing it) or that lyric poetry has no place for polemic, but it is patently clear that he believes that the poems' commentary on social and medical issues detracts from their potency, credibility and craft.

Social Commentary and Subversion via the Manipulation of Discourses

It is my opinion that the social commentary in *Sing-song* is present at a level more pervasive and microscopic than the thematic and tonal ones focused upon by Bland. As I will argue in more depth later, Kennedy's subversion is evident at the level of language and form, in the bricks and mortar of the poetry, not just in the frustration and outrage expressed by the mother. And this is true not just of her book, but of all the collections I will examine in this thesis: The social commentary, in the form of linguistic subversion, is an important part of the poems' craft because it is enacted, not merely asserted.

In both the critical and creative components of this thesis, I will attempt to discredit critical charges of solipsism and impulsivity directed towards these patient-poets and parent-poets, for such accusations marginalise or, indeed, ignore, the way in which they confront difficult, emotive, personal and socio-political themes, by employing as Alvarez said of the Confessional poets "intelligence and skill to make poetic sense of them" in innovative ways (Alvarez 24). These poets do not merely tell a personal story or assert a position with regard to a personal story, but they aim to achieve some sort of universality from a standpoint of individual experience.

In the rest of this thesis, I will contend that with their focus on social commentary, power relations and subversion, contemporary medical poems are eminently open to Foucauldian and Bakhtinian readings,[12] particularly in terms of the questions they raise regarding the symbiosis of discursive and social practices in creating and expressing authority and intention. Specifically, the medical discourse featured in these poems can be viewed as the purported language of scientific truth and, as such, a medium of exclusivity and power. This idea of an in-language, a specialised discourse that empowers the doctor, enhancing acceptance of his authority and his position as gatekeeper—a medium between the disease and the cure—is evident in the work of poets writing about medical encounters. It is in keeping with Foucault's observations regarding the "medical esotericism" of clinical language (*The Birth of the Clinic* 141) that provides clarity of vision and understanding only to insiders: "[O]ne now sees the visible only because one knows the language; things are offered to him who has penetrated the closed world of words" (*The Birth of the Clinic* 141). It is thus precisely the polemical character of these "confessional" voices that suggests the nature of the poetic craft in these books.

Bakhtin's concept of "heteroglossia" (defined in "Discourse in the Novel") is salient here. I use "heteroglossia" in this instance to refer to the hierarchical interactions of languages within a text and the refractions of an author's voice

[12] Fuks et al note the importance of these two theorists when conducting any research on medical dialogues. In particular, "Foucault's analysis of meaning as contingent upon the field in which it emerges" and "Bakhtin's concept of *heteroglossia* … as it affects metaphor, narrative performance, and the pragmatics of meaning" with reference to the clinical interview (307).

within any literary text—in this case, poetry—to draw attention to inequalities or social divisions within society.

It is true that Bakhtin was writing about prose when he described heteroglossia—indeed, he distinguished the heteroglossia of the novel from what he perceived to be the univocal language of poetry. But Michael Eskin (2000) has argued that Bakhtin's concept of a socio-politically aware heteroglossia is as much in evidence in poetry as in prose—more so, even; the poem "bring[s] about a communal language and thereby allows for sociopolitical critique"(Eskin 389). Mara Scanlon (2007) and Elena Semino (2012) too, have challenged the notion of prose's monopoly on the heteroglossic mode and suggest that it is "partly explained by Bakhtin's own agenda, which was to identify the linguistic essence and uniqueness of the novel as opposed to other literary genres, and poetry in particular" (Semino 28). Moreover, Semino adds that Bakhtin's views also highlight how, in the early 20th century, it was still possible for a scholar with an exceptionally wide knowledge of European literature, including English literature, to relegate the use of stylistic variation in poetry to marginal, "low sub-genres"(28). Now, however, "[c]ontemporary Anglo-American stylistics has moved on … It has acquired the tools for investigating the linguistic heterogeneity of texts that Bakhtin was concerned with, and it has applied them to the analysis of a wide range of texts, including poetic texts" (Semino 29). Therefore, just as Bakhtin saw a polemical edge to prose that employed a multi-voiced discourse, polyphonic poetry can be viewed as "shed[ding] light on an alien world" (Bakhtin, "Discourse in the Novel" 287) in a subversive way.

In many of these medical poems, we read "another's speech in another's language, serving to express authorial intentions but in a refracted way" (Bakhtin 324). The language of medicine, used mimetically (when the speaker or author is relaying the speech of, or ventriloquizing, the doctor), "constitutes a special kind of double-voiced discourse" (Bakhtin 324) and reflects the poet's polemical intent, as well as his or her attempts to universalise personal medical encounters authentically, using all of the voices needed to enact experience.

Pertinent, too, is Bakhtin's concept of "a professional stratification of language" (287) common to 'insiders' within institutions. When medical language as a "social dialect" (Bakhtin 287) is appropriated by poets writing on a medical theme, then, the act can be regarded as an intentional acquisition and manipulation of a language from a particular specialism—a power-play, a satirical act of mimesis. "[T]he word does not exist in neutral" (Bakhtin 294), and medical language is adopted by these poets in recognition of its implicit authority and impenetrability.

By extension, contemporary doctor-poetry that uses language which is deliberately colloquial, in direct opposition to medical diction, can also be viewed as subversive or, at the very least, a device to 'show up' the exclusivity and impenetrability of the language of doctors and medical institutions. By means of ventriloquism, parody and the presentation of dialogues between the clinical and the colloquial, poets who showcase doctor-patient talk do so with an agenda.

It has been postulated that "Foucault's re-historicising of the medical present offers a more suggestive and wide-ranging critique of the implications of medical knowledge and the doctor-patient relationship than empirical sociological accounts of the hospital experience have achieved" (Downing 37). However, contemporary sociological and sociolinguistic studies also offer a relevant way in which to frame the Foucauldian and Bakhtinian readings I have referenced because they, too, assert that key to the power of any group is its language:

> The exercise and maintenance of social power presupposes an ideological framework. This framework, which consists of socially shared, interest-related fundamental cognitions of a group and its members, is mainly acquired, confirmed, or changed through communication and discourse. (van Dijk 21)

The most studied area of inequity in medical and lay interactions is the doctor-patient interview. Studies suggest that these conversations are largely controlled by the doctor: "By questioning, by interrupting, and by otherwise shifting the direction of conversation from nontechnical problems to technical ones"

(Waitzkin 231), the doctor dominates the exchange, manipulating its direction and its mood. This is a situation presented not only by the patient-poets: Colquhoun often depicts the doctor in his poems as biomedical inquisitor and the patient as the thwarted teller of a personal story. In contemporary medical poetry, these doctor-dominated exchanges are maligned and undermined, the poem acting as a medium for the demythologisation of the "godlike" (West 151) doctor and the empowerment of the patient's hitherto repressed or depersonalised perspective.

This returns us to the trend toward narrative medicine and medical humanities courses in universities and the growing relationship between medicine and literature in general. These poems are in sympathy with current sociolinguistic scholarship in the context of medicine which champions the personal over the clinical and values the co-construction of a doctor-patient narrative over a doctor-dominated one. These ideas were brought to prominence by medical sociologist and sociolinguist Elliot Mishler, who identified counter-productive tensions between the "voice of medicine" (190) and the "voice of the lifeworld" (190) in doctor-patient encounters in *The Discourse of Medicine: Dialectics of Medical Interviews* (1984). Mishler applied German philosopher Jürgen Habermas' *The Theory of Communicative Action* to the medical interview, employing the term 'lifeworld' to signify the daily psychosocial life of the patient—his or her family life, job, social and economic status—as opposed to the biomedical realities of his or her disease or condition.

By analysing the discourses of the lifeworld and the biomedical world via the doctor-patient interview, Mishler was able to give verbatim examples of the interactions of the two respective languages. Mishler's "voice of medicine" (190) is defined in *The Discourse of Medicine* as the scientific language, position and perspective of the physician. The "voice of the lifeworld" (190) is, by contrast, that which is derived from the everyday personal and psycho-social context of the patient—aspects of his or her family and social life that may have an impact on the course of his illness and treatment. For the sake of this thesis, it can also be construed as the voice of the physician's own personal and psycho-social context,

one which is often in conflict with the more scientific and clinical one. In the doctor-poetry to be discussed, this voice is most in evidence when the subject is familial illness in which the doctor-speaker is involved and personal and professional understanding and experiences of the situation are in conflict.

Medical educational institutions and sociological commentators today encourage physicians to listen to the patient's personal history, not just to his or her medical history and to recognise the voice of the patient as equal to their own in authority and usefulness. Scholars at the forefront of discourse analysis present the process of diagnosis as a dialogue between doctor and patient through which an illness is *discovered* (not *diagnosed*), its narrative constructed from the talk of both parties. Medical students and clinicians are now being advised to revive "[t]he lost tradition of narrative … in the teaching and practice of medicine" and to see it as commensurate with physical testing as a method for diagnosis (Greenhalgh and Hurwitz 50). Contemporary medical poetry seems to share this cognisance of the state of doctor-patient interaction. Mishler's two conflicting voices—those of biomedicine and the lifeworld—are readily revealed in much medical poetry, and they are associated with the relative power status of the doctor and the patient during the medical interview or encounter. Furthermore, the modes of behaviour and language that may ameliorate the doctor-patient relationship are often implicit in the poems that see personal interactions as more intrinsically valuable than advanced computer-assisted diagnostics. As Thernstrom expresses it in "The Writing Cure": "The past five years have seen an explosion of writing about illness by both physicians and patients who—like the Romantic poets during the Industrial Revolution—are trying to restore a sense of meaning and healing to counter the dehumanising effects of technological explosion" (Thernstrom 44).

Research Question and Method of Argument

My research question in the critical component of this thesis, then, has been the following: How are biomedical discourse and the discourse of the lifeworld used and presented in contemporary New Zealand poetry, and to what effect?

My argument is that these medical poems, from doctors', patients' and parents' perspectives, are doing much more than some reviewers and critics would seem to suggest: They are not merely acting as platforms for poets to describe their personal medical experiences or express their feelings about them. Nor are they "blurting" at the expense of craft. Rather, they are lyric poems in the truest sense. In *Lyric*, Scott Brewster describes the "well-made" (101) lyric of the "past fifty years" (101) as "a poem of experience that maintains a unity of tone and feeling to express a coherent poetic voice" (101). And whilst the poems are often polemic in nature, the polemic goes beyond mere complaint or social critique. By means of their expression of a tension between Mishler's two "voices" (their perspectives and their languages), these poems not only draw attention to the accepted authority of medicine and its objective, scientific basis over the patient's relatively inferior, personal, subjective position, but also to the inadequacy of medical language in the context of doctor-patient discourse—its propensity to impose and confound. Also implicit in a number of the poems are ideas regarding the importance of "individualising" (Downing 37) patient care and experience, allowing the patient's own voice to be heard, unobstructed by the depersonalising "biomedical voice," and heeded by the medical professional.

These poems on a medical theme, from both doctors' and patients' standpoints, affirm the legitimacy of a non-medical, personal perspective of experience, often by effectively harnessing or destabilising the dehumanizing "language of the oppressor" (van Boheemen 32), adding medical diction to a rich and potent heteroglossia, often juxtaposing it with vernacular or lyrical language, as well as religious diction, in order to highlight medical diction's otherness and distancing effects—its "alienating presence" (Green, in Green and Ricketts 334).

Like the contemporary American poet Tony Hoagland, who places himself "equidistant between … the confessional … and the social" (Interview), the poets whom this critical component takes as its focus have a perspective and language that acknowledge the heteroglossic possibilities through which poetry from multiple perspectives, based on personal experience, "can become more of an exploration

than a simple experience of crisis and resolution. Less like therapy and more like a salon of interesting talkers" (Hoagland Interview).

Read together or singly, these poets resist the voice of medicine that (unintentionally) makes meaning impenetrable, and makes a passive object of the patient. There is a not unsurprising link between this type of poetry and the rationale behind narrative medicine courses that teach literature to trainee doctors, asking them to imagine their patients as characters, like the ones about whom they read in novels and stories: "Thinking of patients as characters isn't meant to objectify them but to amplify the focus on the individual who happens to have a disease instead of concentrating on the disease that happens to reside in a person" (Baruch 465).

The type of medical poetry to be examined in the critical component is not merely autobiographical, not merely medically themed, but, more significantly, socially observant and reflective. It is poetry of and from the lifeworld that takes into account the spiritual and psycho-social aspects of illness and treatment as well as the biomedical ones, and universalises them. Beyond the realms of subversion and social critique, these poems are lyrics that transcend individual experience to suggest, as the lyric often does, larger, more collective human concerns. The best of them also transcend their authors, as David Lindley describes in his book, *Lyric*: "Craft can turn the poem into an object seemingly independent of its writer as a subjective individual" (80).

This transcendent quality is particularly evident when the term 'confessional' becomes applicable not only to the work of poets writing about personal medical experience, but also to the nature of the poems themselves. Doctor-patient discourse sometimes tends towards the language of the (religious) confessional (Foucault, *The History of Sexuality* 59)—the mode of priest and confessor. This mode highlights the relative power status of doctor and patient, again, but it also articulates doubt and the desire for direction or explanation inherent in experiences of illness and suffering, from the perspective of doctor, patient or parent.

Most significantly, perhaps, religious language often bridges the distance between the biomedical and mystical authority of the doctor and the lifeworld context of the patient (or physician), providing a meeting-ground of hope and communion, a transcendent point at which biomedical/lifeworld concerns are mediated. The use of religious allusion and diction gestures towards the mythic in a transformative way, working to resolve the conflicts/tensions in many of these poems.

That said, here is how I plan to make this argument:

Chapter Summary

In the first chapter of the exegesis, "The Doctor-poets," I will refer to the poetry of Glenn Colquhoun, Angela Andrews and Rae Varcoe in order to illustrate the ways in which the first-person voice of the doctor is adopted to draw attention to the inequalities between doctor and patient—sometimes on a satirical note, but often more seriously.

I will point out that the way in which the doctor-patient hierarchy is presented in a number of the doctor poems is similar to the way in which it has been observed and recorded by contemporary sociolinguists who note that "the general pattern of social inequality is expressed in medical interviews, as elsewhere" (Hyden and Mishler 178), the medical in-language being one of the key factors in producing and maintaining the inequitable status quo, a concept first addressed in Foucault's seminal *The Birth of the Clinic*.

Frequently, the poems which feature the doctor-patient interview (with a second or reported patient-speaker) employ medical language contrapuntally against the vernacular and personal language of the patient—again, an idea echoed by contemporary sociolinguists specialising in medical discourse who describe a situation where "physician and patient often pursue distinct, and sometimes conflicting, agendas in the medical visit: the doctor's medical agenda focuses on biomedical evaluation and treatment, and the patient's lifeworld agenda concentrates on personal fears, anxieties, and other everyday lifeworld

circumstances" (Heritage and Maynard 359).

In the poems addressed in the first chapter, "The Doctor-poets," the opposing languages and perspectives of doctor and patient make for frequent miscommunication. This miscommunication is presented in a paradoxically simplistic formal frame that consists of parallel assertions, short, basic sentences and predictable repetitions or inversions. These iterative structural characteristics help to convey the idea that misapprehension between doctor and patient is common and seemingly unavoidable—a suggestion to which many sociologists would attest. There is an internal polemic at work in these poems—one that points a finger at two contradictory languages that miscommunicate to the detriment of both parties. Patient talk presented by the doctor-poets is often markedly vernacular, the content personal—even seemingly tangential in places. Certainly, it fits the definition of what Mishler would term the "voice of the lifeworld" (190): the voice that comes from the personal, psycho-social context that strives to be heard within the biomedical context of the clinic.

In accordance with the idea of the "talking cure" (Hustvedt 58) that has been influential in psychoanalysis since Breuer and, later, Freud, patients who are allowed to speak from "the lifeworld" (Mishler 190) are said to be receiving better and more holistic treatment than those whose talk is discouraged or discounted; their narratives are "instrinsically therapeutic or palliative" (Greenhalgh and Hurwitz 49). Now, more than ever, "talking cures" which enable the voice of the patient (Launer 117) to participate in the story of his or her treatment plan are being touted by sociologists and sociolinguists as the way to forge relationships and work positively with patients in general practice as well as in the area of mental health care. Current scholarship on the topic suggests that:

> The doctor's contribution to the story is valuable not as a truth which has prior and superior validity to the patient's truth but only if the patient finds the doctor's contributions to the plot useful. (Launer 3)

It is significant that the work of the doctor-poets signals the same way forward, pointing towards the need for a shared narrative—a dialogue and discourse that work together, rather than at at cross-purposes.

As I will show in the first chapter, where the language of the scientific and the personal come together in the poems from the point of view of a doctor-speaker, we see the linguistic enactment of an internal dilemma: how does the doctor blend two aspects of himself—the clinical and the personal? It is a shift in thinking that mirrors a decades-old shift in medical pedagogy from clinical distance to compassionate solidarity. Frequently, these poems use both the biomedical and personal codes to do the work of the lyric—attempting the expression of a subjective truth—balancing medical language and a singular scientific truth with the lifeworld language of their own personal involvement or experience. The doctor-persona narrating the poem tries to bring the language of one world to another.

This blending of codes, as I will argue, is most obvious in poems about familial illness, where the doctor-persona is also son, daughter or parent. In such instances a conflict often arises between knowing and telling, and frequently the poem's speaker chooses the lifeworld discourse over the biomedical one when dealing with family members, in order that grim prognostic truths are veiled.

In the work of the doctor-poets, religious diction and allusion are regularly employed at the point of crisis where the medical and the personal meet. As I have remarked previously, the priestly or god-like qualities ascribed to doctors can be a source of satire, yet other poems featuring religious diction sincerely aim to reconcile the religious, spiritual aspects of medicine, accepting and honouring the privileged proximity that doctors have to living and dying, and acknowledging the presence of subjectivity, doubt and a 'truth' very different from the one proposed by science. In this way, I will argue, religious or spiritual language becomes a point of communion between the biomedical and the lifeworld voices and perspectives.

In the second chapter, "The Patient-poets," I will discuss the work of C.K Stead, Jenny Bornholdt and Sarah Broom. Autobiographical medical poems

constitute a significant part of each poet's oeuvre and, in common with the poetry featuring the doctor-speakers covered in Chapter One, there is a universalising polemic at work, championing the personal, the "voice of the lifeworld" (Mishler 190), and challenging the impersonality, impenetrability and authority of medicine and the biomedical voice. There is also a transcendent quality to these poems, gesturing towards the resolution of emotional conflicts that emerge as a result of biomedical/lifeworld tensions.

In contrast to the authenticity and democratisation attributed to the doctor-poets' proximity to their subject matter, the predominantly personal voice of these patient poems narrated from an "I"-perspective—the closeness of the subject matter to the poet's own experience—is something that critics find problematic. Can this sort of autobiographical patient-poetry be any more than "blurting on to the page" (Bornholdt in Harvey 57)?

In order to address this question, I will explore the extent to which these poems based on the poets' experiences of personal and familial illness can be seen as socially-aware, carefully-crafted works, far removed from the idea of memoir for memoir's sake. To this end, I will examine the methods by which the poets employ biomedical and lifeworld perspectives and languages in order to draw attention to issues of powerlessness and depersonalisation associated with illness and medical treatment, making a case for the individual voice of the patient, and for the place of subjectivity within a largely objective medical context.

The Foucauldian lens I apply to these poems shows the exclusivity, impenetrability and detachment of doctors' language from the patient's / family member's perspective. The relative power status of patient and doctor is maintained by medical diction via its esotericism and its implicit authority. Lacking understanding, or the ability to bring the subjective to bear on the conversation, the patient loses control over his or her own treatment, while the doctor "can take decisions, draw conclusions, or recommend treatments, without anyone other than another member of the profession being able to challenge their authority and judgement" (Oliver 29).

On occasion, a patient-poet will assume the voice of medicine (a doctor, scientific papers) and use it for powerful subversion. Pertinent again is the Bakhtinian concept of heteroglossia, applicable to poetry that possesses and employs another's language for socio-political comment: "one must take the word, and make it one's own" (Bakhtin 294). I will assert that in the context of medical poetry from the patient's perspective, the appropriation of "the word" (the doctor's voice in the poems) is a direct subversion of the hegemonic aspects of clinical discourse. This is also in keeping with sociological theories regarding medical language as an important vehicle for the perceived authority of the doctor, as already discussed with reference to the poetry of the doctor-poets.

The patient-poets also amalgamate the two languages of biomedicine and lifeworld in an effort to comprehend and present key issues raised by particular medical situations. The objectivity of science and the subjectivity of personal experience, two apparently opposing perspectives, are merged as a means to arrive at a version of truth that is helpful and acceptable. As Foucault suggested, truth is a process, and a communal one at that: no individual or group has a monopoly; "direct appreciation of people's experiences provided a more valid approach to 'truth'" (Oliver 134) than its singular and unequivocal assertion by an institution.

Lastly, as contemplation of the spiritual aspects of illness, suffering and medical practice are articulated by the doctor-poets, the patient-poets, too, allude to the spiritual in their work. Again, religious references and imagery are added to medical and personal diction, enlarging the heteroglossia, with the purpose of articulating a truth beyond the secular and an all-important spiritual facet of the lifeworld—that psychosocial context so vital to successful, productive communication between doctor and patient, which is also a key feature of the universalising nature of these lyric poems. The ironies and ambiguities that arise from contemplation of suffering, life and death, raise questions of faith and comfort, and often the patient-speakers seem to doubt the presence of God. But it is true to say there is frequently a faith at the poems' cores—a faith rooted in compassionate humanity.

Ultimately, we find that the transcendence of illness and medical treatment often comes with a belief in something that lies outside traditional notions of religion. In a medical context in which there appears to be "no god" (Stead, "S-T-R-O-K-E" 27), reminders of the lifeworld such as snatches of diurnal exchanges, interactions with others—as human being and not as patient—enable the patient-persona to survive biomedical experience by means of a transcendent knowledge of community and empathetic human relations amid and despite suffering.

The third chapter, "The Parent-poets," will discuss the work of Ingrid Horrocks, Anne Kennedy and Jessica Le Bas. Although the three collections are based on the personal, familial medical experiences of the poets, they largely eschew I-speakers, perhaps in an attempt to avoid the 'confessional' label, but perhaps also because in the work of two of the three poets the subject matter is the illness of the poet's child. Le Bas uses "she" throughout to name the daughter, "you" for the mother. Kennedy uses the third person to describe the whole family, with herself cast as "the eczema-mother" ("The Bells of Westminster" 2). Horrocks most often uses "she" to describe the female character going through IVF treatment. I have described the three poets in this section as "parent poets," as what brings them into a medical environment is parenthood—responsibility for an ill child in the works of Le Bas and Kennedy, and the pursuit of conception and motherhood in the work of Horrocks. The three poets also have in common the linkage of their poems in journey-like narratives, where the woman persona is in a strange land, learning a new language and mode of navigation. They often using the amalgam of narrative position and biomedical/lifeworld discourse to convey a sense of the problematised position of distance and closeness that she feels about her own situation.

I will examine the effects of the various narrative positions adopted by the poets in these three collections and aim to appraise and account for these perspectives, showing how they may have been shaped by the poet's desire to enact an element of social commentary, thereby creating "a distance, a detachment" (Le Bas, Message to the author, E-mail), to avoid being perceived as "sentimental, or indulgent" (Le Bas, Message to the author, E-mail), and to cultivate a sense of a

personal, medical story's "respectability [and] seriousness in the public arena" (Le Bas, Message to the author, E-mail).

I will also look at the ways in which the two discourses are employed by the poets and to what end. *Mapping the Distance*, *Walking to Africa* and *Sing-song* all raise the question of how to continue the processes of daily life in the face of disruptive, often disturbing, medical treatment, how to achieve some sort of balance between the medical 'mission' at hand and the equilibrium of the family as a whole. The language is key to conveying this, but there are larger, social issues at play, too. As in the previous two chapters, I will argue here that biomedical / lifeworld tensions are conveyed by the interrelationship of their respective discourses. Medical language is presented as dominating, babelesque, occluding meaning and asserting distance between patient / parent and doctor. As in the chapter about the parent-poets, we see that in the poems which features doctor-patient discourse, the language of the doctor is very often characterised as distant, insistent on objectivity and, albeit unintentionally, antagonistic to the patient's subjective, personal voice, thus mirroring sociological observations like those of sociolinguists Treichler, Frankel, Kramarae, Zoppi and Beckman (in Van Dijk 40) who posit that the doctor's focus on clinical detail and biomedical talk in doctor-patient interviews usually precludes and interrupts the full expression of the patient's medical concerns and the concerns associated with their lifeworld or larger social and personal context.

In all three collections, translation and assimilation of medical language are fraught but necessary processes, and often both the patients and their accompanying family members are left with ambiguity rather than clarity. However, the almost ventriloquistic utilisation of medical language by these poets is again in keeping with Michael Eskin's argument with regard to Bakhtinian theory that "far from being relegated to the realm of discursive and, by extension, sociopolitical monologicity, poetry may plausibly be construed as the dialogically and sociopolitically exemplary mode of discourse" (379). This type of poetry, with multiple voices, highlights issues of power and inequality as well as competing agendas by 'borrowing' the language of medicine and medical professionals and

countering it with the more vernacular, personal language typical of the layperson patient or parent new to the medical environment.

In keeping with the Foucauldian notion that scientific knowledge and language are no more "true" than the language of any group or institution, that "the pursuit of truth was a continual process of seeking" (Oliver 132), it follows that the poems draw attention to the need for the colloquial to modify the authority, esotericism and depersonalisation inherent in clinical discourse, thereby coming closer to the truth of the matter. The truth of the matter may not equate to a certain diagnosis or a successful treatment, but it does necessarily involve communication and a shared understanding between doctor and patient/parent.

I will argue that running through all three collections is an overarching argument for an emphasis within the healthcare system upon personalised patient care, the assertion of the patient's individuality and dignity—the patient's story—and a defiance of the impotence and dehumanisation often imposed by the medical interview, examination, treatment, and the very language in which these processes are conducted. The poems are polemical, desirous of change where change is needed, and they echo current sociological opinion: "The exclusion of social context from critical attention is a fundamental feature of medical language, a feature closely connected to ideology and social control" (Waitzkin 232).

Lastly, as with the poetry of the doctor-poets and patient-poets, I will demonstrate that there is, within these three collections, a theme of seeking answers to questions larger than the biomedical and the personal—spiritual questions regarding the purpose of suffering and the robustness of faith in trying times. As in the other collections, spiritual language is employed to express the polar opposites—doubt and hope—that accompany the journey towards health or acceptance, and also to convey a sense not only of the authority of healthcare professionals, but also, their beneficence when they aim to provide what solace they can beyond their medical roles. Myth and religion also offer a point of transcendence, functioning, as they do, outside, and perhaps above, scientific/biomedical knowledge.

Chapter 1

The Doctor-poets: Glenn Colquhoun, Angela Andrews and Rae Varcoe

New Zealand's most prominent doctor-poet is Glenn Colquhoun, whose collection, *Playing God*, is one of the country's best-selling and most well-known books of poetry.[13] It has been described in the media as "a revelation" (Freeman) in terms of the way in which the author's "dual life" (Freeman) is explored, and how "our attitude towards doctors … changed with [its] publication" (Freeman). In *Playing God*, Colquhoun was perceived to be acting as a medium between *them* and *us*—speaking "not only eloquently but with feeling" on behalf of an "all-knowing but seldom communicative profession" (Freeman).

The interior life of the doctor is a fascinating topic. Since there were doctors, there was a mystique surrounding them—a mystique enhanced by their almost priest-like closeness to human experience and suffering.[14] In *Playing God*, Colquhoun demystifies medical practice, using a self-deprecating, first-person, doctor persona to mediate between the personal and the professional, "enact[ing] for us the difficulties of his profession and his humanity" (Hero 203).

Following in Colquhoun's footsteps to some extent are doctor-poets Angela Andrews and Rae Varcoe, whose collections also offer insights into doctors' personal and professional lives and explore the dynamic between patient and doctor. Andrews' *Echolocation* invited praise from reviewers for its ability to "touch a common emotional pulse" ("A Chat with Angela Andrews" par. 11). Varcoe's first book, *Tributary*, "a range of poems that builds on personal experience" (Sweetman par.2), has been described as "honest," and "an accessible, enjoyable read" (Sweetman par. 2).

In addition to lauding the approachable nature of text and speaker in all three doctor-poet collections, reviewers have focused on their autobiographical

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[13] "It became the first poetry collection to win a readers' choice Montana Book Award and cemented Colquhoun's place in the public consciousness as a doctor poet" (Boniface par.3).

[14] In *The Birth of the Clinic*, Foucault describes the medical profession as "organized like the clergy, and invested, at the level of man's bodily health, with powers similar to those exercised by the clergy over men's souls … " (31)

aspects. The personal basis of the poetry has been commended for being compelling, emotive and brave—but also for being democratic, levelling the ground between physician and patient. Indeed, Colquhoun has been "popularly picked as the successor to Hone Tuwhare as the 'people's poet'" (Bisley par.6). Another comparison places Colquhoun alongside "William Carlos Williams in the precision of his observations, and his attention to ordinary lives and ordinary details, the same love for people and people's lives" (Jackson in Bisley par. 9). Indeed, it could be said that, like Williams, who "sought to express his democracy through his way of speaking … to speak on an equal level with the reader, and to use the language and thought materials of America in expressing his point of view" (Lochor 577), Colquhoun is perceived as speaking to and for the average New Zealander.

In this chapter, I will argue, however, that there is far more to the medical poems of Colquhoun, Andrews and Varcoe than the democratic and confessional sharing of personal medical experience. In poems from the perspective of I-doctor, there is a polemical voice that calls into question the authority and impenetrability associated with the physician's role—an authority that often imbues the doctor with powers and prowess that he or she neither innately possesses, nor desires. Colquhoun, Andrews and Varcoe are aware that medical authority is partly cultivated and maintained by physicians' scientifically-based, esoteric language that, to the patient, is often an impenetrable "sociolect" (Vice 18), a language that eschews the subjective for the objective, the personal for the clinical. Accordingly, all three poets explore the tensions between medical and lay language and the internal conflicts inherent in the role of clinician, a vocation grounded in the objectivity of science yet framed by the experience of others' suffering, thus requiring a negotiation between clinical distance and compassionate involvement, the professional and the personal.

I will argue that these medical poems convey tensions, questions and critiques pertaining to the physician's role through a careful manipulation of lifeworld and medical imagery, ranging from juxtaposition to blending.

In addition, I will contend that the doctor poets use lifeworld and medical discourses in a manner that approaches Bakhtin's notion of the heteroglossic. That

is, in these poems, the language used by doctors within clinical environments is presented as a potent "social dialect" (Bakhtin 287), "a professional stratification of language" (Bakhtin 289) that arises from its particular context. For however objective medical discourse purports to be, Bakhtinian analysis posits that any language, innately, "is not a neutral medium that can be simply appropriated by a speaker, but something that comes to us populated with the intentions of others. Every word tastes of the contexts in which it has lived its socially-charged life" (Holcombe 1). This "biomedical voice" (190), as the sociologist Elliot Mishler calls it, is juxtaposed in many medical poems with what he terms "the voice of the lifeworld" (190)—the voice of the patient's personal, psychological and social context. This enhances the esoteric, impenetrable nature of medical discourse and highlights the culpability of "the biomedical voice" (Mishler 190) in making and maintaining a hierarchy of power that places doctor above patient, professional above personal.

The doctor-poets frequently undermine the authority and influence of their biomedical role by tempering scientific language with more colloquial language—sometimes, even, the doctor- speakers narrating their poems struggle with whether silence is preferable to speech when, in a particular context, the scientific truth may be too coldly clinical. This issue is problematised further in texts where the doctor's own family member is ill. The question of how a doctor should communicate with an ill loved one is brought to the fore in some of these poems, and the balance between the personal and medical contexts and perspectives is one of the key tensions, the doctor's own "lifeworld" voice (Mishler 190) vying with the "biomedical voice" (Mishler 190).

Lastly, a third repository of imagery and discourse manipulated by the doctor-poets is that of religion. They use religious imagery, diction and allusion, first, to suggest the doctor's perception of the power with which he or she has been invested and to draw attention to the likeness of the doctor-patient interview to the practice of confession. In addition, religious imagery and language is used to express what can be viewed as the spiritual aspects of the doctor's role—its more-than-

secular proximity to life and death. Indeed, the religious discourse featured in the poems often signals a point of mediation and transcendence in these poems, where the tension and conflicts between two competing languages and perspectives can be resolved.

Glenn Colquhoun

In Colquhoun's more satirical poems, reflecting sociological opinion, the voice of doctors, the "biomedical voice" (Mishler 190), is often characterised as implicitly authoritarian and singularly objective. Though this may not be a physician's intention, it keeps a distance between doctor and patient, expert and layperson, proving impenetrable and mystifying from the perspective of patient in the context of the doctor-patient interview. Scientific language complicates and obfuscates, while placing itself above and beyond the more colloquial, vernacular language of the patient. As Peter Ubel suggests in his 2012 book on the topic of doctor-patient communication, "[t]he first barrier to shared decision-making … is a language barrier" (83).

Colquhoun is especially attuned to the misunderstandings that arise from doctor-patient talk, consisting, as it does, of innately conflicting discourses. His poem "A brief format to be used when consulting with patients" acknowledges the ways in which generic doctor and generic patient miscommunicate. It features a seemingly simplistic series of parallel constructions in which the doctor and patient take turns to talk past each other until they are both 'sure' of nothing:

> The patient will talk.
> The doctor will talk.
> The doctor will listen while
> the patient is talking.
> The patient will listen
> while the doctor is talking.
> The patient will think that the doctor
> knows what the doctor is talking about. (1-8)

The pattern established thus far in the poem ensures that we can anticipate the next lines—"The doctor will think that the patient / knows what the patient is talking about" (9–10)—a parallel inversion of the previous two lines. By means of predictable parallelisms and simple syntactical inversions, we are led to believe that patient and doctor are talking at cross-purposes, despite the seeming clarity of each participant. To that end, the modal verbs lend the poem's assertions an ironic certainty, "will" suggesting something we expect to happen. The paradoxical nature of the (mis)communication between doctor and patient is underlined, as is the speaker's satirical cognisance of the course the interview will take. The implication is that doctors are not taught how to communicate clearly and effectively with their patients and thus these counter-productive dialogues persist in modern medical practice:

> These kinds of miscommunications are serious problems, because they create a false sense of confidence in both doctors and patients that they understand each other. An oncologist tells a patient that the X-ray shows she had a "complete response" to chemotherapy. To a patient, that phrase sounds like "You're cured. The cancer is gone." But to a physician, that phrase means "There is no radiographic evidence of tumour," even in circumstances when the doctor knows the cancer is incurable and inevitably fatal. (Ubel 85)

Candace West, in her book *Routine Complications: Troubles with Talk between Doctors and Patients*, comes to the conclusion that "physicians' performance of their clinical work is ultimately contingent on the ordering of their talk with patients" (52). Most seriously, "in medical encounters, lives may be lost in the wake of misunderstandings between physicians and patients" (97), so what she terms "mutual intelligibility" (151) is essential. Unfortunately, "the examination of actual medical encounters indicates that questions and answers do not operate to effect a two-way flow of information between patients and their doctors" (151) and "for at least thirty years, studies have indicated that physician-patient dialogues are

particularly vulnerable to mishearings and misunderstandings by participants" (97).

While Colquhoun suggests that understanding between doctor and patient is not always easily achievable, he also implies that it is the clinician's responsibility to employ correctly-aimed talk that provides comprehensible answers and plain-language explanations for the patient. To this end, and comically, in one poem, the doctor-speaker tries to do just this. In fact, he employs multiple approaches in order to explain the effects and interactions of medication to his flummoxed patient. The title of this poem is as long as the patient's question: "She asked me if she took one pill for her heart and one pill for her hips and one pill for her chest and one pill for her blood how come they would all know which part of her body they should go to (Colquhoun, *Playing God* 14).

The poem alternates (reported) patient-speaker and doctor-speaker, enumerating questions and answers. Cumulatively, the patient's confusion builds, until the "magic word" has been found, and she is satisfied. But this only after the doctor has tried many different approaches, including the scientific approach, his default mode:

> I explained to her that active metabolites in each
> pharmaceutical would adopt a spatial configuration
> leading to an exact interface with receptor molecules … (1-3)

The clinically-phrased answer fails: "She told me not to bullshit her." (6) The contrast between the medical explication of the medication's method of action and the woman's response is stark—and humorous. She manages to destabilise the doctor's explanation by means of a language that is entirely removed from and antithetical to his. They have not yet reached a point of understanding, and the patient's response indicates aggravation and frustration. It is also interesting to note the reversal in terms of syntax. The title of the poem is her lengthy question. The doctor's lengthy answer reduces her to unbelieving (and diminished) bluntness.

The collision of conflicting discourses continues when the doctor tries

simplistic metaphor: "I said that each pill was a key and that her body was /ten thousand locks" (13–14). The patient finds this approach offensively facile and responds with wordplay of her own: "She said she wasn't going to swallow that" (15).

It is only when he says, "It works by magic" (16) that the patient is satisfied and asks "why [he] didn't say that in the first place" (17). The irony and bathos at the end of this poem are brought about by the inability of two languages to find a meeting point for the most part of the conversation, giving credence to sociologist West's suggestion that the "*essentially* asymmetrical" (23) relationship between doctor and patient renders "communication between [them] … theoretically impossible. Exchange is prohibited when parties to communication processes do not have equal access to the symbolic meaning of information they transmit" (23). However, although Colquhoun's ending is deliberately amusing, it can also be read in such a way as to to back up Hanne's opinion that "[p]hysicians need a repertoire of metaphors relating to the management of sickness from which they can choose the most appropriate one for each patient, as well as the confidence to suggest new metaphors" (229). In this case, the patient is happy to believe in the pills' magical amalgam, and so that particular answer is the most suitable.

Much of the satire in the poem is directed at the patient's perception of doctor himself as magical deity, able to provide (and explicate the workings of) the panacea. These (mis)perceptions influence the language of both parties. Indeed, this idea of the mystic/doctor is present throughout *Playing God*, exemplified by the section entitled "Spells," which includes a host of curses, conjurations and incantations to "be used when reversing the effects of a general anaesthetic" (*Playing God* 65) or "to be used in the mending of broken bones" (*Playing God* 61). There is humour here, but also an expression of the unrealistic expectations held by patients, in part due to their position outside a science that is key to their well-being.

In terms of positioning, there is an interesting placement of doctor and patient in "She asked me …", one that upholds the opinion of other contemporary sociologists such as Fielding and Evered, who have found that "doctors may evaluate

their patients differently depending on whether they have a dialect or sociolect" (Van Dijk 37), both markers of class and education. A like element is discernible in the "bullshit" (6) remark of the patient and the ungrammatically long question which is the poem's title. The title, which is reported speech from the patient, together with the patient's reported responses, characterises her as ineloquent and uneducated. It follows that the doctor has had to resort to talking down to her from his position of better knowledge.

Colquhoun's doctor-speaker is clearly well-intentioned and good-humoured, conscious of his responsibilities. Nevertheless, an implicit sense of his prejudice pervades the poem, which suggests that Colquhoun and his doctor persona acknowledge the persistence and rigidity of the doctor-patient hierarchy. It could be suggested, in fact, that in this poem the poet echoes erstwhile doctor Peter Ubel's confession with regard to the linguistic basis of doctors' authority: "Jargon was key to my confidence—nothing like Latinate phrases to make me feel smart" (82); "[j]argon … creates space between professionals and laypeople" (83).

Although the poem has the self-deprecatory humour representative of many doctor personae in *Playing God*, there is also a weariness to his tone suggesting that this doctor understands that there are just some things patients will never comprehend—least of all "active metabolites" and "receptor molecules" ("She asked me …" 1–3): all attempts at medical explication will just be received as either "bullshit" (6) or "magic" in this context of patient ignorance (16).

In "She asked me …", the doctor attempts to provide a factual, objective answer, but then resorts to answer from a subjective reality that will be accepted by the patient. In "A mini mental status examination" (the name for the test administered routinely to dementia patients to map their decline), an antithetical situation is presented, this time from the realm of mental health/gerontology. An unnamed patient presents with dementia. She can remember things from her deep past, but not the present. She can recall "The correct way for casting on a row of stitches" (9) and the lines of "Old Meg she was a gypsy" (15) but, the doctor-speaker recalls, "She told me that my pen was a dagger and that my watch was a fading rose

on my hand" (11–12).

Towards the end of the poem, although the doctor-speaker does not employ difficult medical terminology, he nevertheless speaks from the world of objectivity and fact when he tells her "what day it was and the name of the place where we had talked" (23–24). These are both basic, factual assertions and ones that impose a cognisance of reality, sanity, a time and place no longer her own. What the doctor-speaker exemplifies in these lines is termed by sociologist Howard Waitzkin the "unintentionality of medical social control" (227), meaning that much of the power wielded by clinicians is implicit rather than overt, exercised without the conscious intention of the individual to assert or impose authority. Here we see how inappropriate scientific truth is in this context, as does the penitent doctor who reflects, "I said her name like a cold flannel wiping away the food from/ someone's mouth" (25–26). The simile suggests a patronising diminution of the woman. The imposition of the realities upon her are like reminders of her growing disability (much as wiping the mouth of someone after a meal is a gesture that humiliates). Similarly, the pronoun "someone's" (26) smacks of the dehumanising effect of his approach—he has treated her according to a code of practice, thereby making her into a cipher; he has not shaped his approach to accord with this particular woman. Colquhoun demonstrates here how the assertion of the objective, typical of the voice of science quashes the subjective perspective of the patient. In a speech given to an assembly of his medical colleagues in 2009, he asserted: "We have excluded the subjective, but [medicine] is a very subjective artform" (in Yeats par. 45).

In the final lines of "A mini mental status examination," the doctor realises that he has disenabled the patient by altering her mental timeline, adding a perplexing linearity and reality to her world— a world that "was already backwards and why / make it worse" (13–14). The last line of the poem is isolated, and in it the doctor speaker confesses that "There are times when I wonder why I did" (27). What was the purpose of alerting her to her own confusion with perplexing questions? This is the essence of Colquhoun's collection: a stock-take of the "playing god" aspects of the doctor's role. Colquhoun calls into question the doctor's power to

assert a different reality, disrupting the narrative of another's mind. He challenges the imposition of clinical objectivity upon human subjectivity and highlights the ways in which even a standard test like the Standardised Mini Mental State Examination used by geriatricians to assess dementia patients is a kind of unwelcome control.

Poems like "A mini mental status examination" exemplify Colquhoun's description of *Playing God* as his "confessional … diary of doubt" (Colquhoun Interview with the author). For Colquhoun does write "poems that are willing to admit ambiguity and contradiction, fear and bravado, confidence and doubt" (Hero 203), and it is perhaps this amalgam of semi-autobiographical poetry with a serious theme, playful language and an appreciation of the subjective that accounts for the widely popular appeal of his poetry—an appeal that sees him included in the section entitled "The Popular Poem" (293), alongside Hone Tuwhare and Sam Hunt, in the recently published *99 Ways into New Zealand Poetry*. Academic and poet Anna Jackson also attests to Colquhoun's attractiveness to a mainstream audience:

> Like William Carlos Williams, and like Hone Tuwhare, he has been called a 'people's poet'—writing poetry that is easy to read and enjoy, and ... like Hone Tuwhare, he writes poetry that is both powerful and accessible. (in Bisley par. 10)

Tuwhare is a useful parallel for another reason. Of Tuwhare, poet Bill Manhire has said that he "can sound within the space of a couple of lines as if he's both at church and down at the pub" (Manhire "Dirty Silence" 17). By this, he refers to the tone and style that see Tuwhare slide from one register to another in a line, a phrase, in order to destabilise, to subvert, challenging traditional authority figures by challenging traditional language. This is part of his everyman appeal. Colquhoun's stance and narrative style in *Playing God* are comparable. Colquhoun perceives that medicine is a hegemonic field. He understands that medical language is a divide between specialists and laymen, and he is happy to demystify and destabilise that border.

It is worth examining the origins of Colquhoun's populist, demotic voice in the *Playing God* poems—one he cultivated to do away with any sense of an inviolable authority surrounding doctors—in order to apprehend the polemic that drives the poetic, the way he uses "irony and understatement and metaphor to make a point, prick bubbles" (Colquhoun, "All Our Days" Introduction 3). These are lexical tricks that he learned at his father's workplace. He recalls visiting building sites often, listening carefully to the men's banter:

> The way they talked was funny and what they said was clever … They would say something by not saying it or by overstating it or by turning it upside down. They would compare a character to what they are most obviously not, pretend the dead were alive, and deliberately mix up associations and generally tutu with the whole world." ("All Our Days" 3)

In *Playing God*, the same sort of talk is taking place: testing, teasing and irony. Colquhoun uses wordplay to level, to invite ambiguity and to uphold the power and validity of the subjective. His writing demonstrates the (originally Bakhtinian) precept of pluralism and hybridity in literature, an idea recently championed by Salman Rushdie in his essay on postmodernism entitled "Is Nothing Sacred?":

> The only privilege literature deserves—and this privilege it requires in order to exist—is the privilege of being the arena of discourse, the place where the struggle of languages can be acted out. (988)

Colquhoun explains that part of the potency of the jocular talk among workmen that he overheard as a young man, was its unlikely but ingenious juxtapositions: "The disparate are especially related. It was deeply subversive. It meant nothing and everything at the same time" ("All Our Days"3).

Accordingly, this idea of destabilising wordplay is at the heart of the presentation of doctor-patient discourse in *Playing God*. The apposition of doctor and patient voices draws attention to the hierarchy at play between biomedical and lifeworld languages and often invites a subversive, satirical reading. In fact, the very appropriation of clinical discourse by the poet can be viewed as an example of Bakhtin's heteroglossia—multiple languages used in one text to reflect a socio-semiotic status quo, one that changes "as systems change" and cultures shift (Adams 1259).

Certainly, in "Discourse in the Novel," Bakhtin was making a case for the different nuances of language adopted by novelists in order to present the intersection of heterogenic languages, oftenwith polemic intent. But the same appropriation of languages from different social contexts and positions of relative power and impotence can be found in contemporary poetry, reflecting the interactions and negotiations of differently placed individuals—doctor and patient, for example. Indeed, in his essay "Bakhtin on Poetry," Michael Eskin argues that poetry seen through a Bakhtinian lens takes on "socio-political significance as a potentially subversive and counterhegemonic force" (388). Furthermore, in its heteroglossic aspect, it facilitates "the creation of mutual understanding and, concomitantly, the subversion of sociopolitical, potentially repressive, authority" (389).

A fine example can be seen in Colquhoun's poems that deal with life on the wards. He makes it clear that there are different languages at work in different departments and areas of the hospital. He gives the reader the impression that this was a lesson learnt early in his career, in the section of *Playing God* called "A Portrait of the Doctor as a Young Man," which gives it a *bildungsroman* feel—a sense that this is the part of the book which discusses the making of him as a doctor, his journey from innocence to experience and his acquisition of the blended language with which to describe it.

In the poem "A Medical Education," for example, the medical-student speaker lists what he has learned in different areas of the hospital whilst on rotation

and observation “In obstetrics” (1), “In surgery” (4), “In geriatrics” (8). These experiences are conveyed to the reader through figurative language, and the metaphor or simile is usually related to daily life—the student relies on the familiar world of the layperson to assimilate medical knowledge: he likens hospital experiences to lifeworld experiences so as to better and more empathetically understand them; the impression we get is of the young doctor still being more in the lifeworld than the biomedical world. For example, “In A&E I learnt that the body is a fish. Some gasp for air as though / they had been caught” (“A medical education” 10–11). Again, “In orthopaedics I found the body can be broken. Bones make / angles under skin as though they were part of a collapsed tent” (“A medical education” 17–18). Both images are associated with outdoor life; the doctor, still more of a boy, used to fishing and camping, applies the known to the newly learned, empathising with the patients' experience through activities within his own experience. He ends on a humorous note: “But in the delivery suite I learnt to swear” (“A medical education” 22). Here, truly empathetic understanding must break down—childbirth is beyond his ken—yet still he manages to share the language of the women in labour. In addition, implicit in this amusing admission, is an awareness of the women’s singular authority in the delivery room, the power of their language outside the medical or scientific.

Playing God also includes poems whose subject matter combines the first-person doctor’s perspective with the personal—the filial. These feature an amalgam of languages and tones that serve to convey a sense of the difficulty involved in mediating between two positions and attitudes. This dual perspective is best exemplified by his series of poems about Parkinson's Disease—an affliction with which Colquhoun's father was diagnosed at thirty-eight (“The Therapeutic Uses of Ache” 2).

Colquhoun's “Parkinson's Disease” sequence (1.–8.) presents the doctor-son’s negotiation of the clinical and the personal that manifests itself in the mixture of languages used to describe the father's illness and the son's response to it on both a personal level and, retrospectively, as a trained health professional. At the centre of

the series is a recognition of the foreknowledge bestowed upon doctors—a prescience Colquhoun explains in an autobiographical essay: "Medicine confers on those who practise it the knowledge of how their loved ones will die. We see the weapons arrayed and wonder at times which will be turned on us. It allows us warm deaths in a way, the feeling of being slaughtered by a friend perhaps, knowing exactly what is to come once they slip out of the shadows" (Colquhoun, "Middlemore is my Hospital" 120).

The sequence had its nascence while Colquhoun was at medical school. In his fifth year, part of the course demanded a long piece of written reflection upon a selected patient. He described how he came to write the series of poems to Elisabeth Kumar (neé Marshall),[15] whose Master's thesis involved an extended interview with him:

> … we had to also do a chronic illness study, we had to choose someone and follow them for a period of time … I was just sick of university and the way they assess by that sort of writing or essays and stuff like that, and my dad had Parkinson's disease, so I went to the lecturer and said, Look, this is not hard science. I know my dad pretty well, I've lived with his illness. What if I write you some poems about the experience, and then I get more out of it than just writing an essay. And he's sort of like, oh, um, OK. (135)

The poems in "Parkinson's Disease" (1.–8.), dedicated to Colquhoun's father, move frequently between the familial sufferer viewed from a son's perspective and generic sufferers viewed from a doctor's perspective, and the language and position shift accordingly. The first poem of the sequence starts with a quotation from Psalm 22: "I am poured out like water, and all my bones are out of joint" ("1. Whose disease is it anyway?"). The water image continues as the father is watched by his son, "pushing [his] weight to the / shore of the bed – / where gravity laps" (1. 16–

[15] Kumar now co-facilitates the comparative literature course for medical students at Auckland FMHS with Mike Hanne.

18). Here, the water image complements the heavy, unsteady steps of the man and presages his being overwhelmed by the disease, unable to move by himself. It is a tidal image that can be linked with Colquhoun's personal experience if we align it with the description he gives of watching his father's decline in "The Therapeutics of Ache," and refer back to Psalm 22:

> This is the beauty of the tide gone out over the tight lap of the sea against its belt. Sometimes people seem to make an appearance in their own skin for the first time as though they were stepping out from behind a curtain to take a bow. When the body you are watching fail is a parent all this seems even more poignant, as though the sky and sea itself are melting. (Colquhoun, "The Therapeutics of Ache")

This is overtly the work of the lyric poem: attention is drawn to the universalisation of the personal. The speaker of "1. Whose disease is it anyway?" asks after whom the disease should be named: a long-ago Mr Parkinson? Or perhaps "they should name it after us" (27). His reasoning is based on the fact that the family's experience of the disease has been so all-consuming, so utterly personal. It is interesting to note that the poem's epigraph has placed the point of transcendence almost at the beginning of the poem—its spiritual words come first, then the universalising imagery, then the personal, questioning, secular diction. The poem whittles itself away, backwards, mirroring the disease's erosion of man and faith.

By contrast to the lifeworld focus of "1. Whose disease is it anyway?," in "3. Shaking hands with Mr Parkinson," the sufferer is initially depicted as a patient-figure; the facts behind his tremor are recounted scientifically, in the biomedical mode:

> Shaking hands
> with Mr Parkinson
> is the longest meeting,
>
> hands beating

60 per minute
or 3000 per hour,
or 80,000 per day,
630 million altogether
give or take a few. (1-9)

However, the quantification of the handshakes (the hertz rating of the Parkinsonian tremor) serves to depict the sufferer (the third-person Mr Parkinson of the title) sympathetically, despite (or perhaps because of) the pseudo-satire of the longest handshake. The vernacular "give or take" juxtaposed with the exactness of the calculation helps to imbue the poem with a voice that has components of personal response and medical fact despite the resultant black humour.

By the final stanza, however, there has been a change to the first person with a second-person addressee, and the speaker admits:

I listen closely
to your hands in the wind
to see if they will sing. (22-24)

The son's voice takes over from the doctor's objective one. "I" is more son than doctor. "You" is more father than patient, than Mr Parkinson, and the reader is reminded of the dedication to this series of poems and its Psalm 22 epigraph.

Indeed, more generally, Colquhoun talks of poetry as a vocation that he links to his role as secular and spiritual son: "I call it my Father, my Father's work. I keep saying to myself, I must be about my Father's business" (in Marshall 155).

Beyond the divisions of the biomedical and the lifeworld, then, is a third area with its own imagery and discourse in Colquhoun's poems: religion. At times, Colquhoun incorporates it satirically, to signal and challenge the societal perception of doctors as godlike, but at other times, and more significantly, to draw attention to the elements of the doctor-patient relationship and the practice of medicine that are worthy of reverence.

Given Colquhoun's Seventh Day Adventist upbringing and background (albeit, one he abandoned after training as a minister), it is unsurprising that his poems regularly feature religious imagery and diction. James Paul Gee would term the Seventh Day Adventist iconography and discourse a "secondary lifeworld discourse" (154) to Colquhoun. Medicine as vocation and medicine as responsibility—as duty—are notions that are frequently mentioned by the poet in interviews:

> I always laugh to myself that, in a sense, I've ended up in the ministry, even if it's a small ministry. Not in a preachy way, but it feels intensely spiritual in that small cell, in the consultation, intensely spiritual. So it's still a spiritual fix. Poems and medicine are still two places I go to church …
> (in Marshall 156)

The link between medicine and religion and the investiture of the doctor with priestly powers and connections beyond the secular was one made by Foucault in *The Birth of the Clinic*. Foucault identified the perceived and then actualised power of the medical professional as one directly handed down from the church, a shift that took place in the 1600s, when "[w]hat previously was a concern for the clergy [became] a challenge for [medical] professionals" (Waitzkin 226). Foucault posited that after the French Revolution, the concept of the medical profession's alignment with organised religion perpetuated a belief in the sanctity and mystique of physicians, "the myth of a nationalized medical profession, organized like the clergy" (Foucault, *The Birth of the Clinic* 32).

It is clear that in the confessional context of the modern doctor-patient interview this priest / parishioner relationship is still in evidence. Indeed, this is an idea presented in both modern medical poetry and sociological texts—that aspect of the physician's vocation reminiscent of the role of a "father confessor", allowing him privileged glimpses into the workings of patients' bodies and minds. Colquhoun phrases it thus: "Consultation is the holy centre of general practice, and that's always about communication" (Marshall 138).

So while Colquhoun recognises and respects the transcendent qualities of the consultation process, he is equally cognisant of its shortfalls, as we have seen in poems discussed earlier, and he frequently uses religious diction and imagery to assert what sociologists frequently aver, that "[q]uantitative and qualitative evidence suggests that physicians stand in nearly godlike relation to their patients—as entities not to be questioned" (West 151).

As in the eponymous poem of the collection, for example, Colquhoun seems keen to undermine the authority, impenetrability and esotericism of medicine, as well as medical hubris, counselling doctors only to "play God" at tennis ("*Playing God*" 1), chess (6), cards (11), darts (16) or monopoly (21). Countering society's apparent belief in a doctor's inherent omnipotence and omniscience and its according disappointment when the answer or the cure is not forthcoming, as we have seen previously, Colquhoun frequently depicts the human frailty of the doctor. Another example can be found in the poem "When I am in doubt." The doctor in this poem begins with an ironic assertion of certainty:

> When I am in doubt I talk to surgeons.
> I know that they will know what to do.
>
> They seem so sure. (1-4)

Yet, a surgeon whom the speaker consults claims to look to priests for the answers (5–9), and priests apparently look to God (10–14). Finally, in circuitous form, the poem comes back to the originator of the doubt:

> Once I talked to God.
> He said that when he is in doubt
> he thinks of me.
> He says I will know what to do.
>
> I seem so sure. (15–19)

Attention is drawn to the "I" of the poem—the last stop—who feels the great weight of his own existential uncertainty. There is a wry cynicism to the poem, but also a palpable unease. The impotence of this "I," his vulnerability in this position of ultimate accountability, is highlighted by the last line alone, telling us that it is hard to be human yet also to be invested with responsibilities that are far beyond human capability. The allusion to God and priests in this poem places the doctor's role in the context of spirituality and faith. Again, our attention is drawn to the spiritual imperative of the doctor's vocation, its tremendous responsibilities.

Similarly in "Myths," Colquhoun's doctor persona asserts: "My father was a carpenter but / he has never owned a donkey" (44–45). This jocular, dismissive tone is balanced against a more solemn one of regret and self-doubt: "I wish I had used a different drug. / I consider what would have happened if / I had put the needle in the other arm" (36–37). "[D]rug" and "needle" are the terms used—popular, colloquial terms—as opposed to the more precise "pharmaceutical" and "hypodermic needle / injection". After this line, the use of the second person pronoun, addressing the patient directly (as in "3. Shaking hands with Mr Parkinson," which is discussed earlier), highlights the doctor's personal reaction and personal involvement: "I wonder if you are alive or dead" (38).

The poem's final entreaty, an amalgam of humour and pathos, asks that people understand the reality of doctors' humanity. Colquhoun uses religious allusion to present the vulnerability of a man who runs the risk of being deified and crucified at the same time—a man who cannot always be a saviour and who feels the weight of misplaced faith:

> … do not try to
> hang me on a cross.
> Contrary to popular opinion
> I cannot raise the dead. ("Myths" 53–56)

The biblical reference works with the vernacular to highlight the doubt and the ordinariness of the I-doctor by an outrageous yet apt conceit: doctor as a failed

Christ.

"When I am in Doubt" and "Myths" use straightforward assertion to demonstrate Colquhoun's resistance to the characterisation of doctors as truly godlike; but in other poems he performs the critique indirectly by juxtaposing religious with medical diction. For example, in "Taking Confession," which describes the patient's perception of the doctor as psycho-spiritual confidant and provider of the panacea, the doctor's language is liturgical, structured in a trinity, as he responds to each of the patient's sins, invoking, for example: "*The pharynx, the lung and the alveolus*" ("Taking Confession" 13). The penitent patient divulges his misdeeds as if to a priest: "Forgive me doctor for I have sinned. / It has been three months since my last infection." (7–8). The malapropism of the patient admitting to his "last infection" and the frequent replacement of liturgical words with medical ones during the course of his confession humorously casts him as ignorant, vulnerable. In particular, the sexual confessions uttered by the patient ("It has been three months since my last erection" (15) and "I have watched cattle sex vigorously in fresh fields" (17) invite a satirical reading, again acknowledging the powerful position of the doctor-as-father-confessor and the patient's position as subordinate.

However, whilst there is clearly a strong element of satire, there is also an acknowledgment of the genuinely spiritual aspects of practising medicine. Towards the end of what started as a humorous poem, with the patient making errors and sharing hugely personal aspects of his life, the patient makes admissions that are markedly more pitiful than the sometimes amusing ones that have gone before: "I have forgotten the names of my children. / I have broken my heart on a lover" (23–24). These lines invite a serious and empathetic appreciation of the doctor-patient intimacy that has a larger significance outside notions of power. Colquhoun describes it thus:

> … spirituality is hugely important in medicine and seems at times to be forgotten … human beings need faith to function. Faith and doubt may be more important in our practice than we think … I find myself now in a profession where each day

I sit and listen to people love, cry, praise, confess and ache.
("The Therapeutic Uses of Ache" 3)

In a similar vein to "Taking Confession," but with a gentler humour throughout, "Communion" tells of the visit of a rural doctor to his patient, a retired dairy farmer and his wife. The farmer discusses agriculture more than "his 'prostrate'" ("Communion" 11), and certainly more than "high cholesterol, ischaemic heart disease and recent blood tests," ("Communion" 18–20). It is clear that Colquhoun's doctor-speaker enjoys the humour of "medical lingo undergoing lay transmogrifications" (82), as behavioural scientist Peter Ubel reveals doctors frequently do. More importantly, key aspects of the patient's lifeworld are actively attended to by the doctor who, at the end of the poem, asserts that "three things remain". These are:

Aspirin,
Surgery,
And a cup of tea,

but the greatest of these
is a cup of tea." ("Communion" 23–27)

In Corinthians 1:13, it is written that three things shall remain: faith, hope and love—the greatest is the last, sometimes interchangeable with "charity" (Biblos.com). A serious point is being made by Colquhoun's pastiche and, as a result, "the voice of the "lifeworld" (Mishler 190) is louder than the biomedical voice in this encounter.

This farm visit is part of the doctor's rounds, and he must ascertain the health of his patient ("We will talk about high blood pressure" (3) and "strokes" (11)), but the communion with the man and his wife are more important than the medical assessment. The "cup of tea" embodies that love and charity, and the communion that he enjoys with the old man and his wife is therefore presented as secular and spiritual at once—a presentation that would not have been possible

without recourse to religious allusion, and one that signals Colquhoun's acknowledgement of those parts of his role that enable him to perceive "the most intense and beautiful views of human life" (in Bieder par. 1).

The discourse of this poem is a mixture of the medical, the personal and the religiously allusive. A question to be raised at this point, for it will follow in relation to the other poets who use religious language in their poems, is where does it belong—as a third discourse, or as a part of lifeworld discourse. My reading of Habermas' *The Theory of Communicative Action Reason and the Rationalization of Society,* from which Mishler's ideas about the division of the competing biomedical and lifeworld voices grew (Barry et al. 487), together with the work of contemporary expert in identity theory, James Paul Gee, inclines me to believe that the answer lies somewhere between the two. Gee explains the way in which a person's lifeworld (and its accompanying language) can embrace a secondary mode of being and communicating. The mode is secondary, but also an assimilated part of the lifeworld. He begins by quoting Habermas, then develops his own theory:

> "[O]ur primary Discourse, through all its transformations, serves us throughout life as what I will call our 'lifeworld Discourse'" (Habermas 1984). Our lifeworld discourse is the way we use language, feel, think and interact, and so forth, in order to be an "everyday," (non-specialised) person.... As we are being socialized early in life, secondary Discourses very often play an interesting role. Primary Discourses work out, over time, alignments and allegiances with and against other discourses, alignments and allegiances that shape them, as they, in turn, shape these other Discourses. One way that many social groups achieve an alignment with secondary Discourses they value is by incorporating certain aspects of the practices of these secondary Discourses into the early (primary Discourse) socialization of their children. For example, some African American families incorporate aspects

> of practices and values that are part of the African-American
> churches into their primary Discourse … (154)

So religion and spirituality in these poems appear to be a socio-cultural subset of lifeworld discourse in many respects. Although religious language shares aspects of biomedical discourse—esotericism, mysticism, authority—it is still more familiar to many of us, and more comforting, more allied with the lifeworld, than the specialist discourse some of us will have to acquire should we have to enter and navigate the biomedical world.

Angela Andrews

Like Colquhoun's *Playing God*, Angela Andrews' *Echolation* features a number of poems from the perspective of a medical student acquiring subject-specific knowledge, and experimenting with how that aligns with the personal, lifeworld knowledge she already possesses about human beings. "The Pathology Museum," for example, is a meditation on a display of hearts. As the speaker describes the exhibit, she uses both vernacular and medical language, producing a playfully ambiguous contemplation piece with a tone that balances light-heartedness with wonder at the spectacle:

> … glass shelf upon
> glass shelf, clear pots filled
>
> with small dense lumps
>
> that once knew crimson warmth … (6–9)

The "dense lumps"—thick organs, motionless and purposeless—are contrasted with their former usefulness and vitality. The synaesthetic image of "crimson warmth" suggests the hearts' former multi-sensory animation that "once pumped a body full" (10). For Andrews, it is impossible to address the concept of the preserved hearts without recourse to the age-old emotional resonance of the heart as centre, as receptacle of love and life, hence their personification. Cold, scientific (arte)fact is

never far from its personal, human provenance, hence the need for lifeworld imagery and lifeworld language to articulate her reaction.

The second half of the poem expands upon the wonder of the speaker, who holds one of the hearts in her hands and mentally places it in its absent context. She sees it both as medical object and symbol of human life, signalled by the balancing of medical and vernacular language. This linguistic synthesis adds to the impression of a simultaneous distance and closeness, a coexistent objectivity and subjectivity, which the speaker maintains towards the hearts. She offers phrases that provide both objective fact and figurative meaning with very human resonances. For example, the heart is a "muscular / ball" (15–16) and "formaldehyde grey" (16): the premodifiers contain objective details. However, the point she ends on, the most important and notable part, is the "cusp" (23) that "will not open or close" (24). "Cusp" is not simply an objective, scientific term as were "muscular" and "formaldehyde"; its ambiguity balances the scientific and personal—the cusp (in medical terms, the flap of the cardiac valve) is also the point of *intersection* of life and death, and its inability to open or close is also its figurative significance, signalling the poem's final meditation on death and the precariousness of human life—or love.

To enter "the room called hearts" (1), Andrews suggests, is to enter into contemplation of humanity—not just medical science and its wonders. The lifeworld context is inextricable from the medical context of the pathology museum. It is impossible to see the heart as a simple organ disassociated from its figurative connotations. As human beings, we automatically assign to it significance as the repository of most tender emotion, motor of life. The heteroglossic mode, mixing biomedical and personal, tempers the medical language and context, making it more human, and makes the poem, a lyric contemplative, universalising piece. By the poem's end, the hearts are no longer scientific exhibits; they are love-sick *memento mori*: The poet exploits the ways in which meaning falls between medical and personal language to hint at fatal heartbreak. "The wall is thick. / The scar // is pale" (21–23).

The heart is already a lifeworld object. It exists in the lifeworld vernacular and therefore lends itself easily to being merged with its medical corollary and explored in tandem terms in a poem like "The Pathology Museum": but when medical language is more other, more unfamiliar—for example in a poem about a trainee or new doctor engaging with new areas of a hospital (as we have seen previously in Colquhoun's "A Medical Education") lifeworld discourse is called upon to provide a sort of gloss, enabling him or her to better understand it. This is evident in Andrews' "Grey Hospital," in which the late shift in the hospital is depicted via allusion to its rugged surrounding terrain ("the whole coast stretching up to Karamea" (4), "Then south, all the way down / into Westland" (7–8)) in an attempt to communicate its terror to the new doctor.

The speaker describes her experience of "Night shift" (1) "like / standing on a ledge" (1) reminiscent in its precipitousness of the well-known coast road and the rivers below "that could swell / like an anaphylactic throat / and just as asphyxiating" (10–12). The medical terms' fricatives sound threatening without one's knowledge of their meanings, sharp, cutting, like the "knife-edge" (8) "Angry terrain" (14) that is the precarious ward at night, full of dangerously ill patients. Similarly, the water at the bottom of the remembered "ledge" (1) is "clear as cerebrospinal fluid" (18), a substance most often taken during lumbar puncture to diagnose multiple sclerosis and meningitis, diseases associated with considerable morbidity. Interestingly, the danger seems to be one posed *by* the patients rather than one posed *to* them; the new doctor feels under threat herself from what could happen to them on her watch, and her panicked thoughts regarding the "roads cut off / by snow"—lines 24 and 25 cut also by the poet's line-break— remind the reader of those earlier mentions of anaphylactic throats and asphyxiation (10–12).

The landscape outside Grey Base Hospital in Greymouth and its geographical threats therefore serve as a symbolic representation of the experience of night shift, its potential hazards and horrors. Although those hazards and horrors are biomedical in nature, the mode used to describe them is largely that of the geographical lifeworld, for this gives a visceral and known sense of danger to the

medical discourse used within the poem. Ultimately, in the final lines of the poem, the speaker looks to the window, again searching for a correlative image for what is inside. Yet finally what she sees is herself reflected in the bare night window, just as what has been depicted in the poem is not so much the hospital, its locale or the night shift, but her experience (and fear) of it. She concludes with a statement showing her cognisance of this fact: "You knew outside was vast / but there was no way to see past yourself" (36–37).

The 'self' of the doctor is often a divided one, as we have seen in Colquhoun's poetry. The doctor has two languages, two levels of knowledge and, as in Andrews' "Grey Hospital," a part of the self in service to others and a part of the self that desires its own solace. "Grandfather," a newer poem by Andrews, published in "Unexamined Metaphors, Uncharted Stories," the course book of Auckland FMHS' third year students, describes an experienced doctor (the poem's speaker) visiting a recently bereaved friend. The friend asks her to look at the deceased grandfather's hospice book and explain what the record of his final weeks says in a vernacular way. The friend is calling upon the doctor as a translator of sorts:

> And there I was in my head
> changing between *fluid in his lung*
> and *pleural effusion*, and *the leaky heart*
> and *mitral disease*, and coming to the endpointof *not*
> *enough oxygen* and *the body shuts down*. ("Grandfather" 9-12)

Andrews' italicised parallels show the difference between the lay / lifeworld terms and the biomedical language. The doctor persona becomes an interpreter for the family, being careful to employ euphemism, until the hospice book's documentation runs out, and all the family can recount to the doctor/friend is their last memory of telling the old man he could let go and die (they were all assembled to say goodbye to him). The doctor's relief is huge:

> I sat there in silence, unburdened,
> relieved this could not be changed in my head

and I wasn't supposed to know what it meant.
("Grandfather" 19-21)

To be in silence, not having to gloss the text, is a relief to the doctor. She is glad not to have to try and provide an interpretation of the grandfather's death at the time of the family's gathering at his bedside. To be allowed to share in the mystery of the old man's passing in that fitting manner alongside the family is a gift she appreciates. The rhythm of the lines runs more freely, the chimes of "head" and "meant" support the unburdened feeling of the speaker. Andrews crafts the poem's sound and structure to suit its sense in order that we appreciate the change in mood.

Again, we are presented with the spiritual unknown (the inexplicable nature of the man's death at this point) being larger than science, outside science's ability to explain. This part of our common human lifeworld experience, it seems, is allowed to be unanswerable.

Although one could argue that this is a transformative moment in the poem, I believe that it is, rather, the turning point of the poem; the key point of universality occurs later, after the doctor-speaker has become absorbed in photographs of her friend's grandparents and the objects that furnish their home. Their lifeworld context provides a touchstone. They were from Holland, like her own grandparents, and she begins to realise "how much of [their] history was [hers]" ("Grandfather" 37):

… I noticed for the first time
that our grandmothers had worked the same cross-stitch,
and drank from the same African violet coffee cups
and were collectors of china thimbles … (39–42)

Only in the last three lines of the poem does the speaker bring her attention to where her three-year-old daughter is: "standing on tiptoes / in red stockings, peeking over the rim of the coffin" ("Grandfather" 46–48). The commonality, the kinship, she feels with these people, having shed her role as doctor-translator and

having slid back into her role as friend / grandchild of immigrants is mirrored by the image of her little girl looking without fear, but with interest, into the coffin. This final image serves to move the poem outward from its centre, and it becomes a commentary on the things that bind us rather than the things that separate us (such as the esoteric clinical language that brought the speaker to the house at the poem's beginning).

Andrews' balancing of biomedical and lifeworld discourses in the poem is key to its effect. The poem's early lines are saturated with biomedical language which is explicated euphemistically in colloquial terms. The two languages are uncomfortable together, just as the speaker is uncomfortable in her role. Then, once the man's release into death, his letting-go, is deemed beyond words, we move from a language that is translated mechanically yet humanely to one that is shared. Medical language euphemised into common speech slides into a more familiar set of connections—the Dutch word for grandfather, "*Opa*" (18), "cobblestone courtyards" (38) and "china thimbles" (43) that tell of the shared heritage of the doctor/friend and the other woman, made clearer by the photograph album they look through and mirrored by the "great-grandchildren, building things on the ground / with my son." By the poem's end, the "Grandfather" of the title is brought closer to the speaker than the "few typed pieces glued in" (2) to a "hospice book" (1). The "brief notes" (3) she was given to shape into sense have become a person, an individual, part of a family, recognisable as someone's grandfather.

Familial illness, in Andrews' work, as in Colquhoun's (in his "Parkinson's Disease" sequence in particular), is an area in which the clinical and the personal intersect most problematically and intensely. For when the doctor is dealing with a family member's illness or medical treatment, dilemmas of telling / not telling, speech versus silence, are added to tension between biomedical and lifeworld perspectives. In some of Andrews' poems about pregnancy, we see that the issue is intensified when the patient is herself a doctor, giving rise to questions: What part of experience is scientific fact, and does scientific knowledge shed light on personal experience?

Doctor-poet Renée Liang notes in her review of *Echolocation* that Andrews achieves a perspective balanced between the personal and the clinical in poems which pertain to experiences of familial illness. For example, in "The Wedding Present" the I-doctor speaker describes her grandfather's efforts to make her a gift despite ailing health. He is wheelchair-bound and short of breath, "his fingers stiff / beyond the contraction of age" (8–9). The speaker looks on with "the concerned eyes of a loving granddaughter combine[d]with the precise observation of a doctor" (Liang par.4). The word "stiff" comes from the lifeworld, while "contraction" (9) is from the world of medicine, describing rheumatologically- or neurologically-based deformity. It is also a word that suggests, through its base 'contract,' the ways in which ageing and disease make the sufferer's life smaller and more restricted. The coupling of everyday and medical diction conveys the dual identity and viewpoint of the speaker as doctor/granddaughter.

In "The Wedding Present," while the non-clinical, personal perspective dominates, medical realities are present in the descriptive details. From the poem's beginning, it is made clear that the maker of the titular gift, the grandfather, has, despite illness, struggled to fashion it from wood: "He watches us / unwrap the hours / he spent in his shed, seated on wheelchair vinyl" (1–3). We are told that he worked on the gift while "oxygen streamed / through a clear tube" (17–18). The poem ends with the speaker still able to hear the "hum / of a box / extracting air" (34–36) if she listens carefully. The ambiguity of the noun "box" (an innocuous square container / the receptacle for a gift) makes it possible to read it alternatively as her grandfather's portable oxygen tank or the present the grandfather has made for the speaker's wedding (for we are never told what this present is, except for the detail that it is made from metal and wood and has been carved and chiselled). According to this reading, he has, quite literally, put his life into the gift. It has taken his laboured breaths as he worked.

Again, in "Christmas 2002, Titirangi," the focus is the ailing grandfather. Andrews' doctor-speaker recalls talking with him as he struggles to participate in the day's activities:

… I don't have a disease

you said to me, *I wouldn't call it*
an illness. It's just wear and tear.

Six years of medical school
and yet I was mute. (12–16)

The words "disease" and "illness" are avoided by the "you" of the poem, the grandfather; truth is eschewed for the subjective and euphemistic "wear and tear" which makes something less frightening of his decline, and the doctor/granddaughter can say nothing despite her better knowledge. Her 'muteness' is inextricably bound to the personal: this is not the place or situation in which to employ clinical, institutional language. Again, silence seems to be a sanctuary.

In the same poem, it is made clear that the speaker knows what course her grandfather's disease will take, but she keeps this knowledge to herself. Silently, she reflects on her professional experience of similar clinical scenarios:

I thought of men I had known
who said the same thing
men whose bodies
emptied out like bathwater.
("Christmas 2002, Titirangi" 17–20)

This poem places the speaker firmly at the heart of the family, choosing personal language and compassionate silence over medical exactitude or soothsaying. Her position as a person of two discourses, her primary lifeworld discourse and the assimilated specialist discourse of medicine, causes an internal conflict that must be considered and resolved. In this situation, she sees the biomedical, clinical mode as inappropriate.

However, Andrews also recognises the place of medical imagery and language

in the description of personal medical experience, and how it can add to one's apprehension of complex biological processes. This is particularly evident in the poems in the second half of *Echolocation*, tracing the development of a baby, written over the course of the author's two pregnancies ("A Chat with Angela Andrews" par.5). The eponymous poem "*Echolocation*" describes the way in which an ultrasound device locates a foetus in utero, relaying a picture to the prospective parents. There is an amalgam of medical fact and more personal language used to explain the baby's image on the sonogram: "We find you there / in the dark … and the distance / between two poles / tells us when to expect you" ("Echolocation" 1–2, 9–11). In her appreciation of the child growing month by month, Andrews combines medical knowledge and diction with figurative images of the known world. The "poles" (2) are the measuring lines used by the sonographer. They are also metaphorical markers of how far away the birth seems from the present time—the two are perceived as "poles apart". Additionally, the "poles" (2) are part of the foundations of a new life, contributing to the pervasive image of the baby as building or construct. In another example, the baby grows according to an architect's design, with the necessary "vaults and arches, / bridges, pillars / and harbours" (10–12). The baby is more than genetic fact—it is mysterious and other-worldly, a destination "mapped / by the pencil of a god / or stumbled upon by chance" (13–15) and the image of a building is used once more to relate the child's development to something concrete and known, defining the "Essential structures" ("Nine Months" 8) beyond physiological fact.

As with the building motif, Andrews suggests that medical details (the growth of the foetus recorded by sonography, for example) also require a lifeworld context to describe them accurately and perceive them personally. For example, she mixes the language of medical fact with diurnal, domestic images to make the child's developmental stages more familiar and less coldly clinical: "Cell division like bubbles rising. / Primordium becomes mulberry" ("Nine Months" 1–2). The rising bubbles and the mulberry colour and texture gloss the medical terminology, providing familiar images (reminiscent of jam-making in this case) to which the reader (and the speaker) can relate. The foetus and the child it will become is an

unknown, and the speaker appears to be bringing in every possible discourse to build a picture of him or her, using scientific and lifeworld languages to verify its existence and development.

Similarly, in "Whenua," a poem which takes place after the birth of the child, describing the placenta being prepared for ritual burial, Andrews articulates the delicate balance between the biological and the emotional by means of the interplay of medical and personal language discourse. She uses both biomedical and lifeworld language to draw attention to the complexity of our anatomy, physiology and psychology—the holistic genetic inheritance that defines us as individuals but also as members of a family. For example, in the lines which follow, the speaker moves from describing in scientific terms the DNA composition of the placental blood to the visible influence of genetics on the child's appearance in terms of familial likeness:

> … The blood
> spills heavily down. *Adenine*, *thymine*, *Guanine*,
> *cytosine*.
>
> The hue of his skin. The roll of his tongue. Will
> the hair on his head be there till the end, or lost
> early? It depends on my father. (14–19)

The molecular units or 'codes' of DNA featured in lines 14 and 15, the determiners of genetic inheritance, used in this context, sound like part of a prayer or incantation as the placenta is buried. They also mix with the later (and vernacular) explanation of the traits they may determine, producing a tone that lies between medical certainty and human curiosity. In "Whenua," the theme of family and its generations is given a context of biological fact overwhelmed by the sense of wonder (and wondering) detectable in the lifeworld voice of the doctor/parent.

"Whenua" shows the poet's interest in ritual associated with birth and life, "whenua" in te reo Māori meaning both 'placenta' and 'land', and the ritual of

burying the placenta being a way in which the child's relationship with his or her birthplace is reinforced. Moreover, as we have seen in "Grandfather," Andrews is prepared to accept the mysteries of life and death, such as the release into death of a loved one who has said all of his goodbyes.

Like Colquhoun, Andrews expresses the belief that the doctor's role does somehow mediate between the spiritual and the secular. There is in "The Croesus Track," (5) an allusion through imagery that clearly communicates the aspect of medical practice that is akin to ministry. In this nine-line poem, a very short snatch of doctor-patient discourse, a doctor recollects drawing a cross in iodine on a patient's back in preparation for the insertion of a needle for lumbar puncture. It is very immediate, in the present tense:

> *He says*
> *the iodine*
> *feels cold*
> *on his back.*
> *You draw a cross*
> *for the needle,*
> *fill a syringe*
> *with medicine,*
> *say 'just like a bee sting'.* (1–9)

The action is a clinical manoeuvre, of course, but there is a gentler, spiritual resonance, too—the marking of the patient with the holy sign connotative of God's grace and protection. The physician then tempers the painful intrathecal drug delivery with the colloquial, almost parental "just like a bee sting" (10) and goes in the space of five lines from the religious to the colloquial. Two discourses are in evidence throughout the poem, with "iodine," "needle" and "syringe," coexisting with "cross" and "bee-sting". Together, these words convey a sense of compassionate medicine where a doctor's position of power is defined by his or her beneficent proximity to the body and mind of the patient and his or her ability to use registers and approaches outside the medical to minister effectively to the patient's mind and

body.

Rae Varcoe

Rae Varcoe's *Tributary* is a collection that features large shifts in tone and register; the poet is keen to show the mercurial interplay of medical and layman's language, the title of the book being one example. A tributary vein is one that empties into a larger vein, much as a branch of a river or lake is called its tributary. In addition, a tributary is a person who travels from one land to pay homage to another land. Perhaps this is what Varcoe's doctor-personae enact in this book, journeying to the layperson's world, bearing gifts.

The fluidity of meaning, of image and structure, exemplified for critic Joanna Preston by the water motif pervading *Tributary*, led her to praise the poet's craft:

> Good poetry is fluid—moving, infinitely flexible, capable of solidity, or softness, or both. Endlessly extensible. Seamless, as a river is seamless, but still registering the rocks and ripples, changes of tempo and texture. Musical, because water is inherently musical. As poetry should be. As this book most definitely is.
>
> Unsurprisingly, many of the fluids here are of the body – blood, amniotic fluid, tears, milk, sweat. Also waterfalls, ice bergs, and vapour trails; water in all three states. And a strong rhythmic intelligence running through all of it. ("*Tributary* Review")

Even when Varcoe's subject matter tends to the personal, as it does in the title poem, "Tributary," dedicated to her mother, Alison Clutha Malcolm, who was "named after a river" (2), describing the mother's death by pleural effusion, via metaphors of a "choking"(4) rising tide (6), leaving the daughter/doctor-speaker, "marooned" (27), Preston deems it "personal without being self-absorbed"

("*Tributary* Review").

To agree for a moment with Preston's praise for Varcoe's lack of apparent self-absorption throughout the collection, I would need to add that Varcoe's default tone in many of the poems is an amalgam of resignation and dark humour. Simon Sweetman calls her tone one of "the clinical detachment of a role within medicine" (Sweetman par. 2), but I feel that much of this "detachment" is feigned for wry effect—or to criticise those doctors who do become too immune to the plight of their patients.

It is interesting, for example, to compare the tone of Varcoe's poem "Thoughts on the Brain" with Angela Andrew's poem "The Pathology Museum," about the jars of hearts: both have a doctor-speaker contemplating an exhibit of preserved body parts. In Varcoe's case, it is a display of brains. Both poems rely on ambiguity to draw attention to tensions between the medical and the personal, but Varcoe's tone is far more blunt and satirical. Take for example, the tongue-in-cheek sagesse of the following lines:

> surgically speaking
>
> while eyes are windows
> of the soul the brain is accessed
> through the nose ("Thoughts on the Brain" 13–16)

The unemotional logicality of the speaker as she explores what is "on her mind" via the punning title is what imbues the lines with humour at the expense of medical objectivity. She emphasises the matter-of-fact, technical nature of the biomedical voice by juxtaposing it with the windows adage. Likewise, the wordplay describing how the "selection of brains / in shiny pots / floats suspended / in infinite reflection" ("Thoughts on the Brain" 2–5) lends itself to alternative readings. Not only are we invited to contemplate the embalmed brains in jars, catching the sun, "reflecting", but also to imagine, through the word "reflection," their incessant, unending, captive 'thinking'. This playfulness invites an encouragement of

ambiguity, subjectivity and thought beyond the mono-denotation of the scientific. As in Andrews' poem, clinical observation and creative imagination are symbiotic here. The biomedical fact cannot escape its "lifeworld" (Mishler 190) associations, but Varcoe's approach is less reverential—at first, at least.

Whilst observing the brains with her naked eye, Varcoe's speaker also contemplates the ability of modern medical science to visualise every facet of the organ, inside and out. Medical acronyms are employed satirically, the names of brain-imaging equipment are recited in the form of a liturgy or incantatory prayer, her tone, here, similar to Colquhoun's parodic style:

> E.E.G.
> C.A.T.
> M.R.I.
> P.E.T.
> Lord, have mercy on me. ("Thoughts on the brain" 7–11)

The rhyming acronyms, the trinities of their letters, the final plea—all of these elements suggest an ironic tone that can be read humorously. Yet they also suggest an attitude towards medical science and medical jargon that conceives of them as powerful, godlike, but also hubristic, allowing insights beyond human capability—frightening auguries of mortality and morbidity.

Indeed, playful as some of the lexical ambiguity is during the course of the poem, its last lines become serious when the physiological consequences of an ischaemic event, "the brain's dissolution" (20), is considered beyond the scientific signs evident on examination of the embalmed organs:

> at a stroke
> clotted thoughts lurch
> lonely and stumbling
> marooned (16–19)

This time, the ambiguous phrase, "at a stroke" (meaning 'at once' in the

vernacular), has a tone that is far from humorous: the speaker personifies the thoughts in a stroke-damaged brain as wanderers, lost the instant after the attack. The brains invite a personal response—one based on our ideas about the organ and what it represents, what it contributes to the individual. Interestingly, "marooned," the same word that is used to described the doctor daughter, "the lifesaver" unable to resuscitate her mother in the very personal poem "Tributary" (26), is used here, implying the absolute uselessness of the brain in the wake of this trauma.

The poem ends with "a single satirical thought" (23) which is left "lying discarded / in a sulcus" (21–22), a last poignant image of the brain's lost ability post-stroke. One such "satirical thought" (23), the occasion of the poem, is now caught in its own final fissure. The poem's end is far from satirical. However, as in Andrews' poem, the association of the personal ("thought") with the clinical ("sulcus") is asserted through a blending of vernacular and scientific, the coexistence of these two languages suggests that both are needed to explore the doctor persona's reaction to the medical exhibit. The ambiguities that lie between the codes, the subjectivities, come closer to the truth or core of the observation than objective clinical details.

Although "Thoughts on the brain" does end on a more sombre and poignant note than the one on which it started, it is true to say that Varcoe's poetry shares with Colquhoun's a certain gallows humour that is not so much a feature of Andrews' work. This type of humour, however, is representative of a truth of medical practice—one described by practising physician and bioethicist Peter Ubel:

> When sociologists have studied the working relationship of physicians and residents in hospital, humor has jumped out as an important way that not only helps physicians separate themselves from others—nurses, patients, and hospital staff with different concerns—but also enables them to bond with each other and cope with common problems. (104)

This sort of black humour is present again in "Mercy, Mater, Mercy," in which Varcoe combines the language of a pre-procedure medical administration

letter with the hospital's motto, "God's mercy endures forever" (20). In so doing, she makes two languages collide satirically in order to highlight their contradictions with a paradoxical contrapuntal alacrity:

> wheelchairs and crutches are an added charge
> remember, payment may not be deferred
> cash or cheque are preferred, yours faithfully …
> '*God's mercy endures forever*' (17–20)

The language of hospital props (the "crutches" and "wheelchairs") and the language of administration (the "payment," "cash or cheque") jar gauchely with the biblical motto. Even the adverb "faithfully", a common enough sign-off, takes on an almost blasphemous irony because of its proximity to the line from Psalm 136 and the mercy that is so lacking in the timbre of the letter. Varcoe knows what she is doing, down to the self-mocking rhyme of "deferred" and "preferred" that underline the piece's focus on expediency and money. This is the heteroglossic at work once again, destabilising an authoritative language and voice by means of a juxtaposition or blending that shows it up as woefully inappropriate.

Varcoe's satirical voice seems polemically-inclined, and not a mere mechanism to vent a doctor's frustration at the ridiculousness of some administrative decisions. It seems that Varcoe sees the hospital as a whole as reflective of clinical care, and in taking to task this aspect of hospital miscommunication with the patient, she is calling for a reassessment of medical and lifeworld interaction.

The idea of polemic driven by humour is evident also in "Welcome to our Hospital," in which she mimics clinical and administrative discourses, exposing the inadequacy of both lexicons and their counter-intuitive nonsense in order to make her point: the hospital (system) is not working well and the powers that be, whoever they are, are doing a poor job:

> no madam, you may not have a tampon
> since january's directive

they have been issued only to men
substantially decreasing input,
output and throughput
and making savings re toxic shock syndrome (13–19)

The ludicrous nature of the authoritarian "directive" is highlighted by the blackly humorous puns on "input" and "output," not to mention "throughput," that ironic neologism approaching a language that merges the languages of hospital administration and bureaucratic exigency. The element of code-shifting, of the heteroglossic, whereby a fatal disease like "toxic shock syndrome" (19) (caused by tampon use) becomes less prevalent and therefore less costly to the hospital because tampons have "been issued only to men" (15) is a piece of faulty logic so ludicrous in its parody of the language of healthcare budgets that it enables Varcoe to voice her concern via humour, her dissenting doctor's tone embedded layers beneath the speaker(s) we hear first. She combines codes, exposing tautologous double-talk to ridicule, and to disempower the potentially damaging, "potentially repressive, authority" (Eskin 389) they represent.

Although, like Colquhoun, Varcoe makes common use of humour in her poems in order to highlight the often inadequate and inappropriate nature of medical discourse (or, as in the previous two examples, the discourse of medical administration / bureaucracy), she also writes very solemn poems which deal with the seeming incongruity and harshness of clinical diction when it is employed for the communication of distressing life-or-death diagnoses and prognoses.

The poem "How can I tell you this in 30 minutes?" presents the reader with a common dilemma for a clinician: a treatment plan must be explained, but how can the doctor convey the information to her patient in a way that is neither perfunctory nor oversimplified, given the necessity of describing all options fully within the time-constraints inherent in her schedule? Jack Coulehan, Senior Fellow of the Center for Medical Humanities, Compassionate Care, and Bioethics at Stony Brook University, describes precisely this type of internal conflict as "the tension between emotion and reason in medical practice" ("Tenderness and Steadiness" 2).The doctor-speaker also

considers how to address the patient and present him with options in a manner that ensures his understanding of medical concepts. The poem's tone is one of a learned detachment and humane involvement.

Varcoe has aptly employed in this poem the pantoum form, whose restrictions serve to emphasise these difficulties. In addition, she draws further attention to these restrictions by including more repetitions within the form than necessary. The poem becomes a troubled and troubling internal monologue in which the I-doctor is plagued by the inappropriately abrupt medical language she must use in her explanation to the patient. As she rehearses her speech internally, it sounds far too blunt:

> Chemotherapy may cure you
> cure lasts a lifetime
> chemotherapy may kill you
> cytotoxics will give you side effects (13–16)

In twenty-eight lines, twenty-nine including the title, perhaps reflecting the brevity of the thirty minutes the clinician has to inform the patient, just how is she to convey the necessary information in a manner that is both instructional and empathetic? It appears that one tone must be chosen, and that is the business-like, informative one—the one that will not allow for subjectivity. In the lines quoted above, the crisp, alliterative 'c's and the neat near-rhyme of "cytotoxics" and "side effects" add that clinical, peremptory tone to the piece. There is little wonder that the doctor's internal voice—available only in the title that asks so searchingly just how this is to be accomplished—is eclipsed by what Mishler terms the "biomedical voice" (190) in the poem as a whole. Similarly, the "you" of the title is a person—is personalised—whereas the more generic use of "you" in the poem as a whole suggest a set number of statements that must be asserted in this situation so that any patient knows the possible and probable side effects and larger implications of different courses of treatment:

> if you had no treatment you would die

chemotherapy may cure you (9-10)

The title of the poem suggests the doctor is endeavouring to find a way to explain all of this compassionately, but clinical, distant language is the only mode she can use to inform the patient expediently. She has a duty to present this information to the patient in a way that enables his own decision, yet the pressing weight of her authority and responsibility is palpable. The poem's questioning, riddling lines are dizzying as she perceives what is at once the necessity and the impropriety of her language's clinical objectivity.

A like tension is evident in Varcoe's "Signs." Similarly to Angela Andrews' "Christmas 2002, Titirangi" and "Grandfather," this poem presents us with an example of a situation in which scientific, clinical talk is deemed to be ultimately inferior to silent communion. The poem is narrated by a doctor-speaker whose patient's disease is progressing. The patient, ironically, is a sign-writer who does not see the signs of his own deterioration and imminent death. The key question posed by the poem hinges on the speaker's struggle over whether to tell the patient the scientific truth of his condition. The title, "Signs," as well as alluding to the patient's job, also gives a sense of the doctor's uncertainty as she waits for a signal as to what—if any—action to take.

The pantoum has the quality of a mesmerising lullaby that moves from the concerns of the speaker as clinician to those of the speaker as a person seeking to provide communion and solace for an ill man. The choice of form here underscores the poet's use of diction, some of which is medical and formal and some of which is personal, vernacular, and there is a progression from the former type of language to the latter.

The poem begins with the doctor's reasoning process. The first six stanzas concentrate on fact and language typical of medical parlance—this is the language of clinical measurables: "he's six feet six" (2), "he's just relapsed at twelve months" (13). There is also use of medical acronyms and abbreviations: "his first chemo was ABVD" (8), "chemo" and "ABVD" being shortened in-language—the unnervingly

casual nature of which adds to the impression we have of the doctor's daily exposure to disease and death.

The statement that mediates between this type of clinical language and diction that is more vernacular or personal is "my ruler states the truth" (19) in response to the patient's assertion that he thinks his "lump is smaller" (17). These lines act as a turning point for language. The human ironies of the patient's situation dominate the doctor's thoughts, and she starts to wonder whether the clinical facts are of any import now:

> my ruler states the truth
> does he need to know
> the signwriter cannot read the signs
> where are the words (19–22)

Accordingly, the last two stanzas bring the language of the personal to the fore, and with it the "lifeworld concerns" (Heritage and Maynard 6)—not only of the patient, but also of the doctor:

> does he need to know
> where is his mother
> where are the words
> what should I pronounce (25–28)

The interrogative barrage, its mixture of lifeworld images (the mother) and words heavy with duty and responsibility—and medical inevitability—("pronounce" 28) lead us back to the first line of the poem, by implication, its most important line: "I sit by his side for a long time" (1).

The poem's form and its shifts in language move us from the distant and clinical to the subjective and humane. The poem has the qualities of a soliloquy, communicating the internal conflicts of the doctor as she considers clinical truth versus simple, silent comfort. The language of medicine and fact are replaced, in the end, by the doctor's watching, and waiting to "pronounce": she is not just

monitoring vital signs, waiting for his death; she is serving him on a more spiritual level simply by her presence. Varcoe's doctor-speaker chooses to stay beside her patient in silence, keeping a vigil that "is not totalising or universalising" like the gaze of doctors whom Foucault would have despised (Downing 37), but individualising and compassionate.

The concept of compassion, so central to the poetry of the doctor-poets and to their exploration of the spiritual aspect of the vocation of doctor, is key to "Cadaver Spoken Here," Varcoe's elegy for a man who donated his body to medicine while she was a medical student. I will dedicate significant time to its analysis here, because to a certain extent it acts as a summary of the transformative at work in the doctor poems discussed in this chapter. That is, it demonstrates how they move from a position of the self-referential to the reverential and universal by means of the poets' craft—in particular, their use of the heteroglossic mode.

"Cadaver Spoken Here" contrasts the doctor-speaker's perceptions of—and attitude toward—the cadaver. The cadaver is initially a means for the young doctor-in-training to learn to separate feelings from medical practice (to concentrate on the scientific, eschewing lifeworld associations). With hindsight, however, the cadaver is perceived by the older doctor as a visceral reminder of the very inseparability of the biomedical and lifeworld voices and contexts involved in her vocation. The early instruction doctors receive in distinguishing between the medical task at hand and the humanity of the person they are treating / the body they are learning from is given emphasis throughout the poem, echoing Ubel's critique of the anaesthetisation approach to medical schooling: "desensitisation can cause doctors to lose the ability to see the world through their patients' eyes … even when those eyes are closed" (104).

Ultimately, "Cadaver Spoken Here" can be seen to epitomise the doctor-poets' conception of the holistic nature of medical science and medical training. Reverentially, Varcoe humanises and pays homage to the "[a]ged man, flayed man / generous man" (21–22) who gave his body to medical science so that medical students could learn from him, reading his corpse like a text, acquiring its language.

She makes it clear, however, that to get to this position of appreciation and cognisance she has had to accrue years of medical practice and experience.

At first, the doctor and her fellow students are described using "we" (7), then, later in the poem, "they" (17). The speaker thus becomes more distant from the experience as she reflects upon and criticises the obliviousness of the student group, herself included, as they went about working on the cadaver, forgetting the man he once was and, at the same time, forgetting the sanctity of the corpse. The younger and less experienced the doctor is, the more distant she is from the cadaver and its origins. By contrast, with professional experience comes an acknowledgement of the lifeworld, human context of the cadaver. Finally, at the end of the poem, the doctor-speaker, disdaining her younger self and her student peers, poses one last rhetorical question—interestingly, returning to the first person plural "we," to signify her ownership of (and perhaps atonement for)the past: "why did we never think / to thank you?" (23–24).

Like the poems of Andrews and Colquhoun, many of them written during the early years of their medical study and practice, "Cadaver Spoken Here" questions the validity of a solely objective, clinical perspective. From the vantage-point of age and experience, the doctor persona asks knowingly, cynically: "In his dying what did they grasp?" (17). The implication is that the speaker and her cohort should have learned more from his body than pathological anatomy. Varcoe accomplishes this not just by such assertions of her concerns but through an amalgamation of medical, vernacular and religious dictions:

> Adolescent and absurd
> in greasy short white coats
> we sliced and sawed
> from axilla (a truncated space
> bounded anteriorly by …)
> down ligament, nerve and tendon
> through anatomical space
> into language ("Cadaver Spoken Here" 5–12)

Here, Varcoe not only presents us with the rough-hewn "sawed," connotative of careless, carpentry-style cutting, she also glosses the "axilla," its parenthetical details presumably learnt by rote by the students. In this way, she suggests the dehumanising nature of the students' actions and "anatomo-clinical gaze" (Foucault, *The Birth of the Clinic,* 146). To them, the man is simply a model or illustration, a learning tool—by extension, a book whose language they must master.

Yet, the image of the man as a text recalls the opening of the poem: "In the beginning were the words … / and the words were pared from flesh / which had dwelt among us" ("Cadaver Spoken Here" 1–4). These first lines frame the poem and anticipate further religious resonances later in the poem which underline the adult speaker's sincerity, and her appreciation of a lesson larger than anatomy learnt by cadaver study. By means of allusion, we are reminded of the Gospel of John and its revelation:

> In the beginning was the Word, and the Word was with God, and the Word was God … In him was life, and the life was the light of men. The light shines in the darkness, and the darkness has not overcome it. ("John 1 ESV")

By incorporating the religious allusion into the doctor-speaker's revelation, Varcoe is not only able to highlight the magnitude of her own epiphany but also to move the personal towards the universal, reminding the reader that goodness and benevolence in the form of the man's gift of his body, his sacrifice, so that people might learn and others might be saved, is a form of light shining in the darkness.

By the end of the poem, the human and humane triumphs over the biological for the speaker, who wonders about the man and his dying and the students and their learning, "Were terror, hope, yearning / audible over / arrest, arrhythmia, asystole?" (18–20). For her, the internal, the lifeworld, is valued above ("over" (19)) the biomedical aspects of the cadaver, those abstract nouns denoting emotion placed first and hoped to be louder in the minds of her fellow students than the cardiac rhythms they were learning 'by heart at the time. Indeed, to further substantiate

this claim, "Cadaver," that impersonal term, is only used in the title—elsewhere, it is "he," "his," "man" and, finally, "you," the last word of the poem, a direct address that fully acknowledges the humanity of man to the poem's speaker—a man who donated his body so that others might be healed. "Cadaver Spoken Here" is both an elegy and a eulogy for the man "whose clenched hands / resisted dissection" (15–16), whose humanity must not be forgotten.

The way in which the two discourses are used in the poem serves to underline the journey of the speaker who, as a young medical student, learned scientific facts and processes from the corpse as scientific object/artefact and then, as an older doctor, came to realise the great gift of the man. We progress with her from "words pared from flesh" (3) like "artery, arcuate, acetabulum" (2) to three repetitions of "man" in the last stanza and "thank you" as the poem's last words. Like so many of the doctor poems, this one is more than autobiography or memoir. It is carefully crafted, not just to convey a doctor's experiences but to suggest the vying of multiple discourses and, by extension, the multiple psycho-social worlds and often conflicting values, a physician—a person— must balance.

Varcoe's speaker in "Cadaver Spoken Here" has reached a level of cognisance beyond a "purely bioscientific model [that] offers a limited view of human beings" (Oyebode 2). She has transcended experience and emotion, as does the poem itself, having gained a perspective that would be esteemed by medical sociologists and educators who recognise the need for a biomedical / lifeworld blend in modern medical practice, an acknowledgement of the reverence owed by doctors to those whose bodies—alive and dead—are entrusted to them.

Conclusion

The doctor-poets in *Playing God*, *Echolocation* and *Tributary* blend or juxtapose clinical and personal diction—Mishler's "voice of medicine" (14) and "the voice of the lifeworld" (14)—countering the now outmoded school of thinking (epitomised by prominent 1960s doctor and scholar Herman Blumgart) that counselled medical practitioners against emotional engagement with patients (Marcum 263) "because

emotions are intrinsically irrational and, at least to some extent, compromise the ideal of objectivity" (Coulehan, "Compassionate Solidarity" 593).

Indeed, there has been a shift in the thinking and in the culture of medicine, typified by practitioners such as psychiatrist Femi Oyebode who suggests that "[d]octors need a deeper understanding … that takes account of emotional and existential aspects" of patient care (2), which is reflected in the work of the doctor-poets, whose I-speakers express "a need to want to understand things, to create order, to apply some understanding that was learned in one area to a new area in life" (Sweetman par. 5), and also a desire to acknowledge the place of the subjective and emotional in the context of medical practice. Medical language is shown to be inadequate on its own, inappropriate for the discussion of illness and human suffering. It must be tempered by more subjective, personal language to approach a compassionate truth; it must invite "shared decision making" (Ubel 83) and a language that mediates the medical and the personal appropriately.

Most poignantly, in Colquhoun's, Andrews' and Varcoe's poems, the doctor-speakers' medical knowledge and training make familial illness all the more formidable. As doctors, these daughters and sons know too much about what ails their loved ones and what courses their illnesses may take. This scientific foreknowledge conveyed in medical terms is balanced against and modified by a more personal or vernacular language that communicates the internal conflict most clearly: familial illness for the doctor-poet is the ultimate test of whether the competing elements of the biomedical and the personal can be blended successfully. Very often, it leaves him or her conflicted and powerless in the face of forces more powerful than humanity and more powerful than medicine. Varcoe describes it thus in the poem that tells of her mother's death:

> the waters are rising
>
> and I,
> the lifesaver,
> marooned on the bed coast,

> oarless,
> and afraid ("Tributary" 24–29)

Certainly, there is some authority attached to any role inviting confidence and reverence—"the lifesaver" ("Tributary" 26), but the doctor-poets seem to equate the priest-like role of the doctor with an emotional proximity to the patient beyond any strictures of hierarchy. As witnesses to birth, disease and death, privy to raw and personal confessions of physical and mental struggle, ultimately, the doctor-personae speak from a position of service, ministering to human need. Perhaps Colquhoun's words are most apt:

> At the heart of medicine is compassion, not science, not
> politics nor policy, not commerce but the assorted wreckage
> of human beings, their frailty and the long slow unwinding of
> our bodies. It is a profession of skin and ache and spiritual by
> its very nature. The consultation is its holy place, a source of
> communion and a science lab for the physics we have not yet
> described that occurs between people.
> ("The Therapeutic Uses of Ache" 3)

The doctor-poets' attitude in these poems can be characterised as reticent to rely on (or keen to expose) the clinical mode and its intrinsic authority, objectivity and distance. They stress the validity of the personal, asserting the place of the individual and the subjective in the discussion of medical experience. They are not simply telling stories of their experience as doctors—the amusing miscommunications, the heart-breaking conflicts and elevating moments of communion; they are writing lyric poetry, which is situated in autobiographical fact, but which transcends it. The universality of the poems is not simply in the subject matter, but in the craft's reliance on the two key imageries and discourses and their interplay. The doctor-poets favour a multi-modal, often heteroglossic aproach, demonstrating the craft of merging languages and registers, conveying their ambivalence towards notions of a purely scientific truth of medical language, often adding to it religious discourse as a secondary lifeworld discourse that does not

elucidate, yet it softens and comforts.

Chapter 2

The Patient-poets: C.K. Stead, Jenny Bornholdt and Sarah Broom

Introduction

While doctor-poets receive acclaim for making the professional personal, poets who write from a patient's point of view often receive accusations of interiority at the cost of technique. C.K. Stead's post-stroke poems have been judged as lack-lustre by reviewer Hugh Roberts[16], poet and critic Joanne Preston faults Sarah Broom's poems on the topic of illness, deeming them inferior to the poems in the rest of her collection, and she criticises Jenny Bornholdt more harshly, suggesting that the poems in *The Rocky Shore* would be better suited to prose form, so lacking are they in poetic craft.

In this chapter, I will argue that what is missing in these reviews is an acknowledgment of the craft behind the work that presents and manipulates the biomedical / lifeworld divide—the disparity between medical and personal language, the difference between life inside and outside medical institutions—both in terms of subject matter and in terms of diction and form. Not only is this an aspect of the works' crafting, it is a method via which the poems achieve the universalisation of individual experience, in keeping with the traditional function of the lyric.

In the patient-poetry typical of Stead, Bornholdt and Broom, the speaker's first-person standpoint is characterised by his or her cognisance of the anonymity engendered by institutionalisation within a hospital or clinical environment. This perspective is typified by an inferior position, often literally prostrate, observing and being observed. The poems enact the ways in which medical language perpetuates and upholds the "inherent social asymmetry in doctor-patient relationships" (West 17), often noted by sociolinguistic commentators.

In order to draw attention to the innate authority and depersonalisation of clinical discourse and the clinical context, these poets often appropriate biomedical language, placing it alongside vernacular, conversational language—or even

[16] "The poems are most remarkable for being unremarkable" ("The Book of the Dead" par. 11).

replacing it conspicuously with the colloquial. This placement draws attention to the limitations and objective inappropriateness of the biomedical voice and gives a paradoxically powerful, personal voice to the seemingly subordinate patient, highlighting the importance of the lifeworld concerns that, according to sociologists, frequently frame physical illness, yet may be largely ignored by doctors.[17] Indeed, in juxtaposing "the technical-scientific assumptions of medicine and the natural attitude of daily life" (Mishler 14), these poems echo current sociological research suggesting that a tension exists between the two perspectives and languages, and that progress will only be made in the doctor-patient relationship when such tensions are acknowledged and addressed.

Medical sociologists call for more emphasis to be given to the patient as *person* in order to provide holistic and successful treatment, with the doctor "engag[ing] the patient at an existential level" (Coulehan 600). They espouse a model with parity between doctor and patient, where the "lifeworld" (Mishler 190) is given commensurate significance with the biomedical context:

> The vocation of physicians and other health professionals, insofar as it is possible, is to relieve suffering caused by illness, trauma, and bodily degeneration. However, since suffering is an existential state that does not necessarily parallel physical or emotional states, to relieve suffering physicians cannot rely solely on knowledge and skills that address physiological dysfunction. (Coulehan 600)

These poems from the perspective of the patient, however, do more than pose a social argument in an intellectual way. They fulfil the aesthetic requirements of the lyric poem, which as critic Anne Williams notes, should transcend private experience emotionally and in a voice that is "compelling, 'real' and true to some level of human experience"(13). To this end, the perceived 'reality' and credibility of the lyric is, of course, associated with "its characteristic use of the first person"

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[17] "Medicine's reductionism narrows its gaze, eliminating that which proliferates around the biological phenomena of sickness in a patient's always generative and teeming life" (Charon p27).

(Williams 15), but, more than this, "the speaker's language temporarily becomes our language, his experience ours" (Williams 15). Thus, the confessional lyric universalises through empathy—an empathy garnered, largely, from an "I" voice that comes to sound like "we". That is, the lyric, traditionally, "is a poetry of ideas, or acute political consciousness, that demonstrates, through testimony, an individual's relationship to a community" (Harris 254). This "testimony" (Harris 254) is crafted in a language and style that make an individual's reflection on experience into a "reality-statement" (Hamburger in Williams 13). I will argue that the stylistic elements of these personal medical poems—in particular, their voice ("a first-person speaker virtually identified with the implied poet" (Williams 17) and their engagement with two conflicting sets of images and discourses—belie accusations by critical reviewers that these poems amount to little more than self-indulgent "free-verse blogging" (Roberts, "Is it a Poem or a Blog" par. 8). As David Lindley asserts in his study of the lyric, "Craft can turn the poem into an object seemingly independent of its writer as a subjective individual" (80), and this is what I will argue Stead, Bornholdt and Broom accomplish in their personal medical poems.

C.K. Stead

On 11 May 2005, one of New Zealand's foremost authors, C.K. Stead, suffered a stroke that left him temporarily unable to read. While writing was still possible, "it was like writing in the dark" ("S-T-R-O-K-E" essay), and he experienced odd visual disturbances, proportions and axes shifted without warning. Nevertheless, Stead composed poems in his head, and kept a notebook while he recuperated.

Not many months afterwards, and fully recovered, Stead reflected on the experience:

> As medical matters go it was an insignificant event, but it left me with a notebook of 'debris', or emboli, that seemed worth revising ('Images', Kay said, 'of the mind re-constituting itself after trauma'), and a sharpened sense of impermanence.

> If there was any sense in which I had ever felt 'safe', I never would again. ("S-T-R-O-K-E" essay)

The post-stroke poems which had their nascence in the notebook have been described by reviewer Hugh Roberts as little more than "diagnostic traces of a specific mental impairment" ("The Book of the Dead" par. 11), the records of Stead's attempts to regain cognitive and motor functionality through intellectual exercise. According to Roberts, in *The Black River* Stead is simply "present[ing] us with extracts from writing exercises … he engaged in when suffering the effects of the stroke." ("The Book of the Dead" par. 10). However, the production process was far more involved than this, starting with poems kept in his mind, then transcribed to paper and then edited. As Stead explains:

> I was trying to prove to myself, in my head, that I could still make poems, even if I couldn't write them down … As days passed and the fog began to clear I managed to scribble [the poems] into a notebook … Later again I selected the ones that seemed to work best, and published them.
> (in Harvey 257)

These poems "evoking the extremity of personal experience" (Lawrence Jones in Harvey 257), typified by a "fragment[ed]" style (in Harvey 257), certainly represented "a conscious aim, a test" (Lawrence Jones in Harvey 257). Stead has described them as proof that "the language was still willing and able to work for me" (Stead in Harvey 257). Yet the poems do more than bear witness to the effects that the stroke had on Stead's writing; they explore its effects on technique. And by technique, here, I advocate Seamus Heaney's definition from the essay "Feeling into Words":

> Technique, as I would define it, involves not only a poet's way with words, his arrangement of metre, rhythm and verbal texture; it involves also a definition of his stance towards life, a definition of his own reality. It involved the

> discovery of ways to go out of his normal cognitive bounds
> and raid the inarticulate: a dynamic alertness that mediates
> between the origins of feeling in memory and experience and
> the formal ploys that express these in a work of art.
> (Heaney 19)

In terms of technique, the "S-T-R-O-K-E" sequence is reminiscent of Stead's "Yes T.S" poems of the 70s and 80s which were modernist, playful, and also touching on medical themes. They were written during a period of travel, charting the speaker's reaction to the anonymity of foreign places. In a similar way, "S-T-R-O-K-E" speaks from a patient's journey part-way across "the black river" Styx, caught between the old, known world and the new, uncertain territory of illness and recovery. Stead's description of the "Yes T.S" poems could easily be applied to the "S-T-R-O-K-E" sequence:

> Often I was reacting to being unfamiliarly alone in foreign
> places, but the reaction had to have a justification beyond
> any interest in myself, or in the poem as 'confession': it had to
> have verbal life, wit, some special interest, some kind of
> originality as poetry. There could be rhymes if that seemed to
> be what the moment required; there could be quotation,
> reportage, jokes, anecdotes, juxtapositions, puns—anything
> that contributed to the life on the page and was consistent
> with what preceded and followed. Whatever the changes of
> mood, place and circumstance, there had to be a continuous
> thread, a stylistic unity. Here style and personality are almost
> interchangeable: *le style, c'est l'homme*.
> (in Green and Ricketts 107)

From Stead's bedside notebook, then, came poems of a style that fitted the man at that time, poems that posed riddles, testing the patency not only of cognition, but also of identity and technique. For example, in the following lines, assertion falls away to questions about words, meanings and selfhood. When the

speaker examines each surface, layer after layer emerges—every repetition thereafter reveals an ambiguity and adds depth as the "mine of the mind" ("S-T-R-O-K-E" 21) is plundered by a speaker desperate to find what he left there, pre-stroke:

> words have given me access
> to the inside
> of the inside of the mind
>
> whose mind?
> mine
>
> the mine of the mind ("S-T-R-O-K-E" 15–21)

Past New Zealand poet laureate Cilla McQueen describes Stead's language here as suggesting "a pleasure almost naïve in impish wordplay, the mind suddenly unsophisticated reinventing paths of meaning" (167). She goes on to add: "Some of the (re)discoveries are perhaps a little raw, for instance 'the mine of the mind'" (216). In addition to "unsophisticated," the word "raw" implies that the poetry is underdone, that Stead was being playful in this poetic sequence, rather than careful, that he eschewed stylistic rigour in favour of basic spontaneity and an unchecked stream of consciousness.

I would argue, however, that the naïveté of the patient's voice is a sophisticated construct. The assonance—Stead's play with sound—echoes the plays on meaning. The repetition and lowercase letters that lend the poem a childish quality are elements of craft to enhance the sense of an authentic voice: one of a mind recovering its agency. Another iterative feature of the "S-T-R-O-K-E" sequence is a structural and linguistic leaping and grasping, exploring connotations and connections that smack of new discovery (or, simply, recovery). Reminiscent of the Colin McCahon painting(s) that inspired the poem,[18] there are many "jumps" in

[18] "I dreamed more than once of a McCahon painting I think Allen Curnow may have had on his wall, in which McCahon had represented a downward trajectory and added the word Jump in that

the dark featured in "S-T-R-O-K-E," the hyphenated title itself evoking a sense of disconnection and piecing-together, yet also an impetus. Stead resists passivity, and puts his faith in the active, artistic "JUMP" (98):

> a clean sheet?
> no!
> life's rough on the sheets
>
> and would I want to be dying
> (if I were dying)
> regretting anything
> but the things not done?
> *
> faith hope the JUMP
> these three abide
> and the greatest of these
> is the JUMP ("S-T-R-O-K-E" 88–98)

The "clean sheet" (88)—from which we can infer a fresh start, a blank page, in addition to a change of hospital bedding—is rejected in favour of life lived as it was, the already-written-upon page. The capital letters for "JUMP" signal not only its significance as the title of the McCahon painting that inspired the poem, but also the importance of the concept (standing in place of love/charity in the familiar collocation from *Corinthians* 1 13:13: "faith hope the JUMP" 95), implying that Stead is making his own recuperative movements towards artistic self-impression.

In almost every section of "S-T-R-O-K-E" the patient persona leaps between the safety of poetry he presumably learned by rote in his youth and the inventiveness of the mind of the older poet. The poem's lines are as allusive as they

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writing which became so much a part of his iconography. The poems seemed to gather around the idea of the necessary Jump" (Stead, "S-T-R-O-K-E" essay par. 15).

are elusive, evoking a mood of nostalgia and loss, with memory being a safe place, but also a lonely one, like illness:

> every man is an island
>
> do not therefore ask
> for whom the head aches
>
> it aches for thee (135–138)

Donne is (comically) recalled here,[19] and, in later lines, so are tracts of the Bible and the narrative poems of Coleridge. Familiar works, easily recalled, give a sense of permanence during a time of uncertainty when Stead was creating poems "to prove to myself that I still could" ("S-T-R-O-K-E" essay). The speaker's rote-learned lines, transmogrified by the poet to be self-reflexive, give readers a taste of 'the old Stead' returning. It is a hopeful progression, mirroring the movement from aphasia to linguistic and emotional recuperation.

There is also a movement away from the safely known, into the creative subconscious, when the patient-speaker uses one word as a launchpad to the next via an allusive, intuitive ambiguity, a trajectory that feels automatic and positive, with the speaker seemingly happy to follow one phrase to the next until he sees the destination. This is less safe than the world of rote, but more exciting. For example, the lines, "in Xanadu did Karlson Stead / a stately pleasure dome decree / Dome" (43–45) combine the two elements. Here, Coleridge's lines[20] are infiltrated by the poet's name in the place of that of the eponymous hero, reflecting Stead's situation: he is a man caught in the unfamiliar world of visual and cognitive distortion,[21] finding his way back to "the world" of the mind (12) that he "love[s]" (12) via language. The second "Dome" (43) is a leap from the realm of Kubla Khan to the

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19 "No Man is an Island" (John Donne, "Meditation XVII")

20 "In Xanadu did Kubla Khan / A stately pleasure-dome decree:" (Samuel Taylor Coleridge,"Kubla Khan")

21 "Memory seemed unaffected, including for names, dates, facts, poems; even arithmetical things learned by rote as a child" (Stead, "S-T-R-O-K-E" essay par. 3).

new territory of the patient, and it takes on the additional meaning of head/mind, linking back to "the mine of the mind" (21). This is not a craftless leap. Like McCahon's 'Jump' paintings, Stead's "S-T-R-O-K-E" invites "more than just one possible line of interpretation" (Brown on McCahon par.8).

While one reading sees Stead's patient-speaker re-entering life with verve, another aligns with critical perceptions of McCahon's work. "One reading of McCahon's "JUMP" paintings is that the reiterated word "JUMP" on the canvas "declares McCahon's risky faith" (Hurrell par. 3). In a similar way, Stead's faith (in himself, in life and death, in things literary and spiritual)[22] may be perceived as precarious in these poems. He has remarked that these post-stroke poems "have (not surprisingly) a slightly desperate quality which I think gives them a real edge" (in Harvey 257). The exposed voice of the patient persona as he navigates his situation and memory helps to communicate the uncertainty evident also in the ambiguity of the language.

Stead's poem epitomises the lyric's ability to transcend the personal from the paradoxical starting point of the very personal. As Joan Aleshire notes in her essay defending the lyric poem as a potent medium for the universalisation of emotion and situation, "[t]he effectiveness of the speaker lies in his or her vulnerability, when the 'I' makes no claims to knowledge outside its own experience" (15). In "S-T-R-O-K-E" for example, the I-speaker is very much inside his own experience, communicating a "subjective reality" (Lawrence Jones in Harvey 257), "induc[ing] the reader to know, from within, the virtual experience of a more or less particularized consciousness" (Williams 15). This 'knowing from within', paradoxically, is the very keystone of the poetry's universalising effect. *The Oxford Companion to Modern Poetry in English* describes the best Confessional poetry as "creating character so as to inform the trauma of the past with understanding and, sometimes, compassion," and Stead's stripped-bare patient-speaker does just this,

[22] "god is dying in the desert of the mind
no god no god" ("S-T-R-O-K-E" 22-23)

addressing readers from the first-person perspective, in a seemingly unfiltered manner, allowing them to witness a damaged mind reforming itself.

In "S-T-R-O-K-E," it becomes clear that the ability to 'mine' language has long been part of the speaker's identity. Stead's invocation of many possible meanings for a single word throughout "S-T-R-O-K-E" imitates the ways in which certainty has been lost for the patient after the ischaemic event—and the ways in which it will be reclaimed by the remembering of these multiple denotations. Yet, as discomfiting as the impermanence of meaning can be, there is also something of value to be found in following the trail of multi-denotative language, the creative process, where it leads—to the glistening repository of "the mine of the mind".

The ideas of identity and ownership—agency—are also evident here, in the repetition of "mine," which, in addition to a (nominal) excavation in the earth, can also function as a possessive pronoun. Language's attribution as "mine" (20), then, suggests that, as Williams notes, with regard to the lyric "I," "verbal idiom *is* identity" (15). By testing and following his lifeworld language along a cord of meanings, the patient-speaker reasserts his identity, reconstructs it through pieces of rote and subconscious associations that spring forth once the word has been written. "[T]he lordship of the word / is for ever" (134), he says, and this is where his faith lies. His transcendence of alarming medical experience is "the word" (134), the closest thing to spiritual faith he knows, and from which he derives comfort and impetus when "god is dying in the desert of the mind" ("S-T-R-O-K-E" 24). The links and leaps and reclamations of language see him testing out the hypothesis:

> no good no god
>
> god is dying in the desert of the mind
> no god no god
> JUMP ("S-T-R-O-K-E" 25–28)

With the return of language, then, comes the reassurance of a return to selfhood. In Stead's Hippocrates Prize-winning "Ischaemia," his alter-ego Catullus

puts it thus: "The brain-fog clears and words reveal themselves / with their secret secrets. They tell me I have a future" (32–33). This positive revelation is a far cry from the first stanza's dictated account of the first day after Catullus' stroke:

> Dear friend you enquire of Catullus and I answer
> in my own voice, though the hand you see is another's.
> Since the day I woke to a world of big things small
> and the small large, reading, so also writing
> have been beyond me. Numbers too, and maps –
> the streets of my own town, the rooms of my own villa
> confused. At home in my own head I've been lost!
> ("Ischaemia" 1–7)

The repetition of "my" is again a notable feature, and inversions—from lexical ones ("big things small," "small large") to the larger inversion of the poet using an amanuensis—all suggest confusion and the erosion of identity and ability.

The reclamation and reassertion of identity post-medical event is indeed key to the "S-T-R-O-K-E" sequence. Unlike Stead's "Clodian Songbook"[23] poems in which the poet "is deliberately using the Roman poet Catullus as a mask—not entirely separate from Stead himself but not quite himself either" (Ricketts in Green and Ricketts 138) the patently autobiographical "S-T-R-O-K-E" poems can be seen as affirming the individual and denying the dehumanising effects of illness and hospitalisation. In "S-T-R-O-K-E," Stead emphasises the importance of the personal over the clinical, resisting the anonymity of patient status by the act of writing:

> ward is a word and
> patient
> is pain
> is pen (82–85)

[23] "Stead first adopted his Catullan poetic persona in "The Clodian Songbook" (Geographies, 1982) and "From the Clodian Songbook" (Between, 1988), these poems taking their starting-point in each case from a particular poem of Catullus" (Davidson 2).

The stark and unfamiliar ward is subdued—captured—by the writing patient. It is only a word, not 'The Word', and one written, now, by him. He is more than "pain" (84); he is "pen" (85), active, alive despite the suffering.

Resistance (to passivity in and of itself) is in evidence in the "S-T-R-O-K-E" sequence, but also demonstrated is a cognisance of the relative power status of patient and doctor. The dominant position of the doctor as opposed to the subordinate position of the patient (and, indeed, the nurses) is delineated very clearly in Stead's post-stroke poems, reflecting the sociological fact that "the doctor-patient relationship is *predicated* on institutionalized inequality between those who heal and those who must come to them for treatment" (West 18).

In "Ischaemia," Stead's presentation of the doctors' discourse upholds West's assertion. First, there is the examination and its findings, featuring the formal, somewhat clinical language of the doctors. It is a language indistinguishable from that which modern doctors would use, despite the fact that our main narrative voice is that of Roman lyric poet Catullus (c. 87 – c. 57 BC):

> 'Dyslexic,' they said. 'Innumerate, and with minor
> disorientations. Articulate still, and mobile,
> and with memory unimpaired.' (11–13)

By contrast, next comes the prognosis; Stead phrases this in terms that remind us of the first century BC setting and confers on his doctors the mystical powers of the ancients. His I-speaker, Catullus, vaunts to friends that the "wise white togas" (29) have assured him that he "will soon be cured" (29). For Catullus, there is weight to their words, an implicit authority and sagesse associated with his doctors. They echo the reassuring assertions of the registrar who cared for Stead after his stroke who "was confident that [he] would recover relatively quickly" ("S-T-R-O-K-E" essay par. 7).

In “S-T-R-O-K-E,” too, as Stead’s patient-speaker observes the hospital staff as they go about their daily and nightly business, the hierarchical structure of the hospital staff is implied:

> doctors
> go walking
> down cool green corridors
>
> soft-soled
> nurses are numbers/
> numbness (76–81)

There is a singular difference in the presentation of doctors and nurses, the former “cool” (78) as the objective correlative corridors. The doctors do not just walk, they “go walking” (77), emphasising their purpose, their freedom and autonomy. The latter are “soft” (79) as their quiet, comfortable shoes. They are, to an extent, anonymous, representative of “numbness” (81): the nurses bring anaesthesia, and comfort in their “numbers” (80) while, at the bottom of the hierarchy, the “patient / is pain” (83–84) and the pain itself is patient, enduring, waiting for the attention of doctors and nurses.

Stead’s “S-T-R-O-K-E” sequence is told from the vantage point of a recumbent patient, reminiscent of the position of the patient narrator of Sylvia Plath's poems derived from her ‘Inmate Sketches’ written after a hospital stay for an appendectomy (*The Journals of Sylvia Plath* 333–343). The persona of “Tulips” recalls being propped up and tucked in, her head showing between sheet-cuff and pillow like a “stupid pupil” (“Tulips” 10), watching the nurses who “pass and pass” (“Tulips” 11) occasionally bringing “numbness in their bright needles” (“Tulips”16). It is a position of impotence and objectification.

While Plath’s persona descends into anonymity, Stead’s persona finds that what makes illness and medical treatment able to be transcended is a reminder of common humanity, or human communion. On the ward, the tiniest familiarity

seems poignantly meaningful. In the lines which follow, a very simple exchange of lifeworld discourse between patient and nurse brings comfort. A simple introduction, a small kindness, are remarkable in their poignancy—a poignancy evident in the very recording of the unadorned snatches of conversation and simple scene-setting:

> ward 81
> late beyond any o'clock
> 'what's your name, nurse?'
> 'winnie'
> 'ah'
> and winnie: 'sorry
> not to have told you.' (S-T-R-O-K-E" 29–35")

The ward is like any other, numbered among many; it is night-shift, and the patient is sleepless, anxious, and it matters that he knows his nurse's name because that name brings back the old, safe world of identity and human relationships. It is another manifestation of "the voice of the lifeworld" (Mishler 190) in an environment that renders the patient clinical object: "stripped / disclaimed / misnumbered / unremembered" ("S-T-R-O-K-E" 66 -69). Stead's words here could hardly be closer than those used in Coyle's 1999 study in which patients claimed to feel "dehumanised, objectified, stereotyped, disempowered and devalued" (in Barry 491).

The insecurity of the speaker, his sense of anonymity, his palpable craving for the personal—these qualities are all communicated by the poem's simple, dialogic form, its pared-back language—even the small 'w' for "winnie," reminiscent of basic, childhood writing, the sort of writing that a man tentatively relearning language might produce. This evokes a sense of the communion and comfort to be found in the acknowledgement of identity and the initiation of a human contact that counteracts the anonymity of "ward 81" and the experience of hospitalisation. Here, Stead adds validity to Rita Charon's opinion that "the divides between nurses … and their patients are less formidable than those of doctors" (21). The bridging of

this small divide represents solace and consolation for the patient, the familiar lifeworld ways coming into the unfamiliar and depersonalised hospital context.

Jenny Bornholdt

Jenny Bornholdt's *Mrs Winter's Jump*, written during her tenure of the 2005–2007 Te Mata laureateship and "a period of illness" (Armitage par. 11), incurred some criticism for the poems that "deal with events that take their cue from the medical environment" (Armitage par. 11). In his review, Hugh Roberts commented that in *Mrs Winter's Jump*, "[p]oetry becomes less an opportunity (or, perish the thought, a need) to say something than the performance of an attitude towards experience" ("Holding the Light Quietly"). He is of the opinion that she does not furnish the reader with "anything more than the bloggist's pleasure of exercising her characteristic voice" ("Holding the Light Quietly"). In a similar vein, Joanne Preston, in her second post about *The Rocky Shore*, claims, "reportage is not art. Neither is mere depiction" ("Landfall 218 and A Return to *The Rocky Shore*" par. 6). She sees no transformation of anecdotal material in Bornholdt's 2008 collection. Furthermore, the fact that the subject matter of much of the collection is illness and dying Preston perceives as an outdated homage to the Confessional poets:

> [T]ragedy is not art. Grief is not art. It may be the catalyst or the subject of art, but it is not sufficient in itself. The revelation of psychic trauma was shocking and new when the Confessional Poets first started writing about divorce, suicide, abortion, madness and so on. It was brave and it was important, because this was opening up poetry to a range of subject matter that had been deemed out of bounds. But that too happened a fair while ago. You don't get brownie points any more just for making the world your psychotherapist. ("Landfall 218, and A Return to *The Rocky Shore*" par. 11)

Bornholdt herself has been quick to explain that these poems were not a case of "'writing for therapy': I was telling a story of these things. It was very much a

constructed story. I was very careful with the way I shaped these poems" (Interview with Kathryn Ryan). It is interesting, however, to look at poetic voice at this point, and to what extent Bornholdt goes beyond the voice of blogging or diaristic writing—to what extent she employs anecdote as the catalyst to her poetry and then transforms the personal into the universal to a polemic end. It is my contention that Bornholdt deliberately acquires a voice that invites a reading of the hierarchy implicit in doctor-patient relations, moving personal experience towards universality and subtle critique.

In "The Doctors," for example, she speaks for herself, but also for "we" (1)—for the patients on the ward as a group as opposed to "them" (3), the group of doctors doing their rounds. By contrast to the immobile patients who "wait for them," the doctors' passage is assured; they "burst /through the doors" (13–14) and walk on the "great arcs" before them (10) made by cleaners. The imagery is increasingly grandiose as Bornholdt imagines the "fleet" (16) of doctors traversing "the great/ glass ocean" (17–18), hardly disturbing its surface. The metaphor suggests the impressiveness of the doctors embarking on ward rounds. Likewise, the language used to report the doctors' speech seems reassuring, certain:

> We will recover
> because the doctors tell us
> it is so. (21–23)

The modal "will" and "it is so," however, lose their potency when placed within the frame of the poem and its repetition of how "dangerous" (2) the patients feel: not *in danger*, but dangerous—difficult cases compared to the innocuous babies whom the doctors tend in the poem's first lines. After the ward has been cleaned and the patients have waited, the doctors "sail forth" (15) and deliver their prognosis—their prognostication: "Here they are / at our dangerous bedside. (19–20). The patients are referred to by the speaker as if they are one—they share one depersonalised bedside—and the line break divides the doctors ("they" 19) and the patients ("our … bedside" 20) still further.

The narrative standpoint, the images used to describe the grandiose doctors, the contrastingly passive inferiority and anonymity of the patients—these things point to a voice of resistance to that subordinate position. This is not simply a blogger's voice of complaint or a cathartic recollection of negative medical experience. Bornholdt carefully controls point of view, imagery, diction and the poem's form in order to highlight those aspects of doctor-patient interaction which are hierarchical and, for the patient, dehumanising.

However, there are other points of criticism pertaining to a perceived lack of craft levelled at Bornholdt by Preston: "Rhythm, word-music, patterned language … there's no end to the list of poetic devices she avoids" ("Stubbing my Toes" par. 3). Preston's accusation of craftlessness pertains to the series of long, prose-like poems that comprise the *The Rocky Shore*, the preponderance of colloquial-sounding constructions: "Why on earth is this book being sold as poetry?" (par. 2) Preston continues, "Why pretend these are poems? There is a genre that they fit into much better—the memoir" (par. 5). Again, it seems that autobiographical poetry is seen as stylistically sub-par; personal story has one place, and that is the prose memoir. Preston even goes so far as to analyse *The Rocky Shore* in terms of its fulfilment of the Montana Award categories:[24]

> i) Language: What does the poet do with language? Is language used in original ways to fasten the poetry in the imagination and memory?
>
> Ah, no. Language is used extremely flatly, and there are very few memorable images, let alone lines.
>
> ii) Technique: Is the poet proficient in the use of form, patterning, rhyme scheme and lineation?
>
> Not on the basis of this collection, no.
>
> iii) Originality: Does the overall aesthetic effect and appeal of

[24] *The Rocky Shore* won this award subsequent to Preston's blog posting.

> the work go beyond technical proficiency? Are issues explored in real depth in nuanced tones?
>
> No. There is no attempt to go beyond the quotidian. Quite the opposite in fact (par. 7–9)

This dismissive critique is countered by poet and critic Iain Sharp who views Preston as "evok[ing] the ghost of Shelley who warned in *A Defence of Poetry* that those who distinguish too sharply between prose and verse are committing a 'vulgar error'" (157). Furthermore, he notes that the lineation and form of the poems are "far from arbitrary" (157). For example, in "Fitter Turner" and "The Rocky Shore," generally, there are around sixteen syllables per line and those lines are in couplets. The poems are also divided "into sections signalled by the Manhire-influenced device of an asterisk" (Sharp 157). They may be what Bornholdt herself terms "talky poems" (in Sharp 157), he argues, but they are also accomplished, stylistically robust poems. Bornholdt gives attention not only to the lines, but the spaces between them:

> She uses white space artfully throughout the book to control the flow of words, slowing us down, making us concentrate and, with a bit of luck, take heed of repeated motifs.
> (Sharp 157)

Harry Ricketts, too, observes that Bornholdt's "apparently artless voice with its friendly chitchat about life, the universe and everything, in fact, demands careful artfulness to create and sustain" (Ricketts, "Voicing"). He goes into detail, examining the workings of "Fitter Turner" in order to make the point. Similarly, in discussing that same poem, Paula Green notes that successful personal poetry requires "filtering the anecdote through any number of poetic choices" (Green, in Green and Ricketts 553):

> In the final two lines of "Fitter Turner," returning from the doctor's with a son with a black eye, the poet briefly reflects

> on rhyme: "And we'll drive home – his eye matching sky –
> which is/an easy rhyme, but pleasing, to me, nevertheless"
> [269]. As elsewhere, this is by no means as "plain and
> straightforward" [170] as it might appear. 'Eye' and 'sky' not
> only rhyme with each other but assonantally reach back to
> "sign" in the previous line and forward to "rhyme" itself in
> the next, while "easy" half-rhymes with "pleasing" and fully
> with "me", and the offrhyme of "is" and "nevertheless"
> lightly sketches (without nailing home) the vestigial shape of
> a concluding couplet. (3)

Green argues that beneath Bornholdt's patina of the conversational style lies much crafting:

> The poetic lines are dipped in the immediacy of conversation
> but gain musical life through an exquisite phonic interplay,
> shifting rhythms and words that resonate like solo
> instruments … this conversational flavour is a significant
> ingredient rather than the wholesale replay of an actual
> conversation. (in Green and Ricketts 185)

In addition to such matters of style, it is worth concentrating upon Preston's final criticism: what she perceives to be the banal ideas underlying the poems' subject matter. It is true to say that Bornholdt is asserting the place of "the quotidian" (the daily, the everyday) in the personal medical poem—something that we saw in Stead's "winnie" ("S-T-R-O-K-E"). For the lifeworld is essential to understanding and transcending personal medical experience, and just as it should not be marginalised or overlooked in the doctor-patient interview or the patient's long-term care, it should not be ignored in the lyric that deals with the same.

However, whilst some of Bornholdt's poems take as their subject the diurnal during the course of her illness and recovery, I would argue they are not, by nature

or craft "quotidian"[25] in the sense of 'mundane'. In writing of daily thoughts and experiences in the context of illness, Bornholdt is exercising "the dramatic sleight of hand that has always been at the heart of the lyric" (98), as David Graham describes the transcendence of lyric poetry, "which engages the personal and the local in order to illuminate and animate something larger" (98). The larger question Bornholdt's poems ask is: How does one continue daily life and achieve some sense of equilibrium in the face of illness and medical treatment?

The ways in which she asks—and answers—that question returns us to issues of craft, though I will suggest a different sort of crafting than that defended by Sharp, Ricketts and Green. Not only, as these critics note, does Bornholdt subtly use line-breaks, rhyme and other lyric tactics, but—in addition—she carefully juxtaposes the details or discourses of daily life and medicine. Consider, for example, "A Long Way From Home," set "in the A&E Department" (3). The patient persona, in this busy area, overhears "[s]omeone saying / *I'll get the morphine // from the trauma trolley*" (4–6) and "[s]omeone else / *A cup of tea*?" (6). The domestic "cup of tea" (6) is set against the clinical "morphine" (4); the tea trolley is set against the trauma trolley. The domestic and the clinical sounds are strangely interchangeable in the environment. Similarly paradoxical is the "orthopaedic specialist—male—with the unlikely … name of Joy" ("A Long Way from Home" 7–8). The discrepancy between the specialist's gender and his name, and that between the gravity of his job title and the levity of "Joy" have a perverse fortuitousness. Bornholdt enjoys words that "talk to and sound off each other—there's a kind of conversation going on" (*The Rocky Shore* "Notes and Acknowledgements"). The medical and the diurnal are strange bedfellows, but they are frequently found together in the situation and environment described by the Bornholdt's patient persona.

[25] Bill Manhire writes: "[H]er work offers the same kind of quotidian reach and elegiac undertow that Frank O'Hara delivers when he takes one of his lunchtime walks in midtown Manhattan. Recent New Zealand poetry has been very happy with daily life. Both writers and readers are comfortable with a range of tone and reference that earlier New Zealand poets would have found quite troubling" ("Cream Torpedoes: Recent Poetry in New Zealand" 40).

The mixture of the personal and the clinical in the poem "Fitter Turner" at first suggests the comfort to be gained from this personal/medical hybridity in the flesh—it even presents the idea of medical humanities in the form of a physiotherapist who is an English scholar:

> It was a year when our bodies
> surrendered—knees, backs, lungs—listen
>
> to your shoulder, instructed my physiotherapist,
> who was also studying English Literature
>
> at university. *Wild nights / Wild nights* she'd quote
> from Emily Dickinson as she massaged my neck
> ("Fitter Turner" 1–6)

When she visits her orthopaedic surgeon, Chris ("Fitter Turner" 76), for her "bad knees" ("Fitter Turner" 61), their reported conversation is relaxed, colloquial:

> We talked about joints and their weaknesses and that led us
> to my father's rare, wonky ankle, which Chris told me
>
> had been written about in a *British Medical Journal*. He
> promised to find the article in the medical library and send it
> to me. ("Fitter Turner" 77–80)

However, Bornholdt next shows how uncomfortable the blurring of the personal and the medical can be when Chris sends her the article that features her recently deceased father as a case study. Bornholdt inserts some of the article about her father's ankle—written, she explains, when she was only two—into the poem by lineating it into verse, making a lyric poem within a lyric poem from text that is purely biomedical in its tone and content.

The medical journal article describes her father at age five, then age twenty-one. "It's entitled/ Congenital ball and socket ankle joint" ("Fitter Turner" 113). Bornholdt has referred to the father's defect earlier in the poem as "my father's rare, wonky ankle" ("Fitter Turner" 78), a colloquial, euphemistic phrase. Now, by contrast, the article presents the facts and clinical details of his "disease of the cervical spine" ("Fitter Turner" 115):

> A ball-and-socket
> ankle joint was present,
> and both tibia and fibula helped
> to form the proximal articular
> surface. The scaphoid was fused
> to the talus and the cuboid
> articulated with the 4th
> metatarsal. The 5th metatarsal
> was absent. Only two cuneiforms
> were present. The second toe
> had only two phalanges.
> The right limb was almost
> 1 inch shorter than the left . . . ("Fitter Turner" 21-31)

The biomedical facts and tone of scientific objectivity are at first distancing, possibly even confusing to the lay reader. Yet, I would argue, they also create pathos. This pathos is reliant on the placement of the specialised vocabulary and on our understanding of the poem's context and speaker. This is Bakhtin's heteroglossia at work: Medical details from the article such as "The second toe / had only two phalanges" ("Fitter Turner" 30–31) have an especial starkness in light of the context: a daughter reading about her recently dead father. Particular deficits noted throughout the article (signalled by words like "only," "absent," "shorter"), his deformities ("fused"), contradict normalcy, suggest the practical disability of the "boy" ("Fitter Turner" 114), five, then twenty-one, and remind the speaker of what "came later" (38). In this study, we are told that "no abnormality was noted / in

"the skull, chest, abdomen, / pelvis, hands, knees / and renal tract" ("Fitter Turner" 34–37). Yet, we are aware that the speaker's father has just died of cancer that had spread throughout his body.

Accordingly, the article, together with the accompanying "X-rays of [her] father's spine, ankle and foot" (149) are described as "the saddest things imaginable" (150), revealing how a discourse meant to be emotionally detached can, in a different context, evoke a strong emotional reaction. They prompt the daughter to go outside and busy herself in the garden "until [her own] back and knees hurt so much // [she] couldn't do it any longer" ("Fitter Turner" 152–153). Notably, there is a reflection of the father's physical suffering in the daughter's, a sense that Bornholdt is expressing the empathy and sadness the speaker feels about her father in descriptions of bodily sensations. Finally, she "imagine[s] those bones of [her] father's / in the ground" ("Fitter Turner" 155–6), even though we are told he was cremated. It is as though the arrival of the article, its clinical details and its tone of stark distance have made the speaker realise the loss of her father anew. The lines, completely impersonal, objective, prove discomfiting, and evoke a sense of pity and grief in the speaker as she contemplates the father's suffering as a child and as a young man, not to mention what "came later" (37).

In this poem, then, the clinical intrudes on the personal, and the discourse of medicine seems for a time to be the dominant voice of the story. As a result, we are made aware of an inappropriate and disturbing detachment to its tone, unsuitable for a family member to read or hear objectively. There is too much information, there are too many details, and a lack of any personalising or individualising language to acknowledge the human subject. By turning the article into a poem within a poem—that is, giving it line breaks so we attend to it as language—Bornholdt highlights the otherness and impersonality of medical discourse, and the way in which it makes an *other,* a cipher, of the subject—in this case, a boy, suffering from a painful, progressive deformity and, more importantly in this context, the speaker's late father. Bornholdt's use of clinical language here is heteroglossic; she employs the language of the medical article, but to her own ends, for poetic effect.

The medical voice is appropriated and then refracted to suit her intention, and the effect is a tone that devastates. It would seem to refute entirely Preston's claims that in Bornholdt's *The Rocky Shore* "[l]anguage is used extremely flatly, and there are very few memorable images, let alone lines." and "There is no attempt to go beyond the quotidian …" ("Stubbing my Toes …"). In this one poem, we can perceive a rich multi-voicedness to Bornholdt's writing, a heterogeneity that allows for the inclusion of the voice of the physiotherapist (2–3), Emily Dickinson (5), the intertextual article, and the shift from the language of the article to the language of the personal, as the speaker reflects on it and how it fits in terms of her father's life story and what "came later" (138) in his medical and life story.

In her laureate's collection *Mrs Winter's Jump*, Bornholdt also draws attention to the emotional inadequacy—not of clinical language, but of the administrative, bureaucratic language of healthcare—acquiring that discourse, too, with polemical intent. Like doctor-poet Rae Varcoe who writes of the exigencies of budgets and procedures within a hospital, it is with polemical—more than satirical—purpose that Jenny Bornholdt describes in a "schedule / of benefits" ("Worth"32–33) in which "[t]he loss of both hands / is worth two hundred / and fifty thousand" ("Worth" 1–3). However, she observes, there is "Nothing for loss of weight /or love. Morale and perspective / likewise miss out." ("Worth" 19–21). The personal, lifeworld losses are not "itemised" ("Worth" 11) and the quantification of remuneration for amputation is so bluntly put that it is grotesque in the context of a poem that comes to focus more on the loss of those abstracts "hope, faith, / feeling" ("Worth" 26–27) associated with illness. Reviewer Andy Armitage comments:

> Bornholdt engages with the mentality that produced this incongruous index, which combines severe injuries with monetary values. In doing so, she manages a quiet critique of contemporary social values. (par. 13)

In sum, she employs the heteroglossic mode in order to draw attention to the manner in which the language of healthcare and thus the healthcare system takes little account, so to speak, of human suffering. The discourse of biomedicine is more

than the language of science; it is the language of human clinicians and the language of institutionalised healthcare. In all three areas, it can prove insufficient and inappropriate when the subject is personal medical experience—the experience of individuals who, before becoming ill or requiring medical intervention, were quite autonomous within their lifeworld contexts. Bornholdt's engagement with the language of the benefit schedule, her parody of such a document, is satirical, but it is also deeply unnerving, pointing out the ways in which the individual is dehumanised by illness and medical treatment.

By contrast, in "Medical," it could be said that Bornholdt presents us with the ideal: the doctor-patient interaction which blends the biomedical and the lifeworld, giving significance to both elements and discourses. In "Medical," the necessary clinical, physical tests are carried out on the patient, but, at the same time, the patient's lifeworld is perceived as part of the patient's reality and part of her presenting complaint. The doctor listens with the stethoscope not only for the patient's heart-sounds, but, more than this, "with such / concentration" (3–4) that "[s]he can hear / the domestic / rattle around / like small change (17–20). Furthermore, the doctor can hear the timer signalling a cake ready in the oven, the family's remembrance of dead pets, and the lines merge as she picks up on "a lack of iron, / the fence / creaking in the wind" (33–36), the latter's noise heard over the crepitus of "knees" (37). The doctor even hears "the love" (50) the patient has "for [her] husband" (51).

From concrete particulars (the examination, the stethoscope, the knees), Bornholdt moves the poem towards the fantastical, creating an ideal doctor who is cognisant of all of the lifeworld thoughts, experiences and contexts of the patient as she carries out her examination. Thus, to the doctor's auscultation, the "curtains rattle /on their tracks" (93–94) with the "suck and blow" (91) of the patient's breath and, at moments, "the sigh of the tired" (23). This examination transcends the tensions that exist between the medical and the personal—and this mediation takes place via the doctor's hearkening to the patient's internal and external world outside illness—"allowing the voice of the lifeworld more space" (Barry 503). This is a

progression deemed necessary, it seems, by poets and sociologists alike. Bornholdt's doctor who listens to the lifeworld of the patient as well as monitoring her vital signs and examining her for evidence of illness, is the quintessence of doctors who have "change[d] their notions of success from purely technical considerations to include their patients feeling understood, listened to and treated like whole and unique human beings" (Barry 504).

In terms of craft and language, then, and in terms of shaping her material, Bornholdt appears to be doing more than mere reportage of personal experience in these medical poems. In the defences of her work written by Sharp et al, that is made clear, but I see in her work, too, the kind of positioning of discourses that suggests an acknowledgement of the relationship between medical and lay languages and perspectives, and a desire to address its inequities.

Sarah Broom

The late poet Sarah Broom's first book, *Tigers at Awhitu*, has been described as "a book of two halves" (Green par. 2). More specifically, the latter part of the book was written after the author's diagnosis with Stage 4 lung cancer (Interview with Ryan Van Winkle). The poems from the second half of the book deal not only with the themes of death and dying, but also with the imposing, authoritative, objective biomedical voice and its inadequacy for effective communication between doctor and terminally ill patient. The post-diagnosis poems also draw attention to the depersonalisation inherent in illness and treatment, and perform an active dissent from this state. Broom calls for personalised treatment and interactions with clinicians and clinical environments that surpass the biomedical, including the psycho-social and spiritual contexts of the patient. Her poems decry "the necessity of detachment in medical practice" (Coulehan 600) with which trainee doctors are still inculcated[26] according to some bioethics specialists.

While Broom's collection was well received on the whole, the pre-/post-

[26] "Medical educators [hold that] detachment protects the physician from being personally overwhelmed and paralyzed by a patient's pain and suffering" (Coulehan, "Tenderness and Steadiness").

diagnosis division of the book did invite comparison between the two parts. Joanna Preston comments:

> Unsurprisingly, (and especially as she underwent a major personal crisis in the interim) there is a definite change in these later poems—almost all in the poet's own voice, and with a gaze turned inward much more … For the most part I prefer the work in the earlier parts of the book—the weakest poems of the collection are in this latter section. Having said that, even though I didn't like poems like 'Three Exercises for Oncologists' and 'Panther', they aren't badly written. Just not up to the same standard as the rest.
> (Preston, Rev. of *Tigers at Awhitu* par. 4)

While Preston praised the "fluent and assured" (par. 2) nature of the first set of poems, those close to Broom's so-called "own voice" (par. 4) were judged to fall short in terms of craft and potency. As we have seen, this is not an uncommon finding in reviews of autobiographical medical poetry from the perspective of an I-patient, where closeness to the subject matter of the poems is judged to affect crafting in a deleterious manner.

What appears to have been missed here is the subtle polemic at the heart of many of Broom's medical poems, a subversion enacted through careful crafting of voice so that it takes on qualities of the critiqued and the critic. Take for example the short poem that Preston mentions above, "Three Exercises for Oncologists." It is framed in the form of three straightforward, objective instructions. The voice giving those instructions is heterogeneous: It has qualities of the physician's voice whose view of his patient's prognosis is grounded in the scientific; it has qualities of the scientific studies the physician reads and bases his opinions upon; and underneath these voices is that of the patient, who channels the language of scientific logic and statistics to mock and question such rigid adherence to numbers and graphs when humanity and its wonders and miracles—its hope—is still alive:

1. Define False Hope.
2. Explain why that hump in the centre of the bell
   curve makes you feel safe.
3. Design a randomised, controlled, double-blind trial
   to assess the efficacy of telling patients that they
   will die within twelve months. (1-6)

Broom's tone is defiant; her imperatives question the science and ethics behind the prognosis delivered by the doctor. But perhaps what is questioned most is the mode of telling. She wrests clinical jargon from oncological research papers (the kind of texts cited by her oncologist) and fires it back in a three-pronged attack, demanding that the experts in her illness look more humanely on their human subjects, avoiding the supercilious distance of scientific diction and statistics. To the layperson, the language of scientific research and its analysis is paradoxical—how can a trial be both "randomised" and "controlled" (4)? Broom's implicit argument has a sense of offence at its centre: surely the patient's survival beyond the bounds of prognosis can be entertained by the specialists. She, like so many patients labelled 'terminal', wishes to be "the exception to the rule" (Interview with Kathryn Ryan). Yet, she finds that within "the system" (Interview with Kathryn Ryan) such patients are "not given permission to be that exception" (Interview with Kathryn Ryan). Her sentiments are echoed by Glenn Colquhoun, who pleads, "Let there be somewhere in the hospital where the randomised controlled trial is balanced at least with the ruthless, intuitive, sensual subjective" ("Middlemore is My Hospital" 127). The alternative is too utterly bleak.

The polemical voice of "Three Exercises for Oncologists" is neither completely Broom's nor entirely that of a fictitious patient, specialist or published study; it is polyglottal. It is the poet who is assuming the voice of a patient, who is writing the doctors' language in the manner and tone of research papers, thereby echoing the discourse of researchers and specialists, and this amalgam is used as an ironic mouthpiece for a polemical point. In devising "[e]xercises" for the clinicians dealing with the patient's condition, she is prescribing the antithesis of the

imperatives she suggests. The final line of the poem is the starkest, and from it we infer that there is no "efficacy" (5) at all in withdrawing all hope from the patient or in deeming hope "false" (1). Poet Alison Hawthorne Deming, in her essay on science and poetry, voices a similar opinion: "[I]f science today needs anything, it needs to move out of its insular objectivity, its pretence that it deals only with facts, not with ethical implications" (194)

In assimilating the actual language of the clinician—medical jargon or scientific diction—Broom implements Bakhtin's heteroglossia as a "subversive and counterhegemonic force" (Eskin 388) opposing a seemingly illogical, "potentially repressive, authority" (Eskin 389). Clinical language becomes the medium for satire and critique, reflecting both the frequent sociological finding that often, in doctor-patient conversations, "physicians resorted to arcane medical terminology which mystified patients" (West 24) and the Bakhtinian notion of "different voices and styles competing for attention and ascendancy" (Carter 66) in literary texts. "Parody is a relativizing, deprivileging mode" (Hutcheon 69), and the acquisition of medical discourse by the patient poets is an act of overt parody—what Bakhtin would describe as "a language that has become more or less materialized, become objectified, the [the writer] merely ventriloquates" ("Discourse in the Novel" 299).

Thus "Three Exercises for Oncologists," like other poems by the patient-poets, can be read through a Bakhtinian lens as a very carefully crafted vehicle for social critique. Broom echoes the Bakhtinian precept that "one must take the word, and make it one's own (294)". In this way, the purported bluntness and objectivity of the poem's speaker are ironic and the underlying tone is one of recrimination and resentment. Broom is not seeking the objective and the clinical; she desires tolerance of subjective, the against-the-odds, from the doctors. She requires treatment that is more personally-based than based on research papers and statistical evidence. Broom is not satisfied with the probability of a "bell / curve" (2–3) governing her treatment. In "Three Exercises for Oncologists," the biomedical voice is appropriated and redelivered to the reader in a deliberately destabilising manner. The voice of medicine is hijacked by the poet who produces a dark satire via

mimesis. The patient-speaker performs something akin to Bakhtin's "heteroglossia of the clown"[27] ("Discourse in the Novel" 273), an act that is "parodic, and aimed sharply and polemically against the official languages of its given time" (Bakhtin, "Discourse in the Novel" 215). To perform her point, Broom enters the heteroglossic arena described by Bakhtin, "where all 'languages' [are] masks and where no language [can] claim to be an authentic, incontestable face" ("Discourse in the Novel" 273).

Again, in "NO," Broom's theme is the inadequacy and inappropriateness of a doctor's summary of the speaker's poor prognosis. In this case, rather than medical language as such, she uses the doctor's words, seemingly verbatim:

> TO LIVE / FOR / YOU / TO LIVE
> BUT / WE CAN
> NOT
>
> BUT (8–11)

She presents the inadequacy of the clinician's talk by reducing it to a riddling nonsense of blunt, monosyllabic words that breaks down under scrutiny, her use of the forward-slash '/' between phrases drawing attention to their disjunctive nature. When there is no more testing to be done and no more treatment to provide, the physician is shown to have little aptitude for end-of-life conversations. The poor clichés—"IT'S NOT /SOMETHING WE CAN GET RID OF" (1–2) and "YOU HAVE A LOT TO LIVE FOR" (5)—fall away by the poem's end, reducing to just one or two words, concluding with a negative, a space and a conjunction. The reader understands that the doctor-patient conversation has petered out. The physician

[27] "At the time when major divisions of the poetic genres were developing under the influence of the unifying, centralizing, centripetal forces of verbal-ideological life, the novel--and those artistic-prose genres that gravitate toward it–was being historically shaped by the current of decentralizing, centrifugal forces. At the time when poetry was accomplishing the task of cultural, national and political centralization of the verbal-ideological world in the higher official socio-ideological levels, on the lower levels, on the stages of local fairs and at buffoon spectacles, the heteroglossia of the clown sounded forth, ridiculing all 'languages' and dialects; there developed the literature of the *fabliaux* and *Schwaenke* of street songs, folksayings, anecdotes, where there was no language-center at all …" (Bakhtin, "Discourse in the Novel" 273).

may have realised that on one hand, he is telling the patient she has much to live for; on the other, he is saying he can do nothing to help her. End-of-life conversations between doctors and patients are the focus of Harvard Medical School Professor Atul Gawande's 2014 book *Being Mortal: Medicine and What Matters in the End*, and the subject of his 2010 article in *The Economist* in which he states: "Studies find that although doctors usually tell patients when a cancer is not curable, most are reluctant to give a specific prognosis, even when pressed" ("Letting Go"). Clearly, as Broom and Gawande have both posited via their different media, end-of-life conversations, or conversations about potentially terminal illnesses, are some of the most important exchanges that will happen between doctor and patient.

Broom's "Hospital Property" features yet more vague clichés—this time, of palliation: "BUT WE CAN GIVE YOU TIME" (10). In addition, the CT scanner's pre-programmed, computerised language is exposed as woefully inappropriate when the patient is repeatedly told "of all things, to breathe normally" (4) while she is being imaged for lung cancer. Neither the physician nor "the Siemens Somatom Emotion Duo / CT scanner" (2–3) speaks reassuringly or in a manner that makes sense. Broom's use of the full use of the imaging apparatus further suggests the cold, impersonal nature of medical investigation and treatment—"scanner" would suffice; the full name of the device draws attention to its status as biomedical object—a status that the speaker, dressed as "HOSPITAL PROPERTY" (8), approaches. Nothing in this scene is human or comforting, nothing speaks of or from the lifeworld. Furthermore, voices of the doctors and the machine combine to drown out the sounds of the safe, known world until she "cannot hear … the wind / in the pines just behind the beach" (5–6), that sound of the lifeworld which she tries to recall for comfort during the procedure.

Once more, in "Hospital Property," the patient persona enumerates the ways in which she has been denuded of her identity and volition, the acknowledgement of her life outside illness, since being admitted to hospital. Successive clauses beginning with "because" signal increasing frustration and ire:

> because my gown says HOSPITAL PROPERTY

all over …
and because one fist, held close enough,
was enough to block out the light
from the giant white window where the traffic
kept travelling over and over the bridge … (8–9, 13–16)

The capitals of the gown's label eclipse the other letters of the poem, just as the "fist" (13) obscures the view outside. In the image of that "fist" (13) there is anger at the easy disappearance of the known world, the life that the I-patient has/had outside the hospital, outside illness.

Barfield and Selman, in their chapter titled "Spirituality and Religion" in the *Health and Humanities Reader* describe the shift from normality to ill-health thus: "We find ourselves outside the familiar, "homelike" state of health and in the foreign, "unhomelike" world of illness (Svenaeus 2010)" (376). In a similar way, reviewing the collection, Paula Green comments, "Things outside the clinical procedures and walls wrap about her as windows, anchors and safety nets" (Review of *Tigers at Awhitu* par. 6). It is this safe lifeworld that Broom is at pains to describe in other poems from *Tigers at Awhitu*, countering the imposition of the biomedical by means of poems that depict a holiday home, the birth of children, the natural environment—sea and bush, even the wind: "and what else does the wind do? / it whips around my face and tells me not to die"("What the wind does" 12–13).

In her interview with Kathryn Ryan, Broom explained the critique at the heart of her medical poems, a critique which centres on the sheer depersonalisation of the hospital experience, exemplified in poems like the ones discussed previously:

It's just the system which I think I'm getting at …
Sometimes the model they're operating with is limited …
There is an awful lot of emphasis on things like statistics,
trials and so on, and much less emphasis—not enough
emphasis—on individuality … (Interview)

In this way, Broom's poetry echoes Mishler's sociolinguistic findings, backed up by successive sociological studies: "patients themselves experience the ignoring of their lifeworlds as a painful threat to their identity" (Barry 491). The statement Broom gave in the interview makes this clear. In her opinion, an emphasis strictly upon the biomedical reality of experience is not enough. Columbia University's Director of Narrative Meicine Rita Charon agrees:

> A scientifically competent medicine alone cannot help a patient grapple with the loss of health and find meaning in illness and dying. Along with their growing scientific expertise, doctors need the expertise to listen to their patients, to understand as best they can the ordeals of illness, to honor the meanings of their patients' narratives of illness, and to be moved by what they behold so that they can act on their patients' behalf.(3)

A magazine article that was published after Broom's death, titled "The Pills of Last Resort: How Dying Patients Get Access to Experimental Drugs," describes how Broom, under advisement of an oncologist she contacted via a host of connections, gained access to a trial drug that, it was thought, might prolong her life (as a previous drug procured along similar lines had done):

> [Shaw, the oncologist] asked Broom to have her three children and husband hand-write letters. Daniel's letter read: "Dear Drug Company … Mummy needs to finish reading 'The Lord of the Rings' to Christopher and I, we are at 'Return of the King,' siege of Gondor, page 853. There are 1,069 pages … I love my mum, please help her to get better." Shaw topped it off with a montage of photos: Broom holding her daughter, Amelia, in an angel costume; Broom wading with her kids in a lake. (Sanghavi par.18)

Novartis's senior vice president Barbara Weber received the package

containing the letters and photographs and authorised the release of the drug (LDK378) to Broom. On beginning treatment with it, metastases to her brain shrank; she gained another year of life before succumbing to cancer on the 18 April 2013.

It is unsurprising, then, that Broom's poems refute the notion that "[h]uman approaches do not count in science" (Holub 60). Her work gives voice to the personal, spiritual context of the patient, resisting the objective and the biomedical in favour of the subjective, the individual. These poems are not "report[ing] on a Big Life Event" (Roberts, "Is it a Poem or a Blog?"), nor are they free verse musings on "Stuff That Has Happened To Me Lately" (Roberts, "Is it a Poem or a Blog?"). These are poems which declare that a patient should not be read as a cipher or a point on a graph. Broom uses the lyric as a vehicle for the imposition of her patient persona's will.

Perhaps it is true that, as Paula Green has suggested in her review, Broom's medical poems in *Tigers at Awhitu* "may in part be therapeutic, stand as an aid to life" (par. 7). Certainly, Broom enacts poiesis as "a means to create order and form in a field unified only by chaos" (Hawthorne Deeming 190), subduing the purely biomedical by assimilating and refracting its language, imposing lifeworld diction and images upon the starkness of hospitals and the formulaic medical interview.

Conclusion

Contrary to accusations of a lack of stylistic control by some reviewers, the patient poems are attentive to craft—in particular, via the juxtaposition of the clinical and the personal, the biomedical and lifeworld contexts of illness and daily life. As opposed to the idea that autobiographically-based medical poetry in the first person is little more than diaristic 'blogging', the first-person patient point of view is more aptly perceived in these poems as the "I" of the traditional lyric whose role is to universalise and transcend private experience by employing a convincing I-speaker who invites empathy and a comparison (whether correct or not) with the author. It is an apt standpoint from which to assert the place of personal subjectivity in a

context overwhelmed by clinical objectivity.

By constructing powerful lyric poems that also encompass the polemic, the socially-aware, these patient-poems go beyond the personal and the individual to articulate larger concerns shared by sociologists and sociolinguists whose focus is the inherent power relations of language within an institution, and the inequality of the doctor-patient relationship.

Like Mishler and Charon who suggest that the way forward is the personalisation of patient care and a balance between the vernacular and the medical in doctor-patient discourse, Stead, Bornholdt and Broom resist the medicalisation and depersonalisation that occur as a result of illness, institutionalisation and medical treatment. They give voice to the lifeworld, suggesting its validity and appropriateness for inclusion within a medical context, showing its usefulness in highlighting the importance of the patient as whole person, not just as medical object.

A key tool in the arsenal of the patient-poets as they aim to assert the place of lifeworld discourse alongside biomedical discourse is multi-voicedness. Bill Manhire has argued that "[m]any of New Zealand's best poets are code-switchers" (18); they move from argot to argot, register to register, adding a veracity to their poetry, a richness, which would not exist in a monologic mode. He writes admiringly of "the kind of mix that I think our liveliest poets can produce—a text which is a sort of conversation between words from different languages" (18). In the case of these poets who write about personal medical experience, the different languages are part of the same national language, just as Bakhtin described it when setting forth his ideas regarding heteroglossia, yet they are socially different languages—the language of biomedicine and the language of the lifeworld.

Lifeworld discourse—for the individualised psychosocial world values it embodies—is championed by these poets, and wherever possible, lifeworld language is mixed with the language of the clinical environment in which a patient-speaker finds him/herself. The heteroglossic mode is evident in the work of Stead, when he

makes leaps from the oeuvres of the poets of the Canon to the biblical Word to his own word-association and poetry making after a stroke. His work in the "S-T-R-O-K-E" series is concerned with the hierarchy of words as perceived from a hospital bed, in which the personal and artistic struggles are of commensurate import with the clinical, and isolation is as traumatic as the possibility of permanent dyslexia.

Bornholdt's blending of languages also highlights the coexistence of codes within the clinical environment and, again, asserts the identity of the patient/s (whether it is the patients on the ward watching the doctors do their rounds, or the boy who was her father in a medical article). Despite critics of her "talky" poems (in Johnston and Marsack 130), she asserts: "A poem like 'Confessional' came because I strongly wanted to 'say' things. I wanted to be the 'I' in the poem, not the slippery 'she' or 'you' so often used." (in Johnston and Marsack 130).

Broom, too, uses a blended voice to achieve a polemic that asks, almost as spokesperson, as in "Ward 64," for each patient's individual voice to be heard: "the curtain's beige and orange checks / do nothing to divide us" ("Ward 64" 1–2). Broom's poems take the language of medical authority, process and objectivity, and make it work to her purpose, defiantly instructing those who rely on the bell curve and statistics, "No, but wait. Watch what happens now" ("Hospital Property," 27). She is also able to create the voice of a refracted doctor-speaker whose very assertions are ironic and layered. Broom's poems of this kind, based on a clinical interview, possess a voice of subversion that draws attention to the authority of physicians and their language, their "privilege of expertise" (as Foucault would term it (*Ethics: Subjectivity and Truth* 44)) and its associated distance, impenetrability and inappropriateness when it must cross the border to the lifeworld arena of death, dying, hope and spirituality. In these ways, Broom's poems exhibit a level of craft and social engagement that raises them beyond texts which tell of a single person's experience, and into the realm of transformative, universalising lyrics with a social imperative.

Chapter 3

The Parent-poets: Ingrid Horrocks, Anne Kennedy and Jessica Le Bas

Introduction

As is the case with the patient-poets of the previous chapter, for Ingrid Horrocks, Anne Kennedy and Jessica Le Bas, proximity to the subject matter and a strand of social commentary running through their poems leave them open to accusations of solipsistic blogging or soap-boxing, as well as the question of whether the poets' closeness to the experiences recounted in these collections makes the poems little more than media for personal protest or, worse—in the case of Le Bas, for example—the artistic exploitation of a private family story.

Horrocks', Kennedy's and Le Bas' linked series of poems on medical matters come close to what are now termed "illness narratives" (Kleinman 49). Therefore reviewers can regard them as curious hybrids of the diaristic and the therapeutic, falling short of genuine poetry, and achieving the dubious label—as poet and critic Peter Bland would have it with reference to Kennedy's *Sing-song*—"nearly poetry" (par.9), a story that would have been better presented "as prose, which it often is: as a sequence of letters perhaps, or a long short story, or even as a diary account" (par.9). Another reviewer agrees, arguing that Kennedy's poems function as "short chapters," that *Sing-song* could be "a novella in verse" (Locke, "*Sing-song* Review" par.8). In a similar vein, Hugh Roberts has suggested that Horrocks is "given to free-verse blogging" ("Is it a Poem or is it a Blog?" par. 8), that the poetry in *Mapping the Distance* is stylistically underdeveloped and too immediate, akin to diary entries; it does not contain the linguistic, formal or aural elements that would distinguish it as 'proper' poetry.

However, it is also the case, as I will argue in this chapter, that one can perceive the form as reflective of the content—as an apt stylistic choice—much in the same way that Deming describes the contemporary poetic sequence as a form that "aims for a kind of fragmented connectedness" that "exemplifies the idea that within chaos there is an inherent propensity for order" (196). What these poets

frequently enact in their narratives is an Odyssey-like performance of an arduous journey.

It is my contention that Ingrid Horrocks' *Mapping the Distance*, Anne Kennedy's *Sing-song* and Jessica Le Bas' *Walking to Africa* —all featuring linked, autobiographical, medically-themed poems concerning motherhood—go far beyond what is deemed by some reviewers to be a current New Zealand trend in poetry typified by "exercises in Higher Blogging: free-verse ruminations on Stuff That Has Happened To Me Lately" (Roberts, "Is it a Poem or a Blog" par. 2). Horrocks, Kennedy and Le Bas write lyric poetry that transcends the purely personal and moves towards the universal. Their poetry is typified by a counter-balancing of the domestic and the medical, the vernacular resisting and often rebutting the clinical. In doing so, they introduce a subjectivity and humanity to objective, dehumanising medical experiences, environments and discourses, often with a touch of the heroic—as aspect added by the motif of quest that pervades each story.

There is a sense of involvement in the poems on the part of the poets, but the choice of the non-first-person narrative voice gives the poems a perspective one step removed from that of the first-person patient-poems. Their point of view is still highly personal, yet different from the "I"-lyric poem "which represents the experience of an individual consciousness from within" (Williams 16). Unlike Stead, Bornholdt and Broom, the patient-poets who write as "I" and about the "I" (occasionally invoking "we" to emphasise the universality of the illness experience), Kennedy and Le Bas write about an ill daughter, "she," but from a mother's/carer's viewpoint. Accordingly, both of these collections have a somewhat omniscient aspect to the narrative, balanced against the voice of the self-stereotyped "eczema mother" ("The magazine of white children" 25) in *Sing-song* and the part-objective, part-involving voice of "you," the mother, in *Walking to Africa*. These narrative approaches, blending distance and proximity, create the impression of simultaneously watching and accompanying the child-patient, experiencing her struggles as both observer and family member. Poet and critic Harry Ricketts explains the effect of this type of narrative with regard to Kennedy's *Sing-song*:

> Technically, the poems are fascinating for their filmlike combination of distance and close-up, giving the reader the sense of being simultaneously inside and outside the experience as it unfolds. (in Green and Ricketts 544)

Ingrid Horrocks' poems give an insight into a different kind of medicalised motherhood: the final two sections of *Mapping the Distance* are concerned with the attempt to fall pregnant via the in vitro fertilisation process (which proves successful by the collection's end). Like Kennedy's third-person approach, Horrocks' sections titled "Songs for Children (A cycle in many voices)" and "What Comes Next: In Vitro Fertilisation," feature mother personae who are predominantly 'she'. Only two poems are narrated by a conventional lyric I-speaker. One other poem which departs from the "she"-narrative, "Chat Room Voices (Accessed Days 18–24)," "takes each of its lines verbatim from online chatroom conversations" (Horrocks, *Mapping the Distance* Notes 78); as a result, we are not invited to conflate speaker and poet—rather, an everywoman voice is constructed from the first-person voices of many in a heteroglossic mode. This non-"I" narrative viewpoint allows the three poets to universalise experience more expediently than the traditional first-person perspective in that, already, experience does not reside entirely with the narrator.

It could be said that Ingrid Horrocks' medical poetry bridges the poetry of the patient-poets and that of the parent-poets, in that she writes about her own experience, yet she largely avoids the "I"-narrative voice, and her subject matter is not solely centred on her experience as a single person; rather, her topic is the in vitro fertilisation process and how it affects her and her husband. Furthermore, while Kennedy and Le Bas write whole collections based on their experiences as the mothers of sick children, Horrocks' poems about pursuing motherhood take up just two sections of her book. However, these sections have a narrative thread and follow the IVF process day by day, mapping the central persona's progress—as in the title of the book—as she navigates new medical territory, much as one would chart the progress of a person on a journey. This aligns *Mapping the Distance* with *Walking to Africa* and *Sing-song*, in which both mothers embark on odysseys through alien

clinical environments, encountering challenges that are linguistic as well as emotional.

In all three works, we can observe the juxtaposition and contrapuntal placement of clinical and personal language, as well as competing images of the mother's biomedical and lifeworld contexts. The counter-pointing dissonances of discourses and imageries highlight not only the depersonalising effects of illness and treatment within a medical environment, but also the inappropriateness of medicine's abject emphasis on objectivity of language and approach.

More specifically, the practice and language of medicine are presented as detrimental to the personal, the individual, the patient's own story—the implication being that the usurping of the subjective by the more clinical objective results in an incomplete and dubitable understanding of the patient's experience.

Philosopher Thomas Nagel posits that a position of detached objectivity is limited by the simple fact that

> "there are things about the world and life and ourselves that cannot be adequately understood from a maximally objective standpoint … [T]he attempt to give a complete account of the world in objective terms detached from [other] perspectives inevitably leads to false reductions or to outright denial that certain patently real phenomena exist at all." (7)

Nagel suggests that "[t]he subjectivity of consciousness is an irreducible feature of reality … and it must occupy as fundamental a place in any credible world view as matter, energy, space, time and numbers" (7–8). The juxtaposition of medical and personal languages can be seen as enacting a similar "internal-external tension" to that described by Nagel (6). The opposition of the two discourses, one detached and objective, the other deep within the context of the lifeworld, eventually leading to an experimental amalgam of the two, as we see in much of the poetry here, serves to "produce something new" (Nagel 6). This new, blended mode

acts as part-resolution and part-transcendence of the opposing perspectives and languages.

Discussion of scientific objectivity and personal subjectivity in these poems also touches upon the hierarchy implicit in the doctor-patient relationship and, accordingly, the hierarchy implicit in the relationship between medical and personal language. The language used in these poems presents Foucauldian power struggles between medical and personal discourses and contexts, and, by extension, echoes the work of sociolinguists studying "conflict between the voices of the lifeworld and of medicine" (Mishler 190). In all three poetry collections, as in Mishler's study of doctor-patient interactions and other, more recent, studies, "[t]ypically, the voice of the lifeworld [is] suppressed and patients' efforts to provide accounts of their problems within the contexts of their lifeworld situations [are] disrupted and fragmented" (Mishler 190). Medical language itself, used by the doctor when speaking to the patient, can be oppressive—this from studies undertaken by Peter Ubel writing in 2012:

> Tape recordings have shown that doctors commonly use confusing jargon when talking with their patients, often without defining what their words mean. Even primary care physicians, who tend to focus much more on communication than specialists do, emit an average of five undefined technical terms per minute. (Ubel 79)

But whilst Horrocks, Kennedy and Le Bas present patients (and their families) as often overwhelmed by unfamiliar medical environments, procedures and language, they also write back,[28] both for themselves, and on behalf of others: their children in the cases of Kennedy and Le Bas, and other patients in the case of Horrocks. The voice of the poems asserts itself from within an oppressive biomedical context, communicating "the demand to speak rather than being spoken for and to represent oneself rather than being represented or, in the worst cases, rather than

[28] This is a predominant idea in Ashcroft, Griffiths and Tiffin's *The Empire Writes Back: Theory and Practice in Post-colonial Literatures*.

being effaced entirely" (Frank 13). The voices crafted by all three poets are typical of those on the periphery who demand to be acknowledged by the centre.

The act of writing back involves an exploration of the ambiguities of one language used in different contexts, and the discovery of a new language which represents a gateway (past the gatekeepers) to knowledge, understanding and the right to have a part in decision-making. In addition to the poets' common motif of the search for cure or the journey towards acceptance of the fact that the condition will be life-long, there is also a predominant theme of discovering a mode of expression that does justice to personal medical experience. Often, for the mother personae featured in these poems, meaning is fluid, and ambiguity can lead to or express uncertainty. However, it can also communicate a subjective truth, mediating between the medical and personal worlds of the patients (and their families).

The conflicts between biomedical and lifeworld discourse are often mediated by word-play at their site of intersection. Punning and the performance of poetic inventiveness signal the acknowledgement of uncertainty and subjectivity that is at the heart of the realisation that "There is no truth, only points of view"—a pronouncement attributed to New Zealand novelist Charlotte Grimshaw (Le Bas, Message to the author, E-mail).[29] Allowing room for the subjective, the personal is frequently an attribute that the parent-poets depict as missing from the clinicians featured in their poems, yet something deeply desired by the patients or their carers. It follows that the placement of "the voice of the lifeworld at the center of interest" (Mishler 190) with regard to the patient's illness and treatment is deemed paramount by sociologists. As Rita Charon describes it in *Narrative Medicine*, what is called for is the acknowledgement of the indefinable and personal alongside the measurable and medical:

> In addition to needing expert diagnosis and treatment …
> people simultaneously need those caring for them to recognize

[29] This quotation has originally been attributed to Edith Sitwell (and online websites attest to this attribution).

> that something of value has abandoned them, that a deep and nameless sadness has settled in at home. It would seem that those entrusted with the care of the sick should by nature extend great reserves of comfort, of hope, of tenderness, and of strength toward those struggling through the pain of disease, the discomfort of treatment, and the toll of all the losses. (17)

So, what I shall argue in this chapter is that Le Bas, Kennedy and Horrocks are doing more in their poetry than recording medical ordeals and perhaps drawing attention to the need for better patient care; they are doing more than problematising the relationship between doctor and layperson, and raising Foucauldian issues of authority and resistance. In fact, what they are doing is using language to challenge and mediate between the clinical and the personal, the biomedical and the lifeworld. An analysis of how the poets transcend personal medical experience, using structural and linguistic craft and manipulation of narrative voice to move their series of poems towards the universal, is key to my argument that these are successful lyrics that resist the absolutes of scientific, medical language and bring to our attention the necessity of hearkening to the subjective and the personal.

Ingrid Horrocks

The final two sections of Horrocks' *Mapping the Distance*, "Songs for Children" and "What Comes Next: In Vitro Fertilisation," are comprised of a series of poems that chronicle the poet's experience of attempting to conceive. Reviewed by Hugh Roberts alongside other autobiographical medical poetry, Horrocks' poems are deemed to have "little to compel the reader's interest in them as poems beyond the human interest of the story they tell" (Roberts, "Is it a poem or a blog?" par. 5), despite the fact that they have "extra emotional oomph from a Big Life Event" (Roberts, "Is it a poem or a blog?" par. 8).

Roberts accuses Horrocks of "free-verse blogging" ("Is it a poem or a blog?" par.8), which would appear to suggest a first-person perspective, most commonly associated with the web log. But most of the poems about IVF are written from a third person perspective. The main character, a woman undergoing treatment for infertility, is "she," but her story is told in a voice that we are supposed to perceive as inflected with the author's own. The narrative voice is very carefully crafted to achieve this balance, as Helen Vidler notes in a far more favourable, review: "In this way the sequence conveys intensely personal elements of the experience while also inviting universal contemplation" (16).

Ultimately, narrative perspective is the voice of the lyric poem's "implied artificer" (Williams 17)—the voice of the speaker whom the reader sees as analogous to the poet—and as Williams describes it, "a fictional construct and a dimension that can be manipulated by the author as deliberately as any other—rhyme-scheme, meter, imagery, all of which may indeed contribute to our sense of implied poet, and which in the usual concentrated lyric have an especially obvious power" (17). Therefore, the avoidance of the I-speaker is a defining aspect of the craft in Horrocks' poems. As in Kennedy's and Le Bas' poems, it is a crucial component of "the central organizing consciousness" (Williams 21) of these lyric poems on a medical theme, and evidence against "free verse blogging" (Roberts, "Is it a poem or a blog?" par. 8) or any other lackadaisical narrative practice.

Other criticisms regarding craft include lack of formal stylistics. In his review, Roberts goes on to describe "an irregular sestet[sic]" (sestina) at which "Horrocks takes a stab" ("Is it a poem or a blog?" par. 8), "Hunger," as the finest poem of the collection, and admonishes, "it leaves one wishing the poet had worked this vein more assiduously: it is easily the most compelling poem in the collection, teasing us with a formal paradigm it never quite fulfils" (par. 8).

However, I would argue Roberts' assessment takes no note of the fact that Horrocks uses a complex heteroglossic mode. This blending of discourses unites diverse voices from the hospital, from the patient's lifeworld, from online chatrooms, and from library books. Horrocks experiments with the juxtaposition and ambiguity

of these medical/personal languages to achieve a voice that aptly reflects an experience undergone by increasing numbers of women. Horrocks, like Kennedy and Le Bas, draws attention to the sociolinguistic aspects of personal medical experience, crafting what is essentially "a simulacrum of human experience, not the experience itself" (Williams 13). This is evidence of crafting commensurate to the construction of a poem in set form.

First, we observe Horrocks setting the scene, showing the reader that in this new biomedical context, the way in which language is used in public and in private has been destabilised. Words that would not normally be spoken outside the home are demanded to be shared aloud, and to unfamiliar people. For example, at the beginning of Horrocks' IVF sequence, the woman must "tell a stranger / that today / is her Day One. / She bleeds" ("First" 3–6). The onset of her menses, a private matter, must be divulged to a stranger. "Day One" ("First" 5) is the first day of her menstrual period, meaning that literally "[s]he bleeds" ("First" 6), but the implication of the stark, two-word sentence is also that having to divulge personal information is somehow painful, mortifying. Horrocks exploits both the literal and figurative meanings of "bleeds" ("First" 6) in order to highlight the uncomfortable relationship between the personal and the clinical, which are forced to intersect for her to achieve the conception that does not occur naturally. This is no complaint, but rather an observation, focusing on the awkward blending of the personal and the biomedical. The use of "she" for the narrative point of view seems to complement this problematic amalgam of discourses, combining as it does notions of closeness to and distance from a situation that is personal and impersonal at the same time.

Again, in "Egg Retrieval," the speaker finds that language is destabilised and destabilising: "[r]etrieval" (3), when used as the name of a medical process, has a different meaning from the one she would expect in non-medical contexts—"[e]ven the noun is off" (1). Rather than being defined as "the act of getting // something back" (3–4), the process of egg retrieval that she will undergo involves taking ova from the ovaries and fertilising them outside the body:

> … as though

a long needle passing through

her vagina wall to draw
her eggs out one by one

while she lies sedated, but
conscious, is any kind of re-

turn … ("Egg Retrieval" 4–10)

Words lose their familiar denotations when return is removal and one can be both sedated and alert. In this context, "retrieval" is closer to the alternative definition provided by the speaker: "the finding and extracting / of data from a storage device" (11–12). Here she likens herself to a receptacle of complex data, "her eggs genetic information /to be read and used" (13–14). She is a text to be interrogated, information downloaded from her. Meaning shifts again as we come to understand the mental and bodily effects of the procedure (and the process) on the woman, and "retrieval" becomes defined as: "the rescue / from a state of difficulty or collapse" (15–16) when a friend arrives later "for dinner and / distraction" (22–23).

The new ambiguity of known (lifeworld) language is indicative of the larger conflict at work in these poems—the gap between the biomedical and the personal. The fact that her "eggs are in test tubes in a lab" (24–25) is, to this speaker, "the strangest thought" (23). The distance between the mother-to-be and the child-to-be is an unfathomable disjunction. As is the thought that ultimately, the say-so of the clinician signals the success or failure of the IVF process. It is a judgement that only the doctor can make, based on his observation of the microscopic eggs in test tubes and petri dishes: "her six eggs now outside herself / in the care of embryologists" ("Later" 7–8). The implication is that her body has become ancillary to what is normally a bodily process, and this in itself is strange, depersonalising.

Although the opportunity to undergo infertility treatment is a "cure" ("Aotea Pathology (Day Ten)" 62) that the speaker has sought, and though she is

grateful for its existence, she is also struck by the anonymity of the process that makes her just another "one of them" (46), "a she" (34) who has undergone "medical intervention" (64–65) for something that others may do naturally.

To redress the imbalance of power, the woman realises that the appropriation of medical language and knowledge is key to comprehending the medical procedures she will undergo, and to having some say in the processes she will be required to follow. In a similar way to the women from the "chat rooms / she trawls" ("Waiting (Day 18") 1–2), who claim, "ten months ago I had no idea / now I am suddenly a fertility expert / I know all the lingo" ("Chat Room Voices (Accessed Days 18–24)" 2–4), Horrocks' mother-to-be quickly becomes conversant with the technical details of her fertility treatment:

> … Laura will work
> on her today, now that the right date
>
> and time have been detected and the surge
> (of luteinising hormone) has begun.
> ("Ovulation / Insemination (Day 15) 3–6)

Horrocks' patient-persona tries to assimilate medical jargon in order to subdue its foreignness and to interrogate it for meaning. Power over her own situation can only come with the semi-mastery of clinical language; without it, she is, as described by sociologists who put forth arguments regarding the medicalisation of power, "placed in the position of vulnerable supplicant … with little opportunity to challenge doctors' decisions" (Lupton 97). Without the in-language, she is outside a process which requires her presence alongside the physicians, working closely with them.

It follows, then, that Horrocks' poems about IVF can be read via Foucauldian critique as an interrogation of "how people respond to the external discourses and strategies that attempt to discipline them," as Deborah Lupton puts it in her contribution to a book that examines various criticisms that have been

aimed at the increasing power ascribed to medicine and the medical profession (103). *Mapping the Distance* can also be read as a feminist work, its depiction of the medical profession "as a largely patriarchal institution that … maintain[s] the relative inequality of women by drawing attention to their weakness … and by taking control over areas of women's lives such as pregnancy and childbirth that were previously the domain of female lay practitioners and midwives" (Lupton 97). On a less political level, and a more humanistic one, however, Horrocks' medical poetry can be perceived as resistant to the dehumanising, demeaning nature of the IVF process. Her personae seem to agree that while IVF is a process that will bring a chance of fertility that is much desired, this treatment for infertility (itself still something of a societal stigma) puts women in an objectified position and takes away the autonomy and intimacy of conception from both parents, replacing it with technical, often painful, medical procedures controlled by anonymous others.

To give an illustrative example of a poem in which Horrocks presents an imbalance of power and redresses it with language that invites ambiguity—and invites also a feminist reading, we need look no further than "Ultrasound (Day 14)." The unnamed, male doctor conducting a sonogram in "Ultrasound (Day 14)" is imbued with formidable authority and power. There is an unsettling sense of prurience surrounding the third person account of the procedure; the sonogram becomes aligned with an act of sexual penetration immediately, in line 1: "The doctor puts a condom on before leaving / the room."(1–2). The object that the speaker elides in the previous sentence is, later, figuratively named "the wand" (2), "the divining rod" (6). It is in fact the vaginal probe with which "he evaluates each ovary, // left to right, assessing her eggs" (12–12).

The phallic description of the probe throughout this poem is in keeping with the "she"-persona's assertion that "All the doctors are men, the nurses / are women" ("Ovulation / Insemination (Day 15)," and there is a definite gender hierarchy implied in a number of the IVF poems, alongside the hierarchy based on scientific-versus-lay knowledge, by which the (male) doctors can provide "medical intervention" ("Aotea Pathology (Day Ten)" 63) for women in a manner that

reminds the speaker of battery hens and their eggs whose fertility is controlled by plant operators. "[N]eat red specimen[s]" ("Battery Eggs (Day Twelve") 13) are taken from each woman and, later, as we see in "Egg Retrieval," the persona's eggs, which amount to "genetic information / to be read and used" ("Egg Retrieval" 12–13). In keeping with the third-person, "she"-narrative, and the earlier contention in "Aotea Pathology (Day Ten)" that "I am a *she*" (34), there is no acknowledgement of each individual woman, save the fact that

> Names are taken, first to last, and the date,
> month, year of each woman in the batch's birth:
>
> to pass she must name a day in the sixties or
> seventies when she came sliding, screaming
>
> from between another woman's thighs."
> ("Battery Eggs (Day 12)" 8–12)

The word "batch" (8) again likens the women to battery hens laying eggs. "[T]o pass" suggests that this is a cognitive as well as physical test—a formality to be observed.

By contrast, however, what follows—the reference to the loud, visceral exit of the baby, now, herself, a mother-to-be) "sliding, screaming" ("Battery Eggs (Day 12)"12)—is a vivid reminder of the human reality behind the names and dates. Here, Horrocks juxtaposes the personal ("sliding, screaming // from between another woman's thighs" 11–12) with the depersonalised ("the batch" 9), emphasising the inability of the data-driven biomedical reality of IVF and the lifeworld reality behind each woman's individual situation to merge comfortably. The speaker is not complaining; she is not ungrateful for the medical miracle to which she is allowed access. Like the narrative voice of any lyric, she is "express[ing] a state of mind or a process of thought and feeling" (Williams 7), attempting to reassemble her experience in a way that makes it not just hers, but universal and socially relevant. There is definitely resistance to the dehumanising and demeaning effects of the

treatment process, but there is also a palpable necessity for the poems' persona to continue and to "pass" ("Battery Eggs (Day 12)" 10)—a delicate balancing act is required.

Horrocks' presentation of the woman who seeks and abides by the advice of the doctors as part of the desired IVF process, yet objects to the physician's authority and to her necessary compliance, is in keeping with Foucault's view that "where there is power there are always resistances" (Lupton 102). Although IVF is a useful scientific advance for which many couples are appreciative, that does not preclude the power relations inherent in the practice proving problematic. Accordingly, highlighted in Horrocks' poetry are those discourses and procedures that control the individual and medicalise experience to the extent where personhood is neglected in the biomedical setting.

Once again, in Horrocks' "Then," the doctor has the power to give orders and make rules for the patient to follow (for the good of the process, certainly, but they are commands, nonetheless). In an imperative manner, the list of "instructions" (1) received from the IVF specialist is conveyed to the reader. We are to assume from its tone that we are receiving the message much as the "she" undergoing the treatment received it. It recalls Bakhtin's description of heteroglossia: "another's speech in another's language, serving to express authorial intentions but in a refracted way" ("Discourse in the Novel" 324):

> First blood test
> in eleven days;
>
> No intercourse
> from Day Ten
> onwards. ("Then" 3–7)

The prescriptive element to the process is, of course, necessary, but it is reminiscent, too, of Foucault's findings in *The Birth of the Clinic*, linking the powers and privileges of the medical profession to those of the clergy, whereby the discourse

of the medical interview becomes commensurate with the discourse of the confessional, exercising a similar power over the physical and mental 'health' of patients—focusing particularly on their sexual behaviour as the clergy once did: "When people confessed their sexual activities, priests commented on what liaisons and positions were appropriate and what actions required penance" (Waitzkin 226). In an act of subversion just within the boundaries of medical prescription, the patient and her husband ensure that they "make love," (1) in "Love Song (Day Nine)," twenty-four hours before the advised period of abstinence begins. Although she ultimately obeys doctor's orders, she resists also via language: "intercourse" ("Then" 3) becomes "mak[ing] love" ("Love Song (Day Nine) 1). Just as she resists, as far as she can, the doctor's authority to tell her how to behave, the gentler, romantic language of the lifeworld ("make love"(1)) resists the biomedical language of the doctor's instructions.

This example recalls the Foucauldian tension between the two attitudes that can be assumed by the patient in any doctor-patient relationship. Some patients may choose to present

> the self as an autonomous, reflexive individual who refuses to take a passive, orthodox patient role. Alternatively, they may present themselves as someone who 'follows doctor's orders', who is a 'good patient', working actively in the medical encounter to achieve this. (Lupton 105)

Horrocks' "she"-patient persona suggests via her actions and language in "Love Song (Day Nine)" that whichever role the patient assumes, it is just that: a case of roles and presentations in order to get through the process and achieve the result that she and her husband desire.

The jarring juxtaposition of the lifeworld and the biomedical world exists throughout the sections on IVF, reminding the reader that for every woman undertaking this treatment, the two worlds are, for the length of the treatment, inextricable, and together, they combine to make a subjective, poignant truth of her

experience. In the poem, "Later," for example, after the egg retrieval has taken place and all that the couple can do is wait for news:

> She sits in her garden with her
> swollen abdomen, her hysterical
>
> pregnancy almost as big as the
> belly of a pregnant friend … (1–4)

The procedure has caused internal bruising and so her abdomen is tender and distended. The pain is not just physical. The third-line mention of the pregnant friend is a contrast that we must read with compassion for the persona; the contrast is intended. The reference to "her hysterical pregnancy" is again poignant, suggesting her yearning for a child. The setting of the garden is extrapolated in the penultimate couplet. The poet is careful to use the last two couplets in parallel to show the contrast between her persona's natural habitat and home and the things that grow there by her hand versus those things that have been taken out of her hands:

> now, as shade begins to fall across
> her bean shoots and new flax
>
> her eggs are in test tubes in a lab,
> being carefully fertilised. (9–12)

The "new" (10) life of the "shoots" (10) and "flax" (10) are separated from the far away ova, being tended to by technicians. The separated, parallel couplets draw our attention to what is wrong with this scenario for the persona. She has been able to plant and fertilise and raise these plants in her garden. Why has her body been unable to allow a natural process to take place inside itself?

Throughout the series of poems, Horrocks is able to avoid complaint or the purely personal. Her "she"-perspective allows a narrative at one remove from the

story she is telling and her manipulation of discourses and form enables her to present the reader with contrasts and parallels that provoke thought regarding the degree to which patients' lifeworld aspects are considered in medical practice. In her resistance to the authority (and sometimes patriarchy) of medical discourse, she is an exponent of assimilation of the "language of the oppressor" (van Boheemen 32) but also an advocate of lifeworld language when it is needed to humanise experience and bring the subjective truth of personal medical experience to the fore.

Anne Kennedy

Anne Kennedy's *Sing-song* is a series of eighty poems told from a third-person perspective about a child who has eczema and her mother's attempts to find a cure for the condition. One of the key criticisms of the book has been that it is not "real poetry" according to poet and reviewer Peter Bland; it is "nearly poetry" (par. 9):

> When do we know we're reading real poetry and not nearly poetry? There's a lot of the latter around. Identifying real poetry has something to do with a sense of inevitability, a feeling that this couldn't have been done in any other way. Anne Kennedy's poetry sequence *Sing-song* doesn't convince me that it couldn't have been done equally well as prose, which it often is: as a sequence of letters perhaps, or a long short story, or even as a diary account of her life as "an eczema mother." (par. 9)

Bland's criticism seems very similar to Roberts' 'blogging' criticism of Horrocks and Broom, and his "gut-spilling" criticism of Stead ("The Book of the Dead" par. 6), just phrased less bluntly—the allusion to a diary is key. Again, the critics seem to be saying that personal medical poetry that tells an autobiographical or family story just cannot qualify as *real poetry*.

Yet, in *Sing-song*, we are presented with a number of poems working together to form a narrative. Stanza and line breaks, the use of white space on the page—

these things are deliberate, formal choices intended to control the way the poems look and sound, the way the reader reads.

Kennedy explains that she is naturally someone who writes linked poems; the idea of a poem on its own—one that does not stand with others to tell a story—is a foreign notion to her. Therefore part of her natural style is the sequence, in which poems rely on one another for meaning and effect instead of standing alone:

> While I can admire a short poem that is a thing in itself but
> not a story, I couldn't write one to save myself. There would
> be so much pressure on it! A poem only lives for me if it is
> part of a network, a litany. (Interview with Paula Green)

The idea of a litany is easy to perceive in *Sing-song*—not only are many of the poems linked in motif and voice, their musicality is frequently in evidence. Take for example, a poem like "Plunket visits St Helena" and its driving assonance as the first appearance of the child's eczema is described:

> an itchy patch no bigger than
>
> 'two twenty cent pieces side by side'
> they said, using coins as currency for size.
> Every night it bothered her but only
> for the length of time you could
>
> park your car for two twenty cent pieces
> in the middle of town. That's not very long
> with the price of parking these days. (8–15)

The long 'i'-sounds are musical, pleasant, but the chiming disappears with the bathetic (and humorous) mention of the price of parking. This is a juncture of the story at which the eczema is not serious—not even diagnosed, and certainly not something to worry about. Over the course of the collection, the tone and sounds

change. As the treatments accumulate and become more costly, and the mentions of mortgages and other large economic realities continue, the network or litany-like effect increases, as does the tension in the narrator's tone. Kennedy is adept at patterning sound for mood shifts on a large scale.

Kennedy sees the need for background simplicity in her poetry's structure and language in order to highlight the most arresting feature in language or imagery: "On a line level, I love the element of surprise, but also plainness, because surprise is only interesting when it is set like a gem" (Interview with Paula Green). Hence, the twenty cent pieces, repeated, chimed-against, stay with the reader, both as measure of the child's initial lesion and as reminder of the family's economic position, and the fact that often "[t]he personal troubles that patients bring to doctors often have roots in social issues beyond medicine" (Waitzkin 220).

Lastly, we must keep in mind that Kennedy is adept at double-work. Not only does she employ ambiguity to point out ironies for polemical purpose; she also enjoys pushing the reader to intuit double-meaning. Ambiguity can be as lightly employed as the play on "currency"—"using coins as currency for size" ("Plunket visits St Helena" 9)—used to describe the twenty cents that keep track of the eczematous lesion's area or as loaded with meaning and intricately embedded into structure as in the following lines, telling of a family holiday with the sick child:

> Fifteen times a night or thereabouts
>
> the baby woke in a torment of itchiness.
> A storm at sea, a front like WWI and on it an itchy
> conchie. … ("Little lives, Leigh" 12–15)

The storm could relate to the beach where the family is staying, its unsettled "front" (14), or the storm's "front" (14) could be a correlative for the child suffering from inflamed, irritated skin. Alternatively, the child's "front" (14), her chest, is so besieged by eczema, one 'objector' ("conchie" (15)) having started a riot among the

'troops', to follow the metaphor. Again, perhaps the child is the one wanting peace, herself, the "conchie" (15), and all around her is fighting.

The structure of the lines, the placement of the stanza break, the caesura after "storm at sea" (14) mirror the disrupted nights; the sounds that describe her discomfort are fricative; they catch—"itchiness" (13), "itchy" (14), "conchie" (15), and the setting blends with the emotion in the manner of pathetic fallacy, even on the level of sound: "torment" (13) suggests torrent, "conchie"(15) is reminiscent of conch (shell). All of this is achieved in a way that would not be possible if the medium was diary entries or letters rather than poetry.

Bland's second key criticism is with regard to the "bitter social comment" (par. 4) that drives Kennedy's collection, and this must be discussed at some length in order for me to examine the Bakhtinian aspects of her craft, as well as the polemical nature of *Sing-song*.

Kennedy writes with frustration about the state of the New Zealand healthcare system: "The sequence draws upon the raw material of family life that is disrupted and stretched by the failure of every conceivable health practitioner to find a cure" for the daughter's skin complaint (Green, in Green and Ricketts 30). Much of Kennedy's collection focuses on the mother's search for answers in an environment that is unfamiliar and inaccessible; "each event tests her stamina to decipher the advice of experts" (Green and Ricketts 30). The word "decipher" here is doubly apt, for not only can it be read as to decode or interpret difficult material, but also to *de-cipher*, to reverse the process of ciphering and depersonalisation that occurs so often in conjunction with medical treatment. In *Sing-song*, Kennedy is keen to (re)assert the personhood of both patient and parents.

Kennedy resists the imposition of medical authority from the first, particularly what she views as the socio-economic basis of doctors' perceived power. Satirically, she imagines one specialist "sail[ing] / his yacht on Sundays" ("Jung" 14–15). Another "will wave the manicured, scrubbed-up hand / that went through Medical School and // cast an expensive spell" ("Christ, not another rite!" 7–9) or

specify "this scribbled cream" ("Christ, not another rite!" 18), "spell" and "scribbled" connoting the (to her) unknown nature of what is being prescribed for use on her child's skin. The dermatologist speaks "matter-of-factly (dollar-fifty a sentence)" ("Christ, not another rite!"11), the brackets enclosing the mother's cynical aside. As far as the mother persona is concerned, clinicians are privileged, male, and emotionally uninvolved in her daughter's care. This notion is one backed up by the scholarship of Waitzkin (writing of a time that would have been relevant to Kennedy's doctor-visits):

> The extremely limited recruitment of doctors from working-class families has persisted despite recent increases in the proportion of women and racial minorities entering the profession. For the small numbers with working-class roots, as for the rest of the profession, the acquired class position of physicians is one of relative privilege. Their predominantly comfortable lifestyle does not encourage professionals to criticize the social structural roots of their clients' distress, especially the sources of suffering in class structure. Instead, professionals' life experiences predictably lead them to help clients adjust to things as they are. (227)

Further problematising the unequal relationship between patient and doctor in this case is the family's mixed-race status: the mother is Pākehā; the father is Māori. Kennedy's presentation of the specialist's prejudice is worth quotation and discussion at length for the light it sheds on how the heteroglossic works in *Sing-song*—something that remains unobserved by critics who perceive that the sequence as little more than a "vehicle for personal complaints" (Bland par. 4). What Bland judges to be Kennedy's "chip-on-the-shoulder attitude" (par.16) appears to me to be far deeper than this: her perception of unintentional social control via medical language is one thing. Implicit racism is another.

> They've been in there five minutes, long
> enough for him to shake his head and say

there's more incidence of eczema among
ah, half-caste (sic) children, unfortunately.
He looks over his glasses at her, one
Pakeha to another—should've married

your own kind, mm? ("Christ, not another rite!" 19–25)

In an example of what New Zealand poet and essayist John Newton would term "postcolonial confessionalism" (par.18), the supercilious (white) specialist's speech is presented with the rest of the narrative, not signalled by any structural device, change in font or quotation marks, merging seamlessly with the voice of the speaker. Here, Kennedy has the doctor speak for (and thereby incriminate) himself. To report his speech indirectly would weaken the effect. Her third person "she" perspective is by no means objective, however; we know this from reading thus far in the collection (and this is part of Bland's critical objection). In presenting the speech and gestures of the doctor, as opposed to the mother, who is silent at the time, the looked-upon object of his implied scorn, Kennedy makes the narrative voice subjective and accusatory.

The narrative voice merges with that of the specialist, but "[sic]" suggests that his words are being quoted verbatim; the fillers "ah" and "mm" make for subtle differentiation between narrative and clinical talk, at the same time providing a gentle and ironic polyphony. We do not know if the second statement was actually said, or just implied by the way in which the doctor looked at the mother (or the way in which she would have us interpret his look). We do, though, know how she interpreted it.

Although the encounter is reported by one speaker, we are essentially presented with an example of "double-voiced discourse" (Bakhtin 324) which appears to be "a concentrated dialogue of two voices, two world views, two languages" (Bakhtin 324–325).

Williams sees the narrative voice of the lyric poem to be one perceived by the reader as "the consciousness pervading the whole, not as speaker or subject, but as implied artificer" (17); by this token, it would seem important that Kennedy's speaker remain clearly the voice within the narrative, telling of personal experience. The voice of the speaker throughout is the same—has the same wry, sardonic asides, the same desperate tone. As Williams notes, "verbal idiom *is* identity" (15) in the lyric, and so we come to associate the voice of the collection with the "eczema mother" ("The magazine of white children" 25) and take her side when presented with combative narrative. The "she" becomes almost synonymous with the teller of the story, so involved is the third-person narrator, yet the faux remove implied by the third person adds an extra dimension that is missing from the poetry of the patient-poets' works where the "I" is the narrative perspective of choice. One explanation of the effectiveness of Kennedy's "she"-perspective in creating the illusion of narrative objectivity while describing an inherently subjective situation brings us back to the heteroglossic, whereby two speakers are heard "at the same time … express[ing] simultaneously two different intentions: the direct intention of the character who is speaking, and the refracted intention of the author" (Bakhtin, "Discourse in the Novel" 324).

"The magazine of white children" features a clear example of such Bakhtinian "double-voicedness" ("Discourse in the Novel" 325) when the mother is reading a magazine for parents of children with eczema. The mother's voice is clearly the main voice of the poem, channelled through the third person; the other italicised voice is a collective one against which she dissents, and which she presents to the reader for critique:

> Auckland, the biggest Polynesian city
> in the world and the medical practitioners
> keep telling her there is *more incidence*
> *of eczema among half-Polynesian children*
> the eczema mother never saw a Polynesian-

looking child in the magazine …
("The magazine of white children" 21–26)

This time, the italics set the doctors' words (from the previous poem "Christ, not another rite!") apart from the other text, but still the effect is that of heteroglossia: there is more than one voice in this poem—we hear the third person mother (her voice refracted through the speaker) and the chorus of medical practitioners, and these are combined with a third implied text: the magazine itself, featuring the pictures and stories of "the great / grandchildren of the colonisers" ("The magazine of white children" 8–9) which originally catalysed the mother's reflection on its exclusively Pākehā content.

A sense of otherness on the part of the mother is also fostered by the inclusion of medical terminology ("more incidence of eczema" 23–24) alongside the secondary lifeworld parlance of religion. In "Christening," The mother is at pains to keep her child from assimilating the word for her condition, as if assimilation of language means a long-term association with the eczema itself. Its repetition three times over six lines suggests the way in which the word insinuates itself into the family's daily life despite the resistance on the part of the family:

… Ah, there! She was keeping the word
unspoken, but it squeezed out, eczema

in its white gown, plain as day, all mystery
gone. They learned not to say it, eczema

in the baby's presence. She'd look up knowing
it was something, it was the thing, eczema.

Then she learnt off pat all the euphemisms:
itchy skin condition, skin complaint

topical problem, a toddling thesaurus. ("Christening" 3–11)

The "Christening" of the poem's title becomes the naming of the child "eczema baby" (12) despite initial resistance, "and the mother // by association, an eczema mother" (12–13). The title's irony is that naming is curse rather than blessing. Life for the family has become dominated by the condition and their search for a cure to the extent where normal family life is displaced.

As the collection progresses, the baby's treatment becomes associated with further rites into which the parents' faith is invested; these ultimately fail. As in the work of the doctor-poets and the patient-poets, a religious dimension is discernible in Kennedy's sequence, as the process of searching for efficacious treatment for the child becomes analogous to a spiritual trial. The vain application of aqueous cream is described as the baby being "anointed" in "The First Rite" (3). When further topical treatments fail, the mother loses hope for "these / creams were as useless / as rites and so they were / rites." ("The anointing with steroid cream offered by the General Practitioner" 17–20). Neither medicine nor religion is worth her faith. The mother comes to see herself and the child as akin to the Pietà, "a double icon" ("The Cult of the Virgin" 10), "the mother as bystander / at her own child's suffering. The universal tragedy." (11–12).

The mother's disaffection becomes not only one of faithlessness with regard to religion and medicine, but one also of cultural alienation. The speaker describes the exchange between the mother and the "GP and the / chemist" ("The anointing with steroid cream offered by the General Practitioner" 5–6) as analogous to discourse between the Māori and the Pākehā settlers of New Zealand:

> This was the problem
> with Te Tiriti o Waitangi.
> Interpretation and shattered
> hopes.
> ("The anointing with steroid cream offered by the General
> Practitioner" 9–12)

The colonisers' deceit, enacted through ambiguous language(s) in the Treaty of Waitangi (1840), is alluded to here. The fact that there were both English and Māori versions of the Treaty—versions which differed significantly—meant that while Britain perceived that they gained sovereignty and governance over New Zealand, Māori believed they still had autonomy. In a similar way, Kennedy's speaker feels duped, misled, by the doctor and the pharmacist. She placed her trust in these people and they failed her. The implication may be, too, that their advice was disingenuous, perhaps based on a cultural prejudice—something to which she alluded in "Christ, not another rite!," and a point made by Chapman et al in their 2013 article "Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities." The authors of the article, all health researchers, posit that

> Although the medical profession strives for equal treatment of all patients, disparities in health care are prevalent. Cultural stereotypes may not be consciously endorsed, but their mere existence influences how information about an individual is processed and leads to unintended biases in decision-making, so called "implicit bias". All of society is susceptible to these biases, including physicians. Research suggests that implicit bias may contribute to health care disparities by shaping physician behavior and producing differences in medical treatment along the lines of race, ethnicity, gender or other characteristics. (1504)

Rightly or wrongly, the language of the Pākehā clinicians is distrusted by the mother. Hope and comfort come from outside medical language—sometimes, even, outside English and its worn-out clichés; they reside in the clear-cut, the jargon-free. Two thirds of the way through the collection, the family visits "the Chinese doctor" ("Pacific" 4):

> The doctor speaks little English, thank
> God, no end-of your-tether, colour-therapy

don't forget the aqueous-cream
more-incidence-among-half-Polynesian-

children-unfortunately crap.

Just three words. *Heat no good* ("Pacific" 17–22)

The mother's relief at having no medical terminology, no racist assumptions, no patronising to contend with is palpable, and with the Chinese doctor's suggestions and preparations, "there's a slight / improvement" ("Dragon Spleen (seventh rite)" 48–49) in the child's condition, but a recrudescence is not far away.

A reprieve (physical for the child, mental for the parents) only comes, at the very end of the book, with the prophetic dream of the father and the decisions that ensue. It is interesting to note the Eastern spiritual symbolism:

… the father sees a Buddha in the
window, floating, then a girl's sore
body bearing the imprint of the trees
and the roar of the motorway ("What he saw" 41–44)

Immediately after his vision of the girl as microcosm of the natural and industrial world, presided over by the symbol of Eastern enlightenment, the husband has an epiphany. Suddenly, he wonders if the aqueous cream recommended by all of the medical advisors—including "the GP" ("What he saw" 49) and "the dermatologist at the hospital" ("What he saw" 50)—as "the most benign // cream" ("What he saw" 55–56) may actually be the agent responsible for perpetuating the endless cycle of eczema.

Miraculously, when the parents put this theory into practice, withdrawing the emollient cream, "the eczema shrivels / before their eyes. By day three it's / almost gone" ("What he saw" 83–86). The miracle is the grail at the end of the quest; it has nothing to do with medical interventions, it has everything to do with lifeworld contexts (spirituality, the environment). The epiphany of the father

contradicts all they have been told by the medical experts, yet it is instantly effectual. That the solution is one inspired by Eastern religion and parental intuition can perhaps can be seen as the ultimate repudiation of the biomedical context and voice by one from the parents' psychosocial and spiritual lifeworld. Certainly, it is an apt illustration of a resistance to medicalisation—one that would be championed by most who still regard medical authority in a Foucauldian light, "challenging the right of medicine to make claims about its powers to define and treat illness and disease … challenging the decisions and knowledge of doctors" (Lupton 97).

So Kennedy's collection repudiates the authority and exclusivity of Western medicine, and raises an issue that Colquhoun's *Playing God* also touches upon in a small way (in his poems that allude to the class/education divide between doctors and patients). Kennedy highlights issues of mixed-race marriage, mixed-race children and a lurking racism not only in medicine, but in New Zealand. Her poems embrace multiple voices and multiple meanings, blending the discourse of medicine and the lifeworld in order that hierarchies and inequities be emphasised in the medical setting that she depicts in *Sing-song*. Kennedy's is no blog, no diary, no memoir; it is a book-length series of linked lyrics that tell the story of a child's illness in a way that draws attention to those aspects of the experience, often noted by sociologists, which are dehumanising and lacking in clinical cognisance of the "person at the heart of patient-centred care" (Barfield and Selman 380). Furthermore, she shows how the family of the patient can be dehumanised within the clinical context. The voice she chooses to adopt—that of "the eczema mother," not only demonstrates that dehumanisation but helps to universalise what started as a personal journey.

Jessica Le Bas

In Le Bas' collection *Walking to Africa*, a mother charts her child's journey through the mental health system, and her own journey towards acceptance of her daughter's depression. The mother is "you"; the child is "she". The choice of narrative position is interesting, in that "you" is an instantly involving pronoun to encounter as a reader. It puts the reader in the position of the mother. However, it

also has the effect of making the mother appear to be perceiving herself from a distance or talking to herself as she encounters each of the trials that befall her (the poems are present tense, too, and this adds a sense of uncertainty to the narrative—frequently there are questions, such as "*where is she going?*" ("White, and Shades of Pale" 19). These add to the mood of disconcerted anxiety that pervades the collection. "She," the daughter, is the object of the interventions, diagnostic workups and treatment trials. At one or two points in the book, the mother places herself so imaginatively close to the daughter's position (once when she receives electroconvulsive therapy, and once when she escapes from the adult mental health unit) that "you" is a blurred perspective. It is this shift from the patient-poets' "I" which gives the parent-poet collections a narrative complexity that mirrors the difficulty of a mind trying to cope with the disorientation of medical treatment that does not belong entirely to the speaker's physicality or mentality—an experience that is self and other at once.

We are plunged into the story of the child's depression, not at the condition's nascence, but at the mother's attempt to fathom its catalyst, via a section titled "Was This the Beginning?" A poem called "Summer" chronicles the things that happened during those months and examines the girl's decline, calling every detail into question. Next come poems about months of trips to Doctors A, B, C, D and E ("Autumn," "Winter," "Spring") and "A&E" ("Summer, by Another Name" 5) and then "a psychiatrist" ("Summer, by Another Name" 11).

As the journey progresses for mother and daughter, we perceive that the medical environment is like a foreign country. Much as it is to Horrock's main character, medical language is unfamiliar and alienating to the mother; even the meanings of once-familiar words are newly precarious, and words she 'knew of' but did not need to understand are vitally important:

> Out come the psychiatrists
> Out come the psychologists
>
> Once in another life, these two words had the same meaning

Before that, they had no meaning at all.
("Finger Knitting" 12–15)

Walking to Africa abounds with terms unfamiliar to the mother: a brain scan is "the MRI thingy" ("Autumn" 10); the language used by the doctor might as well be a foreign one:

He uses words like receptors and inhibitors and synapses and serotonin and dopamine, and you know there is meaning somewhere that you have never been. ("Being There" 8–10)

The chiming of "dopamine" and "never been" ironically accentuates the chasm between the doctor's terminology and the mother's understanding. The words rhyme, so we anticipate some sort of relation between them and their meanings; instead, there is only discord. In the lines quoted above, it is clear that the language of psychiatric medicine, neurotransmitters and brain hormones is outside the lifeworld of the mother who accompanies her daughter on clinic visits; it comes from "Another Universe" ("The Beyond" 10). Again, the use of "you" has the effect of putting the readers in the mother's position and inviting them to consider the biomedical words and whether or not they would understand them. The cumulative effect of many such instances (often followed by questions) is to invoke confusion and frustration in the reader, possibly recreating the mother's original state of mind.

To show confusion once more, in "Voices (iv)," Le Bas presents the cacophonic "jumble of voices … from a foreign place" (1) that surrounds the mother in the hospital, by running the words together, their delineations unclear to the layperson:

fluoxetinelithiumrisperidonequetiapinetricyclicbenzodiazepin
esserotoninreuptakeinhibitorselectroconvulsivetherapycitalop
rammoclobemidetardivedyskinesiacognitivebehaviourtherapy
("Voices (iv)" 2–4)

As individual words these are names of drugs, drug classes, treatment modalities and the side effects thereof: "Fluoxetine Lithium Risperidone Quetiapine Tricyclic Benzodiazepines Reuptake Inhibitors Electroconvulsive Therapy Citalopram Moclobemide Tardive Dyskinesia Cognitive Behaviour Therapy". However, the words have been elided by Le Bas in order to express the overwhelming nature of the information with which she has been presented. All of this information must be assimilated in order that some input or control may be exercised over her daughter's treatment. As for the daughter, in response to this torrent of information, "She says whatever" (10), so it is clear that if anyone is going to have input into the treatment plan apart from the doctors, it has to be the mother.

Yet even the abbreviations—the short forms of treatment and diagnostic modalities—are puzzling. The medical acronyms might as well be hieroglyphs. Like the mother ("you"), the reader is left to decipher what the following might mean: "CAMHS CBT ECT TCA SNRI IPT PST SSRI OT TD MRI CAT EEG ECG" ("Voices (iv)" 8). This is Bakhtin's heteroglossia at work, whereby the esoteric nature of specialist discourse is highlighted to make a polemical point. Like exotic road signs, the medical acronyms proclaim the layperson a lost stranger—"an alien in an alien world" ("Voices I (v)" 9). "You have never been there," says the voice of the mother: "There are whole cities / You have never seen them on a map of your world" (5–7).

The metaphor of the lost traveller aptly sums up the patient/carer experience, as evidenced by numerous sociolinguistic studies. Peter Ubel, physician and behavioural scientist, writing in 2012 on the subject of doctor-patient communication, found that patients and their families were subjected to "indecipherable strings of jargon" by doctors (Ubel 82), and disadvantaged by a "language barrier, a gulf between doctors and patients created when physicians toss out arcane terminology, unaware that their words are not part of daily conversation" (Ubel 83).

It is interesting to note that in the sequence, "Voices" (35–37), the "karakia" ("Voices (iii)" 1) (prayers) of the visiting Māori elder performing a blessing are less inscrutable to the Pākehā mother than those medical voices that come from the "foreign place" ("Voices (iv)" 1) that is the biomedical voice ("Voices (iv)" 1). She can intuit his intention, his purpose:

> The kaumatua comes with his taonga and his karakia
> His dark eyes melt the room
> He asks for peace and goodwill to all people …
>
> *He honore, he kororia ki te atua* ("Voices (iii)" 1–4)

The words of the doctor, by contrast, even when they are not medical jargon, are obtuse, equivocal, mysterious. He is presented as the authority figure, smugly senior to the nurses ("you know [he's] their leader because of the tweed coat and the sandals / and the way he smiles like he knows things that are good to know" ("Beside Her" 14–16), yet he is unable to shed any light on the daughter's condition or suggest a mode of treatment: "You look for answers between his lips but there are only rows of possibilities / lined up to choose from" ("Beside Her" 17–18).

Other anonymous, indistinguishable, clinicians are labelled "specialist A" ("Autumn" 6) to "specialist E" ("Spring" 2), none offering the panacea, all offering the same equivocal response to the daughter's continued decline:

> perhaps some more pills
> perhaps some more …
> perhaps some
> perhaps ("Spring" 12–15)

The poem is whittled away to the ultimate equivocation, akin to Doctor B's admission when he says "it is Beyond Him" ("Winter" 8), the capital letters in "Beyond" and "Him" perhaps hinting at a despair larger than a single clinician's, larger than the medical and the secular—this is doubt on a metaphysical scale.

Like Horrocks' "she"-speaker, one tactic the mother in *Walking to Africa* uses in order to participate in the medical decision-making regarding her daughter's care is to harness the language of medicine:

> You ask about strategies to combat psychosis
> The psychologist tells you not to bother
> and to have a nice day ("The Colour Blue" 1–3)

She has phrased her question by combining the commonly used medical metaphor of warfare[30] (the noun "strategies" and the verb "combat") and the medical noun "psychosis." However, the answer she receives from the psychologist is a patronising rebuff in the language of vernacular cliché. From reading Broom's poetry—particularly "Three Exercises for Oncologists" and "NO," we are aware that when there is an inversion of discourses (the layperson taking on the physician's language and the clinician taking on the layperson's language and especially resorting to evasive cliché) the conversation (or the condition's treatment) has reached an impasse.

Unable to glean answers from medical professionals and finding the medical terminology inaccessible, inscrutable or simply too coldly objective, the mother does something that none of the other personae has done: she makes up her own definitions. For "[m]edical jargon" is "an alienating presence" in this collection (Green in Green and Ricketts 334), and in order to be processed and made less 'other', the mother persona perceives that it requires translation and explicatory metaphor, as in the poem "Newly Discovered Sites on the Moon". Here, some of the names of medication the daughter takes are apportioned metaphors by the mother in order to explain—or even conceive of—their effects:

> Fluoxetine is a dry river-bed
> Moclobemide is a long dark valley

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[30] "One study, from 2010, found that physicians use metaphors in almost two-thirds of their conversations with patients who have serious illnesses … Military metaphors are among the oldest in medicine and they remain among the most common." (Khullar par. 6, par. 12).
On "the military metaphors of Western medicine" (304) see also Fuks et al (304)

Risperidone is the highest mountain she climbs. (1–3)

We are taken beyond merely 'foreign' territories; these places are new discoveries on the face of the moon, challenging landscapes to traverse or ascend, and so the terrifying also becomes the potentially assailable:

> Epilim is the rock shelf she falls on
> overlooking a forest of Citalopram craters
> Quetiapine is the blue lagoon
> in starless light
> Lamotrigine is a crater lake purged by the blistering flow
> of Olanzapine …
> ("Newly Discovered Sites on the Moon" 4–9)

All the medications are depicted using perilous, dark images of the "strange and dangerous" (13) landmarks of her journey. The poem moves towards odyssey-like imagery: "Blinded, she did not see the Port of Lithium / Dazed, Lorazepam passed by" (11–12). The anxiolytic medicines are bewitching, part of "a strange and dangerous planet" (13) which both daughter and mother are orbiting.

There is power in asserting one's own definitions and descriptions, where the subjective explicates the objective and the personal writes itself upon the inscrutable scientific, but there is also a desperation to understand and be allowed within an in-language shown via this juxtaposition of poetic invention and medical discourse. In "Discourse in the Novel", Bakhtin was keen to point out the way in which prose readily borrowed "an alien language" (287) "to shed light on an alien world" (287). This appears to be what Le Bas is doing in her borrowing of medical terminology and her invention of its planets and places. It conveys the mother-persona's desire to understand the esoteric nature of the medical discourse she encounters and the equally esoteric practices and pharmaceuticals described by that discourse. Yet at the same time her speech act is one of subversion.

This idea of defining medical terminology in a personal, creative way is again evident when the mother imagines what "ECT" (electroconvulsive therapy) entails in the poem "Cutting the Deck". As background to this poem, in an interview with Kathryn Ryan, Le Bas explained that until this treatment was suggested for her daughter, she did not know what the three letters stood for, let alone what was involved. "Cutting the Deck" features a frighteningly visceral imaginative definition designed to communicate the mother's horror. Here, the "you," usually reserved for talk of the mother character has a duality to it—the pronoun seems to embody the mother undergoing the brutal imagined treatment with the daughter, who is also "you":

> E is for Electricity
> C is for clapping your hands over your ears
> T is for turning you over
> and under
> and out
> until you cannot breathe (4–9)

There is a movement from the factual, scientific "E is for Electricity" (4) to the physical responses as imagined by the mother—"T is for turning you over / and under / and out" (6–8). The subjective perspective of the mother, now identifying herself with her child, combines with the scientific acronym to provide a visceral, ghastly image: a person being almost degloved and then asphyxiated by the current, the shock, imbuing the poem with a tone of anxiety and fear on the part of the parent. "Horrified" is the word Le Bas used in an interview (with Kathryn Ryan) to describe how she felt when she imagined the ECT treatment her daughter underwent in the adult psychiatric unit. This horror is conveyed by the movement from the scientific discourse to the layperson's discourse. This movement is again discernible in the description of ECT preparations in "White, and Shades of Pale":

> There is a drip drip drip in the crease of her elbow
> *where is she going?* An oxygen mask

White paste lays her hair down down
to the soft sides of her
head
brain
mind

temples are for praying (18–26)

The "drip" (18), the mechanical drip feed inserted via a cannula, is changed to its "drip drip drip" (18) action via repetition. The voice of the mother interjects in the italicised section, interrogating the sedation's effect, but with a question phrased in lifeworld terms of travel. The "oxygen mask" is another notable piece of medical apparatus that is noted (as if the mother is observing, looking down on the daughter being prepared for the treatment), and then repetition is employed again to describe the paste for the electrodes plastering the daughter's hair down—the hair is also "soft"(22) as "down." Via these manoeuvres, Le Bas signals the subjectivity of personal, medical experience. At line 26 in particular, with the mention of "temples"—again employed for the word's multiple meanings—we are alerted to the very personal, human experience being played out. It is as if the sanctity of the child's mind is being violated by the procedure, her 'temples' desecrated by electrodes and interference. The poem is thus as much about a loss of faith as a loss of innocence and childhood.

When treatment fails and Doctor Beam is "not the saint you needed" ("The Coffee Table" 8) and he "may not be the person you are hoping he is" ("Talking to Doctor Beam" 29), Le Bas employs religious imagery to make her point further: "As he turns you look for wings / None" (30). Like the doctor-poets and patient poets who turn to the discourse of religion, so, too, does Le Bas. In this way, we see once more the element of crafting that suggests not only the use of a discourse aligned with that of the lifeworld, but also one aligned with the sociological studies that highlight the spiritual needs of patients with both physical and mental illnesses.

At this point, I will quote at length from the work of Barfield and Selman, because theirs is the only writing on the health humanities that I have read since I began my research that has drawn together Foucauldian analysis and modern sociological analysis, with literary texts as suggested media to help with the assimilation of key ideas regarding, for example, spirituality and medicalisation. Their chapter in the *Health Humanities Reader* (2014) discusses Kazuo Ishiguro's novel *Never Let Me Go* as a text for study by (trainee) doctors and patients. In their preamble, they state:

> Medicine provides a unique challenge to the way we live our spirituality, and the challenge arises, in part, because of the astonishing success modern medicine has had in understanding and affecting human disease. As technology has advanced, medicine has increasingly become sequestered within the walls of complex institutions where the primary language is that of biology and technology (Foucault 1973) and where the distribution of power is unique and heavily weighted toward the physician (Starr 1983). At precisely the moments when we are most acutely in crisis—facing loss of function, opportunity, or life because of disease or injury—we are thus removed from the context in which we navigate the remainder of our lives. (376)

The verb "navigate" used by Barfield and Selman is interesting, as it complements the extended metaphor used in Le Bas' collection of the journey to unfamiliar lands. Barfield and Selman's description of the patient lost in the foreign land of illness and biomedicine is mirrored by Le Bas' description. Even when Le Bas goes to the hospital chapel, it provides no spiritual salve, as we see in the poem "Voices (ii). The mother walks the daughter to the hospital chapel's service in search of solace, but this, too, proves a vain odyssey: "Together each day you walk the labyrinth of hospital halls to the empty chapel, for / exercise and a quiet word on the side, with

someone who might have some clues" ("Voices (ii)" 13–14) but they "hear no voices" (18).

In another poem, "An Afternoon Walking," a sense of religious consolation is also wanting despite the mother's best efforts to kindle it:

> The lights in the hospital chapel are out
> You turn them on
>
> No one is there (14–16)

The chapel is not just dim and deserted; it is utterly desolate. God is absent. Like the mother's attempts to find successful therapy for her daughter by navigating a way through foreign territory, her attempts to find some hope or sanctuary are in vain despite her proactive approach, her questioning of clinicians, her wrangling with unfamiliar language, her attempts to shed light where there is darkness, and her search for spiritual salve. We are reminded of Stead and his:

> no good no god
> god is dying in the desert of the mind
> no god no god ("S-T-R-O-K-E" 25–27)

However, solace does come, and it is in the form of reminders of the lifeworld, like Stead's first JUMP inspired by the McCahon painting ("S-T-R-O-K-E" 28) or like the compassionate nurse "winnie" who comes to him in the middle of the night. In the case of Le Bas and her child, it is the ministrations of an "angel /nurse" ("The Angel Nurse" 1), and the "nurses not in white coats" ("Beside Her" 9) who "have smiles and real names" (10) and "offer you cups of tea and sandwiches with real tomatoes / This is real" (11–12). It recalls, too, Colquhoun's "Communion" telling of a cup of tea shared with his patient, which is the greatest of virtues ("Communion" 23–27).

To Le Bas, the figure of the "angel/nurse" ("The Angel Nurse" 1) becomes the embodiment of the mingling of the lifeworld and the biomedical world; she makes life bearable not only by way of provision of the patient's basic needs such as water and pills ("The Angel/Nurse" 1–4), but also by way of her reassurances to mother

and daughter in personal, vernacular, familiar language: "*It's ok to cry / She's doing ok*" ("Aftermath" 12–13). The angel/nurse also has transformative powers that move between medicine and spirituality. In "O Another Winter," for example, the daughter is hallucinating, aggressive, and the nurse on duty calms her. A metamorphosis ensues—the mother's own welcome hallucination:

> The nurse grows wings
> small knobbly bits at first in the hinterland of her back
> unfolding like the puckering of a smile
> (21–23)

The nurse becomes almost a sanctuary in and of herself, representing a safe bridge between the known world and the medical one. She exemplifies empathy and hope:

> The angel/nurse
> grows round like a globe of the world
> There is a little dark space behind her eyes
> enough for stars, and other worlds
> She has seen other worlds (12–16)

Contrary to the "other worlds" (16) of medical language and experience that dehumanise the patient and leave mother and patient dispirited and lost, the mediation of clinical and personal that occurs in the context of the "angel/nurse"'s (1) compassion enables hope to seed and bearings to be taken. She is of this world, but other-worldly, a construct of the mother's mind in turmoil, but also recognised by the mother as a person and place of safety. The nurse is a figure who has witnessed travels and travellers like the mother and her daughter, and who knows their language.

Conclusion

Horrocks, Kennedy and Le Bas are concerned not only with Foucauldian notions of the hierarchy implicit in language, but also with the social reality of medical/personal relations. These three collections support John Newton's statement in the essay "By Writing and Example: The Baxter Effect": "[the] self-revelations of modern confessional poetry have always aspired to be more than merely personal"

(par. 23). These poems transcend the "merely personal" by means of craft, the juxtaposition of personal and clinical languages presenting a multi-voicedness that affects meaning and tone, but also enacts the social arguments that they raise—arguments that mirror those put forth by contemporary medical sociologists. Most notably, they use speakers outside the traditional lyric "I" to widen the reach of their personal stories, adding power to the polemic strand of their journey-like series of poems.

Horrocks' *Mapping the Distance* seems to be speaking in part for the other women who have been through or who are going through fertility treatment, like those whose confessions and questions the persona reads online in chat rooms, becoming "hooked on [their] voices / letting out stories / day by day" (4–6). IVF is "marvellous" ("In the Library (Day 25")" 52) "miraculous" and "extraordinary" (Interview with Lyn Freeman) in terms of what it achieves, but it is also a process that can be "intensely difficult" emotionally, as well as "physically painful" (Interview with Lynn Freeman). Horrocks presents these realities not just as an individual telling a personal story, but in a way that highlights issues of identity and dignity that are of universal significance and importance—and not just to women. Kennedy's "sequence draws upon the raw material of family life that is disrupted and stretched by the failure" of the system within which the mother and her daughter find themselves" (Green, in Green and Ricketts). Likewise, Le Bas' portrayal of her daughter's suffering and depersonalised care in the adult mental health clinic, and the perception of adolescent mental health issues in New Zealand today is "a sad indictment on how we are dealing with mental illness in our society" (Le Bas, Message to the author, E-mail).

In calling for a more balanced and holistic medical system, with medical staff who combine the clinical knowledge necessary for successful practice with a personally-orientated provision of patient care and a language that can adequately explain that care, Horrocks, Kennedy and Le Bas do far more than merely enact the performance of poetic memoir. Their manipulation of narrative perspective can be perceived as part of their struggle towards producing poetry that is not judged as

outmoded or anodyne confessionalist 'blogging', where their writing is not perceived as a "kind of therapy that thrusts private experience upon an unwilling reader" (*The Oxford Companion to Modern Poetry* on "confessional poetry at its worst" 97), but rather as crafted, polemical truth-telling.

In all three collections, the poems feature, in some form, a non-first-person perspective, whereby "the speaker is placed in the role of storyteller whose business it is to relay a mixture of action and psychological insight" (Williams 22). The poet has put in place an apparatus of distance and objectivity (the "she"- or "you"-speaker), whilst also employing a layered multi-voicedness and a careful refraction of discourses, which tether the narrative point of view to an implied "I". That the speaker has an autobiographical link to the poet further strengthens this composite position.

The avoidance of an overt "I" by these poets can be viewed as the cultivation of "distance, a detachment that [keeps the writer] away from being sentimental, or indulgent" (Le Bas, message to the author, E-mail). It may "offer the lyric poet the illusion of impersonality and universality when [the poet] wishes to escape suspicions of solipsism" (Williams 21) or it be may be viewed as a method of overtly problematising the relationship between poetry and autobiography.

Whatever the case, in eschewing "I" and narrating from an involved yet once-removed perspective (either of 'she' or 'you'), the poets remind us that "the speaker of the poem and the author are not identical" (Williams 16). Yet, there remains a very palpable sense of the "implied poet" (Williams 16) throughout the three collections: we are aware that much of Horrocks' book is deeply personal, yet that she is also speaking from a universalised viewpoint; we perceive that Kennedy and Le Bas are speaking as mothers with sick children. There is a sense of a semi-confessional "shadowy self" (Williams 17) that pervades the collections, not only because the poets themselves have given interviews that locate the subject matter of the books in their own life experience, but also because they have crafted poems that demand attention be paid to the personal within the medical context.

Epilogue

The burgeoning narrative medicine and medical humanities movements have had an effect not only on the training of medical students, but also on the work of academics, sociologists, theorists and poetry and fiction writers. Ideas from the field of the medical humanities are recognisable in the poetry investigated in the critical component of this thesis, as well as in those collections which were mentioned only in its introduction.

In keeping with the socio-historical and cultural backdrop of these texts, the polemic at the core of the poems resists the concepts of authority and depersonalisation that Foucault opposed in *The Birth of the Clinic* in 1963. The poems also posit the same contemporary sociological ideas regarding doctor-patient discourse and narrative medicine as those published in the latest health humanities textbooks, thereby "inform[ing] the patient-provider relationship by representing the subjective experience as an overtly political act of looking back at and speaking to a diagnostic gaze" (Garden 129–130).

This is a poetry which is aware of clinical language and its potential for being used for linguistic subversion. Medical poems from the perspective of doctors, patients and parents assert the place of the personal, illuminating psycho-social, lifeworld factors of illness and medical treatment that are frequently (if unintentionally) obscured by a biomedical approach to patient care.

The polemical aspect of the poems is not one that many reviewers noted at the time of the books' publication. Reviewers praised the doctor-poets and their I-speakers' revelations of life on the ward, whilst some disparaged the first-person patient-poets, accusing them of solipsism, or the inability to rise above self-centred memoir. By connection, the parent-poets, who eschewed the first person, thereby putting in place another layer of distance, were subject to similar criticism, but with the added implication, that to make a loved one's suffering the subject of one's poetry was in itself questionable. The opinions put forward in such reviews raised Foucauldian questions regarding the relative position of doctor and patient in our

society and current levels of social discomfort with illness and self-revelation, but they also raised questions of craft, because alongside the criticism of the subject matter of the patient- or parent-poets' poems were comments regarding stylistic control—or lack thereof.

However, close reading and analysis of the poetry explored in all three chapters of the critical component show that, essentially, the poets all employ similar methods of crafting and manipulating the discourses of the medical world and the lifeworld to much the same purpose and effect. These poets demonstrate, just as Bakhtin recognised in regard to prose, the polemical edge of writing which utilises a multi-voiced discourse in an attempt to "shed light on an alien world" ("Discourse in the Novel" 287). They all write lyric poems telling autobiographical stories of medical experience, but with the necessary transformative elements that move them from the personal towards the universal. The universalising components essentially involve the combination of narrative perspective, the use of blended discourses and the internal polemic at the core of the works that draw attention to issues of healthcare, family, authority and identity, aiding the reader in his or her understanding of the inequities of power and personhood that will persist in modern medicine so long as the "voice of the lifeworld" (Mishler 14) is not given sufficient credence and attention.

The doctor-poets, Colquhoun, Andrews and Varcoe, frequently use lifeworld and biomedical voices in a contrapuntal way within their poems to represent, for example, the doctor-patient interview. There are satirical examples of the unfortunate "dialogue between different stories: the patient's biographical one and the doctor's professional one" (Launer 3), but also examples of genuine communion between the two parties where a blend of languages (even a blend with a bias towards vernacular, lifeworld language) is achieved. On occasion, the doctor-poets employ the two discourses in different parts of a poem in order to highlight a conflict between their filial and professional selves, portraying the biomedical/lifeworld struggle as an interior one when the doctor-persona is also the son or daughter of a sick parent, for example. In times of especial internal conflict, religious language is

added to this heteroglossia. Spiritual discourse and imagery are also used to communicate attitudes towards patient care and the doctor-persona's sense of duty towards his/her vocation, as well as to broach larger questions of faith.

The patient-poets similarly adhere to the traditional lyric "I" to give first-person perspectives of medical experience. Like the doctor-poets' first-person narrators, the "I" of the patient poets is not narcissistic or self-involved, but often, quite literally, positioned relatively subordinately (supine, in a bed, for example). Again, the patient-poets juxtapose the position of doctor and patient to show hierarchy at work, using imagery as well as diction. The empowerment of the "I"-patient comes not courtesy of his or her narrative position, but with the manipulation of discourses, diction and imagery that enables the reassertion of identity during the course of a poem or poems.

Stead, Bornholdt and Broom take risks and liberties with the language and form of their poems—they experiment to draw attention to the need for subjectivity and imagination in the stark, objective setting of "no god" (Stead, "S-T-R-O-K-E" 25). In all three poets' work there is evidence of subversive linguistic and formal play involving resistance to the objective, distant and dehumanising elements of medical language, from Stead's childlike punning and Bornholdt's layering of medical and poetic texts to Broom's ventriloquism of the doctor's voice. Ambiguity is often exploited by these poets—especially when the subjectivity of language manipulated by the patient-speaker expresses potency and ingenuity in the face of illness. There is also an emphasis on being able to humanise their own stories via vernacular, personal and poetic language—the language of the lifeworld (and secondary lifeworld language), whether it is via a poem learnt by rote being remembered post-stroke in the case of Stead ("S-T-R-O-K-E" 135–138), "the domestic rattl[ing] around / like small change" ("Medical" 19–20) on Bornholdt's speaker's mind while she is being examined during a physical, or Broom's patient-persona making up poems from signs in the hospital environment, finding "poetry all over the walls of oncology" ("Ward 64" 10–11).

Inhabiting a point of view at one remove from the traditional lyric "I," the parent-poets use "she" or "you" to maintain a distance that adds a further refraction to the voices they present via their main narrative. A maternal persona in a clinical environment features in each collection, and she is frequently shown "appropriat[ing] the word, adapting it to [her] own semantic and expressive intention (Bakhtin 294), ensuring that the attitudes and opinions that are heard most clearly are those which align with the work's essential polemic. Merging voices of doctors, patients, chatroom voices, concerned friends and Māori elders, Horrocks, Kennedy and Le Bas enact a powerful resistance to the negative (and patriarchal) aspects of medicalisation, not least those which threaten to destabilise family life or neglect the needs of the individual.

Adopting the standpoint of a "she" or "you" against a backdrop which reduces individuality may appear to be a strategy fraught with risks of unintentionally subscribing to the depersonalisation process. However, the three poets achieve, by contrast, a position from which they can tell a personal story, highlight their positions as marginalised "she" or generic "you," and invite the readers to participate in the story (as a "she" or a "you") or simply acknowledge that such stories happen to ordinary people every day. The anonymous "she" undergoing IVF, the "excema mother" and "you," the mother of the child with depression, are therefore everywomen figures; their namelessness and the lack of first-person self-identification, coupled with the frequent conflicts between lifeworld and biomedical language in their poetry, underline powerfully the necessity for a person-centred healthcare system that supports the whole family through medical treatment.

The books of poetry examined in the critical component of this thesis are typical of texts used as part of medical humanities papers for trainee doctors[31]. They shed light on the lifeworld realities of illness from the perspective of patients and their families. They also highlight issues of communication (and miscommunication) between doctor and patient. Head of the Department of Psychiatry at the

[31] See *Teaching Literature and Medicine*, eds. Anne Hunsaker Hawkins and Marilyn Chandler McIntyre.

University of Birmingham, Femi Oyebode, expresses the importance of these types of texts which allow a window into the lifeworld, when all that doctors usually see in practice is the patient out of his/her normal context:

> These accounts by patients bring to life how illness adversely affects life, in many cases, in subtle yet pervasive ways, and allow clinicians insight into what is now termed the 'lived experience' of illness …
>
> Patients present to doctors with clinical symptoms but these symptoms in the home setting have a personal, indeed an intimate, dimension which operates at a register quite distinct from the clinical. ("The Medical Humanities: Literature and Medicine")

It is interesting also that Oyebode sees these sorts of texts as important for trainee doctors not only as ways into their prospective patients' stories and insights into the lifeworld realities of illness, but also as mirrors held up to themselves as future professionals, for he perceives a reciprocity in the relationship: "just as physicians appraise the patient's condition in their role as clinicians, [the physician's] humanity is also being reciprocally judged by the patient" ("The Medical Humanities: Literature and Medicine").

So, in the works of the doctor-poets, patient-poets and parent-poets, then, not only is there evidence of resistance to those things which they find depersonalising and inequitable in their medical experience, enacted primarily via linguistic manipulation of discourses, but there is a very valuable bringing-to-life of complex character inter-relationships and a personification of the kinds of problems that pervade health humanities readers—"Which is a 'truer' account of reality: the patient's or the doctor's? Can both be true? If so, how?" (Launer 117).

These medical poems are valuable texts in a literary sense, but also as texts for use in the medical humanities, because in addition to teaching students to

question, based on context, whether the speaker means what he/she is saying, or what other possible meanings might be, the poems also set out the lifeworld/biomedical conflicts very clearly and draw attention to themes of patient-centred care and the need for shared doctor-patient narratives and discourses that may lead to more equitable and successful treatment-partnerships.

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Bridging Statement: Introduction to the Creative Component

In Brief

The poems in *Family History* are about a mother's illness and death, told from the vantage point of an only daughter, although, at times, a medical professional's voice is ventriloquized and refracted. There are tensions in the poems between the biomedical voice and the "voice of the lifeworld" (Mishler 190), illuminating the ways in which patients and their families can be dehumanised by the experiences of illness and medical treatment, and the ways in which vernacular and medical language can merge—or unsettle each other. Dormant familial tensions are agitated by the clinical environment; pathology and medicine can catalyse changes in underlying conflicts and make for exacerbations beyond the control of laypeople and lay language, experts and expert language. It is here that the blending of both discourses and approaches can represent an attempt to acquire control in order to subdue or understand the illness or its best course of treatment—most usually in vain.

In Detail

"Family History" examines the themes of identity and medicalisation primarily through the story of my mother. The first section's poems draw parallels between her position as adopted child and a cancer patient, and link the mother(s) and daughter(s) through the possibilities of genetic testing. The first section also examines the interactions of doctor, patient and family inside and outside the environment of the hospital. The post-treatment poems in the second section concentrate on the dread of recurrence and the recurrence itself. The third, final section deals with the mother's unexpected death in a car accident and the daughter's grief, from the first overwhelming moments in the hospital after the accident, to the lasting, everyday reminders.

Each section starts with a quotation from a medical textbook or pamphlet, which is another way of juxtaposing the medical and the non-medical discourses, showing how the two languages work together and against each other. On one hand,

we see the statement of the medical text playing out in what follows. If the medical text advises that many families struggle with the anticipation of cancer's recurrence, then the poems which follow show this to be correct. They illustrate the searching for signs, the anxiety, the neurosis of the family members and the moments that the patient herself is caught wondering about her future. But I conjecture that no medical text or terms can aptly and viscerally capture the mind grasping at the shock of what, for example, a "flail chest" injury may be. Imagery from the lifeworld is needed to imagine—to attempt to depict—what this looks like, what this is and what it means.

It is difficult to say how much the poems I have studied have affected my own poetry, in that never in my writing did I set out to formulate a facsimile Broom poem, for example, but I was certainly conscious of the ways in which the poets as a group used medical language in a refracted, channelled way to highlight its otherness or difference.

Some poems in "Family History" pit medical and personal language 'against' each other, as in "How Large Was Your Heart?," in order to contrast the precision and distance of the biomedical language presenting its facts about a loved one with the lifeworld realities of the loved one's abstract qualities. It is not just a juxtaposition of languages and images , but of positions. Sarah Broom's poetry was my strongest touchstone here, in that her anger in poems with doctor-addressees is directed in particular towards their neglect of the human and the personal, and to that end, she uses a form of indirect quotation (for example in "Three Exercises for Oncologists") in the clinicians' own refracted language, adding an especial power to her arguments.

The language of medicine, if one has the time to acquire it, is, like all language, a source of power. By contrast, not to know a word, or words, is to be outside knowledge and therefore, as a patient, or as a carer, impotent. The text from my study most in agreement with this line of thought is Jessica Le Bas' *Walking to Africa*. For the mother, the esotericism of her daughter's treatment-language is a frightening and babelesque monster until she manages to subdue it via imagination

and word-play, transforming the names of medicines into places that constitute part of her daughter's journey to wellness:

> Fluoxetine is a dry river bed
> Moclobemide is a long dark valley
> Risperidone is the highest mountain she climbs
> Epilim is the rock shelf she falls on
> overlooking a forest of Citalopram craters
> Quetiapine is the blue lagoon
> in starless light
> ("Newly Discovered Sites on the Moon" 1–7)

Harnessing the language of a specialism and turning it to one's own use by combining it with the language of other specialisms can be seen as an act of subversion, and, certainly, power-play is an element of my poems in "Family History," particularly those which deal with the equation of specialised medical knowledge with authority and power. Although I am hesitant to provide a detailed exegesis of my own poetry, I will give a few examples of how I see these poems working.

"Radiologist's Report," for example, takes the language of medical science—in particular, radiology—and mixes it with the language of art ("craze," "craquelure"), drama ("finale") and psychology ("ink-blots," "craze"), giving, I think, a sense of the radiologist speaker trying for clarity, expressing an understanding (not merely knowledge) beyond the medical, but obfuscating meaning by code-switching between the emotionally-involved and the clinically observant. In addition to diction connotative of the act of writing and interpretation ("indelible"; "dot to dot"; "full-stops"), I chose also the more mystical language of telling ("runes") that lifts the speaker beyond medical science and into the role of augur. The last line, I hope, sums up the multi-faceted nature of the radiologist's standpoint and attitude by means of ambiguity, alluding to the emotionally-shattering consequences of (the mother's) condition for the whole family as well as the way in which the disease will destroy her bones, making them thin and crumble.

His prognostication goes beyond the medical here, and a (fore)knowledge outside that of medical science. The assonantal chimes of the poem were chosen to make it sound musical, deceptively pleasant, even, but also build to the last heavy "all of you" triple-stress.

Another type of poem that can be found in the collection is the short, elliptical poem. For example, "Lines Overheard at the Teaching Hospital," "Flail Chest" and "The District Nurse" have loose, yet concise forms, which I hope manage to draw attention to the moment/phrase of central import by their very spartan nature. These poems are supposed to work in the space between what is known and what is assumed. There is a guilelessness implicit in the poems' pared-back structures, presenting speech that has been overheard or read, and processed subjectively and within the context of personal medical experience. These seem to have been most influenced by Stead's "S-T-R-O-K-E" series; they share the snatches of dialogue, the connections made seemingly quickly and the omnipresent sense of foreboding palpable even in comedic moments.

"Lines Overheard at the Teaching Hospital" did grow from overheard lines, and is presented almost verbatim, yet I've attempted to make the line breaks and the ambiguities do the work in expressing many of the medical/personal tensions central to a doctor's role.

Lines Overheard at the Teaching Hospital

Today, I learned that heartstrings
are called *chordae tendineae*.
I touched them.
In fact, I got to cut them
in half.

The medical student is learning the Latinate medical name for something she probably once only knew of as a metaphor, *heartstrings*. Not only that, she has now had the experience of dissecting a heart and palpating those tendons, slicing them in

two. To return to metaphor, she has begun a vocation in which she will have the power to be so close to human life and death that she will hold people's hearts in her hands. She will be able to touch them, to cut them, physically and emotionally, once her training is complete, such is the power of this profession she has chosen. The repeated "I"/"ae" assonance brings focus to this power of the I-speaker.

The poems in "Family History" are predominantly from the perspective of a patient's daughter, and so I have evaded the conundrum of narrative perspective that faces the patient/parent-poets. I steal words from doctors, nurses, doctors' secretaries, on occasion, in the collection, but I am not using a doctor persona, nor am I a doctor. The closest my poems come to the narrative voice of the poems I have studied in the critical component of this thesis is the maternal voice of Le Bas, Kennedy and Horrocks (and, of course, Bornholdt when she writes as a daughter). I trust that I cannot be said to exploit my subject, who is deceased. So the criticism they are most vulnerable to is the one levelled at Bornholdt—that which accuses her of too much personally-indulgent telling: "Her subject matter is almost exclusively personal: her father dies; she builds a shed; her kid gets sick; she gets sick; other people get sick; she moves plants around her garden …"
(Preston "Stubbing my Toes on Jenny Bornholdt's *The Rocky Shore*")

In my opinion, whether the subject matter is autobiographical, eaves-dropped, derived from diary notes or a journal kept beside a sickbed, the key is the perceived authenticity of the voice, and the poet's crafting to that end, and to the point of transformation from personal to universal. And while every critic and reader will have his or her own opinion of what makes for authenticity of voice and quality of style, I think it is defensible to posit that all the poets discussed in the critical component share the qualities of poetry that possess multi-voicedness as well as a strong and independent narrative voice. To suggest, as some critics have, that the patient/parent poets have produced collections that are weak on craft and rawly self-indulgent, is to have missed critical aspects of their work. Those aspects Fiona Sampson, in *Beyond the Lyric: a Map of Contemporary British Poetry*, sums up as "plain deal[ing]" (12). She explains: "No poem is ever entirely an Honest Joe, doing

what it does without reflection. By definition, it is the result of artifice—even when that passes itself off as nothing more than technique, control or indeed intention" (12).

Like Jenny Bornholdt, who said of her personal medical poems, "I wanted it to be clear that it was me as a writer talking" (Interview with Kathryn Ryan), I wanted to ensure that the poems in "Family History" had a story and a voice that belonged to me *as a writer*. Having looked carefully at Bornholdt's poems, and at the work of the other poets I studied in the critical component of this thesis, I am even more certain that the veracity of the story and the craft of a poem are not mutually exclusive. Indeed, they are often symbiotic: it *is* possible to base poetry on personal fact without sacrificing stylistic elements.

It is true that the poem cannot just tell an anecdotal story, however gripping that story is in and of itself; it must perform and transform, and, in a collection such as the one I have undertaken, a series of linked lyrics must function as a working narrative, which is a difficult task. I found it problematic to write poems 'for' a collection, as in my limited experience, the collection is shaped by the poems after they have been written. It was interesting to learn, therefore, that for Anne Kennedy, the opposite is true, and I tried to keep her vision in mind: "While I can admire a short poem that is a thing in itself but not a story, I couldn't write one to save myself. There would be so much pressure on it! A poem only lives for me if it is part of a network, a litany" (Interview with Paula Green).

So I had to accept that not every poem in "Family History" uses both medical and personal language, for example; not every poem explores the tensions inherent in doctor-patient discourse or employs a many-voiced form; but, I hope that, as a collection, "Family History" tells a story through the individual poems working collectively as a narrative, examining the relationship between medical and personal language, and focusing on the themes of a patient's dehumanisation in the clinical environment, the familial conflicts born of illness and, conversely, the importance of the lifeworld and its redeeming reminders.

Creative Component: *Family History*

(i)

First-degree relatives are particularly at risk for a difficult adjustment to a Breast Cancer diagnosis because they are most likely to experience role changes, be called on to provide emotional support to the diagnosed patient, and be confronted with the possibility of a familial predisposition for the disease.
(Caple and Schub par. 2)

Inheritance

All my mother
ever got from her mother
was a sentence:
I am your mother
(dressed up as a visiting aunt)
then a punishment
for repeating the sentence
to her mother:
Auntie said she is my mother
and proof positive
posthumously
with some letters:

ER/PR–Her2+
is the classification
of your mother's tumour
defined by immunohistochemistry

which she never read
although she received
that particular sentence
loud and clear

Medical Miracles

A small sample
of my mother
in wax
is winging its way
back from the UK
to be tested
for faulty genes
that might have
got to me
by other means.

One day,
one decade,
this block
(not my property,
and certainly
no longer her/s)
might be spliced
and grafted
onto the spines
of knockout mice
and grown
into a batch
of tiny mothers.

I'd have to
find that lab—
perhaps, as a pensioner
in animal protestor
camouflage—
break in
and fill my pockets

with little ladies
atop white rodents

with whom
I would escape
into the darkness
to start my own
family circus.

Photograph of Forest Gate Hospital
Unmarried Mothers and One-year-old Infants, 1938

Which two are you?
There are so many small and smaller faces
in this long photograph.

All the women are thin and straight,
their hair cut in the same square shape,
and the babies wear off-white simple-stitched gowns.

Won't you smile, wave at me,
poke out your tongues
for devilment?

I need someone here to own.
Not to know feels remiss,
like leaving you in a cupboard
while I count on interminably.

Perhaps I'll just pick two.
The happiest. The best fed.
The first to be caught by my eyes
when I open them again.

Come out, come out, whoever you are.

Captions

Some of the pages
of Mum's old albums
have empty mountings
still with captions
under their bare grey squares:

FIRST COACH JIM HELPED TO BUILD
TOWNHALL CERTIFICATE-GIVING—
far more mysterious
than those with photos
of MR AND MRS DUNNE AT OURS
and VIOLET ON TINKER,
but less compelling
than the ones labelled ME

just in case anyone wonders
who hid behind a leafy tree,
swung, in a bathing suit,
from ropes attached to the sky,
or peeked out
behind steely-headed MOTHER,
who stands,
arms folded,
in front of a fading house
called INVICTA.

Maureen in a Row of Lettuces, 1972

They have been stemmed, cut at their bleeding ducts.
She holds two of them face-out from her chest, sappy.

In this photo, there is so much she's yet to know
about horticulture—how to raise a row from graft or seed,
how to feel for Brown Spot on the underside of leaves,

how to topdress crops between the right rains in spring,
how to harvest them while young, before first rot sets in.

Cool Storage

This big white room meant the difference
between freshness and spoil.
Mum and Dad took turns
to stack the day's leftover fruit and veg
onto blurry shelves,
the hair on their arms thick as peach fur.

It was too hot in the shop,
but now nothing would expire before its time.
All they could think of was how they'd won
longer use-by for their labours.
How far they'd come
to afford preservation.

Anonymous

Winter arrives,
a white envelope
on the kitchen table.

Inside, a blanket letter
from The National Tumour Bank
(its regional representative)
who *seeks permission*
to store a small sample of tissue
from YOUR DECEASED RELATIVE.

This spare flesh,
excised
during the resection
of a malignancy,
would normally be discarded.

Instead, it will be kept
as a snap-frozen block
for cancer research,

encoded and anonymous.

You can be assured
no one will ever know
who the donor was.

Waiting Room Music

The music here
recalls the records
played at Granddad's
on our Sunday night visits.

Like three kids,
my parents and I
would sit like this:
bored, under the slow-
turning ceiling fan,

a bit on-edge, waiting
for the Minstrels to start
waving their gloved hands
at Cilla Black
(who used to be Cilla White);

waiting for Granddad
to get the Cadbury's King-size
from the fridge and give us each
the six-square line
we'd earned by listening quietly
to Seventies tunes—

Close to You,
The Whole World in His Hands
and *Love is a Beautiful Song*—
most of which made Dad cry
and grasp Mum around the waist.

She'd shrink back a bit,
tickled, then sink against him,

her warm cheek to his wet face,
his liquored lulling—

It's so good to see you now,
looking as lovely as ever
It's so good to be alive,
knowing that we are together—

And here we are again, we three, stuck,
waiting for the first act,
a song we might learn the words to,
a routine we can understand,
something to sink our teeth into.

Lines Overheard at the Teaching Hospital

Today, I learned that heartstrings
are called *chordae tendineae*.
I touched them.
In fact, I got to cut them
in half.

How You Guess She Doesn't Have the Best Breast Surgeon

He says *growth*
and is surprised
when we don't know
that *Cancer*
is implicit.

He balks at reconstruction:
We just need to cut this out.
To illustrate,
he draws a cake,
shows which slices
he will take,

keeps it pared back
to understatement
and euphemism
for our sake.

Just to be safe
he'll add *belt and braces*
post-surgery—

Radiotherapy will leave you
with slight sunburn;
chemotherapy may make your fingers
and toes go tingly, and you might lose
some of your hair.

As he leaves his office
to let us *take it all in*
and *make some decisions*,
his nurse mimes

Psycho stabbing signs
behind him
with surgical scissors.

The Surgeon's Secretary Is also His Wife

She calls late
with the results of pre-op tests.

It's night.
We've been waiting all day
in the dark.

She can't gloss the text
on her own—
Invasive, *lobular*, *negative nodes*,

and her husband is sorry
he couldn't answer his phone;
he's been operating since 3.

As we speak,
he's probably up to his arms
in another woman.

Understanding

So, I ask, what precisely is a *grade three carcinoma*,
and is a *two-millimetre margin* large enough?
Not being in the lymph nodes is good, I know,
but what's the prognosis? You mentioned a 66%
chance of survival. Would you explain?

He asks me which students in my class
will get an A, which a D. Can I tell
with any degree of certainty?

Well, I can be pretty sure.
Same here, he says. Same here.

The Girl in the Back Row Has Come off Prozac

She has facial expressions,
doesn't shrug down into her blazer,
punctured by my questions.

Her eyes don't look blown-pupilled.
They're live and small.
They dart about.

It's not that she's forgotten
that day balanced on the bridge.
She's simply remembered what it is to live,

like finding a forgotten winter jumper,
still with the fit and give in the right places,
the small fix that no one will notice:

See how her arms move open-palmed
to make a point; her fingers tip to steeples.

Shared Lines

Mid-Donne,
I turn
to blink back
The Dream,
tripped by something
I can't put a finger on.

The line's dumb slack
is taken up
by a girl at the back.

Last year,
her Dad died.
She knows the sudden
need to cry.

Kindly,
she hides me
under two dropped iambs.

On My Shoulders

I carried a three-foot gorilla,
his hairy legs clamped
at the prehensile toes
around my neck,
his big, jolly bonce
bobbing in time
with mine
as I walked to the ward
that smelled always
of toast, jam and necrotic lilies.

In the doorway
with my silly gift
I spied her face, lifted
to the warm window,
right arm under the blanket,
over her left breast,
the other hand in a fist,
pulped papier maché
tissue poking out the top.

I knocked on the wall,
and—caught out—
she wrought her delight
in seconds: animated eyes,
happiest smile, little giggle at me,
and the surprise I'd brought.

Sure, he'd be a hit on the ward.

You could squeeze his hand
and make him roar.

Night Nurses

appear at curtains
in cameo profile,
nod to obs sheets,
tick boxes.

The night nurses
pickpocket pulses
from bedsheets,
slide and turn
whole bodies
from pain
to comfort.

In the light,
their names
will be forgotten—
like the sound
of their kind shoes
on linoleum,
their answers
to muddled
midnight questions,

the nightmare admissions
taken in their stride.

Curtains

Walls and doors and dogs and bells
will disappear in the end.
We're all reduced to curtains.

Think Havisham. Diaphanous
disappointment. The queer
unanonymity of the ward,

where family shadows show
behind white plastic sheets;
whispered words play out—

somebody else's *how* and *why*
and *where does it hurt*
with no filter for fear or shame.

Then in the evening, alone:
a plea for water, a radio's static company,
a call for mother, a name, a home;

God, the notion that life may be collapsible,
reducible to something a small arm may draw
three sheets around in one swift movement.

Lines Overheard on Ward 5

So, present to me.
Seventy-one-year-old female became dizzy
and disoriented in the shower at 7 am.
At 8.30, her friend arrived
and noticed drooping of her right eyelid and cheek,
some slurring of speech.
On examination at 3 pm,
no neurological deficits were observed.
I suspect a TIA.
Good. History?
History remarkable for polio in childhood,
breast cancer in 2001—partial mastectomy—
and uterine cancer 2005—hysterectomy.
What tests should we run, then?
ECG; bloods CBC, blood sugar, electrolytes,
liver and kidney function, prothrombin time; head CT—
Fine. Head CT. Why?
To look for bleeds, narrowing of vessels …
And what else?
Uh.
The history, remember?
Oh yeah, the cancer;
CT to detect distant spread—
Metastatic tumours in her head.
Cool. Yeah, that's what I was after.

No No No

The old lady in the bed opposite you
has dementia. Her eyes are brown,
though cholesterol has haloed them blue.

Most of the time, she lies
like a vague angel, mouthing
only memory and mimicry,

but now she wants to go
to the bathroom and has forgotten how
and that she is not allowed.

No, *no*, *no* she howls when told
she must use the bedpan or soil her nappy.
She says *toilet* and *take me* and *please*—
I can't go in the bed, Mum.

She is a nuisance to the nurses,
must be held and hoisted.
Her arms bruise like bad apples.

She struggles and struggles
until it's over, then smooths
her blankets down, tremorous,

looks at us, says:
Thank you, darling.
Thank you, dear.

Lines Overheard in Hospital on Good Friday

5 pm *Age Concern*

Who do we have coming in?
94 year-old with gastro bug.
Lost eight kilos in four days.
What's the point?
Yeah, no point, eh?

6pm *The Changing of the Nurses*

Hiya, you off now?
Yeah, so relieved. What a day.
What?
Gastro Ward all day. Smelly, smelly.
All day the smells. You know the one I mean?
Ha, yeah. Smelly as. Have a good Easter, Sister.

Sick Room

The air is too thick. There are too many blankets
and pillows propping you up, wedging your legs.
"I may be here tomorrow," you say.

It reminds me of all the little wax-eyes
I tried to save from cats when I was a girl—
I'd place them in warm shoeboxes overnight,
only for them to die by morning,
shocked by a surfeit of comfort.

Ward Rounds

We arrive in good time,
after they've been bathed and
rearranged in their beds.
Dentures perform a rictus to the left,
right arms are bruised and dripped.
Old people are propped
up in anticipation of the specialists.
Nurses flap and smooth sheets.
Doctors young as grandsons
shadow at curtains, shuffle, cough.

Women—ladies—addressed like babies,
acquiesce in order, naked to the waist,
ribs pressed for tenderness, breasts palpated,
diaphragms auscultated in silence.
Restless, you wait your turn to be appraised and let go.
Our hope is that we will not be back.
Undressed or shrouded in a sickly green gown,
neither mother nor wife is recognisable to us.
Daughter, husband—we are still here,
seeing you being seen.

[Sic]

Her discharge notice
(dated 27 December)
lists many codes
we do not know
and events
she can't remember.

But "all pulses are presents,"
it's true,
is quite the fitting
Christmas Message.

The District Nurse

Dad [from upstairs]:
Where's that fucking nurse?
She's always late.

[Silence]

Dad [coming downstairs]:
Maureen, Where's—

Mum [from downstairs]:
She's here, dear.
Go and put the kettle on.

Norma-Jean, Naomi, Tammy and Grace

Ladies,
You're killing me
with your bulkiness,
your outmoded styles,
the long, odious fringes that fall
where eyebrows should be. No surprise
wan, bashful women sink
under the weight of your personalities
when all they were seeking
was something unobtrusive
that made them feel mildly healthful,
little changed, walking out
into the world of observers again
after so many months in hiding.

Bad wigs,
with your timeless names,
you serve as reminders of all the bad bald stories—
the shower blocked with hanks of hair,
that embarrassing, thick moult
down the back of a coat two days unnoticed,
and once,
a sleepless five-year-old
found knotting pieces from her pigtails,
cut with dangerous blades,
onto a hairband for Mummy,
whom she'd espied crying
naked in the bath.

Good Doctors

Auscultate the heart
with neither disc nor cup
to the chest.

Test and record further
than clockwork
beat and murmur.

Listen beyond molecular,
anatomical,
functional.

Good doctors,
pore over
the truth table,

poor puzzles of people
pieces to fit back together.

Say, *Here is an image*
to hold up to the light.

(ii)

Only recently has cancer been recognized as a family disease. Both stress and depression have been noted to increase in patients and their family members as a result of concerns regarding recurrence. (Lenhard, Osteen and Gansler 826)

Signs

They're everywhere
if you look long enough:

In the posh café,
the plummet of the see-through
plastic seat before you sit,

the front door's broken lock
and four new tacks
in the skew of a workman's mouth,

the open and close of an empty lift
calling, again, for nothing,
no one on the ground floor.

Ka Mate

A tan boy with seaweed hair
is playing drowned on the beach,
lying face up, letting lines
of tired waves break over him.

He is clever. He listens, knows
when to hold his breath and when
to let it go. He has passers-by
craning necks while his parents
watch from deckchairs, in on the joke.

He is composing a poem on the tide,
its old rhythms threatening:
Watch me live. Watch me die.

Cracked

In this drought
a crack has worked its way
up or down our lounge wall—

a crinkle
to a hairline
to a mad jaw of a thing.

The builder talks of settling,
waiting for a change in the weather,
giving it a few days,

and you are fine
with putting panic on hold
for a rainy day,

while I'm on a fault line,
looking up past the picture
you have hung to hide it,

pulling out the settee
to see how much worse
it is tonight,

until the cross-hatch
of buckled tape
and seamed board

look too much
like a mistake
or a torn page.

When wrinkles
spread across ceilings
and doors swell shut

so I have to tug and sweat
to get out,
I expect you to be there

on the other side.

Kit

Sprung from the cat's trap,
the kit played dead
in my hands,
from the doorstep
to a shady shock of hay
by the boundary fence.

I'd worried he'd bite
or struggle,
scream
that terrified
baby blood-curdler,
but he was silent,
a solid brindle
ornament,
dumb, still,
when I set him down.

"You'll be alright, now," I said
to his black tonic eyes,
to his static fur,
to the mad electric
quiver
of his ears.

He looked past me
to the impossible hills,
the ticking fence line,
and would not move
until I'd gone.

And Then It Spreads

Of course, I'd read up—
bought every heavy oncology tome
on the tendency of this cancer
to spread metastases to bone,
like the ugly towels of tourists
all over the beach in summer.

So when Mum complained
of shoulder pain—
she'd probably pulled something
playing badminton or lifting shopping—
I let her go through Panadol,
codeine and icepacks

but drew the line
at a cortisone injection
in the socket:
that larger and more painful
delaying tactic.

I suggested an x-ray,
knowing what they'd find.
And when they found it
I felt like Judas.
I'd betrayed her
with radiation,
shown her up,
turned my head
while some sonographer
held her up to light,
fingering the holes
in her arms, her ribs.

Ultrasound, Monday Afternoon

This is like watching Armstrong on the moon
bouncing static from a safe umbilicus.

On the bed is a foreign body whose arteries open
like craters, then close to silence on cue

before another strange wave of underwater sound, and
the sonographer stops, pushes down—Christ, what's he
found:

friend or foe in that shallow unknown? He squints,
stretches measures of width and height.

All night, we'll be wondering if his intensity was concern, and
his small talk, as he wiped off the probe, a dead giveaway

or just the usual form once an examination is done.
For what else can a man of images do, but go mute

until the radiologist arrives to transcribe the film
first thing Tuesday morning?

MR I

Do we worry
that on our way out
the radiographer
says, *Have a good day*
when he told the family before us
to have a good Christmas?

Radiologist's Report

Lytic inkblots stick to the spine, ribs and arm,
connect the crude metastatic plot that will craze her body.
Dot to dot, ugly indelible pebbles lodge between vertebrae.

Fatal rune-stones wait to be read in the sternum,
squat like filthy fat full-stops in the gap of the glenoid,
threatening the slow craquelure finale

that will shatter through all of you.

Against Overhearing

The table of ladies to my right
clack their fussy forks and knives

over the smother and mumble
of fish and chips.

They're old enough
to be my mother.

Their talk turns, in time,
to who's ill and who's died.

Hear their pride at being alive
and not too much the worse for wear.

Who cares about a few dubious teeth, a cane,
when poor Jan's got the cancer back again?

On chemo and radio, she'll lose her hair,
when it's only just grown back.

My appetite runs cold
as the hollandaise congealing

on the plate; the salmon's slick, grey edge
is flesh and gristle in my mouth,

impossible to swallow;
impossible to spit back out.

Cry

She'd read that it's impossible to cry
two days before you die.
Just when life's about to leave,
you can't even wave a hanky at it—

Invicta

Tame two years
and three litters,
one day,
the lean tortoiseshell
disappeared forever.

Too wise for car wheels
or poisoned rats,
she must have
taken herself off
into the shade
of a wooden bridge
grown through
with moss and weeds
or the safe cave
of a rotted willow's trunk
or the proud dark
under a stranger's house.

She was still wild enough
to know better
than to tell us
that something hurt,
and badly.

(iii)

Once death has occurred, grieving has acute and chronic components. Reminders of the deceased precipitate waves of an overwhelming sense of loss, crying, fatigue, and agitation. The intense distress of the first few months is characterized by social withdrawal, preoccupation with the deceased, diminished concentration, restlessness, depressed mood, anxiety, insomnia, or anorexia. … Over months, grief usually diminishes in intensity. (Lenhard, Osteen, and Gansler 849)

My Mother Wasn't Supposed to Die

in a car crash caused by a boy racer
who took a chance at the crossroads:
she was destined for cancer—staged.

We'd already talked through ways
for when the time came, stockpiled pills
with the labels peeled, panicked

we wouldn't be able to get enough
and if we did, that they wouldn't work,
could leave her worse than dead.

So my mother wasn't meant to die
at that junction, *instantly*,
the kind policeman said,

of flail chest, cheating death
or life—whichever of those inescapables
posed more of a threat on that day,

at that particular time,
that crossing-place.

Flail Chest

A portion of the ribcage
hangs
like a trapdoor,
swings
between breaths.

Shaken Down

In the hospital corridor,
the one two of my shoes
on hard lino,
then something
sounds broken—

a thermometer—

I have left people here
in rooms
and cabinets.
They've gone cold
in others' hands.

The red of me
spills
into so many
ball bearings…

Orderlies wheel
prone passengers.
Nurses pass
with busy eyes,

until one pauses
to put on gloves,
coveralls, booties.
She sticks up a sign
(DANGER HAZARDOUS SUBSTANCE)
and calls
for a flashlight,
holds it at an angle

to find beads of me-
rcury lodged in cracks
between wall and floor.

Without a fuss
she gathers masking tape,
an eyedropper,
index cards,
and uses them to
corral what is herdable
into new glass tubing.
Her cards say:
MY MOTHER DIED
WHEN I WAS YOUNG TOO LOVE

What miracle
to approach
naked breakage,
to chase it unafraid,
gather it up
and talk it back down
to something
resembling normal.

How Large Was Your Heart

The coroner reports a haematoma
over the anterior pericardium,
and an oedematous pericardial sac
incidental to force of the side impact. For him,
these things explain the generous weight
and size of the organ post mortem.

But a daughter can account for its mass and span
without taking the dead heart's heft in her hands.
For she has felt its beat in full swell
through warm, unbroken ribs.
And I say a woman's heart in a 5'2" frame
does not reach 325 grammes by accident.

Mother and Child

I dreamt my mother
conjured for comfort
in the chill suggestible
hours of morning

draped my body
across her small lap
marvelled at her jaw
her chin
        my own
felt warm
known flesh
and bone
all angles and softnesses
re-membered

down to the distance
between the thin dark
arches of eyebrows
the crooked smile

the silent shape
of her lips on my palm
as I showed her my wounds
and she healed them by heart

Undertaking

We leave from the same door we used to come in.
This is our tacit habit, simple
as the wiping of feet or genuflecting,
between good manners and ministry.

This is our tacit habit—simple:
We're there for the showing of pictures, the weeping—
between good manners and ministry,
but we exit as we enter, shedding death at the door.

We're there for the showing of pictures, the weeping.
We keep company with grief as a priest might,
between good manners and ministry.
We do not flinch at sentimentality.

We keep company with grief as a priest might.
Confessions like these are our stranger's duty;
We do not flinch at sentimentality.
We tend the living as we shall tend the dead.

Confessions like these need our stranger's duty;
like the wiping of feet or genuflecting.
These details determine our undertaking.
We leave from the same door we used to come in.

Old Habits

I inspected the paradise duckling
lying alive at the top of the stairs,
paralysed, save the follow of its eyes,
the slow upheaval of its wing-buds,
and found only the two clean punctures
of cat incisors on the floppy neck:
no other insult wrecked its prettiness.

At the vet's watching the feet's spasticity,
the hopeless wobbliness of the heavy head,
I saw splints and delicate operations
to repair damage done to the spinal cord—
before the word "euthanise" brought me back
to why we'd come, taught me that old habits persist
however strongly we feel the need to resist
old tendencies, believing them left behind.

Chardin Rabbits

It's not the dead ducks,
one wing stuck up,
feathers splayed
back to the shafts
nor the possums
ruched like rugs;
it's these Chardin rabbits,
lithe and buff,
that still live softness
of their eyes
staring beyond
the roadside.

Every time,
they leave me fielding
a scream inside—
Someone get her out of here
or cover her up:
she's somebody's mother,
for Christ's sake.

Heartache All Around

There's heartache all around today.
At the vet's, on the noticeboard:
MAX = MUCH-LOVED PET
MISSING 3 DAYS
and a picture of a cat
under the arm
of a sleeping girl,
tucked in the crook between
her shoulder and the thumb
stuck in her mouth.

Oh, MAX
and oh, little sleeping girl,
all the cruelties of love and absence
have struck at once.
There will be no finding,
no reunion,
no comfortable slumber
for the next weeks or months.

This is how it is—
spectacle of attachment and loss,
all of us looking and calling
for nothing,
even though there are microchips
and rewards
and twelve small tabs
with a phone number printed on them
in fat felt tip.

Resting Tremor

The last
pictures
I have
of you
are blurs—
the swift sweep
of cheers,
the freeze-frame
flipbook arch
of head and neck
in laughter.

After all,
this persistence
of vision:
the fan
of one hand
on your knee,
caught out
when the rest
was still.

Glass Bowl with Pink Swirls

moves a little whirlpool, still,
reminds me of your last, small desires—
to dabble a hand in warm, soapy water,
playing the boundary notes of here
and not here, testing a surface
the beneath of which none of us knew.

To perceive you seeing nothing and everything,
to watch the loop of your hand in its benediction
or to sit at your feet with my hot cheek tilted
to meet the roll and stroke of soft fingers,

was to be most steady and most moved
by your tender infinitive. That keepsake.

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