Gerry's wig

My left breast: an unusual film about breast cancer
Gerry Rogers, director; Peggy Norman, camera; Paul Pope, producer
St. John's, Newfoundland: Pope Productions, Ltd; 2000
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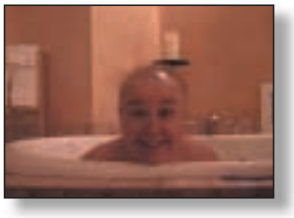

Courtesy Pope Productions

Gerry Rogers looks at the camera through the two zeros in the middle of her zany millennium sunglasses and asks, "Should we talk about the year 2000?" The question is addressed to her lover, companion, caregiver and camerawoman, as well as to the viewer of this intimate autodocumentary, *my left breast*. Behind the camera, the voice of Peggy Norman is sceptical: "What is there to say about it?" she asks. "Hopefully," Gerry answers, "the year 2000 will be better than the year 1999 for us, although I still think we were really lucky."

Gerry Rogers' luck fizzled rather badly in 1999, the year she and her partner started a bed and breakfast business in Carbonear, Newfoundland, and then discovered Gerry had breast cancer. Gerry started making this film the day her hair began to fall out during chemotherapy. It was, to use Peggy's word, an "outlet" for her feelings. In the small hours of sleepless nights Gerry points the camera at a mirror and talks about her fears, her sense of isolation, her feelings of loss. She shows us how her hair comes out in tufts, the incision left after modified radical mastectomy, the flushing of her Hickman catheter. She takes us to her chemotherapy and radiotherapy sessions and to follow-up visits to her doctor. Although centred on self-disclosure, this is an an extremely *helpful* film, one that posits a viewer faced with a similar situation herself.

This creative outlet, the film, documents another: the collective project, guided by a professional wigmaker, of making a "healing wig." Gerry asks friends, family, neighbours, the women behind the post office counter, everyone she knows, for a lock of hair. The idea catches on. Offerings arrive by mail from across the country. Samples from entire families, including cats and dogs. A carefully packaged and labelled collection from the childen at a school for the deaf. Thick tresses kept in a drawer for 30 years. The hair that a women had cut off the year she herself started chemotherapy. It's a complex impulse to preserve a lock of hair: a hedge against loss, a nostalgic gesture, an act of hope, a memento mori. These very personal artifacts are given as a benediction, a wish for Gerry's restoration, an expression of solidarity.

Gerry inspires generosity, first because she is so likeable, and second because she so clearly values the love and support she receives. She confides to the camera that "love and tenderness are so important to me right now." Metaphors of battle don't really interest her; the important thing, she muses, is to be gracious and to do the best she can. This means welcoming the organic produce, herbal potions and (to her mother's consternation) packages of marijuana people give her. It also means submitting to modern medicine's more brutal means. Disfiguring surgery, the infusion of "the red devil" in her veins, skin scalded by radiation: Who can embrace these as an experience of *healing*? This is the most difficult thing: to face unpleasant treatments with feelings of deep ambivalence. Gerry worries about this: To get better, should she not always be thinking positive thoughts?

Courtesy Pope Productions

The quiet triumph of this 60-minute film is that it convinces us that Gerry Rogers *is* lucky. She has a deep respect for herself and others, a buoyant sense of humour, a gift for communication and community building. She knows what she needs and asks for it. She shares, unasssumingly, what she learns. Giving and receiving, she achieves an amazing grace.

Anne Marie Todkill
CMAJ

Room for a view

The gravedigger's bed

When I was a junior intern in Montreal, we had no problems with beds being blocked by patients with chronic conditions, at least not in teaching hospitals. One of the reasons for this was simple: at that time there was no national or provincial health insurance. Many people had private insurance, but this covered only acute care and usually terminated after two weeks in hospital.

But there were other means of preventing bed-blocking. There was a rule, for instance, that people with stroke, even of recent origin, could not be admitted to the public teaching hospitals. The justification was that the diagnosis was obvious, and there was no treatment that could not be given elsewhere. When we were on call we might be telephoned in the middle of the night by a harried general practitioner with a stroke

patient, but we were adamant: disposal of this patient was his problem, not ours.

On one occasion, however, a soft-hearted staff physician did admit an elderly man, a gravedigger by trade, who'd had a stroke and had no one to care for him. Since he could not be admitted to a teaching bed, he was admitted to the private pavilion. Very quickly it was realized that, financially, he was utterly ineligible for this privilege, and he was transferred to a public (that is, teaching hospital) bed. The next morning we found him breathing stertorously. He was unconscious. When we made ward rounds, the physician in charge expressed indignation and ordered the patient to be discharged. This meant calling on the social worker to find a nursing home bed. She was able to comply at once, as she had a working relationship with several nursing homes. They called her when they had an empty bed, and she undertook to fill them. So by mid-morning the stroke patient was gone. We didn't know where, nor did we care. I realized later that, as there was no treatment or rehabilitation in nursing homes, the patients sent there quickly developed bed sores and aspiration pneumonia and died. The turnover of cases was quick and efficient.

On another occasion, a patient on the ward became confused, noisy and violent, unsuitable for a nursing home. We decided he should go to a mental hospital. There were two: the Verdun Protestant hospital with 1500 beds, and St. Jean de Dieu with 5000. But these hospitals were always full. In the days before effective therapy they housed many young schizophrenic patients who were there for life. Indeed, their parents were encouraged to consider them deceased and to put a death notice in the newspaper. There were also severely manic or depressed patients and some with dementias arising from syphilis or Alzheimer's disease.

How were we to discharge our noisy patient? We called the police. Two burly officers arrived, saw that the patient was disturbing the peace and took him to jail. The jail medical officer quickly determined that he was a mental hospital case and ordered him transferred to one or the other mental hospital, depending on his religion and language.

Some time later I spent several years in Britain, where the recently established National Health Service was undertaking to provide treatment for all persons "from womb to tomb" or, as we jokingly said, "from erection to resurrection." There I met the remarkable Dr. Marjory Warren, who had shown in the 1930s that with accurate diagnosis and simple rehabilitation many chronically disabled patients could leave institutional care. Her appointment was at a large county hospital with a workhouse attached. She was able to discharge some people to jobs, some to sheltered housing and some to their own homes. The workhouse was converted into a general hospital, which included a 180-bed geriatric unit. Here she treated her own patients as well as those transferred from other hospital wards. Because the other physicians had nothing further to contribute to their patients, they considered such transfers as "clearing their beds," a kind of social work, and referred to Dr. Warren as Miss Warren.

When I returned to Canada I started practice as a geriatrician. Very soon, elderly patients were referred to me by local practitioners. Unfortunately, I quickly discovered that these patients were referred when their hospital insurance had run out and they had to be discharged. They could not afford to pay me. Although there was a small rehabilitation department at the hospital, I explored the possibility of longer-term treatment at a large chronic care hospital that had recently built a rehabilitation unit with a grant from the federal government. This hospital was staffed and administered by a devoted order of nuns. Almost all the patients were in bed, and few used the rehabilitation facility. To occupy their time, a loudspeaker had been installed in each room over which the prayers and religious services of the nuns were broadcast. There were no magazines or radios.


Art Explosion

I proposed to the nuns that I could organize a rehabilitation program and encourage activities. They gave my offer careful consideration for a few days and then declined it. They quietly explained that these patients had not long to live and should profit from their remaining time by preparing for eternity. Moreover, if their own physicians had not ordered rehabilitation, it was probably not needed.

In a town nearby was a home for English-speaking elderly people. I spoke to the physician in charge about the possible need for diagnosis and medical care, especially as on the day of my visit a resident of the home had just died of heart failure because no one had reordered her diuretic medication. He agreed to speak to the board of directors. But, on my return visit, he declined my offer. Apparently the board told him that I was trying to turn the home into a hospital, and that was not its purpose.

I was encouraged to apply for a position in the Department of Veterans' Affairs chronic care and rehabilitation

Putting in time until the party is over

Alone in a corner she sits
hands folded
patiently waiting.

Belle of the ball,
bathing queen,
no longer aware,
she needs
a diaper change.

Robert C. Dickson
Family physician
Hamilton, Ont.

hospital at Ste-Anne-de-Bellevue. After interviewing me, the director general of treatment services told the chief of the medical service that he could hire me if he wanted to, but any young doctor who would take this job must be sadly lacking in ambition.

We were able to develop an active rehabilitation and treatment program, including training of residents and some research. I thought it could be used for teaching medical students and spoke to the dean of medicine at McGill. He replied, "Listen, Bayne, if we *ever* wanted to teach geriatrics, we would admit a patient to our teaching hospital beds and teach it there."

Thus I found myself back at the beginning.

Since then, of course, every medical school has developed a program in geriatrics, and geriatric medicine is a recognized medical specialty. Elderly people receive excellent medical and surgical treatment and rehabilitation. But still, we hear grumblings about them blocking beds, using too many drugs and costing the system too much. But who could wish back the efficiencies of the past, at the price of moral bankruptcy?

J. Ronald Bayne
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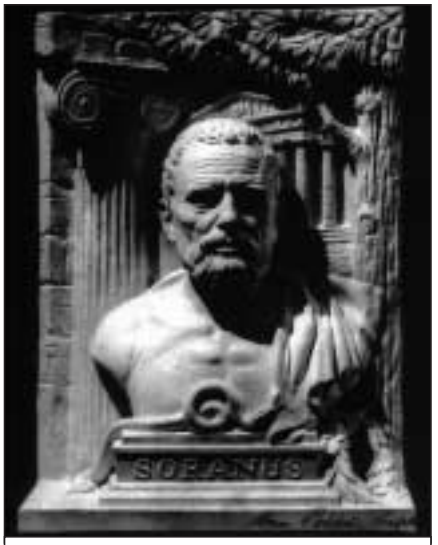
Past progressive

The Soranus score

In the second century AD, Soranus of Ephesus described a method of assessing the health status of newborns that very much resembles today's Apgar score. Soranus studied in Alexandria and eventually moved to Rome, where he practised medicine. He authored close to 20 works on topics ranging from internal medicine and surgery to the nature of the soul.

In his influential treatise on gynecology,[1] part of which has survived in the original Greek, Soranus devoted an entire section to the care of newborns. He begins with instructions on "How to recognize the newborn that is worth rearing." He suggests to midwives that the following characteristics are indicative of a worthy infant: "its mother has spent the period of pregnancy in good health … it has been born at the due time, best at the end of nine months … when put on the earth it immediately cries with proper vigor … it is perfect in all its parts, members and senses … its ducts, namely of the ears, nose, pharynx, urethra, anus are free from obstruction … [and] the natural functions of every member are neither sluggish nor weak." Finally, Soranus pointed out that the joints should bend and stretch, and that the newborn should be of "due size and shape" and "properly sensitive in every respect" (which could be tested by pricking or squeezing).

Both Soranus' assessment and the Apgar score recommend the evaluation of muscle tone, reflex or irritability and respiratory effort. Soranus, however, does not specifically mention heart rate or colour of the newborn as prognostic factors. Of greater importance, though, is the fact that these evaluations had different objectives. The Apgar score is used as a reflection of the condition of the neonate. Soranus' assessment was used to determine whether the newborn should be accepted or rejected. Acceptance was symbolized by the paterfamilias picking up the newborn from the earth where the midwife had placed it. Rejection meant that the family would not raise the child and could legally dispose of the baby in a number of ways.



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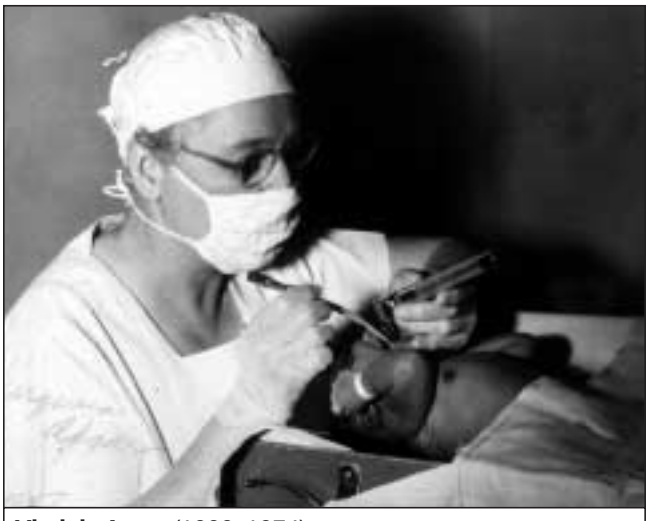
Soranus of Ephesus (died *circa* AD 129)



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Virginia Apgar (1909–1974)

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