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BODY OF EVIDENCE

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**Documentation and commentary on the body of practical work
submitted to meet the requirements for the Degree of
Master of Fine Art, University of Cape Town, 2002**

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*'I don't have an agenda for my art other than for it to have deep meaning to me...
My work is about my life, and it protects my life. I trust my motives for doing things
because I know they are deeply connected to me – the more I look after them,
the more they will look after me.'* – Kiki Smith¹

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ABSTRACT

This body of work is an experiential study which aims primarily to investigate the effect of the Western medical anatomisation of myself – the cancer patient – on and through my artmaking.

The dissertation aims to contextualise my practice – to situate it somewhere between the different readings of cancer according to the Western theory of disease, the Eastern and New Age understandings of the body and ill health, and the work of other artists. It seeks balance between these competing discourses and looks for integration through them. The responses of other artists to their ill bodies are described, several of them exploiting medical technology, others subverting the language of the dominant discourse and the image of the 'good' patient with a 'bad' body.

My own work attempts to make art around and out of the experience of cancer. The artmaking is an attempt to gather an understanding of my condition and to integrate art and life. The challenge is to visually represent this. I began the work with an ambivalence – was I an activist helping others, or was I merely immersed in my own struggle to maintain sanity, to reach a peace with my body, a calm space from which to deal with my condition? I have dismissed this ambivalence and settled on the latter position, which has the indirect effect of helping others. I have realized, like Jo Spence, that it is easy to burn yourself out when you work from a position of anger.

Art and science have exploited and depicted the body throughout their history, sometimes in ways that overlap, sometimes at cross purposes that conflict, and sometimes in mutually supportive ways. When examining the binaries of revealing and concealing, visibility and invisibility, legibility and illegibility, one cannot avoid a conflict with the medical system. However, through the excavation of my body by modern medical technology, I have evolved from previously seeing only the horror of a tumour to now also seeing the hidden beauty of the other landscapes inside my body. My artmaking is thus taken up as a personal issue, not attempting to shock or to be placatory, but to externalize the cancer experience and, rather than simply reacting to it, to find the beauty inside my body.

1. MOTIVATION AND KEY CONCEPTS

1.1 Diagnosis and History

I received a diagnosis of systemic low grade non-Hodgkin's lymphoma in April 1993 and underwent ten months of chemotherapy from 1995-'96. After a year in remission, by mid-'97 a 1,8cm pelvic tumour mass was detected in a routine CAT scan. After conflicting medical advice and careful consideration of all the options I chose to have no medical treatment, and adopted what is called a 'watch, and, wait' approach. I have subsequently undergone surveillance CAT scans every six months in order to monitor the rate of the growth. In October 2000 the tumour mass measured 4,2cm at its largest diameter. At the date of the latest scan in June 2001, it measured 5cm.

The oncologist who is monitoring the progress of the lymphoma believes that if I can wait without experiencing any side effects (cosmetic, energy level, night sweats) or interference with organ functions, I may benefit from the new research breakthroughs that are currently gaining ground. This reminds me of the words of my first oncologist who, in 1993, said 'we will find you a cure', even though none was available at that time. In both of these well-intentioned attitudes it is evident that there is no expectation of patient responsibility at all, except to get on with life and wait.

1.2 Experience

This crisis of health called cancer has introduced me to my body through the perspective of the Western medical system and its discourse, in which one becomes classified as the disease (lymphoma), as the lymph node (retro-peritoneal) or as the cancer cell (small-cleaved cell). As a patient one is referred to as a lymphoma. The patient caught up in this discourse – being identified as the disease – experiences the disease as an abstract and unplaceable condition. Details of these locations are not explained and remain notated and inaccessible in one's case folder. This is the experience of disembodiment.

I was once 'caught' reading my folder by an oncology sister in a state hospital corridor. She admonished that patients are not supposed to read their own folders. This pervasive attitude in state hospitals is more reinforced by outdated laws than in private clinics, where patients do not carry their own folders to and fro. Here the folders are transferred from filing systems to doctors' desks, but patients still are never invited to look at them. This lack of access to one's folder is symptomatic of denial on many levels. I needed to understand this disease, this medical attitude to the patient and the patient's position in the discourse before I could accept it. This imbalance of power in doctor/patient relations is discussed more extensively in 2.2.2.

1.3 The Shifting Truth

Since 1993, I have watched medical opinion and treatments change as science painstakingly continues to break down the cancer puzzle into smaller and smaller pieces. Concurrently 'alternative' or 'complementary' therapies and 'New Age' thinking have emerged along with age-old and rapidly changing 'answers'. 'Complementary' therapies (Chinese medicine, ayurveda, reflexology – recently combined with Chinese meridian theories, polarity therapy, macrobiotics, homeopathy and naturopathy) depend on the individual practitioners to interpret their belief systems and principles, but have remained fairly stable in their explanations for and approach to cancer. They sometimes offer 'medicinal' or herbal options in combination with 'body work' (for example chakra balancing, massage, acupuncture, body alignment).

Some of the well-known figures working in the body-mind health field draw on the 'complementary' therapies and are medical doctors. Deepak Chopra is a medical doctor who is trained in Ayurveda and Western medicine. Carolyn Myss (Ph.D.) is a medical intuitive who draws on various 'mysticisms' such as the Kaballah.

Berney Siegel (MD) is a surgeon who works with visualisation. Lawrence LeShahn (Ph.D.) has written on the cancer personality.² They have all published books making their thinking and advice widely available in the self-health/help arena.

A host of others such as Bays (*The Journey* 1999) are not medical doctors but follow the thinking of these 'gurus' and develop specific quasi-scientific systems that situate themselves within the healing practices. Their work is also widely publicised and available as books, videos and workshops and would fall under 'New Age' thinking, along with crystal healers. The 'New Age' discourses have continuously changing interpretations, depending on the latest scientific understandings that are released. These disciplines are developed and led by 'gurus' working in the field of body-mind health.

Psycho Neuro Immunology (PNI) and Kinesiology are fairly new fields with their own specific ideas. Faith healing or charismatic healers are other phenomena altogether, based on faith and its miracles, usually within the context of Christianity.

All these therapies and curative philosophies, 'alternative' to the dominant scientific medical option are talked of as 'present day healing sciences'. I will comment on these abovementioned discourses later in the text.

The Western scientific discourse focuses on disease and its intention is to be curative. Eastern health discourses focus on the promotion of health, longevity and vitality, and their intention is to be preventative. In this way they are more self-empowering. Western medicine, however, is slowly starting to absorb part of the prevention discourse.

1.4 The Patient as an Object

In my search for explanation and clarity on my condition I decided to become a subject rather than an object and to find my own agency within and through this discourse. I decided to study this 'thing', this tumour that causes so much to change. Access was through the medical images and terminology generated and understood by the specialists. My route would be first as a patient whose body is the object of medical study, then as an artist and researcher whose body became the subject of my own study. A body that outwardly seems healthy, yet keeps reflecting back its diseased images via the scrutiny and excavation of medical practice which, though efficient in the anatomisation of my body and the classification of my disease, cannot cure it.

1.5 The Search for Questions and Answers

I have inspected endless medical textbooks, body atlases and diagrammatic representations from various paradigms. I have also viewed many images of myself during the above medico-scientific investigation and partitioning of my physical body down to single cells and genes. The most riveting of these investigations was during a colonoscopy – an on-screen, live trip through the interior of my large bowel. (See App II fig 36)

Motivated by indignation, anger, curiosity, helplessness and discomfort within the Western approach, I made my way through some of the alternative discourses and their attendant practices. I wanted to see if I could enter my body through these and whether they could balance the purely scientific Western discourse. Do they offer a way to enter one's body in a more 'whole' way, or is there no such thing as 'whole'? Does this exploration lessen the sense of dislocation and fragmentation?

In addition, by making art from life with disease, a series of questions arise: Do I become more whole – less divided into and between the 'well' person and the 'sick' person? Does this embracing of 'the abject other' offer a possibility of integration? For a person with cancer, is this the only integration that is possible?

1.6 Managing Cancer

In the eight years that I have dealt with the lived experience of cancer, and the six years that I have been conscious of it through the artmaking process, I have 'managed' my cancer. For me, this has meant negotiating not only the medical and complementary discourses but also the 'New Age' ones – with their own discomforts – and the surfeit of every other well-intentioned opinion and piece of advice. Questions too, such as 'so what does your cancer mean to you?' or 'why do you think you got this cancer?' have had to be 'managed'. Questions like these, asked by well-meaning individuals, have pushed me toward a need to understand the 'New Age' discourses. They are pointed questions, directing one to introspection and interrogation of psycho-spiritual reasons for illness. The subtext of the question is 'what lessons do you think you needed to learn?', 'what lessons have you learnt?' It is difficult to remain objective and avoid self-persecutory thoughts in the face of such questions. ³

The 'management' has entailed an attempt to keep up with the latest research and thinking (scientific as well as body-mind) in order to maintain a healthy immune system and healthy organs through physical exercise, nutrition, avoidance of carcinogens and a healthful 'mind', free of stress (this includes the stress of well-intentioned questions) – as the yogis say, keeping body, mind and soul healthy. It means containing oneself in the face of the onslaught of advice and the myriad of treatment options available (scientific as well as others). It means having ready answers for oneself and others.

Initially I set out on this journey in the hope of warding off further chemotherapy. The journey has become a project and another level of 'management'; an attempt to communicate how this experience feels, what it requires, and its effects. This is a continuous cycle of disintegration and reintegration, some of which will be reflected in the practical work and explored in the theory section on cancer narratives.

1.7 Jackie Stacey

I have drawn extensively on Jackie Stacey's comprehensive work in *Teratologies* (1997) in order to consolidate my own analytic process. Stacey's background as an academic in Women's and Cultural Studies had equipped her with the skills and tools needed to interrogate and expose her experiences of cancer in written form. In Stacey's words: 'The path through the maze of information, mythology and fantasy varies according to a multitude of factors. Mine was that of an academic: highly sceptical, obsessively self-reflective and with a sense of entitlement that feminism had added to what my class and ethnicity (middle class and White) had promised' (Stacey 1997: 28).

For Stacey, the most natural outcome of her cancer was an academic project resulting in a book. She explains: 'Turning the disease into a research project channelled my otherwise overwhelming fear and panic. The desire for information, and the confidence to access it, is often the privilege of those with certain educational histories and race and class backgrounds, but also belongs to a new generation of what I call "participatory patients"'. For Stacey participatory patients means that 'those of us who have been influenced by the information cultures of the last twenty years are more susceptible to the desire to know and to the fantasies of knowledge as power. We are encouraged to seek out information about ourselves with an obsessive curiosity' (Stacey 1997: 3–4).

As an artist, I have navigated and communicated the maze through visual imagery – a need to expose the unseen, to be creative while physically and emotionally curtailed, to integrate art and life. I have also found myself, like Stacey, sceptical, self-reflective, and carrying a sense of entitlement. Some of the reactions I have been subjected to by those uncomfortable with this project are that I am morbid and self-obsessed. Rather, it is this sense of entitlement that made me want to share it and encourage entitlement

in others. The practical work gives me a process through which to assert myself and to make otherwise 'unsuitable' (patient) demands for access to medical materials.

1.8 Artmaking

My primary interest in this study is the 'ill' body, which I have been dealing with through artistic production. My work has started off in the medical discourse and as I make my way through the alternative therapies, this too will be reflected.

This project, which deals with the disease through artistic production, began with the onset of the chemotherapy in 1995, two years after diagnosis. I began by recording my experience in an attempt to make the patient's 'private' experience public. The formation of a visual aesthetic around my 'dis-ease' began with a photographic and video recording of myself receiving chemotherapy in the 'drip room', and has continued with photographic and video documentation of all the subsequent and ongoing procedures, (the 'bleeding room' included) up until the present. Some of the documentation has been by a professional photographer and videographer accompanying me, others by family members, friends and hospital employees present at procedures. At other times, where possible I made the recordings. Most of these views have been those accessible to the patient and 'outsiders' brought in by myself, the patient. A few other views have been gained through negotiation via the lenses of doctors and technicians in 'behind the scenes' locations, where I have found myself gathering evidence.

I was initially motivated by the knowledge that chemotherapy was unseen and unknown, to myself who had already been a cancer patient for two years, and my immediate family and friends. The chemotherapy experience is hidden from the 'outside' world, where one in four people are likely to receive a cancer diagnosis at some time in their life. What a shock it is when one is first introduced to the 'drip' room.

The first year and a half of documentation resulted in a body of work entitled *Cancer Ward: LE 32*, exhibited in 1997 and '98, two years after my first chemotherapy treatment. This work was a display of trauma, a confrontation with the vulnerability of the body, and a 'quiet' view of chemotherapy. It consists of curtained colour photographs of a bone marrow biopsy and a stem cell harvest, black and white photographs of chemotherapy, found objects, and a looped video of the biopsy procedure.

1.9 Representation

All bodies are basically the same yet the way in which we experience them and the way we perceive them is at once the same and different. The factors that govern our experience and perception of the body are multifold: cultural and personal. I have searched for these discourses, traces and threads.

One of the factors is representation. The connection between art and visual perception has been explored by E.H. Gombrich in his book *Art and Illusion* (1977). 'Gombrich suggests that there is a never-ending link between art and object – that we see what we know from representations, just as we can only represent what we know' (Woolf & Cassin 1987: 6).

My experience of this concept (in school classrooms, of diagrammatic representations of the body in which we all look the same and with which it is very hard to identify even though they are supposed to be 'you') made me curious and stimulated my need to find out what artists are representing about the body and whether it indeed changes with and reflects the knowledge of the time. That is, do artistic representations reveal different understandings of the body? For example, what was being represented at the time of

the Renaissance was the body as a machine, separate from the soul, which reflected medical and scientific thinking at the time.

I attempt to examine this logic and its application, believing and feeling that it is absolutely applicable to our experience of the body at any stage of history, and to my personal experience of cancer. It is the underlying theme of my first chapter in which I look at the history of the body in Western art, the body as the interface between art and medicine, and the practice of anatomy as the particular area of overlap between art and medicine. As an artist I wonder whether the artists' discourse is outside of the medical discourse, or whether they overlap, and if so, how? Other questions that arise are whether the artist and medical anatomist share a common discourse, and whether one or the other is more powerful in this shared discourse.

The changing representations of the body in Western art also speak of the changing relationships to death through time. Binski (1996) and Llewellyn (1998) have explored this in depth. I have not brought this discussion into this study – theoretical or practical – in an explicit way. I do, however, feel it informs my own approach to my body and my death which, hopefully, is implicit in the work.

1.10 Life/Death Discourses

Living with an incurable disease is like living in a state of limbo, between the polarities of life and death, where life has become a state of dying. Being in this state means to be and simultaneously contain the 'other'. In contemporary Western society with its obsessive preoccupation with youth, health, beauty and its denial of mortality or, in the words of Damien Hirst (quoted in Grey 1996: 36), 'a culture permeated by the paranoiac denial of death', facing the 'other' is frightening for both the carrier and society at large. Illness forces confrontation with the vulnerability of our physical body and its inevitable death and decay. As such it is a source of great discomfort and a cause of deep anxiety on both a personal and social level. By forcing the 'looking' at disease, through the means of visual production, I hope to lessen this anxiety and fear in the social body and make the exposure of disease more acceptable. On a personal level I have also needed to explore and face this discomfort.

Becoming aware of this fear of death in a more conscious way and not accepting it as 'normal' is another motivation for this study. The recognition of this uncomfortable tension between our inevitable mortality and our fear of death is forced upon you with a cancer diagnosis. It is different to knowing that you could die of accidental or natural causes at any moment. Cancer is a kind of death sentence, like waiting indefinitely on death row, at first one begins bargaining and eventually realises that that is not going to work. Even if you are a 'believer' you cannot bargain with God – you accept 'His' plan.

Cancer forces me to confront and philosophically approach this fear of death. I might understand and accept that being and non-being – life and death – are complementary levels of reality that co-exist. But one has to accept the in-between stages as well. I needed to understand and find my own position on death. The following questions arise: Is it part of a continuum or is it a cut-off point, 'The End'?; is it the culmination of life or are there simply two states: being and non-being? Is there an afterlife? If so, what is the nature of this afterlife? The Judeo Christian religions, dominant in the West, have a belief system and explanation that concur but with different understandings of heaven and hell, god (good) and the devil (evil). Eastern religions have a different set of beliefs. I have lightly explored this in order to interrogate and consolidate my own personal position (one which I did not adopt from my initiation at birth into Judaism). It has been necessary to develop a personal position (that of mortalist) in order to deal with all the competing discourses. I realise that our contemporary Western belief is the most uncomfortable with death. As Boltanski says:

Death is a very strange thing. We are unique beings, with a small history, knowledge, and a memory, and from one moment to the next we become an ignoble, disgusting object. This passage is very strange. If we are not believers, and think that there is nothing after death, the question is even greater. Nowadays death is considered as a shameful thing, which we hide, we die in hospitals, all alone... Like illness, it is completely rejected. In traditional societies, the relation with death was much better, burial was a great celebration, death was much more part of life. Now we have rejected death completely, to the point where we deny it. (Quoted in Belloni E. (ed. coordination) & Eccher D. (curator) 1997: 96)

In Mexico, where traditional societies still appear to exist, and traditional practices persist on a large scale, the general relation to death seems to be more comfortable. While beliefs vary regionally, the belief in the afterlife is pervasive. This is highlighted in the festival of *Todos Santos* ('Day of the Dead'), a joyous occasion tinged with sad remembrance.⁴ The beliefs played out in this festival are a mix of pre-Hispanic, Spanish Catholic and urban Mexican, arriving at what has sometimes been called folk-Catholicism. The deities and systems of worship have been interchanged through a long history of colonisation and missionary attempts to convert the natives to Christianity. It is difficult to determine what is carried forward from pre-Hispanic rites such as the decoration of real skulls which are now decorated sugar skulls, and the skeletons that mimic the living, as in Spain, where this took the form of the grim reaper.

Because of this festival, the rituals that accompany it, and other practices, it has been said that Mexicans have a special relationship with death. The question is whether this manifests as a closer relationship with the concept of death. Some Mexicans vehemently refute such generalisations while others affirm the truth of such a statement. But interestingly, some Mexicans interviewed in the book, *The Skeleton at The Feast* (Carmichael & Sayer, 1991), say they do not believe they have any more or less fear of death than those in other societies where festivals of death are not celebrated. However no one can deny that in Mexico children grow up familiar with the concept of death.

To the modern Mexican death doesn't have any meaning. It has ceased to be the transition, the access to the other life which is more authentic than this one. But the unimportance of death has not taken it away from us and eliminated it from our daily lives. To the inhabitant of New York, Paris or London death is a word that is never uttered because it burns on the lips. The Mexican, on the other hand, frequents it, mocks it, caresses it, sleeps with it, entertains it; it is one of his favorite playthings and his most enduring love. It is true that in his attitude there is perhaps the same fear that others also have, but at least he does not hide this fear nor does he hide death; he contemplates her face to face with impatience, with contempt, with irony: 'If they're going to kill me tomorrow, let them kill me once and for all.' (Octavia paz quoted in Carmichael & Sayer 1991: 10)

1.11 The Afterlife

Are flowers carried to the kingdom of death?

It is true that we go, it is true that we go!

Where do we go? Where do we go?

Are we dead there or do we still live?

*Do we exist there again?*⁵

1.12 Entering the 'Contested Arena'

As Stacey notes, diagnosis of cancer 'brings a person into a highly contested arena', where they are inundated with 'competing definitions and explanations of the disease and how to treat it... Different expert knowledges wrestle for the power to determine exactly what cancer is.' She writes that soon after her diagnosis, she found herself 'engaging with two opposing accounts' of her disease ... 'on the one hand, I read medical textbooks about teratomas, and endodermal sinus tumours in particular; on the other, I began what proved to be the first of many encounters with alternative medical approaches to cancer which offered very different readings of my condition' (1997: 30).

In *Teratologies* (1997) Stacey captures the essential experience of a person with a cancer diagnosis. Her comment, that you enter a 'highly contested arena' was made evident to me when different doctors gave me various treatment options. As Stacey says, one is confronted with 'competing definitions and explanations of the disease and how to treat it [that] circulate widely in professional and popular contexts.' Quoting Rose (1995), she explains that 'in some ways, of course, it is a meaningless term, including so many different diseases and treatments that any generalisations are rendered redundant' (1997: 30).

As Stacey points out, one finds oneself researching biomedical information on one's particular malignancy and consulting specialised medical textbooks for possible outcomes. One finds oneself 'wrestling for power' in trying to understand what this cancer is.

I identify strongly with Stacey's account of her first encounter with alternative discourses. She describes the quandary of the cancer patient who has to 'engage with two opposing accounts' of their disease', the one account biomedical, and the other the 'alternative medical approaches to cancer which offered very different readings of my condition' (1997: 30). With an open mind, she found herself at a Reiki practitioner who took it upon herself to identify the source and interpret the meaning of her cancer in her lifestyle choices. It is very difficult treading the fine line of faith imbued with reason while trying to absorb and assimilate or deflect such readings, when one desperately wants to get better. It is very tiring. Just like Stacey, I had my first experience when friends, distrustful of the medical profession, referred me to a homeopath, demanding I take responsibility for my own cure, thereby avoiding medical intervention. This is the familiar story of many cancer patients. Though, perhaps to their credit, not all cancer patients, when they find themselves in the 'arena' choose to enter the contest. It is getting more difficult not to do this, as the popular media are increasingly publicising anecdotal 'alternative' miracles.⁶

In this written exegesis of the practical work, that has evolved in the last three years in a continued response to my disease, I will trace and partially analyze the reasons behind my choice to enter into the contest and my encounters in this 'highly contested arena' which began for me in 1993 with the lymphoma diagnosis, intensified with the chemotherapy, and have continued escalating till the present day. Stacey (1997), Sontag (1979 & 1989), Spence (1995), Kristeva (1980), Nead (1992) and Sawday (1995) have provided the key theoretical texts, often elaborating on ideas in a way that switch on a light in the darkness.

Stacey's cancer 'bible' describes and analyses her various encounters and highlights the multiple discourses and their effects. I have drawn on Stacey's work in order to build an analytic framework for the theoretical excavation and will refer to *Teratologies* while covering the commonalties and idiosyncrasies of the experiences further from a personal point of view, at the same time locating the study within art practice and art theory. In the dissertation text I will not engage with the sociological debate on the contested nature of the concepts of 'health' and 'illness', 'normality' and 'pathology'. Stacey, Canguilhem and Sontag have made excellent philosophical and sociological studies of these concepts. I will, however, evidence these issues

through the work of various artists, such as Helen Chadwick, Bob Flanagan and others. Jo Spence and Hannah Wilke, whose work strongly iterates these issues, have been the key 'cancer' artists to inform this text. Spence, in particular, was trying to make it all not so concealed. Wilke, in the *Intra Venus* (1991–'92) series, continued with her body in performance to bring her lymphoma into her work. Flanagan who had cystic fibrosis, took his sickness and turned it into his rationale to question the label 'sick', and eroticised the main ingredient of his experience – pain – as his subject matter. All of these artists query the rationality versus irrationality of disease – the fact that because things are hidden they become 'abnormal'.

1.13 The Artmaking Process – Paintings, Collages, Photographs and Video

My first body of work in this field, *Cancer Ward: LE 32* (1997) recorded the clinical medical gaze, displayed the external view and physical trauma, the vulnerability of the body, with traces of abjection such as loose hair, bandages and linen soiled by excretions, and a test tube of blood,⁷ and dealt with the public and private dimensions of cancer and illness. This work was a direct reflection of the medical discourse. This is followed by my current need to understand the discomfort, not to simply record and reflect it, and a continuation of my need to aestheticise disease.

Through further revealing my own experience and explorations of my cancer, sharing some partial answers and posing and forcing further questions in and through the art work, I initially proposed to: challenge public perceptions of cancer and of the usual cancer narratives and create a more informed public dialogue; add my voice to the attempt to normalise the experience of disease (in reaction to the medical discourse's pathologisation of disease, and being made more imperative by the AIDS crisis); I hoped to encourage the layperson to become more literate with regard to the specialist medical language and the interpretation of the language of medical imaging for their own empowerment; and to step beyond the limitations of the civility and politeness that shroud avoidance, and to ask questions, be difficult patients, confront the issues we all know but choose to deny, (clearly articulated by Spence) and stop the invisibility and 'disappearances that everybody denies' (Zizek quoted in Isaac 1996: 221).

This next stage of the art making, presented for the MFA, is also about the internal view; the attempt to look inside at what is normally only seen and understood by medical professionals who diagnose, interpret and treat. The work is also a response to the practice of anatomisation and pathologisation of the medical discourse.⁸

A question I received in 1998 at the *Cancer Ward* exhibition, supporting the methodology of photographic installation, was 'how can you paint cancer anyway?' A criticism was that I had failed to reveal the lived experience of the pain and loneliness of the disease as well as the superstitions involved: 'Lomofsky tried too hard to disguise the real lived situation of the disease, the extent to which it can be as much about guesswork, prayer, superstition, as it is about scientific 'objectivity'" (Atkinson in *Electronic Mail & Guardian* 14 April 1998, quoting an artist whose sister has cancer).

In this ongoing, yet distinct, body of work, I have attempted to tackle these issues as a starting point and to interrogate scientific objectivity, to reflect the pain and the loneliness, the superstition, the guesswork and the prayer (see section 2.2.3), and the task of painting an invisible cancer. As Jo Spence (1995: 215) wondered of her leukaemia: what was she to do with her invisible disease?

As this work continues to arise directly out of my experience with lymphoma it is a continuation of my other previous concerns: The exploration of the body as political arena, asserting the visibility of issues (some mentioned above) that have been hidden and denied by society and individuals, the condition of whose diseased bodies are perceived as a cause for shame.

1.14 Illness as Metaphor

Sontag (1979), writing after her experience with breast cancer, describes how society uses cancer as a metaphor for everything that is evil, shameful and ugly about itself. It is this treatment of disease as the shame of society and society's consequent attempt to hide its shames that made me want to visibilise it. My desire not to be labelled sick, internalise shame, be marginalised and discriminated against, or simply to be labelled 'brave', in the world of the 'well', pushed me toward this exploration. In my own experience Sontag's point that the cancer patient absorbs and internalises this metaphoric reading of the disease is absolutely correct. Stacey (1997: 48), commenting on Sontag's text, points out that it is not only disease (TB and cancer specifically) that is read and experienced metaphorically but that all of language is metaphoric and metonymic. Stacey (1997: 62 – 64) does however extend Sontag's discussion and agrees that metaphoric thinking is deeply ingrained in the experience of the cancer patient. I believe that one of the ways this can change is through politically correct cancer groups lobbying, among other things, to change the word cancer or to prohibit its use in negative metaphors such as crime 'spreading like a cancer through our society'. The metaphoric thinking about cancer however runs far wider than this. Cancer societies and associations also need to start telling the whole 'truth'.⁹ I have realised that the function of the cancer associations is to support the status quo and to supply funding for conventional chemical research.

Part of my own investigation is an attempt to find another reading out there, apart from the metaphor of shame and ugliness, and apart from the metaphoric reading.

1.15 Illness as Punishment

The other aspect highlighted by Sontag is that disease is seen as punishment, that is part of the shame. I needed to understand this for myself and reach a position where I could categorically state that my cancer was not a punishment and I did not bring it on myself. I will discuss this in the section on alternative cancer therapies in 2.2.2, when I deal with the weight of patient responsibility and the persecutory nature of these discourses.

1.16 To Dis-cover

I have attempted to absorb the multiple discourses, the different 'readings' of the disease into the texture and form of the visual artwork. If there is a gap between the theory and the work, hopefully the theory is the landscape against which the work is made and informs the reading of the work. Hopefully too, the practical work stands on its own and is not too document dependent. I hope the practical work elicits an emotional response in the viewer while at the same time being enlightening and visually exciting. For me the 'marvels and monsters' (Stacey 1997: 10) of life with cancer immediately conjured up all kinds of visual possibilities. The fact that the experiences of a cancer patient are so bizarre and yet so hidden meant they were waiting to be revealed and made into artwork.

My aim is not to experiment on the body, but to see how much of my body I can dis-cover through medical imaging – driven by the need to understand what is going on inside with the lymphoma and therefore limited to the specific procedures deemed necessary by my doctors. I also wish to explore whether what I see through medical images makes me more familiar with my body interior and comfortable with my disease.

Taking ownership of these images of my body and creating new levels of meaning, beyond their mechanical application in the field of science, has been an empowering process.

In this way my representation is a combination of the anatomical, physical and spiritual aspects and experiences of the body. It is a play on the understandings of the body that I have 'seen'. The artmaking has been informed by the journey I have taken and the theoretical study has sparked off certain ideas for the practice.

In addition, this may be a social experiment: to see how much new awareness I can generate in terms of cancer as a widespread yet fairly unknown entity; to expose to and familiarise the lay person with medical images in the hope of generating an interest in their ability to interpret medical images; to challenge the reach of medicine in terms of ownership of information about the body and ownership of the body, and the shielding of knowledge from patients.

Of course as artists today we could demand the return of anatomical studies and corpses to our art schools, demand to register in courses at medical school; or more realistically obtain a degree in anatomy or do a seven-year medical degree plus, in my case, a specialisation in oncology – but if not, at least we can come to understand certain images and representations of the body, and practice 'testing out taboos and imperatives, challenging conventional fears' (Goodall in *Artlink* 1997: 15).

By making this work I hope to alter perceptions of disease, deepen knowledge and through the process of exteriorising my own inner experience to reclaim control over my own body. The formation of a visual aesthetic around my disease has added to this sense of control. I will examine the meaning of this sense of control later in the text (see 2.2.4).

1.17 Practice

In the final chapter I will discuss my own work and its position within the above context and within these various discourses, as well as how it reflects the various discourses elaborated upon and traced in the text. I have highlighted the dominant Western medical discourse and other subjugated and marginalised discourses. There are many others around the body, which are on the fringes of this study and are not incorporated. My search for cancer has led me to a fascination with the beauty of the body's interior, which is a current concern in contemporary art practice. Critics speak of a return to the body, a 'rediscovered source of inspiration. The body has become a landscape simultaneously strange and intimate. Such a return to the body is certain to have implications that reach far beyond the art world' (Gray in *Mail & Guardian* April 26–May 2 1996: 36).

2. CONTEXT AND THEORETICAL BACKGROUND: Do the Parts make the Whole?

Anatomy = Science of living organisms (noun); structure of the body (noun).

Anatomise = Break down into parts (verb).

Synonyms: Analyse, Dissect, Resolve into elements, Disintegrate, Break up, Separate into parts, Fractionate.

2.1 The Body in Western Art

'Each Individual's narratives are influenced by the narratives in the cultural surrounds, that complex of cultural discourses that have been negotiated over time within relations of knowledge and power and that are accepted as "truth".' – Foucault¹⁰

2.1.1 Introduction

This section, examining the relationship between artists and the anatomical body and the power politics around ownership of the body in art and medicine, is a contextualisation of my artistic practice within a selected history and cultural understanding of the body in art and medicine. In addition, the theme of the anatomisation of the body is introduced as a thread that will run through the dissertation and into my own work.

I will briefly trace the relationship with the body in art and anatomy and the contiguity of art and the practice of anatomy in the West. This tracing of the body as the interface of art and medicine serves to highlight 'the points where art and medicine collide', 'raise questions of power and possession' (Bywater in *The Sunday Independent* 2000: 13) and to situate the current position of the human body in art in its socio-historico-cultural context. Different modes of representation are examined along with issues of access and possession. The development of Kristeva's theory (1980) of the abject body within the critique of the nude body and the gendering and feminisation of the abject and of death is included in the survey, as a preface to section 2.2.

Throughout the text I will highlight relevant artists and particular artworks which illustrate the interaction between art and anatomy. The work of contemporary artists, who have engaged with the body as a site of struggle and of politics, will be highlighted. They have contributed to these various debates within the framework of the postmodern search for and formation of identity, that centres on the body.

Thereafter I address my primary interests: the ill body in art, the anatomising practice of contemporary medicine, the Western understanding of disease and the various discourses that shroud it, each with their own multiple histories of which many are hidden.

2.1.2 A Brief and Partial History of the Body in Western Art

There is an inextricable link between the depiction of the human body in Western art and the concurrent evolution of anatomical practice from the end of the fifteenth century onwards. In the sixteenth century there was an overlap between the practices of art and anatomy – anatomy fitted both into an artistic and medical life.

Jordanova asks: 'Who were the makers of anatomical images? What was their social position? How did diverse occupational groups work together? How did anatomy fit into an artistic or a medical life?' (in Petherbridge *The Quick and the Dead: Artists and Anatomy* 1997: 110). Today there are ethical and medical controls making it clear who the anatomists are and in which domain anatomy belongs.

The contemporary practices of artists working in the area of the body are challenging this domain, causing a rupture in this field and a subtle shift to take place. Bywater comments that doctors 'were (and still are, though

their hieratic authority is being eroded) custodians of the body, whether that body had been given into their custody or not' (2000: 13).

Since humans have made marks the body has appeared in artistic production. Artistic representation of the body has taken many courses. Artists have delved into the body literally and figuratively, have used it as both a tool and a canvas, have idealised and schematised it, have exposed its raw viscera and bodily fluids, sometimes engendering both fascination and horror. Western artists have represented the body from a variety of sources ranging from the dissected corpse, the 'passive' and smooth exterior of the 'nude', the living, breathing, 'oozing' body, through to the fluidless, lacking-in-mess, state-of-the-art medical imaging technologies which today dissect and examine the living body bloodlessly.

The idea of dividing the body into parts as a way of seeing was introduced in thirteenth-century Italy. This would seem to be the beginning of anatomisation in art. Woolf and Cassin (in *Bodylines* 1987) assert that it 'seems reasonable to assume that the ... artists would have learned to divide up the body into schematic sections from earlier paintings' or master's pattern books. This schema of the male body met the requirement 'that the image may easily be read as a man on the cross' (Woolf & Cassin 1987: 7). Giotto (1266/7–1337), while introducing some innovations, still worked from pattern books and finished works by other artists. Piero della Francesca (1410/20–92) changed the formula in a different way by working from a new model – antique Roman sculpture – and 'by the end of the fifteenth century most Italian artists had adopted this antique pattern for the depiction of the male body.' In fifteenth and sixteenth century Italy, when artists started to study and draw live models nude or clothed, 'not only the poses, but the proportions of antique sculptures were "seen" in the life-models' (Woolf & Cassin 1987: 10–11).

Pattern books, based on the conventions of anatomical atlases, became increasingly popular as artist's manuals and by the sixteenth century were 'contrary to the holistic plan of anatomical atlases' and completely 'predicated on parts of the body. ... The engraved artists' manual is a jolly assemblage of body members, a sort of conceptual kit-of-parts to be reconstituted in the studio' (Petherbridge 1997: 64). (See App III: 4)

By the sixteenth century, despite the disapproval of the church, Leonardo da Vinci, and his contemporaries, motivated by the desire to understand the underlying mechanical workings of the body and how they affected the surface, attended or conducted dissections and made anatomical studies from corpses (obtained from the proletarian class and other marginal members of society). Some artists continued copying anatomical drawings, yet studying from dissections was practiced well into the seventeenth century. This is clearly shown in the early seventeenth century etching by Pietro Francesco Alberti entitled *Accademia di Pittori* (*The Academy of Painters*), that depicts the ideal pedagogic programme for artists. The etching shows art students in a large studio with various larger-than-life-size sculpted body parts and busts, antique sculptures, a standing skeleton, and a corpse on a slab. (See App III: 4)

Ecorchés, which were 'flayed figures' or casts made in wax or plaster and taken from bodies that had been flayed to expose the muscles, appeared in the Royal Academy in England in the eighteenth century to avoid the necessity for repeated dissections. The most famous ecorché, cast from an executed smuggler, is known as *Smuggerius* (W. Pink 1834, after Agostino Carlini 1775). His flayed cadaver was forced into an antique pose (that of the 'admired' classical statue of *The Dying Gaul*) before rigor mortis set in, and then cast in plaster. This practice, along with the denial of a burial, was deemed a suitable punishment for a criminal. (See App III: 10)

To be condemned to flaying, 'or any kind of dissection, after execution was a punishment dreaded more than the death sentence itself' (Heller, *Spectacular Bodies* Exhibition Guide 2000: n.p.). At this time the Royal

Academy had its own Professor of Anatomy and casts such as these were seen as essential teaching aids in Britain and France. Heller adds that in the eighteenth and nineteenth centuries, 'the three-dimensional representation of the human body was central to the study of anatomy by both artists and scientists' and that at the Royal Academy and The Ecole des Beaux-Arts, casts of flayed bodies were a common sight. 'From the Renaissance until well into the twentieth century, drawing, ideally directly from a specimen, was a vital element of anatomical education for both artists and medical students.'¹¹

There are many beautiful surviving examples of these eighteenth century wax ecorchés, such as *Femme assise, anatomie de viscères (Anatomy of Seated Woman)* by André-Pierre Pinson.

By the nineteenth century artists such as Gericault and Degas broke away from the dictates of the academy and its limited use of the model, whose poses continued to be based on antiquities, in search of representations not 'seen' via the antique model. 'Degas was probably able to set new poses and perceive natural proportions in his models partly with the help of photography, for which he was an early enthusiast. The camera could be an "innocent" eye and reveal fresh views of the figure, so enabling the artist to escape the visual trap of his traditional training' (Woolf & Cassin 1987: 14)

Francis Morris makes an interesting point in reminding us that while 'medical technology grew more and more sophisticated, a "civilising" process of hiding the body was also taking place: during the nineteenth century decorum demanded that private experiences, both painful and pleasurable, be kept from view' (Morgan & Morris 1995: 104). Two centuries later we still suffer from this to a large extent. Various taboos keep from view things that threaten the dignity of the body (see 2.2.2).

In the mid-twentieth century anatomical studies were discontinued at most British art schools as artists moved away from perceptual to more abstract and conceptual art. 'Recently, however, the artistic preoccupation with identity has meant a return to the subject in a very different way. In a subject/object shift, the artist's own body has taken the place of the model "out there", and has become the art work' (Petherbridge 1997: 10).¹²

Artists in this category include Richard Sawdon Smith, Roberta Graham and Melanie Manchot who, in the words of Chris Townsend, explore 'the boundary between body and identity' ... 'through the photographic representation of the artist's own pathologised condition(s)' (Townsend 1998: 68). (See also Orlan, Stelarc, below, whose bodies really are the artwork, and in South Africa we have our own Peet Pienaar and Steven Cohen.)

This subject/object shift in contemporary art practice has its origins particularly in the advent of feminism in the 1960s. Feminist performance artists of the seventies such as Carolee Schneeman, whose means of production was her own naked body, changed the body in art for all artists, male and female. Feminist critiques and artistic practices have continued to challenge issues of the model, ownership and control of the body and its fluids. These critical practices have impacted on all body-based art and the challenges have taken many forms.

Some artists have gone out of their way to damage their bodies – Eric Burden, Gina Paine [*Aktion Sentimentale*: 1973], Rudolf Schwarzkogler [*Aktion Wien*: 1965-66] – but in none of these cases was the injury without context in some kind of social or ideological challenge. If the experiments of artists don't definitively advance science or knowledge, this doesn't mean that they do not advance understanding and awareness. Experiments on the body can serve as important social experiments, by testing out taboos and imperatives, challenging conventional fears and reinvesting in excluded possibilities. Bryan Turner's

sociology of the body – identifies the importance of the body as a limit, and it is the limits of the body that most performance artists want to test.' (Dr Jane Goodall in *Artlink* 1997 vol. 17 no 2: 15) ^{13, 14}

In this brief historical survey, we see how artists alter traditional schema, aided by changing morals and technology and their own curiosities, against a background of shifts in social consciousness, suggesting 'the never ending link between art and object', knowing and representation, as pointed out by Gombrich in *Art and Illusion* (1977) (referred to by Woolf & Cassin 1987: 6). (See also 2.1.4 and 2.2)

2.1.3 Art and Anatomy

The Western way of thinking and its language has become that of dissection (partitioning or breaking up into parts) and taxonomy (categorising, classifying, describing, and grouping), parallel to the development of the core practice of Western medicine, that of anatomisation. In my artistic practice I have used the same methods to dissect my experience and to cut it up into slices and parts. What I have found is that the sum of these parts does not necessarily equal a whole.

For this reason I concentrate on the Renaissance in the following section of this study. I examine this period in more detail, as a way of understanding the relationship between art and anatomy, artists and surgeons, and the origin of today's practice of the anatomisation of the body in Western medicine. The latter, in particular, is pertinent to my artistic practice and the underlying suggestion of this study regarding my understanding of my experience as a 'cancer patient'.

The way in which anatomy developed from the end of the fifteenth century onwards has defined the practice today and continues to determine our relationship with our bodies. It was then that 'the modern, ostensibly neutral, scientific sense of "dissection" or "anatomization" [came] to be the predominant meaning of the word' (Sawday 1995: 1) and the predominant method of organizing human knowledge in the West. It is the impact of this period that primarily informs one's experience of disease in the Western system. It is the Renaissance taken together with other periods in the history of the body (in art and medicine) that has led me to an understanding of my experience.

As Sawday succinctly puts it: 'In medicine, anatomization takes place so that, in lieu of a formerly complete "body", a new "body" of knowledge and understanding can be created. As the physical body is fragmented, so the body of understanding is held to be shaped and formed' (1995: 2).

A primary pursuit of the Renaissance was an attempt to see and define the body as a mechanical machine. Previous to the Renaissance the body was seen as a whole, as a reflection of and under the same governing forces as the cosmos. The practice of dissections during the Renaissance was the turning point of this perception.

2.1.3.a The Artist, the Surgeon and the Corpse

The late fifteenth century to the end of the seventeenth century was the most prolific period for dissections in Europe, with Amsterdam in the 1600s seeing the height of its glory days. By studying the paintings of public dissections from this period an important link between the history of art and anatomy and contemporary medical practice can be established.

Commissioned works of this nature were intended to glorify and sanctify the surgeons who performed the dissections and those who paid to appear as spectators in these group portraits, which were hung in the guildhalls. The corpses were hanged criminals fresh from the gallows (also used by da Vinci, in conjunction

with those illegally dug up in graveyards). It was therefore not 'improper' to reveal these abject bodies as they were of the proletarian class and it was part of the aim of the commissioned work to elevate the surgeons' contrasting bourgeois status; to portray them as men of learning. Highlighting the dark and sombre attire of the surgeons, which signified them as men of standing in the community, would be effectively achieved by the contrast with the white, passive and naked corpses in the paintings.

In discussing this genre of dissection paintings that emerged in Holland, Sawday argues that all of them commemorate 'the anatomical prowess' of the surgeons and that, despite differences in style, the one constant factor is a group of men surrounding a corpse; a group of 'leading members of the political order of their respective cities.' He goes on to say that 'by publicly proclaiming their civic and intellectual worth, the surgeons who clustered around a dissected corpse offered a challenge to any potential charge of having become tainted members of the community' [through association with the gallows] (1995: 151).

Sawday ironically describes these seventeenth-century portrait works as a sort of *vanitas*, with the 'whitened other-worldliness' of the corpse 'as the traditional *vanitas* figure' (1995: 152). He sees them as reminders to the viewer of human mortality which, despite the glorified status of the surgeons, is something even they cannot escape. Their triumph over death is only temporary.

The artists responsible for these anatomical gatherings were invariably Christian, and while drawing heavily on Christian iconography in their portrayals of dead bodies they also, in effect, reversed the traditional meanings of that iconography in their attempts to uphold their patrons' social and political agendas. Instead of displaying the adoration of the dead body so prevalent in Renaissance works, the anatomical paintings had, as their primary objective, the proclaiming of 'the absolutely unambiguous subjection of the mortal body to scientific and political power ... Just as Christ was condemned and executed amongst thieves, so the anatomized subject ... represented an order – that of the stranger, the thief, or the murderer – which had to be violently subdued by the magisterial and rational judgement of the city' (Sawday 1995: 152). Thus the extinction of the criminal will and the superimposition of the surgeon's will raised the intellectual triumph of the latter.

Sawday makes the analogy between these paintings of the Dutch bourgeois surrounding a human corpse (a depiction of the subjugation of the 'deviant will') and a hunting trophy image where the hunters are depicted standing over their dead subject, the will of the 'wild' animal therefore subjugated to the will and intellect of the 'civilised' hunter.

This analogy can be applied to the practice of medicine today, with the body of the patient replacing that of the corpse; the 'deviant will' of disease (and perhaps in some cases also that of the patient) needing to be 'tamed', and the doctor's 'taming' of disease and patient proclaiming his intellectual triumph and superiority.

The 'deviant will' of the patient must be subjected to the same 'taming' as the 'wild' trophy, and should never be pitted against that of the doctor for fear of becoming a deviant or 'difficult' patient. Further, the doctor triumphs by keeping the patient alive, who then becomes the trophy. The doctor is the predator, the hunter of disease.^{15, 16}

In 1543 Vesalius had prescribed and illustrated how the surgeon should set about a dissection of the brain. Descartes, whose contribution to the culture of dissection was seminal and who had reasoned that the pineal gland was the 'seat of the soul', challenged Vesalius' methods on the grounds that the head was always the last phase in a dissection. By the time the head was reached the search for the pineal gland would be almost impossible as the gland (*conarium*) would have undergone a natural process of decay or shrinkage and

would be difficult to find.^{17, 18}

Two of Rembrandt's best-known anatomy paintings, commissioned by The Amsterdam Surgeons' Guild, are *The Anatomy Lesson of Dr Nicolaes Tulp* (1632) and *The Anatomy Lesson of Dr Jan Deijman* (1656). Both corpses under the knife were convicted criminals. Dr Tulp's subject, Adriaenszoon, had stolen a coat in the cold Amsterdam winter; Dr Deijman's subject is known only as Fonteyn. Sawday describes these works as 'fictional re-creation[s] on the part of Rembrandt, underlined by a dense sub-stratum of theology and moral reflection' with the corpse 'as the point of convergence of different registers of social meaning' (1995: 150).

Sawday suggests that there was an underlying subversion in Rembrandt's portrait of Dr Deijman. According to Sawday it was painted six years after Descartes' death, after which, in 1656, Descartes' *Les passions de l'âme* (*Passions of the Soul*) – with its detailed discussion of the pineal gland – was translated into Latin and published in Amsterdam' (1995: 157).¹⁹

In the earlier painting of Dr Tulp the point had been to demonstrate that the mechanics of the body could continue to work without the application of its own mind and will. For example, if the surgeon tugged on the tendons of the opened arm the fingers would twitch. Thus the surgeon could use his intellect and his mind could substitute for that of the corpse. 'It was in the anatomy theatres of Leiden and Amsterdam that Cartesian man was born, in the person of a grotesquely twitching criminal corpse, at the behest of the medical and judicial authorities of the city' (Sawday 1995: 158). 'The creation of "Cartesian Man", at some point in the early seventeenth century, was also the moment at which an alienated human subject was born.' (Sawday 1995: 159).

Rembrandt's 1656 painting addresses the next Cartesian project, that of finding the soul that was proving to be elusive and was not divisible. Sawday describes Dr Deijman as about to embark on dissecting the brain according to Vesalius' instructions in book VII of his *Fabrica*. Fonteyn's head, as presented by Rembrandt, alludes directly to the Vesalian drawing of the head from *Fabrica*. There is, however, a crucial stage of the dissection procedure, as laid out by Vesalius, that has been skipped in this representation, in order to get to the head before the 'seat of the soul' disappears, as advised by Descartes. (It is speculated that this stage was skipped by either Dr Deijman or by Rembrandt in his representation of the procedure.)

Sawday posits that this departure from procedure was in direct response to Descartes's frustration. 'It is as if Rembrandt (or, indeed, Deyman), following Descartes, had deliberately challenged the received methods of dissection (1995: 157).

Rembrandt's subversive agenda is further apparent in that the portrait of Dr Deijman makes obvious reference to the Andrea Mantegna painting *Lamentation over the Dead Christ* or *Cristo in scurto* ('*Foreshortened Christ*') (c. 1478–85) in the representation of the corpse. This devotional painting, created almost two centuries before Rembrandt's *Dr Jan Deijman*, was widely known in the seventeenth century and was obviously known to Rembrandt. Sawday notes that there is 'the echo of Mantegna's dead Christ in the body of Fonteyn' (1995: 157). Rembrandt has altered only the viewing points: the body is observed from a lower point than Mantegna's and the head is propped up so that this viewing point is also lower than that of the Vesalius drawing. Sawday points out that it is as if Rembrandt had symbolically combined the image of Mantegna's Christ and the Vesalius head in order to provoke the question:

Is the significance of the Christ-like posture of Fonteyn Rembrandt's ironic commentary on the blasphemous project upon which Cartesian science was embarked? ... Were the citizens of Amsterdam in 1656, on entering the Guild-Room of the Amsterdam Surgeons' Hall where the painting was hung, expected to

notice the echo of Mantegna's dead Christ in the body of Fonteyn? Did Rembrandt expect them to recoil in horror at the implications of Cartesian science, and recall the devotion and pity with which Mantegna's Christ was surrounded? Or does the painting celebrate the gaze of rational science (embodied in the dispassionate face of the young assistant who surveys his master's handiwork) and the victory over yet another criminal will which Deyman, in keeping with the very latest views of Descartes, was about to bring into the light? (Sawday 1995: 157) (See App III: 5)

It is this Cartesian separation or split of the body and mind and body and soul, entrenched by Descartes, which still distinguishes Western medicine from the traditional Eastern, Chinese and Ayurvedic medicines, complementary medicines and the alternative 'New Age' body-mind fields of health practice (body mine fields of new age medicine!). Here a different kind of embodiment is at work and in contrast to Western medicine the attempt is at reintegration with no separation of body, mind and soul. This might point to Western science as irrational.

One can deduce that the battles taking place between artists and scientists at this time reflected an uneasy rupturing of religious, philosophical and secular ways of being in the world. These ancient battles predate and signify similar battles of the twenty-first century. The centre of this conflict is the notion of building a world based on individualism versus wholism – the conflict between environmentalists and industrialists, communities and drug companies, small communities and global powers, and between the individual's need to be reintegrated through 'New Age' explorations – a return to ancient systems (and wisdoms) – and science's rational march forwards.

Sawday points out that, while the term 'culture of dissection' suggests a system of networked, interlinked social structures, practices and rituals around the production of fragmented bodies, which does not sit comfortably with our conditioned image of the European Renaissance as the age of individual realisation and a sense of self, the 'scientific revolution' of the European Renaissance was interested more in dividing, fragmenting and partitioning every aspect of the world.

This 'partitioning' reached into all aspects of civil, social and intellectual life. Whether in the spheres of logic, art, literature, science, nature, philosophy, politics or the family, everything had the potential for division. Sawday argues that the 'pattern of all these different forms of division was derived from the human body. It is for this reason that the body must lie at the very centre of our enquiry. And it is in this urge to particularize that "Renaissance culture" can be termed the "culture of dissection"' (1995: 3).²⁰

2.1.3.b The Feminist Critique of the Body in Art

Social and cultural theory and philosophy have accompanied the previously outlined historical developments, either in the form of corroboration or opposition. The agendas appear quite clearly in retrospect, although at the time things are not quite so transparent. For example, throughout the years I studied art at school the feminist debate was raging, yet nothing of this was formally imparted to me.

Alongside the basic historical outline of the body are the feminist critiques that have made these agendas transparent. These critiques target the cultural reasons for and the implications of the way of seeing and representing the (female) 'nude' up to the present day, opening new and previously concealed avenues in the representation of the body. While paving the way for new dimensions of seeing and representing the female body, at the same time they have widely extended the territory of the body for contemporary art practice in general. The 'articulation of differences' sparked off by feminist discourses of the sixties has pervaded the whole of art practice since, including and beyond the depiction of the female nude.

2.1.3.c The History of Kristeva's Theory of Abjection

Kenneth Clark published *The Nude: a study of ideal art* (1956), in which he describes the nude in terms of its 'unthreatening beauty' and lays down canonical laws for its representation in art. In Clarkian terms the Nude refers to the figure or form, naked down to the skin, not to the body beneath. This is not 'the body'. Clarke's nudes could never have anticipated the abject, 'obscene' and fragmented bodies appearing in contemporary practice today, facilitated by the feminist theorisation and critique of such inherited patriarchal ideas of the female nude as the ideal subject for art.^{21, 22}

In *The Female Nude: Art, Obscenity and Sexuality* (Nead 1992: 25–33), Lynda Nead explores the notion of the obscene. Its history is described through its application by Kenneth Clark to the female nude behaving badly, and traced to the evolution of Julia Kristeva's theory of abjection. Its beginnings are noted in the eighteenth-century writings of Edmund Burke and Immanuel Kant, and even earlier in Plato and Aristotle. Its shifted meaning is picked up by postmodernism after the writings of feminist theorists, in particular Mary Douglas, who wrote the seminal essay 'Purity and Danger: An Analysis of the Concepts of Pollution and Taboo' (1966), which was a forerunner to the articulation and crystallisation of Kristeva's theory in the 1980s.

Nead discusses the polar opposites of beauty and obscenity and begins by noting that 'the etymology of "obscene" is disputed but it may be a modification of the Latin "scena", so meaning literally what is off, or to one side of the stage, beyond presentation' (1992: 25).

Nead refers to Edmund Burke's *A Philosophical Enquiry into the Origin of Our Ideas of the Sublime and the Beautiful* (1757), in which the terms sublime and beautiful are defined as opposites, with sublime referring to the masculine and beautiful to the feminine.

In 1764 Kant further developed the opposition of the sublime and the beautiful and the gendering of the terms. He distinguished between the experience of the sublime as kinetic, 'setting the mind in motion' and the beautiful as always contemplative 'setting the mind in restful contemplation'. This sets up the continued notion of the gendering of the beautiful as feminine. However, there is another level in operation, as Nead explains: 'The sublime is not simply a site for the definition of masculinity but is also where a certain deviant or transgressive form of femininity is played out. It is where woman goes beyond her proper boundaries and gets out of place' (1992: 29). Or, in other words, where the unsettling interior makes itself known.

Discussing the Kantian aesthetic of universal judgement, Nead notes that:

... Kant's whole analytic of aesthetic judgement presupposes that you can distinguish rigorously between the intrinsic and the extrinsic ... According to Kant (and we have seen these values operating in Clark's book) what is bad, what is outside of or goes beyond aesthetic taste and judgement, is matter – that which is motivated, which seduces, embarrasses, or leads the viewer astray, away from the proper consideration of intrinsic form. (Nead 1992: 24–5)

As Nead points out, the Kantian sublime is distinct from and not to be confused with the Romantic counter notion which arose in the nineteenth century popularizing the sublime as an awesome and uplifting concept.

In a court case in 1972 Kenneth Clark stated: '... art exists in the realm of contemplation, and is bound by some sort of imaginative transposition. The moment art becomes an incentive to action it loses its true char-

acter' (quoted in Nead 1992: 27). Clark testified against pornography as art, and defined pornography as an 'incentive to action' and on these grounds as not belonging to the beautiful. In order to satisfy the notion of the beautiful and the contemplative, the female form could not be befitting or 'proper' as art, if it was disruptive or incited the viewer in any way. Thus we see Kantian values operating in Clark's ideas on the female nude.

It is a long but linear journey from this to the current obsession with abjection in body art, and the metamorphosis of perception and the changing relationship to the body in contemporary Western culture, which can be attributed to the debates and awareness sparked off by the texts and art practice of feminist critiques.

Douglas (1966) wrote a feminist reworking of the Kantian and Clarkian ideas of the aesthetic notion confining the feminized female nude to the realm of the safe and contemplative. Douglas began to unpick the ideology behind these constraints and revealed the driving force behind these ideas, namely, the fear of the female breaking these bounds.

In the 1980s Jean-Francois Lyotard popularized and helped instate the sublime in contemporary culture. Nead writes:

In the 1980s the category of the sublime was the subject of an enthusiastic revival. Indeed, the present discussion is itself a product of the revival of interest in the ambiguities and uncertainties raised by speculations on the sublime. The sublime is now a buzzword of postmodernity. It has been presented as the only viable aesthetic for the contemporary age, while the harmony and wholeness of the beautiful is dismissed as the outmoded dream of an earlier utopian moment. Jean-Francois Lyotard's interpretation of the sublime is based on a close reading of Kant. Lyotard presents the sublime in terms of the gap between the subject's faculties of presentation and judgement, and the idea or object of knowledge; the sublime is the apperception of the unrepresentable. (Nead 1992: 29)

Nead goes on to say:

... what remains suggestive about this category [the sublime] is its uncertainty, its questioning of categories of judgement and experience ... More specifically, the sublime provides a suggestive starting-point for theorizing the gap between knowledges of the female body produced through such discourses as medicine and advertising, art and religion. Rather than seeking to maintain the pure autonomy of art or suggesting a happy (or unhappy) diversity of "images of women", a critical art practice would draw attention to the incommensurability of these regimes. (Nead 1992: 29–30)

Nead adds that feminist literary criticism has attempted to 'reinvent the sublime as a female mode.' She argues that some Anglo-American feminist critics, 'recognizing the destabilizing potential of the sublime,' have pioneered a new way of understanding femaleness (1992: 30).

Kristeva (1982) extended the work begun by Douglas and consolidated her theory of the abject. '[It is] not lack of cleanliness or health that causes abjection but what disturbs identity, system, order. What does not respect borders, positions, rules. The inbetween, the ambiguous, the composite' (Kristeva quoted in Nead 1992: 32).²³

'Objects that produce abjection are those that traverse the threshold of the inside and outside of the body – tears, urine, faeces and so on. The abject, then, is the space between subject and object; the site of both desire and danger. ... For Kristeva the abject is on the side of the feminine; it stands in opposition to the patriarchal, rule-bound order of the symbolic' (Nead 1992: 32).

2.1.3.d The Body – the Obscene to the Sublime to the Abject

By articulating differences (such as in race, size, health) a feminist analysis 'breaks the boundaries of the [patriarchal] high-art aesthetic symbolized by the female nude.' Eroticism and aesthetic experience 'is replaced by a direct address to the relationship of desire, visual representation and the female body. Rather than "being framed" it is a question of who draws the lines, where they are drawn and for whom' (Nead 1992: 33).

Traces of abjection were allowed into the frame prior to the twentieth century. There was the medieval representation of the almost abject body of Christ as in Mantegna's *Cristo in Scruto* (1480) – previously discussed in relation to Rembrandt) – disguised as 'pious devotion' (Sawday 1995: 157) and Hans Holbein the Younger's *The Body of the Dead Christ in the Tomb* (1522), hardly disguised at all. Holbein's *Dead Christ* definitely shows abjection as it transgresses, and points to the fragility of many boundaries.

In her essay entitled 'Holbein's Dead Christ' (in *Fragments for a History of the Human Body: Part One: Zone Books* 1989) Kristeva discusses these paintings. At the start of the essay Kristeva inserts the sub-titles 'Some May Lose Their Faith', 'The Man of Sorrows' and 'A Composition in Loneliness', followed by others. The first is excerpted from Dostoyevsky's *The Idiot*, and brackets a piece of dialogue from the play, in which a character looks at the painting. The character exclaims:

...how could they possibly have believed, as they looked at that corpse, that that martyr would rise again? Here one cannot help being struck by the thought that if death is so horrible and if the laws of nature are so powerful, then how can they be overcome? How can they be overcome when even He did not conquer them, He who overcame nature during his lifetime and whom nature obeyed ... The picture seems to give expression to the idea of a dark, insolent and senselessly eternal power, to which everything is subordinated, and this idea is suggested to you unconsciously. The people surrounding the dead man, none of whom is shown in the picture, must have been overwhelmed by a feeling of terrible anguish and dismay on that evening which had shattered all their hopes and almost all their beliefs in one fell blow. (Kristeva 1989: 240–241)

Under the third sub-heading – *A Composition in Loneliness* – Kristeva states: 'It is a vision that opens out not onto glory, but onto endurance. ... With no intermediary, suggestion or indoctrination, whether pictorial or theological, other than our ability to imagine death, we are led to collapse in the horror of the caesura that is death, or to dream of an invisible beyond. Does Holbein forsake us, as Christ, for an instant, had imagined Himself forsaken?' She goes on to suggest that perhaps, on the contrary, Holbein is inviting the viewer to 'participate in the painted death and thus include it in our own life? In order to live with it and make it live, for if the living body in opposition to the living corpse is a dancing body, doesn't our life, through identification with death, become a "danse macabre," in keeping with Holbein's other well-known vision?' (Kristeva 1989: 244).

Kristeva relates this painting to Mantegna's *Cristo in Scruto* (c.1480), suggesting that it seems Holbein had 'picked up the anatomical and passifying lesson taught by Mantegna and Italian Catholicism'. She considers

this painting to be 'the precursor of the quasi-anatomical vision of the dead Christ. With the soles of the feet turned toward the viewers and the foreshortened perspective, Mantegna's corpse imposes itself with a brutality that verges on the obscene.' And yet, she adds, 'always heedful of the Gothic spirit, Holbein maintains grief while humanizing it, without following the Italian path of negating pain and glorifying the arrogance of the flesh or the beauty of the beyond' (Kristeva 1989: 248).

Taken with *The Dead Christ* Holbein's other series, the *Danse Macabre*, a series of woodcuts, prompts Kristeva to say, that 'it is by acknowledging his folly and looking death in the face – but perhaps by facing his mental risks, his risks of psychic death – that man achieves a new dimension: not necessarily that of atheism but definitely that of a disillusioned, serene and dignified stance. Like a picture by Holbein' (Kristeva 1989: 249–252).

The links are very interesting in terms of how closely these representations of the body tie in to current concerns. They are in fact paintings of abjection – subversive considering the concerns of the time and the moral and ideological constraints under which the artists were working. Of course the artists were under a different set of constraints, namely those imposed by the Church. The underlying sentiments were, however, the same and the doctrines of the church set the standards for Western secular morality. If Christ were really dead without the possibility of resurrection so was everyone else doomed and this would therefore be a cause for anxiety in the social body. The real death of Christ was un(re)presentable and the only way to escape this constraint was by applying new formal concerns – the formal concerns (foreshortening) therefore seeming to be the subject, not the really dead corpse of the un-resurrectionable Christ in Mantegna's painting. Kristeva states of Holbein that 'appreciated in the nineteenth century, disappointing in the eyes of twentieth-century artists, he may perhaps come closer to us in the part ironic, part gloomy, part desperate, part cynical light of his *Dead Christ*. Living with death and smiling about it, in order to represent it, was perhaps not the way to blaze the trail for a humanistic ethic of Goodness' (1989: 256).

In Holbein's *Dead Christ* a human death is depicted, devoid of Mantegna's insertion of piety in the faces of the women. Painted half a century after the Mantegna, it is representative of the birth of humanism in the Renaissance. The only factors that point to the Biblical Christ are the specific wounds in the hand and feet. Otherwise this is a painting of a very dead mortal being. The Mantegna, too, remains a brilliantly poignant image, with or without the devoutly pious figures in the corner of the frame, and speaks eloquently of the human condition – the condition of a dead mortal body. Even more abject was the realism of the brutalisation of the flesh visible in Holbein's *Dead Christ*.²⁴

2.1.3.e Artists and the Body

From this historical overview it is important to note that the practice of medicine has been, for centuries, linked to civic power. If artists have been tools for the glorification of the medical profession, maybe finally artists can use the tools of medicine, subvert the products of medicine (the naming and imaging, the diagnosis, the prognosis) for their own ends. Thus the artist may share the access to that which medicine believes is its own – custody of the corpus/corpse. The German scientist, Professor Dr. Gunther von Hagens – is exhibiting his plastinated bodies in a travelling exhibition entitled *Körperwelten (Body Worlds)*, with the intention of democratising anatomy and letting the human body teach. The exhibition, billed as *The Anatomical Exhibition of Real Human Bodies*, is accompanied by a website and educational materials. With this latest touring exhibition from Berlin, now in London²⁵ of plastinated flayed corpses, by the medical practitioner who invented the technique in 1978 at the Institute for Anatomy at Heidelberg University (and who has bodies willingly donated to him for this purpose)²⁶ still more science than art, it nevertheless holds the potential to break these bonds. Perhaps the body may yet arrive equally in the domain of both art and science.

Sawday points out:

The body-interior speaks directly of our own mortality. Hence, the sight of these hidden contours has traditionally been denied us since they are usually encountered only at the risk of enduring great pain and quite possibly death. The surgeon (even within the harshly empirical structures of western medicine) therefore enjoys a rare cultural status as mediator between the exterior and the interior worlds. The surgeon seems to share the iconic status of the artist (or the visionary) within our culture, since both are held to be in possession of a privileged gaze which is able to pass beyond common experience, through surface structures, to encounter a reserved core of reality. (Sawday 1989: 12)

Now the general public, through the seizure of the body into the domain of art, catches the glimpses it has been shielded from in previous centuries. The audience is still a select one – the gallery-going art audience – but with exhibitions like *Spectacular Bodies: The Art and Science of the Human Body from Leonardo to Now*, the viewing audience is certain to broaden. *Spectacular Bodies*, held at the Hayward Gallery in London in 2000, unites a broad range of work from the culture of dissection with that of eight contemporary artists and interrogates this gaze.²⁷

2.1.3.f The Body and the Body-interior in Contemporary Art

Kiki Smith

A strange thing is that I find myself following in the footsteps of Kiki Smith. Once, when mistaken for her at a gallery office in Toronto, I assumed her identity for a brief moment, not knowing how important her work was going to become for me, six to eight years later. Now I realise that I have taken up similar artistic concerns fifteen years after their exploration by Smith. I think I share an affinity that many women have with Smith's work. The affinity is led by the images (hair, doilies, female bodies) but also through some of the materials (such as Xerox transfers, handmade papers, wax, fabric, embroideries) carefully and specifically selected for their ephemeral and non-permanent qualities. These materials are seen as feminine, in relation to more masculine materials such as bronze, and are used to express these very conditions. (See App III: 6)

[Is there inherent in femininity a more willing tendency to confront the impermanence of physical existence, to face the unknown without fear (or at least brave the fear) because femininity embodies the possibility of creating life?]

The nude as idealised object of male desire clearly precludes any possibility of illness or 'imperfection' and denies the 'unacceptable' hidden truths within. Kiki Smith was fascinated with the mystery of the human body, accepting it in its entirety and celebrating its vulnerability and imperfect beauty. She invites the viewer to examine not only the exterior but also the interior of the body, embracing its seemingly conflicting capacity for pain and pleasure, and recognising it as the vehicle for every kind of human experience and emotion. She perceived the body as both a reflection of the cosmos and an intensely individual, subjective entity.

One area of Kiki Smith's importance as an artist lies in her challenge of the patriarchal gaze toward the female nude, realised through her 'feminine' choices of materials and subject matter. Most recently her work has 'expressed her growing sense of the deep interrelationship that exists among female sexuality, nature, and the cosmos' (Posner 1998: 27). Posner suggests that Smith's entire oeuvre till now has been a creation myth culminating in her nature works – arriving at paradise. 'Over a period of just a few years Smith's representations of the female body, and the focus of her work as a whole, had run a remarkable course, progressing from the profane to the sacred' (Posner 1998: 24). Anthony Bond (ed. *Body* 1997: 76), speaks of

artworks that reflect 'humanity's search for reconciliation with nature.' I would like to suggest that this is the underlying desire that makes itself felt throughout Smith's work and that comes to fruition with her later work.

Smith's work is holistic in essence, treating the body, ultimately, with loving respect in her inclusivity of all elements and aspects of physical, emotional, intellectual and spiritual reality. She recognizes the body as a reflection of the cosmos, a universal blueprint, while at the same time the site of original subjectivity. Nor does she prescribe to the viewer, but extends her inclusivity to allow each viewer to interpret the experience from within their own frame of reference. The power of her generosity stems from her acceptance and embracing of all that is human, not just the 'palatable', 'acceptable', pleasurable facets of being. In freeing herself from fear of the 'unknown' she offers to do the same for her viewers. She rejoices in that which 'does not respect borders, positions, rules. The inbetween, the ambiguous, the composite' (Nead 1992: 32) ²⁸ – not for the sake of being contrary but in the interests of deeper understanding of the human condition.

In order to gain a closer understanding and contact with the body, Smith had at one point enrolled as a medical technologist. Her series of body works (1985–1995) identifies her as an artist who has investigated the question of interiority and has not been afraid to encounter and to present this 'reserved core of reality', to confront the 'body-fear' previously spoken of by Sawday. Smith's many works (sculptures, prints, and works on paper) discuss the body as our vehicle of being here, of existing, and of our relationship to this body in its entirety, with its incorporation of the physical, emotional, intellectual and spiritual.

'The body, in Smith's work, is always in process, just emerging from, or on the verge of slipping back into, inchoate matter' (Isaak 1996: 214).

Kiki Smith is important for repositioning the female body, no longer object and objectified – the repository of male fantasy and desire as it has been represented by male artists – but rather as 'the site of women's lived experience' (Posner 1998: 20). Smith's way was to exteriorise the secrets of the body, demystify the perfect nude – 'the fixed, self-contained, or harmonious body of Classical art' – and celebrate 'the uncontrollable body that leaks, stains, defecates, and otherwise exposes its interior' (Posner 1998: 20).²⁹

Smith's sculptures represent the rebellious female body refusing to obey the strictures imposed on it by society. They are bodies that 'refuse to behave. *Pee Body* and *Train* release their fluids and stain the world' (Posner 1998: 20). There is resonance here with the concept of the ill body, which refuses to behave as its inhabitant might wish it to, and also an acceptance of the body as a multilayered entity consisting of a 'beautiful', visible exterior and an interior which, although invisible except through its excretions and, less often, actual physical probing into its layers, is no less beautiful once accepted for what it is – an integral part of the whole, and the part perhaps containing secrets of creation and the cosmos.

While Smith attempted to lay bare and confront the interior body with imagery of its contents in the form of fluids and secretions, I have attempted to do the same by means of images of my actual bodily interior.

In confronting the realities of the interior one confronts the 'unknown', which is always perilous and therefore demands courage – the courage not only to face possibly fearful things but also things that might challenge our entire system of beliefs and overturn our preconceptions, forcing us to admit that our thinking and feeling has been based on misconceptions. It is far more comfortable simply to let the unknown stay that way, unexamined, unexplored and unchallenging.

Kiki Smith puts forward the Medusa's glance without the polished shield to protect the viewer. She exhibits

the signs sometimes dispersed yet intact and unslain: her blood, her skin, her head. The power of the Medusa remains her own and ours, so long as we do not fear it. Smith presents the archetype and violates the taboo that Sawday explains as:

... perhaps, one of the oldest known to human beings – that the interior recesses of the body are not merely private to others, but peculiarly private – that is expressly forbidden – to the owner or inhabitant of the body. The encounter with the Medusa, then, a confrontation which is easily understood as an expression of male fear at the sight of the female genitalia, is significant, too, for what it tells us of any attempt at representing the secret world in the body-core. (Sawday 1995: 14 – 15)

Helen Chadwick

'Helen Chadwick tilted at the boundary markers around correspondences, and either upset them or exposed some unspoken truth about them' (Warner in Chalmers (ed.) 1996: n.p.).

Helen Chadwick's work focused on the body. She 'was always more at home in the personal – in the space of the body, in our own writhing interiors. Her works, sometimes literally, got under our skins, and showed us how uncomfortable, and how marvellous and strange, it is to be in the world.' Her work was 'alarming, funny and deeply serious' (Searle in *Mail & Guardian* March 29 – April 3 1996: 30).

In discussing Chadwick's *Self Portrait*, Warner (in Chalmers (ed.) 1996: n.p.) describes it as 'a concise, interrogatory image, which puts the mind-body problem to the viewer with pointed audacity and wit' and goes on to say, 'as so often with this artist's inventions and reversals, her flight of ironic, delightedly contrary fancy doesn't resolve into the jester's nihilism or the rationalist's mocking laugh.'

Chadwick's work, which challenged inherited values and taboos, is rooted in questions of disease, decay, transience, life and death. Body fluids were just some of Chadwick's broad range of 'materials'. Her work tested notions of the 'normal', the 'monstrous' and merged the boundary between male and female. As a child she owned a microscope, and this way of looking and investigating beyond the normally visible became her trademark as she set out to see below the surface of all things naturally, artificially and culturally constructed. She continually experimented with new ways of seeing things, using all manner of optical prostheses ranging from microscopes and photocopiers to Polaroids, lasers and computer-generated manipulations. Her 'enthusiasm for what is strange' is evidence of her need to get below the surface to the core truth.

In *Piss Flowers*, Chadwick deliberately overturns notions of maleness and femaleness – she contributes the phallic elements of a flower – the stem and pistil – and he contributes the petals, the flower's open face – in an instinctive appreciation of nature as inherently paradoxical, of everything containing also that which it is not. Her works encompass traditionally 'unpleasant' images, but with a humour and lightness of touch that bely their 'unacceptability'. She acknowledged 'human baseness without wallowing in abjection' (Warner in Chalmers (ed.) 1996: n.p.).

Chadwick not only imaged things normally invisible to the human eye, but also those things kept hidden from view. For example, she accessed and photographed medical specimens in the Hunterian museum collection and brought them out into the public gaze. In this way she perfectly epitomises an artist in possession of what for Sawday is the shared 'iconic status of the artist (or the visionary)' and the surgeon, and utilised what Sawday believes the artist and surgeon have in common, – a 'privileged gaze which is able to pass beyond common experience, through surface structures, to encounter a reserved core of reality' (1995: 12).³⁰

Through her work with the medical 'abnormalities' found in the collection, she had begun to explore the territory of classifying by species and health, provoked by the eighteenth-century vision of difference. The resulting pieces are a photographic series of six specimens from the collection that she had chosen to make visible again. For Chadwick, these were not monsters of difference, but creatures of beauty with the 'wrong' labels. Freaks of culture rather than of nature. The unfinished series of 1995 is entitled *Cameos*.

'For her the monster was a natural occurrence and should not be set beyond the pale; she thought that famous hybrids of myth, like the Cyclops or dragons, or the Chimaera with three heads, represented creatures which had existed and whose difference had been exaggerated by the terror and the prejudice of observers.' Therefore the six specimens in the Hunterian which she chose for *Cameos*, 'were all attractive to her' (Warner in Chalmers (ed.) 1996: n.p.).

Chadwick's use of these 'monster' specimens expresses her intuitive knowledge that that which at first appears 'ugly' is something else completely when viewed with a different set of attitudes, when an attempt is made to get beyond the surface or exterior and probe the physical or metaphorical interior. Her empathy for the 'monsters' reflects her acceptance of the 'ugly', 'abnormal', 'alien' or 'aberrant' as natural, if not necessary, components of being. The 'wound of difference' is imposed on us by nature and as such should be accepted as part of the whole truth, not something alien to be feared and reviled. The question that perhaps needs posing is whether there exists in fact any such thing as 'alien', or whether everything known and unknown is part of the same cosmic body.

Chadwick took up a residency at King's College Assisted Conception Unit in London. Here she 'immersed herself in the intricacies of medical practice in order to compose her own artistic *Unnatural Selection*.'

Human pre-embryos, that would otherwise have been left to perish, were suspended in formalin – their development thereby terminated – and then manipulated by the artist. They have been photographed in various compositions, sometimes as solitaires, sometimes interdispersed with other organic matter. In these literal and metaphorical still lifes, distinctions between nature and culture, art and science, dissolve and are fixed in the medium of photography, which in itself can be seen as a form of suspended animation. (Buck in Chalmers (ed.) 1996: n.p.)

These life forms evoke the mysteries of life and death, and through titles such as *Nebula* (1996) are connected to the cosmos. *Nebula* also contains an image which Buck likens to 'a dead eye', and describes as 'a paradigm for the relentless eye of science, a symbol of our pathological desire to probe and examine beyond horizons where sight can normally operate' (in Chalmers (ed.) 1996: n.p.).

Chadwick's pre-embryo works 'are a meditation on both the beginning and end of life, and in their cyclical nature, signal a kind of return' (Searle, *Mail & Guardian*, March 29 – April 3 1996: 30). Chadwick wrote, in *Lofos Nymphon* 'As a modern, with no centre, no core of belief, it is possible to encounter the void of Origin, to give it form and a body, and so return to the site of beginning ...' (quoted by Warner in Chalmers (ed.) 1996: n.p.).

Chadwick did not cry over the abject but celebrated it. She has been quoted (in Chalmers (ed.) 1996: n.p.) as saying: 'Art, like crying, is an act of self-repair, to shed the natural tears that free us, make us strong.'

Chadwick's *LOOP MY LOOP*, 1991, is a work I find very powerful. Betterton describes this work: 'Typically,

Chadwick suggests a slippage between opposites, living and dead, human and animal, surface and depth, to suggest an indivisibility of erotic attraction and repulsion which are held apart within the conventional binary division of sexual difference.' ... 'Chadwick reveals a multiplicity of sensations mediated through the body' (1996: 142–143).

Unnatural Selection engages with this insatiable human compulsion to look. But it offers another perspective to the supposedly disengaged, empirical eye of medical science. By harnessing the intimate, intricate procedures of IVF to the artistic impulse, Helen Chadwick radically and fantastically reclaimed the pre-embryo not as a frozen, objectified specimen, dangling in a cultural void but as a desirable subjective presence, full of creative – if problematic potential. Science is frequently accused of outstripping our moral codes and Helen Chadwick's *Unnatural Selection* offers no solutions to the ethical conundrums raised by current medical practice; instead her loops, knots and clusters point to different and often conflicting needs and expectations. (Buck in Chalmers (ed.) 1996: n.p.)

It is possible to make a connection between Chadwick's perception of the pre-embryo as a 'desirable, subjective presence', full of creative potential, and Hannah Wilke's belief that 'to strip oneself bare of the veils that society has imposed on humanity is to be the model of one's own ideology' (Fischer 1998: 48). The pre-embryo can be seen to symbolise original freedom, before 'pre-conceptions', societal conditioning and fear alter our ways of seeing and experiencing.

In various ways Chadwick's work opened new ethical debates, beyond the common ones. Her celebration of 'perverse beauty' brought to light questions of morality and perception, challenging conventional acceptance of body categories – what is 'right' and 'wrong', 'good' and 'bad', 'beautiful' and 'ugly'. Ethical dialogue is necessarily predicated on preconceptions of moral 'correctness' and Chadwick pushed these boundaries beyond the comfortable to the genuinely inquiring.

2.1.4 Medicine and the Body

2.1.4.a Ethical Debates

The history of medical ethics dealing with possession of the body centres on the outcome of the Nuremberg Trials. The Nuremberg Code, which enshrines human rights in relation to testing, was set up to prevent medical atrocities like the experiments performed by the Nazis.

The question of ethics in art is a fraught one, and whether moral ethics can be applied to art in the same way they are applied to medicine will probably be argued for eternity. Codes of ethics in medicine were born out of a need that developed as the frontiers of science grew ever more far-reaching and previously uncrossed boundaries were met and explored. When one considers the plethora of modern-day 'medical ethics', it is seemingly unthinkable that contemporary medical practice could include the use of paupers' cadavers in the way that the anatomical painters did.³¹ But much is still hidden from public view in the practice of medicine and science, and the irony is that it is exactly the artists' need to expose to public view that which is hidden that causes moral outcry.

Goodall writes that 'experiment in art may provoke a great deal of moralising, or even moral panic, but there are no codes of ethics to regulate practice. She argues that medical and art experiments have come to have widely divergent status in contemporary culture, scientific experiment being imbued with institutionalised regulatory mechanisms devised to justify its existence within a context of necessary knowledge, 'in which it is

supposed to attempt some kind of advance.' On the other hand, she asserts, 'there are versions of experiments that are deliberately anarchic, improvisatory, spontaneous, even reckless. Expertise becomes a dividing criterion between experiment in art and experiment in medicine. Many performance artists acquire specialised knowledges of the body, but these do not belong to professionally accredited traditions of knowledge. Ethics codes are one of the means by which medical experiment claims legitimacy' (*Artlink* 1997:10).

Chadwick's work, for example, questions the interpretation of 'legitimacy', always pushing the boundaries and probing the possibility of another viewpoint from which seeming realities can be understood.

'Moral panic' arises when artists challenge the medical establishment's exclusive domain over the body (this is a moral grip as well as a physical one), and these challenges might be seen to have loosened the grip to some degree, although seeming concessions may also be due to other factors such as the democracy of the Internet or economic concerns such as those mentioned by Stacey (1997: 211 – 212), who says the Self Health approach of the National Health Service (NHS) in Britain is due to economic hardship within the NHS, and that individuals are being encouraged to take responsibility for their well-being in other ways, by becoming informed participants in their own health care, lightening the load on the state. This view would indicate that it is only out of necessity that a certain degree of control is surrendered.

Earlier (2.1.2) I mentioned Goodall saying that 'if the experiments of artists don't definitively advance science or knowledge, this doesn't mean that they do not advance understanding or awareness' (*Artlink* 1997: 15). It is in this light too, that the following artists are to be seen. Performance artists speak not of 'my body' but of 'the body', meaning the body that belongs to all of us, the body as a social category.

2.1.4.b The Body in Contemporary Performance Art

Following from the artists mentioned earlier in 2.1, more recently the 'extreme' performance artists Stelarc and Orlan have taken up the issues and challenges introduced by feminism, in particular the 'radical assertion that we own our own bodies; we can do with them as we please.' (Gray in *Mail & Guardian*, April 26 – May 2 1996: 36). I refer to Stelarc and Orlan as two of the artists who have claimed and extended this freedom. These are artists who have made a 'subject/object shift', and 'whose bodies have become the art work' (Petherbridge 1997: 10).³²

Stelarc, an Australian-based performance and techno artist, claims artistic ownership and control of his own body, and in the suspension pieces of the seventies and eighties, 'draws our attention to the limits of the body ... by attaching the wires which hold his body aloft to meat hooks pierced through his skin. ... In more recent times he has made use of medical technology to extend the performance of the body and to disrupt its boundaries' (Bond 1997: 55).

2.1.4.c Body Limits and Technology

In his efforts to physiologically control the body Stelarc created complex prostheses controlled by the body through signals from the muscles, which led to the development of the Third Hand, a mechanical electronic hand which he strapped to his arm. It was capable of duplicating the intricate movements of a human hand. He 'used the Third Hand-to-concretize his theory of a body increasingly having to look to technology for its much-needed transformation.' ... 'Referring to the Cartesian split between body and mind, Stelarc has always been concerned with prejudices held against technology in contradistinction to the body.' (Schmuhl 1996: 30) According to him 'technology is what defines being human, ... it's part of our human nature' (Atzori n.d., n.p. quoted in Schmuhl 1996: 34).

2.1.4.d The 'Obsolete Body'

Stelarc's performances of his *Suspensions*, started in 1969, made him increasingly aware of the limitations of the human body. 'In an evolutionary sense, we have reached a crisis point where the body can no longer cope with the environment. ... Having reached a developmental standstill, the human body is increasingly finding itself lagging behind its own technological produce' (Stelarc quoted in Schmuhl 1996: 30).

Schmuhl saw Stelarc's body as 'an adaptable response to its hostile physical environment', reflecting 'the technodeterministic belief that an invincible technology, given its appropriate application, will help overcome all the physical and mental shortcomings and ills of an organic body so prone to the decrepitude and vicissitudes of time' (1996: 32).

The debates and critical questions raised regarding Stelarc's work revolve around his assumption of the neutral stance of scientific objectivity which is so-called 'context-free', and his denying figurative readings of his work, in his examination of the obsolescence of the organic body. The point made by critics of Stelarc's work (with reference to his claims of scientific neutrality), that nothing can happen in a social vacuum and that events and ideas occur always in a socio-economic and political context, is a notion that I embrace and that forms a background to my own study.

What is relevant about Stelarc as a performance and techno artist, in the context of this study, is his claim of artistic autonomy with regard to his/the body, and his investigation of the organic conditions that limit that body. In addition, Stelarc asserts that this work with its exploitation of technology exists in the realm of the poetic.

In the 1990s Orlan created 'Carnal Art', the art of 'refiguration' and 'defiguration' of the flesh, where for her the body becomes a 'modified ready made'. Orlan pays for the privilege of cutting her body open and seeing herself right down to her viscera without suffering, an activity that could only be realised through the possibility of medical technology. (*Orlan Manifesto of Carnal Art* quoted in *Artlink* [Britton ed.] 1997: 8). (See App III: 8)

These two artists are inextricably dependent on medicine and its surgeons, without whom their work would not be possible. By doing this work, they and their surgeons are crossing many medical ethical boundaries and codes. To some their experiments may seem pointless, as they do not carry the 'serious purpose' of medical experiments. However, in the words with which Goodall ends her essay 'Ethics and Experiment in Art':

Essentially, ethical judgement is a mediating activity, which involves weighing up conflicting investments and negotiating conditions on which they can be balanced, especially in relationships of unequal power. When codes of ethics lose their alertness to shifting fields of knowledge and changing social factors, they become catechisms. If performance artists stir up new thinking and cause ethical judgement to seek new bearings, that in itself is valuable experiment. (*Artlink* 1997: 15)

2.1.4.e Performance Art and Medicine: Artists that use Medical Imaging and Draw on Medical Technology

As we have seen, the body has been of central concern in the history of Western art, and artists have needed to study anatomy in order to accurately represent the body. They have had to dissect, examine and explore the bodies of the dead to facilitate their representations of the living.

This is no longer true. We now have the option of the bloodless dissection of the living, breathing body in order to understand and depict the living. This has obviously changed the possibilities of representation once again, as a new way of knowing and therefore perceiving the body has opened up.

2.1.4.f The Question: Why?

The reasons for artists' experiments on the body have been looked at through the work of Stelarc and Orlan. The use of medical imaging by artists has been touched on in the section on Helen Chadwick. The question as to why artists examine the body's interior via medical imaging is approached again in a little more detail here.

Earlier I mentioned the effect of the photograph in opening up new ways of seeing. While new medical imaging technologies are having this same effect and making available interior areas previously invisible, Donald Brook takes a dim view of the impact of the CAT scanner in particular, as opposed to the camera, on art and makes the following observations:

Now we are offered even more surprising and dramatic mechanical ways of representing the world than by wet photography, whether in a simply mimetic or in a more subtly revelatory way. Medical imaging is just one bundle of the smartest of these ways. ... this time around, the mechanical image does not usurp art's driving program. It does not appropriate art's best results and then – heaping insult upon injury threaten to do better. Hence the frivolous reason that artists might give for paying attention to medical imaging – to pick its brains and pinch its mannerisms – makes very little sense. And ... being unchallenged in its own agenda this time around (if, indeed, art can be said to have an agenda this time around) art does not need to invent a new one. ... In short, the CAT scan is not important to art now in anything like the way in which photography was important to art a century ago. (In *Artlink* [Britton ed.] 1997: 6).

These technologies are postmodern in the sense that (no longer understood through ritual and theology) we search for the topography of the body in screens and monitors. Celeste Olalquiaga states: 'These give us the language and the images that we require to reach others and see ourselves' (quoted in Schmuhl 1996: 41 – 42). Thus the importance of these technologies, including the Magnetic Resonance Image (MRI) and the scope, is that they enter previously unexplorable terrain in the living and the dead, offering views on a variety of microscopic levels. In this way they change our knowledge, our perception and our view of ourselves. (And despite the fact that they do require interpretation by a medical specialist – the radiologist – they are broadly understandable to the untrained eye and many artists have drawn on them to relook at the genre of the self-portrait.)

Robyn Daw comments: 'What this also means is that the function of the body, and not just its form can be observed, opening up possibilities for unique encounters between the exponents of medical technology and artists whose concerns lead them to this field' (in *Artlink* [Britton ed.] 1997: 21).

The idea of searching for an objective truth of the body also enters into this debate. In her works *Foreign Body* (*Corps étranger*) (1994) and *Deep Throat* (1996) Mona Hatoum, as with Stelarc's early work, has taken up the exploration of the body beyond the flesh. She explores and reveals her own body's digestive system, through means of medical fiberoptic cameras, the endoscope and the coloscope.³³

Petherbridge writes of *Corps étranger* that Hatoum 'presents us with a voyage through the living, pulsating channels and orifices of her own body via the technique of endoscopy'. She adds that 'the human body, as represented in contemporary 1990s CD-Rom pictorial atlases, is a sequence of radiosopic sections of ever greater reduction or magnitude, completely remapping the terrain of the body' (1997: 64).³⁴ This underlines the all-pervasive impact and effect of technology on our ways of seeing.

This intimate view of the internal landscape, offered by medical technology, is at once penetrating and distancing, questioning whether the mysteries of the body and the soul can be revealed beneath the flesh, or whether as the work shows – what you see is what you get. Or as Morgan and Morris state in *Rites of Passage*: 'From the Renaissance until our own faithless age the body has been regarded as housing something of spiritual significance. Hatoum reveals a body that is, if anything, dispossessed. No governing agency, no mind, no soul, no centre is revealed' (1996: 103).

Sawday draws attention to the paradoxes surrounding exploration of our interiors, arguing that modern surgical techniques, together with medical imaging, have made it possible for us to have intimate knowledge of our own interiors, and yet 'the taboo still exists and we violate it at some risk of producing reactions [of horror] akin to those displayed by Robert Lawrence's girlfriend.^{35a, 35b} And, even if we risk the taboo, have we thereby discovered the precise mark of individuality which distinguishes MY body from all others?' (1995: 15). He goes on to cite the words of Roland Barthes, writing about his experience of viewing images of himself:

But I never looked like that! – How do you know? Which is the 'you' you might or might not look like? Where do you find it – by which morphological or expressive calibration? Where is your authentic body? You are the only one who can never see yourself except as an image; ... even and especially for your own body, you are condemned to the repertoire of its images. (Sawday 1995: 15)

Sawday ponders the irony of 'the impossibility of knowing oneself other than through a "repertoire" of images ...' and the extremity of this truth in relation to the knowing of our insides. He poses the question: 'Was it ever possible to gaze at the body's interior without encountering the boundaries of proscription? Or is it that the discovery of a densely packed interior – a complexly articulated internal volume of cavities, vessels, fluids, movement, process, and mechanism – is the moment when the interior becomes private?' (1995: 15).

There are many other contemporary artists who are using medical imaging to make work, to see their interiors. Catherine Wagner, a photographer who has actually used the tools of medical science to make work, to photograph that which is not accessible to a camera lens, was recently named in *Time* magazine (October 2001) as an innovator. The article is titled *PHOTOGRAPHER: Through a Different Lens* and carries the caption, 'Each age finds its own technique.– Jackson Pollock'. Wagner collaborated with scientists and their institutions, and began using MRI machines and electron microscopes as cameras. She has produced photographs of fruit, vegetables, sharks' teeth, organs and even dividing cells. These mysterious images are shown in an exhibition titled *Cross Sections* (See App III: 17)

Veronika Bromová, a contemporary Czech artist, uses what she calls 'photo-surgery' in her composite photographs. Using digital technology, she 'implants' anatomical areas onto a photographed body, creating 'worrying images such as a shouting woman with her brain exposed' (Petherbridge 1997: 58). (See App III: 18)

William Kentridge's animated charcoal drawing video works incorporate the language of anatomical drawings and contemporary medical imaging, set out in landscapes, to examine an ailing society. In addition to drawings from old anatomical atlases Kentridge has used the format and signs of medical imaging technologies. A view through a car window appears in the shape of an ultrasound picture, and when the wipers move over it, the image changes. Sites of risk on the landscape are marked with the red cross of a computer screen, that doctors use to identify sites of risk in the body image. Cross section images of the head appear as they would be seen either in a CAT scan or an MRI. These are all integrated into the parables. In an earlier video work titled *The History of the Main Complaint* (1996) Kentridge himself appears as a character undergoing

diagnosis. He lies in a hospital bed, surrounded by curtains and a fluid bottle on a drip-stand. He is also the doctor, listening to the heart of the patient, with a stethoscope. In *Medicine Chest* (2001) the screen is a found object – the medicine chest of the title – onto which disturbing newspaper billboard headlines are projected. All these works are reflections on the construction of self and identity.

The way that contemporary artists are using medical imaging technologies to make work, to access and examine the body, returns us to a crossover point in the history of art and anatomy, by appropriating the tools of the medical profession as well as its specialist language. (This time, is the debt of artists to medicine perhaps greater than the seventeenth century debt of doctors to artists?) As the camera allowed Degas to change the schema, we need to examine how this technology and its use by artists, who bring the view to a small but broader audience, and its display in the media, is perhaps aiding a changing of our view of our contemporary selves, our relationship to our individual and collective body, the amount of respect we have for that body, and the amount of control we exercise over it.³⁶

The view of the inside of the body is to a certain extent no longer bound by so many of the laws and taboos that restrict the viewing of dissections (although we still need to consider the paradox outlined above by Sawday). Images of X-rayed, scanned, scoped, ultrasounded, magnetic resonanced, nuclear resonanced, microscopically examined living bodies are becoming more commonly seen and appearing more widely in the media. Tickets are no longer offered to the wealthy and curious to view the spectacle. The viewing rooms are only big enough to accommodate the few computers, technicians and doctors who are there to monitor the procedure. Although Orlan manages to traverse this boundary and has an audience for her operations, watching the proceedings on video in a gallery, to whom she speaks through a microphone while being operated on. Much like dissecting theatres of the Renaissance! In addition, possibly referencing this, her cosmetic surgery was aimed at making her look like Renaissance models, such as the *Mona Lisa*.

On the Internet one can view the 'visible human male' – the contemporary equivalent of *Smugglerius*. The VHM is a twentieth-century executed prisoner who voluntarily donated his 'young' 38-year-old body to science. (Science was delighted as usually the bodies they receive are physically damaged due to the nature of the deaths.)³⁷

The body was physically sliced up like polony in millimetre-cross-sectional slices and then virtually sliced up in other lateral sections. All the slices are revealed to anyone (anatomists as well as lay persons) dialling up to the site and/or buying the book and the CD-Rom. Adam and Eve are now complete: This is the twentieth-century virtual realisation of the Vesalian 'Adam' and 'Eve' figures in the *Epitome* (1543) referred to by Petherbridge (1997: 64).

Not only is this view publicly available but the anatomisation of the body is extended further in an apparently non-violent way. However, as Sawday argues, violence is intrinsic to the practice of anatomy and cannot be dismissed simply because there is no blood and the knife is replaced by the laser as in the CAT scan. Similarly, the powerlessness of the owner of the dissected dead body (the corpse) now extends to the owner of the dissected living body (the patient).

2.1.5 Conclusion

The medical 'anatomisation' of the body began mainly in the Renaissance, as evidenced by the manuals of Vesalius, and continues to this day although without knives and blood in the case of the new imaging technologies. The dissection theatres are now the technologist's viewing rooms.

In the teaching hospital of the University of Cape Town, Groote Schuur, my experience is that the dissection begins with tests of different parts of the body which themselves are broken into parts. Blood tests search for specific ingredients, X-rays of the chest seek enlarged lymph nodes, and CAT scans of the abdomen and pelvis identify lymph nodes, the appearance of malignant tissue and abnormalities of size and shape in organs. The dissection continues when the medical specialists (oncologists, radiologists and haematologists) get together at a weekly clinic to read the results, combine their specialist knowledges and decide the follow up procedure for the cancer patient. It is clear that the paradigm of Western medicine is still one of 'anatomisation' and this is the primary experience of the cancer patient. 'Anatomisation' is still the primary method of medicine today and informs its current practice and therefore the treatment and experience of the patient.

This concurs with my experience in the hospital when the doctors relate to the disease rather than the patient, when the oncologist slaps a scan film onto the light box, indicates that the images on the film are somewhere in your body and the tumour is somewhere in there, unable to interpret the image without the specialist knowledge of the radiologist, when you are sent down a long corridor for an X-ray, another long corridor for a scan and so on. The entire hospital can be seen as one large dissection theatre. Which just goes to show that the thirteenth – seventeenth century practice of anatomisation is still up and running. I use the term 'anatomisation' from its derivative 'anatomise' meaning to break down into parts. Anatomy refers to the structure of the human body. To anatomise is to break down the human body into parts. With the occurrence of disease or illness medical science breaks the disease into its components and names it accordingly. This is how the patient becomes the part or parts. The patient is broken down into only the relevant components. The rest do not seem to exist, especially the mind. This is contrasted with the systems of alternative medicine, which will identify the problem by identifying an imbalance in the whole interconnected system and attempting to correct the imbalance thereby restoring wellness to the whole in the microcosm.³⁸ On a cosmic level the idea is that wellness is restored to your connection with the cosmos, which takes us back to a time pre-Vesalius.

The response of artists to the taboos and limitations placed on ownership of the body has exposed the search to view the inside as a legitimate pursuit free from macabre curiosity and prurience, and as a right of every human being. These taboos and prohibitions placed on viewing the body by the medical profession and supported by its institutions exist largely in order to protect and reinforce their reign over the body. However due to the democracy and visual nature of the Internet this kind of information and these images are now freely available to be seen and understood by an increasingly visually literate public. Perhaps the dismantling of the taboos and the exclusionary hold of the medical profession and its exclusive ownership of the body, is simply a natural evolutionary step.

If anatomisation is an inevitability, which the patient may attempt to recover or 'reintegrate' from (see 2.2) the taboos are not. The work of artists is challenging them and the ethics that uphold them. The patient too can attempt to challenge the taboos by creating open dialogue about them. What has created these taboos and therefore needs to be dismantled is what Sawday refers to as the fact that 'the body-interior speaks directly of our own mortality.'

Hence, the sight of these hidden contours has traditionally been denied us since they are usually encountered only at the risk of enduring great pain and quite possibly death. The surgeon (even within the harshly empirical structures of western medicine) therefore enjoys a rare cultural status as mediator between the exterior and interior worlds. The surgeon seems to share the iconic status of the artist (or the visionary) within our culture, since both are held to be in possession of a privileged gaze which is able to pass beyond common experience, through surface structures, to encounter a reserved core of reality. (1995: 12)

The origin of the word 'patient' explains why it is that this need for secrecy is promoted by a diagnosis such as cancer.³⁹ The patient reads the subliminal expectation and carries it out. Jo Spence noted 'a need for some sort of assertiveness training for those of us who feel totally intimidated by the medical profession' (1995: 122).

Increasingly contemporary artists and scientists are beginning to recognise this common status and to realise the possibilities of working creatively together. This is evidenced in a publication from Holland titled *Formule 2.1* (Dander, D., Dik, I., Henkes, P., Tannert, C. (Eds.) 1999) and in Britain a public exhibition titled *INVISIBLE BODY: under the skin of art and medicine*, which took place at a shopping centre in London in 2000. The exhibition and accompanying events at the shopping centre and The Science Museum were the result of collaborations between 12 contemporary artists exploring the 'world of medicine' and 12 'specialists in medical science'. The exhibition was billed as examining 'the role that medicine plays in contemporary culture' and as revealing 'what happens when you place an artist and a scientist in the same room for any length of time. The exhibition exposes the arguments and celebrates the agreements through a diversity of visual arts.' (See App III: 15 & 16)

ARTSci2001: Catalyst for Collaboration, the third symposium of its kind, took place in New York. Co-produced by Art & Science Collaborations, Inc (ASCI) and the Science Research and the Continuing Education & Public Programs departments of the Graduate Centre at City University of New York (CUNY), it was funded by private and corporate sponsors. Participants and presenters included artists, scientists, authors (such as Susan Sontag), technologists, educators and others. The symposium explored the collaborative cross-disciplinary possibilities and difficulties that occur when barriers between disciplines are removed. In addition, the event saw the launch of *ARTSci INDEX* (an incubator for collaborative inquiry), an online research tool and database of art-sci collaborative projects and resources.⁴⁰ While such synergies are increasingly being explored by institutions and individuals, there are still pockets of resistance to opening disciplines in the world of medical practice and research. Of course not all artists or scientists are attracted to collaborative projects. But those who enter collaborations of this nature, are drawn together by the creative potential of sharing expertise and by a shared delight in the exploration of that which is or appears mysterious. As Albert Einstein is quoted as saying: 'The most beautiful experience we can have is the mysterious. It is the fundamental emotion which stands at the cradle of true art and true science. Whoever does not know it can no longer wonder, no longer marvel, is as good as dead, and his eyes are dimmed' (in Steiner, R. 2000 *Wonderland*: n.p.).

The way that contemporary artists are using medical imaging technologies to make work, to access and examine the body, returns us to a crossover point in the history of art and anatomy, by appropriating the tools of the medical profession as well as its specialist language. (This time, is the debt of artists to medicine perhaps greater than the seventeenth-century debt of doctors to artists?)

2.2 The Ill Body in Art and Medicine (And there, but for the grace of God, go I)

'The potential for pathological disorder, for a body that can spiral out of control, is something inherent to us all.' – *Vile Bodies: Inside/Out* (1998: back cover, n.a.)

'How do we deal with the abject loneliness of the long struggle for health (the most boring of subjects to other people who are "well")? How to present yourself as a subject in daily struggle? People are used to the "narrative resolution" of illnesses like cancer (in the media's terms you are either "dead" or "better". The actual struggle over many years to regain health is not good box office. It is more like soap opera with its continual peaks and troughs and minor resolutions for most of the time)' (Spence 1995: 122).

2.2.1 Introduction

In this section I will look at the relationship with and to the ill body from the point of view of the 'patient', the social body and the artist. The power politics previously examined obviously extend deeply into the area of the ill body where they are very apparent. The final section of the chapter will investigate artistic production in relation to disease – that of my own and others.

My search for cancer has led me to a fascination with the beauty of the body's interior, which is a current concern in contemporary art practice. Critics speak of a return to the body as a 'rediscovered source of inspiration. The body has become a landscape simultaneously strange and intimate. Such a return to the body is certain to have implications that reach far beyond the art world' (Gray in *Mail & Guardian* April 26–May 2 1996: 36). The brief history in 2.1.2. described how the obsession with the body has manifested at various periods.

In *The Normal and the Pathological* (1991), Georges Canguilhem presents a philosophical examination of what is normative, average and pathological. Canguilhem describes how an understanding of these terms is not scientifically or statistically based but is shaped by societal, cultural and environmental beliefs, patterns and circumstances; in other words he constructs a social history that links notions of health and disease to ever changing institutional power. Susan Sontag, in *Illness as Metaphor* (1979), raises these questions too and further develops this reading of disease, where she looks at the cultural construction of health and illness. These issues will be evidenced in the work of the artists discussed at the end of this section.

I continually live in a liminal state between appearing to be outwardly well, yet on internal examination am seen to be in a state that is not accepted as healthy or 'normal'. To illustrate this I show the tumours (as seen on a CAT scan), which are an accumulation of immature white cells or lymphocytes, that live within my body. (See App I fig 26; App II figs 9, 37, 42). This is seen as a dangerous body, a 'bad' body that contains the seeds of its own potential destruction and sites of risk or danger that threaten to explode. It is this that I struggle to represent and befriend.

In this regard I will refer to the British artist and photographer, Jo Spence (1934–1992), who made a series of photographic artworks out of her own experience first with breast cancer and finally with leukemia, and whose experiences and thoughts resonate with my own. Our positions are however slightly different. Spence was a socialist feminist-activist documentary photographer working in the '80s and early '90s, and her breast cancer work is largely made from a position of anger. Spence talks of how she came to realise that with her body of work around the breast cancer she initially 'took on the medical profession rather than the illness itself!' (Spence, 1995: 122). She talks of the toll the activism took on her health and on her vulnerable body in that it left no time for care-taking of herself. Only toward the end of her life, with her second encounter with cancer in the form of leukemia, did she let go of the anger and in the resulting work looked at her condition and pending death from a personal position of self-love. (See App III: 55)

I will survey work by a few other artists (alive and dead) who have made and continue to make art around their experience with chronic and life-threatening illnesses such as cystic fibrosis (Bob Flanagan), cancer (Hannah Wilke) and AIDS (Sunil Gupta, Felix Gonzalez-Torres). I have previously referred to work by Kiki Smith, known for her images of the abject female body and her explorations of the blurring and crossing of the borders between inside and outside and the work of the apparently 'healthy' ⁴¹ artist Helen Chadwick, who imaged cells and viruses. This work informs my own investigation of how the ill body and its interior is seen and examined.

In chapter 3, I discuss the position of my own work (painting, photographs and video) within the above context and how the various discourses elaborated upon and traced in the text are reflected in the work.

2.2.2 Cancer Narratives (Oh, but you look so well!)

2.2.2.a Gaining Access

By entering the medical discourse via the lymphoma diagnosis primarily as a 'patient', and secondly as an artist and post-graduate research student, I have found myself in a position to be able to search my own body for signs of disease. Along the way I have viewed whatever biological, histological or anatomical images and codes that exist, and the tissues and their images that may house and reveal signs of the disease. These images have been drawn from my colon, lymph nodes, bone marrow and internal body tissues during such surveillance procedures as CAT scanning, X-ray, colonoscopy, blood analysis, Erna test, bone-marrow and tissue biopsies. (See App II fig 5 & 6) Consequently the images I have access to and the readings I receive are those deemed necessary and interpreted by the medical profession.

If, like Orlan, I was willing to pay I could request a 'photographic' record of every part of my interior reachable by modern technology. This would be deemed macabre. However, why should it be more macabre than wanting a photographic record of your external manifestation(s) taken at any time? The people captured in photographs are dead in the sense that they no longer exist in the same form. This sentimental practice of capturing the living dead is however enjoyed as socially acceptable – our social context does not question the preoccupation we have with having our pictures taken, predominantly on happy occasions, in order to hold on to memories. In contrast, in some cultures photographs are feared for their power to remove or capture the spirit of the individuals photographed, thus completely rejecting the Western tradition of holding onto images on paper. On the other hand, Mexicans in North America have begun the practice of sending video recordings of funerals to relatives back home who are unable to attend the burials. This seems to extend the Latin American tradition of taking elaborate tableaux portraits of dead children, underlining a different relationship to the body and death. South African 'township' funerals are often attended by paid videographers. In 'white' society these practices would indeed be deemed macabre.

Images of 'my inside' sometimes provoke adverse reactions in those who cannot understand what they call my 'morbid obsession' with seeing the inside of my body. (They ask: 'Why don't you rather look at "nice" images like sunsets?') (See App II figs 8 & 9) However, this belies the human fascination with the insides of other people's bodies that is largely fed by a curiosity to know what 'we' look like inside. Those who look at images and scenes of corpses, road accidents and the like are drawn by a mixture of curiosity and fascination that is described as morbid, while there are, of course, some who present an inability to look. There is perhaps a kind of denial going on here that leads Sawday to refer to 'the potentially transgressive gaze of the subject who studies his or her own bodily interior' (1995: 8). Is it not OK to go in search of one's own images of interiority?

For myself, this newly discovered fascination with my interior, propelled by the medical excavation of my body, is with the hidden beauty and brilliance that is invisibly active within. In no way do I see this as morbid or transgressive, but feel privileged to be in a position that offers the opportunity to see this view.

It is from this position as patient, artist and researcher that I approach this section. My ability to have seen things normally not deemed necessary or suitable or appropriate for a patient, has been due to my fascination, tenacity, determination and perseverance in wanting to be allowed to see, and has been given legitimacy by the fact that I am pursuing an academic research degree. The fact that the degree is in Fine Art – not a legitimate medical degree – has been a bit of a deterrent to some who hold power and wish to use codes of ethics held by medicine to keep me out. Other medical teachers and practitioners have been very pleased to share their intense passion for the workings of the body and its hidden interior with me.

I have encountered similarly varied responses in the hospital setting. My desire to visually record, whether it be a blood test, a doctor's examination, an X-ray, a bone-marrow biopsy or a CAT scan, is met by a range of responses: a willingness to assist, amusement, perplexity, disbelief, fear and a need to deny the endeavour. In two separate hospital situations (one in a private and the other in a state hospital) a need to set up a barrier by a medical doctor and a nursing sister were encountered.

The degree of negativity of the response seems to depend on the position of the person within the hierarchy. A doctor in charge of a clinic in a state hospital would fear a higher authority (such as the medical superintendent) and needs to shield him or herself from the potential consequences of breaking the ethical code. A sister in a private hospital would find the recording of such un-presentable material too bizarre and therefore try to stop the recording because it disturbs a sense of 'correct morals'. Usually the person with the least fear of authority, whether they are a doctor, a nurse, or a sister, is the most at ease with the recording process.

The point is that the taboos are put in place by a higher authority declaring and exercising the power of the medical profession – the domain in which you find yourself when you enter a hospital with your own body – and making decisions about the evidence with which you are allowed to leave.

I will narrate another encounter, not involving my own body, which partially reinforces this idea. I wished to experience first-hand and record some evidence of the visual physical manifestation of an infected lymph node. I sought the permission and cooperation of a professor of anatomical pathology at a state teaching hospital connected to the University of Cape Town, for access to the department's slide library, museum of anatomical pathology and pathology laboratory. In order to gain a proper visual and experiential understanding of the lymph system I asked to be allowed to see a dissection. I also wanted to take photographs of the lymph nodes and lymph system. The professor explained that these things are only the proper territory of a medical student under supervision and that therefore I had no place in 'his' labs. Accordingly he wanted nothing to do with my request although as a last word I was granted permission for a guided tour of 'his' museum, but without recording devices. I will describe details of this encounter in order to highlight some key issues. (See App II fig 13)

The first point in the argument denying me access was that the body parts are highly sought after as commercial items for 'muti'. The second that he cannot satisfy those seeking to look out of macabre curiosity. The third point was that he couldn't accommodate every patient wishing to engage with his or her disease. I pointed out that my motivation was none of these factors but rather academic research. The final reservation was that his staff was overworked and it would be difficult to supervise me, implying it would simply be an irritation to accommodate me. I was nevertheless invited to submit a letter outlining my request that would be passed by other staff members, as the decision was not his alone. The final issue was that the specimens and bodies in the labs and museum belong to private individuals and could not be made available for public display. In my follow-up letter I assured the professor that I had no interest in revealing the identity of the patients, as in medical textbooks. The reply was: request denied.⁴²

My next step was to draw the director of the School of Fine Art, who has a good working relationship with the professor of anatomy, into the discussion. Her e-mails to the professor of anatomical pathology were ignored. We then elicited a meeting with the professor of ethics, who enjoyed my proposal and attempted to mediate. The professor of anatomical pathology was not interested in the invitation to attend a meeting with the three of us. His response was that he wanted nothing more to do with my requests. The professor of ethics offered me his sympathy and said there was nothing more he could do to intervene, and suggested I approach another teaching hospital for access to the materials. Obviously he had no ethical problems

with my requests. He followed up by asking other heads of department, for example in radiology and oncology, to assist me. The only thing he could not do was gain blanket access for me to my patient folder.⁴³

The next development was a chance meeting between the director of the art department and the professor of anatomical pathology at a university event. When the latter realised the former's credentials he immediately became amenable towards her and requested her expertise in helping him turn the pathology museum into a public-access facility.

The reason I detail these events is to highlight the point about power relations. When an anatomist realises how much credibility he can gain by associating with an artist, he is able to autonomously open the door and attempts to co-opt that artist into his agenda for his own benefit and the promotion of his career or image. Apparently at the latter meeting, the professor also said he would be willing to reconsider my requests. I did not attempt to renegotiate with him as I had other possible sources for access to the material. Since this time I have been guided on a fascinating tour through a cadaver and his lymph nodes, at the Medical School. (See App II figs 46–49)

This example demonstrates the point made earlier, that the medical profession can selectively call on its authority over the body and attempt to use its code of ethics to regulate artists and their access to the parts of the body that exist in the medical domain. Of course this took place in one university, in one state teaching hospital, in one small city in South Africa. I cannot claim that this is a universal example.

In contrast, I have experienced a good exchange with a doctor of anatomy who specialises in teaching medical imaging in the same university. I made a contribution to his work and he to mine.

2.2.2.b The Debt Artists owe to Anatomists

In a newspaper review of the exhibition 'Spectacular Bodies', seen in 2000 at the Hayward Gallery, London, the subheading is 'Cutting Edge: Art's debt to anatomy'. The sub-header reads: 'It's all very well flaying the skin off a human body, removing its legs and revealing the organs in the name of medicine – but in the name of culture? Michael Bywater dissects an extraordinary exhibition that acknowledges the debt that the visual arts owe to the anatomist's knife' (*Independent on Sunday*, 8 Oct 2000: 10–16).

In the article Christine Borland, a contemporary participating artist, is interviewed. Borland reveals a different perspective: 'In earlier times, there was an unspoken relationship between art and medicine.' ... 'Anatomy and dissection were afforded a kind of dignity and respect by their link with art. It might be useful if that relationship were reinstated' (*The Independent on Sunday, The Sunday Review*, 8 Oct 2000: 13). This returns us to the questions asked earlier in 2.1 regarding the potential for breaking down these boundaries.

2.2.2.c Discovering my Interior View

The first time I was admitted, or rather 'admitted myself', into the CAT scan viewing room was the first time I had a photographer with me to document the process. The photographer was given permission to set up equipment and to stand in the cubicle with the technicians and radiologist behind the viewing glass in the green area (i.e. not radioactive) while I lay on the scanner bed in the red area. After the scan I went in to the normally 'not for patient access' area to see how the photographer was doing. On the monitor I saw an outline of a body. I asked if that was a template. I was told it was in actual fact my body. I had not expected to see my own body, nor had it occurred to me that my body could be such a perfect, ideal shape, hence my assumption that it was a template. I had expected the exterior at least to be lumpy in the way I perceive my own body. Perhaps I simply did not know what to expect! But I surely didn't expect a startling

image of my own interior to be visible to others, without being asked if I had an interest in seeing it myself! What I was seeing was a full lateral body scan of my interior, including the contour or outline of my skin. I then realised the particularity of MY own body.

This was highlighted for me when a radiologist in a private hospital agreed to my request for him to explain the cross section images on my scan films to me. We met in his quiet time in a viewing room with light boxes and incidentally, a monitor transmitting live a scan procedure taking place somewhere else in the clinic. On the monitor was an interior view of a completely different-looking body. From the immediately apparent gender difference I realised it was a male body. It was the body of an 'older' man I had earlier seen entering the clinic and I could put a face to it. In the lateral- and cross section interior scans I could see exactly the form of his exterior body shape, outlined by his skin and filled by his organs, tissues, muscles and fat. My amazement reinforced for me how ignorant I was and how little I had expected interiors to differ from one another. This must be due to the fact that all anatomy diagrams are of an 'ideal' shape. Of course I suddenly realised that the interior differs as much as the exterior form! The organs, and of course the fat and muscle tissue, differ in the way they sit, the amount of space they fill and in the position that they occupy in each individual, yet still remain compact while taking the shape of the outer contour. Crussi's realisations only occurred to me through my own 'privileged' observations.⁴⁴

This refers us back once more to the Gombrich suggestion (referred to in Woolf & Cassin 1987: 6) that what we see is what we know and what we know is what we see and how representations and our perceptions are inextricably linked. This is 'the never ending link between art and object – that we see what we know from representations, just as we can only represent what we know.'

I was terribly proud of my own interior photograph. I began showing it to everybody (See App II fig 18) I had the opportunity of being allowed to pry into my own body and to make this view publicly identifiable with an individual identity.

I realised that the interior view I was so proud of was an interesting new version of a nude. I had an inter-neg and photographic print made of the X-ray film. The image could then be reproduced to a larger scale. It eventually became *The Nude Descending a Staircase*. This was a surveillance of my own – watching others walking on my body up a flight of steps. (See App I fig 21–25)

Even this view, however, was not complete or completely explanatory. I had to move to the detailed cross-sections of the topogram in order to fully see my own interior organs and understand their placement. This was another very interesting journey. It began when I met the radiologist after hours in a viewing room. He was explaining my sections on the X-ray film to me. In the viewing room I saw a monitor with another person's CAT scan. I watched his sections moving on the monitor as the scanner sliced through his body. I realised that this was the view the technicians and radiologists have while conducting MY scan. They had seen the symphony of my organs in motion – a wonderful sight – yet again, no one had ever thought of telling me this or asking if I wanted to see it. This would not be impossible, perhaps slightly inconvenient and time-wasting for the technician. The moving view remains on the computer for a while – anything from three hours to eight days, depending on the institution's equipment. Some can store it on the hard drive for up to eight months, some for only a few days. In the USA doctors are networked within hospitals and can call up any patient's scans on their own computers as they remain on the hard drive permanently, in the same way files used to be stored in filing rooms indefinitely. The difference is that these images can be animated and played in motion at the speed chosen by the technician. The full-body topogram can be displayed on the screen beside the moving sections, allowing the technician or radiologist to cross-reference the lateral section with

the cross sections, or the cross sections can fill the screen. The technology, however, does not exist to allow the patient to leave with their own 'home movie', so this view is not offered.

To have my own body video, the static images were scanned off the film, transferred frame by frame into a video programme and animated. This resulted in the video titled *Cross Sections II* (See App I figs 26–28). A non-medical viewer's first response was to realise and marvel at the compact, well-organised and clever manner in which the organs are fitted into the frame of the body. On witnessing a modern post-mortem, Michael Didbin comments: 'Everything seems so lovingly packaged and arranged, like a cabin trunk stowed against breakage with just those items necessary for the voyage' (quoted in Sawday 1995: 6).

2.2.2d Health and Illness – Normality and Pathology (What is Disease?)

Disease (di'zi:z) n. 1. Any impairment of normal physiological function affecting an organism, esp. a change caused by infection, stress, etc., producing characteristic symptoms; illness or sickness in general. 2. A corresponding condition in plants. 3. Any condition likened to this. –dis'eased adj.

Dis a loss or absence of

Ease n. 1. Freedom from discomfort, worry, or anxiety. 2. Lack of difficulty, labour, or awkwardness. 3. Rest, leisure, or relaxation.

Sick adj. 1. Inclined or likely to vomit. 2.a. suffering from ill health. b. (as n.): the sick. 3.a. of or used by people who are unwell: sick benefits. B. (in combination): a sickroom. 4. Deeply affected with a mental or spiritual feeling akin to physical sickness: sick at heart. 5. Mentally or spiritually disturbed. 6. Inf. Delighting in or catering for the macabre: sick humour. 7. (often foll. by of) inf. disgusted or weary: I am sick of his everlasting laughter... 10. Not in working order. –n., vb. 11. An informal word for vomit. – 'sickish adj.

Sickening adj. 1. Causing sickness or revulsion. 2. Inf. extremely annoying. – 'sickeningly adv.

Sickness ('siknis)n. 1. an illness or disease. 2. nausea or queasiness. 3. the state or an instance of being sick ⁴⁵ (*The Collins Paperback English Dictionary*, London & Glasgow: 1986)

Somatic [GK somatikos, f. somat-, soma body] of, pertaining to, or affecting the body, esp. as distinct from the mind; bodily, corporeal, physical; spec. pertaining to the soma.

Somatization n. The occurrence of bodily symptoms in consequence of or as an expression of emotional or mental disorder.

Somatize v.t. express (a mental state) in the form of bodily symptoms

(*The New Shorter Oxford English Dictionary* Vol 2. [Brown, L. Ed.] 1973, 1993)

'Disease. Pestilence. Plague. Unclean – how dare they label me so. Parkinson's, so far as it is known, is no more infectious than a broken leg. Why don't we talk of Broken Leg Disease?' (*Mail & Guardian* March 17–23 2000: 30). This is the sentiment expressed with indignation by David Beresford writing on the discrimination he experiences as a result of his visible disease, which manifests in the form of shaking. People with various forms of cancer internalise the same vocabulary and experience the same sentiments when thinking about their own internal and, most often, invisible condition.

These are the effects of labeling.(Susan Sontag eloquently examines how these associations have come to be made ⁴⁶). However if we look at the word 'Dis-ease' it is quite a different concept with another meaning altogether – more like dis-equilibrium. Yet, the word disease and the conditions it denotes, according to allopathic medicine, have acquired these connotations, which are in turn absorbed by those living with such a bodily condition. The patient's body contains the 'other'. With cancer, one feels invaded by foreign entities, dirty, tainted, plagued. So, even though these meanings are not intrinsic to the word 'disease', through a combi-

nation of the effects of the dominant Western medical discourse and cultural beliefs, it evokes the same feelings (and ironically actually causes 'dis-ease' in those around the diseased ones!). The root of the word is dismissed in contemporary speech. Language is a cultural construct that determines how we see things. Thus the effects of labelling raise another experience of the body – the body as invaded, as a site of struggle or battle. (Western understanding of the body as a chemical composition, and cancer as a disease of contamination that is fought chemically, give rise to the use of terminology of chemical warfare. This in turn has the effect of the metaphorical reading that Sontag talks of. The contamination metaphor can be extended to cancer being a disease symbolic of world contamination with pollutants, chemicals, GM foods and the like.)^{47, 48}

Patients have spoken of cancer as 'a silent and deadly disease', 'a malign agent', 'the silent killer...eating away at your body', 'unpredictable', and have described 'the fear that will get you in the end' even if the cancer doesn't (Terre Blanche, Bhavnani & Hook 1999: 196).

The patient internalises this discourse and becomes unhappy and angry with the body that has let him or her down, feels helpless at having a body that is out of control, and wishes to exchange the body for a new and 'perfect' one. This is of course impossible unless one follows the Stelarc route of attempting to be a cyborg. This is the effect of the experience of disease and the relationship to the body encouraged by the dominant discourse.

When we think of the body, we tend to think only of the surface. In Western society, one usually only enters into the realm of the body when one has a crisis of health. It is then that we turn to allopathic medicine for diagnosis and help to fix what is wrong. In this way we enter our bodies through the dominant medical discourse and its biomedical model. This can be a very frightening and alienating experience, as it is not often accompanied by much of a comprehensive explanation. An understanding of the body and the condition is not easily offered to the patient. The view into the body is a privileged one that is not generally shared with the patient. (Of course one cannot make huge generalisations and there are exceptions in allopathic doctor-patient relationships.) The patient is thus not encouraged to fully enter the body in biomedical terms. As I have said previously, the disease becomes an abstract condition, which cannot be located. In my case it felt as if the lymphoma was a floating entity. I perceived my body as filled by a big amorphous black mass that was inside, all around, all consuming and with no specific physical location. I couldn't imagine it and therefore couldn't know it.⁴⁹

In addition to the effect that this has on the patient, of becoming a disembodied entity, the patient becomes an invisible one too. The doctor relates to the patient as a disease. At this stage we need to explore the politics that will reconstitute the patient, bring the bodies into visibility. Terre Blanche, Bhavnani & Hook address this question in *Body Politics* (1999) and imply that the climate is right for this to happen. A shift is noted at the end of the twentieth century toward an acknowledgement of 'real' human bodies and of a proliferation of media and academic representations of the true nature, rights, privileges and proper management of such bodies. 'The body-politics of the twentieth-century do not operate only from a political center to subjugate bodies, but also vest ownership of the body in the private individual, encouraging him or her to assume responsibility for it and to resist all attempts at outside control' (Terre Blanche, Bhavnani & Hook: 1997).

There is another kind of visibility in question here. If we were offered a blood-and-guts view beneath the surface of the skin (the acceptable, social surface) we would probably be quite horrified. We hardly ever choose to perceive that just beneath the thin protective surface layer of the skin is an oozing, messy system ready to disrupt its borders and to 'spiral out of control' (Townsend 1998: back cover). Sawday (1995: 12), quoting Richard Selzer, refers to the incident when during an operation, a patient under spinal anaesthesia was in a

position to catch a glimpse of himself in the reflective surface of a light, when the surgeon protectively shifted his body in front of the patient's view in order to shield him from the sight of his own opened flesh.

The denial of the interior experience manifests in another interesting way. The patient is not offered the possibility of recording an operation or a visit or stay in a hospital photographically or by video as would be the case with any other milestone in one's life – this action is not really invited in the hospital context. When one does operate a recording device in such a situation, one is treated with apprehension and suspicion. This is a consequence of society's attempt to conceal and hide images of ill health from our lives. Jo Spence advocated 'creating a new family album through snapshotting and documenting that which is absent or customarily ignored' (1995: 172).

If we train ourselves to 'see' differently, visual markers of various rites of passage which are socially tabooed within the family album can be made: for example, divorce, illness and death; undervalued everyday events such as signing on for the dole, childcare, schooling, housework, visiting the doctor. (The experience of those who tried to take snapshots within institutional contexts immediately foregrounds the problem of the institutional gaze, as permission is often hard to obtain, or limited access only is offered. This in itself is a useful learning process in relation to forms of external censorship and self-censorship.) (Spence 1995: 172) ⁵⁰

The attempt to shield the patient from knowledge of interiority (including the privileged view seen by the 'inner circle') is partly the result of the body being kept secret and partly the result of a society that denies disease and cannot find a place for it. The body is kept from view and unless we demand to see it we will never see what is going on inside. Of course there are exceptions under happy circumstances such as pregnancy, when one is offered an ultrasound view with printouts, and more recently video, to keep.

2.2.2.e The Body as Vehicle

'Our bodies are basically stolen from us, and my work is about trying to reclaim one's own vehicle of being here' (Kiki Smith quoted in Isaac 1995: 22).

Sawday asserts: 'The creation of "Cartesian Man", at some point in the early seventeenth century, was also the moment at which an alienated human subject was born' (1995: 159). (See 2.1.3.a) The human being disappears! In another view the body is only the vehicle for the soul.

In terms of an illness such as cancer, unless the part that is malfunctioning can be removed (by surgery, chemotherapy or radiation), fixed or replaced, Western medicine does not seem able to offer much help and is fairly impotent to do anything about it. The body is not looked at as a whole system out of balance but rather as a system of parts much like a car engine. Replace or rid the body of the problem part and things are solved. The problem having arisen due to a defect in the whole system is not considered, seldom is the rest of the system cleaned out, and supplementation of the nutrients depleted by the chemotherapy is rarely mentioned. As Spence noted of her treatment for breast cancer: 'The feelings generated that our body is merely a set of parts, and those parts are someone else's property, are intensified by the treatment we receive from doctors when something goes wrong ... If we detect a lump on our breasts we are expected to hand them over to the medical profession' (1995: 125). You park your body in the hospital garage! (and they will tell you when it is ready).

The acquisition of cancer is not yet fully understood by Western medicine. The complex nature of this uncer-

tainty may be another partial reason for the lack of sharing of information. In the scientific view cancer is seen as multi-factorial: a. the result of genetic predisposition (i.e. starting off with one bad gene copy by inheritance from parents or being born with a new mutation found in neither parent.)⁵¹ ; b. environmental carcinogens or ionic radiation causing gene mutations; c. DNA replication (copying) mistakes, OR d. a combination of the above. There are some definite physical factors causing cancer that fall under errors in DNA replication such as old age – where cell regeneration isn't so good anymore – and environmental factors such as the sun, ingestion or inhalation of or exposure to chemicals, and viral infections (such as Hepatitis leading to liver cancer). Then of course there are incidences such as Chernobyl to which few would be immune and escape unaffected, no matter what their genetic predisposition, which can be explained by any combination of the above. These concepts were all unfamiliar to me before I was launched into the world of cancer. Today learners in high school are already introduced to the basics of this 'knowledge' in biology textbooks.

Most often these factors seem to be out of the individual's control. The only contributing factors to some forms of cancer that are offered in explanation (by the official cancer spokesbodies) and which the individual can temper are lifestyle – stress, smoking, drinking, sunbathing – and nutrition (and yet, even in terms of nutrition the literature is conflicting). A point made in 1983 and echoed by many since is that 'the discovery of a genetic determination for a disorder may provide the best hope for an environmental treatment of it' (Nesse and Williams 1995: 106). The hope is that through the study of DNA and the actions of genes, explanations will be found for different forms of cancer and logical treatments or prevention mechanisms, such as environmental manipulation through diet, will be possible. (See App III: 24–29)

This scientific view sees the body as a complex society of rather autonomous worker cells that function without a master overseer. When these cells are public spirited a very complex order exists. Tumour cells are lineal descendants of a single renegade progenitor cell and are cast in the image of this distant ancestor cell.

In lymphoma, for example, perhaps it was one stem cell in the bone marrow that made a mistake in its DNA replication. That mistake could be the result of one or a combination of the factors described above. All of the 'grandchildren' of this founder cell have not been public spirited, are selfish and behave independently of the host, despite the fact that their survival depends on the survival of the host. (All kinds of metaphoric readings into this situation are possible, regarding cancer being a 'modern' disease symptomatic of 'modern' life, for example the focus on individualistic pursuit versus consideration of society as a whole).

An interplay of wayward genes ensues, in which the expression of growth-regulatory genes (cell-division acceleration pedal) is stuck to the floor, and the expression of the growth-normalising genes (the brake pedal) is defective (as described in Weinberg's *One Renegade Cell*, 1998).⁵²

Thus science looks for one cell.⁵³ New Age theories look for one master overseer – your mind! I will address the difference between the 'scientific' and 'pseudo-scientific' viewpoints later.

Returning to the meaning of the word dis-ease, it refers to a state of disharmony, and defines illness holistically, as do the Japanese, Chinese and other Eastern systems of understanding and defining the ill body. The word dis-ease implies that it is the body that is in crisis, the body that is ill, the entire body system, both physical, mental/psychic/emotional and metaphysical, that is not in harmony. The obvious implication is that the key lies in trying to restore balance and harmony. The question is how we attempt do this.

Stacey asserts that the mind-body models of the self-health cancer industry which understand 'the body as a text of the psyche' are infiltrating the 'biomedical "mechanical" view of the body (1997: 26). She attributes

this to the 'scientific' discovery of the immune system and its pervasive effect on 'popular perceptions' of the body and its health (1997: 163) Thus one theme that runs through all disciplines is the immune system. After a long silence on the effects of immune boosting 'science' is now developing immuno-therapies to be given in conjunction with chemotherapy. A drug therapy that has been available for a while as an adjunct to chemotherapy is interferon, which works with the immune system but has unpleasant side effects. It is therefore not freely prescribed.

2.2.2.f The Immune System

Lymphoma is a cancer involving the immune system – in my case the B-lymphocytes.⁵⁴ This has led me to explore the nature of the link between lymphoma and the immune system, to ask whether looking after your immune system helps your body arrest the lymphoma. The immune system breaking down due to various factors such as bad diet, is still a puzzle to me, as some people eat so badly and seem never to get ill. Perhaps the effects are simply delayed. A key question is whether one can rid the body of renegade cells by building up the immune system, i.e. whether a stronger immune system is more capable of killing cancer cells than a challenged one.

According to a friend with HIV the way to prevent the lymphoma worsening was by boosting the immune system with vitamins and natural foods. According to a macrobiotic healer, crucial to the healing potential of the macrobiotic diet is the boosting of the immune system with all the right nutrients.⁵⁵ This means not to ask your body to deal with processed foods and at the same time to provide a balanced diet, i.e. balancing all the systems, the organs and the blood pH, with the correct ratios of grains, sea vegetables, beans, soya and the like, as related to the five elements (not to the RDA food groups). According to oncologists, whose opinions I desperately sought in 1997, there was no interaction with regard to the question of the immune system and they were not prepared to engage on the topic. The one oncologist who did engage stated that he had seen cancer cells growing in vitamins in the laboratory, referring to vitamin supplementation as an as yet undefined area.

In the past few years it has come to light that scientific research has been done on the links between cancer and the immune system. For example, there are very well proven and well-defined chemical pathways that link stress to immune system damage that can lead to cancer. Benefits of immune system boosting by various means, or simply taking basic care of one's immune system, may allow the development of stronger organs less susceptible to infections and more able to withstand and recover from the effects of chemotherapy.⁵⁶

Discussing 'miraculous recoveries' Siegel writes:

The more we learn from stories like these about the mind and body as a unity, the more difficult it becomes to consider them separately. What's in your mind is often quite literally or 'anatomically,' what is in your body: Peptide messenger molecules manufactured by the brain and the immune system are the link. There are approximately sixty known peptide molecules in the body, some with names that may be familiar to you, like endorphins, interleukins and interferon. They make feelings chemical and effect the link between psyche and soma. "Endorphins, for example, are now thought to account for the placebo effect. ... explained physiologically by the fact that the positive psychological expectations aroused by administration of the placebo lead to an increased production of endorphins, which are painkillers. So the pain relief really is 'in the mind' – because that's where the endorphins are. (Siegel 1989: 20)

For Siegel, then, the will – or the will to live – can access the source of the mind's healing system. The placebo is the link between the will and the body. ⁵⁷

As I write this document, an article is published in *The Sunday Independent* (April 7 2002: 4) headed 'That healing feeling is real' (See App III: 22). The report refers to the biblical gospel, which states: 'They shall lay hands on the sick, and they shall recover.' It goes on to say that 'scientific evidence is now showing that the effect is not due to 'divine intervention' but rather a 'natural chemical called immunoglobulin A, which serves as a first line of defense against invading micro-organisms and disease. The research discovered that the act of laying hands on flesh can trigger the release of those chemicals to fight disease.' American faith healers and many religious practices across cultures have claimed therapeutic touch (TT). Now, according to the article, 'There are about 10 000 people outside the churches who claim to possess TT. They heal by a number of methods, from "holding the space" in which the patients heal themselves to stimulating the body's energy channels.'

This underlines Stacey's assertion that 'immune system discourse' is now 'central to cancer patients' understandings of their illness, whether they use conventional or alternative methods, or a combination of both' (1997: 163) and is an awareness I was introduced to early in my cancer experience (See App III: 30–32).

2.2.3 Alternative and New Age Theories and Medicine

2.2.3.a Introduction to the Multiple Discourses

A whole range of alternative treatments and cures and simple solutions bombard a person with cancer. Some of these are the more established disciplines, known as complementary therapies, of homeopathy and naturopathy with their range of pills, powders, vitamins and potions. Volumes have been written on the subject of alternative cancer therapies, the proliferation and investigation of which could exhaust the cancer patient. These systems accept the diagnoses of Western medicine although they differ from the institutionalised mind-body split of Western culture. They differ in their explanation of the causes, in the resulting treatments and in the experience of disease and discourse that they offer to the patient or client.

With the myriad therapies being practiced today I have had some experience (varying) of the following and have investigated (some thoroughly and others less so): naturopathy (including essiac, mistletoe, vitamin therapy, visualisations), homeopathy, Chinese medicine (including herbs, acupuncture, tai chi), colour therapy (food, visualisations), kinesiology, reflexology (recently combined with Chinese meridian-systems), massage therapy (shiatsu, deep-tissue massage, aromatherapy), reiki, feng shui, psychotherapy, energy medicine and medical intuitives, nutritional therapies (macrobiotics, Hoxsey diet, juicing, candida diet, vitamin therapies), yoga, meditation, parasite treatment, iridology, a 'white sangoma' and 'transformation' workshops. Of these, I have selected a few for discussion. (See App III: 33 – 86)

Ayurvedic medicine, cranio sacral massage therapy, magneto therapy, polarity therapy, aural healing/sound therapies (chanting acting on a vibrational level, creating a chain reaction in the cells), meditation, and possibly Reiki, are therapies I still wish to experiment with. Also on my list is a visit to a medical intuitive.

Therapies others swear by, which I have rejected, include drinking urine, grape cure, cleansing fasts, colonic enemas, raw foods diet, oxygen therapy, faith healing and hypnotherapy. (See App III: 80–83)

2.2.3.b Complementary Medicine

When I was first diagnosed in 1993, a friend recommended a doctor of Chinese medicine who had helped her with a chronic illness. I asked my oncologist what he thought of me going to see a Chinese medical doctor for acupuncture and herbs. His response was, 'as long as it doesn't bankrupt you...'

For the duration of the chemotherapy I followed a very rigid macrobiotic diet (definitely health giving but problematic in its own way). My oncologist was trying to be encouraging about the chemo. She said you can eat what you like – ice cream, chips, chocolate – and you probably won't put on weight. I was horrified at the contrast between two systems that were both trying to heal. The one completely banning dairy and sugar, the other encouraging it as something that would give pleasure and in this way aid healing.

Another example: a friend who had leukemia was undergoing a bone marrow transplant procedure by a renowned haematologist in Cape Town. Her family wanted to put her on a macrobiotic diet while she was in his care. He refused, saying he did not know how it would conflict with the drug therapy. This is pure ignorance and shows a lack of communication between modalities, and an utter dismissal of the connection between healing and nutrition.

In this way the conflicts between modalities become apparent and confusing for the patient who is trying to juggle and balance.

The changing theories reflected in some of these disciplines and in all New Age discourses are: Personality (see LeShahn 1994) ('characterological predisposition' is Sontag's term); stored traumatic cell-memory (individual trauma stored in cells); collective memory – bad DNA passed on through inherited ancestral deviations from nature, affecting present generations; Environmental pollutants (the accumulated effect of carcinogens in food and environment) combined with individual vulnerability.⁵⁸

It is interesting to note changing cultural beliefs in the above list. New Age systems, theories and beliefs about disease in the twentieth and twenty-first centuries have followed the changing orthodox medical understandings. New Agers claim that medicine is only catching up to them now (i.e. medicine will establish 'scientific proof' for ancient wisdoms). A brochure for Polarity therapy makes the following claim: 'Energy is the foundation of all life. Modern scientific research is just beginning to document this simple truth which has been the basis of Eastern medical traditions for thousands of years.' Another example is the Hindu philosophy of the third eye and how medicine is now linking the functioning of the pineal gland to these ancient beliefs about the 'powers' of the third eye. Once cancer scientists got down to discussing the behaviour of the cancer cell, New Age talk was about cellular memory. Cell memory could also be another way of saying the lowering of immuno-defences by previous illness or emotional trauma. Ironically, whereas the New Age therapies are viewed as 'esoteric', the previously quoted brochure claims that Polarity therapy is 'bringing the study of energy out of the esoteric realm of quantum physics and nuclear particle acceleration into, quite literally, the palms of our hands.'⁵⁹

Stacey investigates how cancer is perceived, experienced and theorised in contemporary society. She explores changing beliefs about the causes of, and the cures for, this disease in both biomedicine and its increasingly popular alternative counterparts. 'Stories of cancer are full of monsters and marvels: the monstrousness of the disease and the treatments, the marvels of the cures and the saved lives. Still one of the most dreaded diseases to haunt our imaginations, cancer is more than an illness – it is a cultural phenomenon. People who have cancer are bombarded with competing explanations of their conditions: It is genetically inherited; it is environmentally produced; it is the result of their personality' (1997: back cover).

A Senior Lecturer in Women's Studies and Cultural Studies in the Department of Sociology at Lancaster University, Stacey has written a cultural study of cancer, which has thoroughly covered and theorised all aspects of hers and the general experience. 'She brings accounts of her illness under the critical lens of academic scrutiny and situates these personal theories within a discussion of contemporary cultural change' (introduction to *Teratologies* 1997: i).

Stacey defines the patient's experience as a struggle with truth, meaning and identity and cultural definitions of disease. In *Teratologies*, in describing the aims of the book, she writes that it:

explores some of the ways in which a person with cancer is subject to, if not bombarded with, powerful and contradictory discourses about the nature of their illness. Confusion and panic are the likely responses to such a proliferation and range of theories of cancer and how to treat it. As well as coping with the trauma and discomfort/pain of the illness, the person with cancer confronts a host of beliefs and practices which compete to define the meaning of the illness: its prevalent metaphorical manifestations; the connections between body and psyche; constructions of the healthy and the diseased self; and questions of duty and responsibility. They all offer the promise of different solutions. Some threaten recurrence if theirs is not chosen. Part of the experience of cancer in today's culture is suddenly confronting this excess of opinion about the meaning of the disease and the logic of the cure. (Stacey 1997: 28)

Thus Stacey examines the quandary of the cancer patient and goes on to describe the heroic manner in which the patient is supposed to respond to being given the responsibility for his or her own cure.

The patient is confronted with the fact that even the doctors don't know how to explain the cancer or its causes, nor do they know what to do with it (so how are you, as the patient, supposed to know?). Stacey describes how the 'different knowledges wrestle for power' (1997: 30). The patient too has to wrestle for power, knowledge and understanding. Like Stacey, I have realised that as a patient it is very difficult to arrive at a settled position. The medical discourse itself is full of internal competing explanations and treatments. Additionally, one is viewing illness from so many competing discourses, and despite the alternative range, none of them completely remove the discomfort of the medical discourse.

Caught up with all these 'excesses', it has taken me three years to tease them out, untangle them and include them in artwork.

In Stacey's words:

The path through the maze of information, mythology and fantasy varies according to a multitude of factors. Mine was that of an academic: highly sceptical, obsessively self-reflective and with a sense of entitlement that feminism had added to what my class and ethnicity (middle class and White) had promised. My experience of the illness was continually inflected by the interplay of intellectual, emotional and political identifications and allegiances. At times I felt completely dependent upon medical science to save my life, while noticing (and cringing at) the heroic status I was tempted to bestow upon it. At other times I was fully engaged in alternative therapies, diets, spiritual healing, meditation and acupuncture, accompanied by a critical analysis of their appeal. As I swallowed my vitamins every three hours, I reflected upon the profits of these renewed self-health industries (and resented my own burgeoning overdraft). As I meditated twice a day, visualising myself cured (or even 'healed'), I wondered about the emergent pervasiveness and persuasiveness of the 'healthy mind, healthy body' philosophy which surrounded me. (Stacey, 1997: 28–29)

I identify strongly with Stacey's description of her illness. I wonder myself about these same issues and this latter philosophy and find myself continually scrutinising the self-help literature in books, magazines and pamphlets, and attending 'self-help' workshops.

Cancer is seen as such a multifactorial disease on so many levels that it invites a demand for multifactorial answers to the extent that millions of them come pouring in from everywhere. As Susan Sontag noted in her classic response to breast cancer, the more the understanding of the nature and cause of the disease increases, the less speculation there can be as to the causes, origins and remedies. Sontag talks of the general agreement that cancer is 'multi-determined'. She disputes this thinking and says: 'The resemblance of current ideas about cancer's myriad causes to long-held but now discredited views about TB suggests the possibility that cancer may be one disease after all and that it may turn out, as TB did, to have a principal causal agent and be controllable by one program of treatment' (Sontag 1979: 60). She clarifies her argument: 'The notion that a disease can be explained only by a variety of causes is precisely characteristic of thinking about diseases whose causation is not understood. And it is diseases thought to be multi-determined (that is, mysterious) that have the widest possibilities as metaphors for what is felt to be socially or morally wrong' (1979: 61). This echoes what Stacey has written, two decades later (see above).

New Age thinking is offering more assured answers with less doubt than the medical profession, perhaps also because as the disease becomes more prevalent there is a need for people to feel comforted by a sense of control to either prevent or cure. (New Age thinking around illness is, however, peppered with metaphors.)

'New Ageism' has erupted at a time when our contemporary urban lives appear so fractured that people are wishing for a return to the idea of unity, to a time before the Renaissance when everything was one with the cosmos; the physical, the spiritual, the earth and the body were united under the governing forces of the cosmos. An interesting question is whether 'New Ageism' is a new theology returning to a time when the categories of description of the body were 'bounded by theology and cosmology – the polarities of ritual', when 'the possibility of thinking about the body as a discrete entity' was not admitted (Sawday 1995: 16). The difficulty now is to marry the two ways of seeing and understanding body-behavior.

The New Age terminology for self-actualisation is 'to find your soul purpose'. The popular body-mind transformation workshops aim at freeing the mind from the body and freeing the mind from its traumas so that the body can stop reacting to and reflecting the 'unhealthy' mind. This view is almost a reinforcement of the mechanical model in that these approaches 'simply reverse the hierarchy, positing the mind as controller of the body.' (Stacey 1997: 134) Mastery of the body is achieved through mastery of the mind/soul and there is thus a new duality where the mind and body have a direct relationship. This is beginning to shift the statement that: 'In the twentieth century it is virtually impossible to think about the body outside a prevailing medical-scientific discourse' (Sawday 1995: 16). Perhaps now that we are at the beginning of the twenty-first century, and at the end of the culture of dissection (Sawday 1995: 270), we are at the edge of a cusp, before the merging of the two seemingly polar opposite world views. There is no neat relationship between Western dualism and Eastern monism (which posits no body-mind hierarchy), and if there is to be such a merger it will be a 'messy' one.⁶⁰ Sawday points out that in the West, prior to the late sixteenth and seventeenth centuries, the interior of the body was impossible to understand without 'recourse to an analysis of that which gave its materiality significance – the essence contained within the body. A belief in the presence of that essence, a belief, that is, in the existence of an anima, a soul or a thinking entity, necessarily informed any possible perspective of the body. To consider the body in isolation was not merely difficult but, strictly speaking, impossible, since the body's primary function, it was held, was to act as a vessel of containment for the more significant feature of the soul' (1995: 16).

This relationship was not, however, unproblematic and without conflict. Sawday adds that, depending on your point of view, the body was 'either the unwilling host to a nagging and parasitical arbiter of right and wrong, or it was the close prison which perpetually sought to constrain the expansionary desire of the soul. ... The body's

gross physicality could ensure the endless enslavement of the soul to corporeal existence, defined in the soul's terms, as punishment. Equally, however, the soul's desire to escape the terrestrial existence of the body involved the destruction of its temporary and temporal residence' (Sawday 1995: 16).

And further: 'Beguiled by the body, the impure soul is "weighed down and dragged back into the visible world" so that at death, rather than fleeing towards God, it is imprisoned once more in a body' (1997: 17).

This sounds very much like the rationale adopted from Buddhism by many 'New Agers' today, who believe that one needs to return to a body after death if you haven't completed what you were supposed to learn in this life. Once your learning is complete you do not have to come back again, you are freed from imprisonment in a body. The lessons you are sent via traumas and illnesses are all to do with realising your 'soul-purpose'. I have even read accounts where a person has achieved their soul-purpose in mid-life and then in the same physical form goes on to incarnate into a new soul. So your soul is imprisoned in your body for as long as it takes you to achieve your 'soul-purpose'.

An interesting connection can be made with the medieval European phenomena mentioned earlier. Carolyn Walker Bynum describes how women used to pray to god to send them the gift of suffering in the form of a disease or an illness: 'Dauphine of Puimichel commented that if people knew how useful diseases were to the spirit, they would purchase them in the marketplace' (in *Zone* 1989: 166). Some contemporary accounts of patient testimonies of healings make the same point, and they thank God for their cancer. Sometimes, in Medieval Europe, 'the gift' was considered a prelude to sanctity. A similarity is the shaman or sangoma who is called through illness, which is not quite sainthood but is perceived as a calling from above.

2.2.3.c My Narrative (An Object Object Am I)

Two years after diagnosis I could no longer ignore the thus far invisible growths now protruding from the familiar landscape of my skin. They began pushing outside of the boundaries of their previous confinement, creating new little outcrops on the familiar contours of my body. In addition, the disruption of the normal functioning of the lymph system caused a mountainous arterial swelling on my chest threatening death by thrombosis. I was forced to acknowledge the unknown and unseen monster that had been growing inside me for the past two years, perhaps longer. The need to reduce the multiple swellings led inevitably to chemotherapy and an attempt at remission. The body I had lived in for 35 years demanded attention. The purgatory of chemotherapy introduced me to my interior and its fluids, propelling me towards a new experience of this body I thought I knew so well.⁶¹

The other new experience, which had been simmering for two years, but which became more apparent to me when the effects of the chemotherapy became visible, was seeing the fear created in other people by my diagnosis; this apart from the suppressed fear of another kind in myself. It is the fear of death.

I was forced to help others with their fear, which I felt was mostly caused by the unknown and the un-askable questions in their eyes – 'are you going to die?' and 'how long do you have left?' and 'do you need treatment?' These are all horrifying and layered questions. All these issues provoked the need in me to make visible and share the hidden questions demanding further interrogation, of which neither those others nor myself had any experience or the expertise to answer.⁶²

I wondered who did.

In addition, the chemotherapy had an effect on my work. Chemotherapy depletes one's physical strength and stamina; it limits the physical possibilities of art making. I changed my mode of production and field of practice. I embarked upon the route of documenting, recording, collecting and gathering imagery and information around the cancer experience. I made small-scale work and many notes for later exploration in art practice.

Cancer is not a polite disease – it does not knock before it enters, it does not ask permission to take a seat, and neither does it leave when asked. It never says please or thank you, nor does it hide away its unacceptable secretions and raw skin in a polite place or with a nice plaster. Yet the statistic most commonly heard is that one in four people will get cancer and it is still the most dreaded disease in the Western world, apart from AIDS. Could this perhaps be because it is waiting to knock at so many doors but we disguise or cushion the anticipation of the knock with the 'it will never happen to me' belief?

Few in the world of the well want to be part of the mess in the life of the person with cancer. When they ask how you are, they do not want to hear the details. 'I am fine, thank you' is the right answer.

2.2.3.d But the Mess!

The notion that cancer is a random, spontaneous degeneration of the body's tissues, a random capricious act of nature is challenged, as previously mentioned, by epidemiologists having shown that those external factors affecting the body – lifestyle, diet, the environment – play an enormous role in determining the onset of the disease. Experiments have shown directly that cancers can be provoked at will in the laboratory by specific chemical cancer-causing agents or carcinogens. This means instead of being a random act, it can be actively induced. Thus cancer is not the invader, but the carcinogenic agent is. However, one experiences it as a random act, as coming from inside, as the self in rebellion, as the body in rebellion against the self, as stated in the extracts from Stacey above and below:

'... what is abject ... the jettisoned object, is radically excluded and draws me into a place where meaning collapses' (Kristeva, 1982: 2, quoted in Stacey, 1997: 79).

'Cancer and pregnancy have both been described as abject conditions by Kristeva (Kristeva, 1980:11). As such they are both 'borderline states in which there is confusion and lack of distinction between subject and object' (Grosz, 1992:198). ... Normal and deviant divide their purpose, but cell division unites their mode of expansion.' (Stacey, 1997: 89).

'Cancer is dreaded as a disease of undifferentiated cells endlessly reproducing themselves, robbing the body of its internal recognition of subjects and objects. It is seen as a disease in which tumours threaten to break through the borders of the body and set its functions in reverse. Chemotherapy strips the body of its adult coverings and removes any sense of control over entry to, and exit from, its interior; the dread of the lack of differentiation; the return to the maternal state where mergence of self and other threatens existence itself' (Stacey, 1997: 95).

Borders maintain order; without them things merge. The diagnosis alone, prior to the treatment, had this effect on me: the removal of the sense of control, the interior physical messiness, the psychological and emotional messiness, not being able to distinguish 'self' from 'non self'; and it made itself manifest externally as a messiness and disorganisation in my immediate environment. Uncertainty became a theme of my life – pushed and pulled, unable to make decisions, unable myself neither to stay within borders nor to maintain 'things' within borders. I was 'all over the place' as people have told me. I became untidy. Unable to throw things away, unable to organise material things, I built up a collection of clutter and seeming confusion.

(Although the crisis is in remission for a while, I still tend toward untidiness.) This demonstrates, too, my assimilation of metaphorical thinking. As Varmus and Weinberg (1993: 25) describe it: 'the unifying aspect of all cancer is uncontrolled growth – the appearance of disorganised tissues that expand without limit' (quoted in Stacey, 1997: 141).

What a relief, that finally I am able to organise this clutter in this body of work – to do a postmortem on the bandages I was unable to throw away. (Out of the clutter, what has risen to the surface has been dealt with, but there is more...)

2.2.3.e The Loneliness

Stacey describes 'the denial, avoidance, and displacement of the C word' as withholding 'the kind of external confirmation which takes place routinely around other cultural categories.' This is one of the integral elements of everyday life that 'only become visible by means of their absence. Part of the feeling that we belong to a culture occurs in the moments when such recognitions bestow a legitimate sense of place on us. When no such place appears on the horizon, even as a distant promise, its absence marks the subject as other, as outsider, as alone. This surfaces here through the repeated negotiations of the responses of others.' She adds, 'and through their shocked reaction your own sense of discrepancy between who-you-thought-you-were and who-you-must-be-now is repeatedly rehearsed' (Stacey 1997: 69–70). So the loneliness is internal and external, as you are isolated from the self you thought you were and from others who isolate you with their silence.

Despite the late twentieth-century 'therapy' culture in the Western world, in which much is made of talking openly about illness or disease, people still find it difficult (and some impossible) to discuss cancer or to engage anyone diagnosed with cancer in uninhibited, unfeared and open exchange. The spectre of cancer pervades our culture and yet once diagnosed with it, you are confronted by a silence or avoidance that implies you have 'entered stigmatised territory' (Stacey 1997: 70).

The loneliness referred to is connected to the shame, and shame is not something you can share. You do not feel that others want to hear of your 'messy' emotions and experiences, or the details of your survival plan – it is almost a fear of contaminating them with your unwanted 'stuff', your abject self.⁶³

As stated by Stacey and Spence, the usual cancer narrative does not account for the lived experience of the disease, the struggle to stay alive. This is an additional element that needs to be countered by those with a voice. I hope to add my challenge to the usual cancer narratives as described accurately by Stacey in *Teratologies* (1997) and by Spence in the posthumous publication of her writings and photographs. Spence was eventually 'cured' of her breast cancer only to have it return, 10 years later in 1990 along with leukaemia, of which she was to die in 1992.

A person with disease is living in a state of limbo between the two polarities of life and death and is therefore in a state of dying. Being in this state means simultaneously to be and contain the 'other'. In referring to this idea visually I rely on the macabre image of the skeleton, the signifier of death, confronting the living being the vanity of the human condition, and explored with humour and irony by Holbein in the fifteenth and sixteenth centuries.⁶⁴

2.2.3.f The Threat of Death

'Am I going to die, doctor?'

'We all have to die sometime.'

Stacey, overhearing this conversation between a doctor and a patient undergoing chemotherapy, was 'struck by the incongruity between the personal terror of death on the one hand, and the professional reduction of mortality to an inevitable mundanity on the other.' This seemed typical to her of 'the ways in which biomedicine responds to death so inadequately and yet, surely, so frequently. Within a system that seeks to control life, death can only be recorded as a failure, and as such must be minimised in terms of its significance.' She points out that some people respond to this cavalier treatment by seeking out alternative health practices, where they find 'solace' in the expectation of patients to have 'powerful emotional responses to death.' But, says Stacey, 'even here, I found much evidence of a flight from mortality in the models of self-healing that promised the individual total control of their medical destiny. If the mind can control the body, then we may indulge in fantasies of invincibility and immortality' (Stacey 1997: 27–28).

This poses questions of whether this 'flight from mortality' is an avoidance of looking at death, and whether these models of self-healing are pseudo-scientific. This leads us back to the question posed earlier, of whether 'New Age' therapies have become a new kind of religion or religious belief system.⁶⁵

Stacey quotes Kristeva in proposing that it is not the denial of death that is the major cause of the stigmatisation and fear of an illness like cancer, but the incorporation of death into life which Kristeva elaborates on in her theory of abjection:

'Perhaps fear of death is at the root of these cultural anxieties. But it is more than a desire to deny mortality that fuels these fears, although that is also there. Rather, abjection is "immoral, sinister, scheming and shady: a terror that disassembles, a hatred that smiles, a passion that uses the body for barter instead of inflaming it, a debtor who sells you up, a friend who stabs you" (Kristeva, 1982:4). Indeed, for Kristeva the utmost abjection is not to be found in death itself, but in "*death infecting life*" (Kristeva, 1982:4; my emphasis).' (In Stacey 1997: 79)

The paradox of cancer is that it is about cell growth. Just as life begins with cells multiplying at conception, cancer signals the possibility of life ending with cells multiplying. 'By exaggerating the reproduction of life, cancer introduces the threat of death. Too much life; too many cells; the work of a deadly enthusiast. ... Cancer thus not only promises death but it promises death by the means of life, death by reproduction. Cancer is "death infecting life" by the means of life itself. ... The source of life that destroys, cancer echoes the horrors of abjection' (Stacey 1997: 79–80).

When diagnosed with cancer, one finds oneself on rapidly shifting ground. All of the possibilities and impossibilities contained in being merge in unanswered questions, unspeakable fears, undared hopes; betrayal of oneself by oneself, what seemed known and familiar revealing itself as unknown and treacherous. The foundations of all that has been perceived as 'known' and 'safe' are rocked by the realisation that one's own body has failed to recognise the 'enemy within'; the experience and sensations of one's own physicality cannot be trusted.

'If only the body could be relied upon to recognise the difference between self and other, then deviant cell replication might be nipped in the bud. The failure to identify the malignant cell as a threat puts the body at risk from an internal outsider. But how did this masquerading traitor gain acceptance? Like the kiss of Judas, its generosity masks a desire to destroy its keeper' (Stacey 1997: 80). And in the words of Kristeva, 'abjection is elaborated through a failure to recognise its kin; nothing is familiar, not even a shadow of a memory' (quoted in Stacey 1997: 80). Stacey goes on to say that cancer is a disease of 'misrecognition of legitimate familial members. The dread of betrayal is finally confirmed. Loyalties can no longer be relied upon' (Stacey 1997: 80).⁶⁶

Paradox comes into focus again. As Stacey further identifies and clarifies the confusion: biomedical cancer treatments have to destroy to heal; pollute to cleanse. Radiotherapy destroys cells in order to heal others and chemotherapy pumps the body full of toxins in order to render it non-toxic. And one's own body is the traitorous vehicle for these therapies to carry out their work. 'The veins offer convenient transport for the "alien" fluids. ... All fast growing cells must die, benign and malignant, regardless of origin, regardless of purpose. The only hope is to wipe out the lot. The faster growing the tumour, the greater its vulnerability to such attack. The quicker it can kill you, the more likely you are to outlive it. The cocktail of chemicals, as they call it, is especially effective; ⁶⁷ ... But they have trouble spotting the enemy; all rapid cell growth is a potential threat, hair or tumour, skin or tumour, stomach lining or tumour.' The 'unknown' has manifested with a most ironic twist: 'Neither the body's defenses nor the medical cure can recognise the disease for what it is' (Stacey, 1997: 81).

Stacey contends that it is not death itself that 'truly disgusts', but 'that which must be eradicated in order to live'. She quotes Kristeva:

A wound with blood and pus, or the sickly, acrid smell of sweat, of decay, does not signify death. In the presence of signified death – a flat encephalograph, for instance – I would understand, react or accept. No, as in true theatre, without makeup or masks, refuse and corpses show me what I permanently thrust aside in order to live. These bodily fluids, this defilement, this shit are what life withstands, hardly and with difficulty on the part of death. There I am at the border of my condition as a living being My body extricates itself, as being alive, from that border. (Kristeva 1982: 3, quoted in Stacey 1997: 82)

In my experience people are deeply afraid of cancer and when you have cancer they are afraid of you because you are walking with death in you. Kristeva may call this abject but it has essentially been a part of me for the past nine years. My work is about befriending this abjection, making it part of myself and not waging a war on it in the sense of the cancer orthodoxy's terminology, 'war on cancer'. As Betterton says of the abject: 'While the vulnerability of the borderline is a threat to the integrity of the "own and clean self" (Kristeva 1982: 53), it can also offer 'a liminal space where self and other may intermingle' (1996: 143).

2.2.3.g Cancer is not a Polite Disease

I do not feel my work can be polite if it is going to be truthful. One ingests and expels all sorts of gruesome matter in the course of healing, one watches one's hair floating in the bath, sticking to the pillow, revealing a rudely bald head with stray hairs sticking out nonsensically. It is very impolite to sit at a dinner table with your rude hairs sticking out while complaining of nausea, or reject someone's dinner invitation or home-cooked meal because the food may contain carcinogens or ingredients that your macrobiotic practitioner and acupuncturist advise against. One either has to stay polite, bring your own meal, wear a hat or tuck that balding head away under a covering of someone else's hair (i.e. a wig) – or stay away.

The matters of the body, the tonics, the cures, the insides of the body in all their abjection, are what I wish to reveal. It does not all appear ugly or make one's stomach heave – some of it is very beautiful and incredibly awe-inspiring.

The cells of the body under a high-power microscope, the sewage pipe that is your intestine, the bloodless dissections of the CAT scanner, are all totally intriguing, and no matter what bad news they reveal, they are yours. They are views of Yourself you have never previously seen and it is a privilege to be able to look into your interior.

Not every cancer patient wishes to be part of this viewing. For myself it was a way of unraveling the mysterious goings on inside myself and became part of my research project. The fact that I could say I am at an academic institution doing research was a way of gaining credibility and entry into this world of protected knowledge. I am very excited about what I have seen and wish to share it.

The work of Spence, Stacey and others is an attempt to create representations and values other than Hollywood-type genres and beyond standard media-presentations of heroes and heroines, victims, bravery, sobbing spouses, a beautiful Meryl Streep wearing a turban on her head while slowly dissolving out of view until you see the funeral and understand that she has succumbed to her cancer and is dead. What does it mean when the media says one has died of their cancer? Did the tumour eat you up? Did the crab's legs poke holes in your systems? Did your organs fail as a result of a weakened immune system? Did your blood stop flowing? Did your heart stop beating? How did you fade away? (It is a relief to note that the journalistic euphemism, 'he/she passed away after a long illness' has recently been replaced with '...died after a long battle with cancer.')

2.2.3.h Biomedicine and Alternatives to the Medical Discourse

In this section I discuss how other selected discourses define and present the ill body, and how it is diagnosed and treated.

2.2.3.i Eastern Understandings

It has been the inadequate response of Western or allopathic medicine to the rash of seemingly new diseases and the failure of the Western promise to explain or cure everything through the scientific method based on the philosophies of seventeenth-century science and rationality that has encouraged sufferers and healers to turn elsewhere for answers and cures. Thus older and more ancient Eastern systems (such as Chinese, Japanese and Ayurvedic medicine) have gained prominence in the West, as advances in the treatment of cancer, specifically, are not being made, despite the apparent breakthroughs by the cancer industry, which are constantly lauded in the media, and despite the identification of the human genome and DNA sequencing (the real effects of the latter will take years to be realised). (See App III: 24–29)

These other discourses, which are seen as competing with that of Western medicine, are gaining ground but are not yet on an equal footing. Only those that have been sanctioned by Western medicine as 'scientific' are seen as having a valid place, for example osteopathy. Because certain models have dominance over others, other models are not accessed unless they are actively sought out and can be financially afforded by the individual. Often these modalities 'compliment' allopathic treatment. At other times, these modalities seem to offer 'better' or more easily accessible explanations and kinder treatments for diseases failed by Western medicine. They in turn have had to adapt to find treatments, explanations, rationales, diagnoses and therapies for these new diseases and this new patient base. The representation of the whole bodily system and the way in which the body is examined is slightly different in each modality, although they are beginning to cross over and the principles are basically the same. (Some ideas, such as those espoused by Louise Hay, do not derive from any founding principles.)⁶⁸

2.2.3.j Chinese and Japanese Medicine

These systems differ drastically from the mechanistic approach of Western medicine and are based on another whole set of principles and philosophies that are seen as equally rigorous and valid. Health and sickness are explained according to the body's harmonies and disharmonies, the principles of yin and yang and the five elements (water, fire, wood, metal and earth). These ideas in turn are based on the tenets of Taoism (pronounced daoism) which is based on an observation of the natural world and the belief that our bodies operate

universe, with each organ relating to one of the five elements. These systems are closer to Galen's theories of humours, which at one time formed the basis of Western medical beliefs accompanied by a whole host of treatments such as leeching. As Morris comments: 'In the sixteenth-century the body was widely perceived as a "microcosmic representation of the cosmos" speaking of metaphysical truths. This was before the proliferation of elaborate anatomical drawings.' (Morgan and Morris 1995: 104)⁶⁹

Chinese and Japanese medicine build up an understanding of the body's difficulties by elaborating on ideas of excess and deficient *qi* (Chinese) or *ki* (Japanese), which is loosely translated in the West as energy or life-force patterns. Ill health and disease are seen to result from the whole energy system being in disharmony in various ways due to various influences that have disturbed the balance. Disharmony may be a result of multiple causes – internal (anger, joy, sadness, grief, pensiveness, fear, fright, being out of balance), external (cold, damp, wind and heat), miscellaneous causes (pre-heaven inheritance, constitution, lifestyle, activity or work, exercise, diet, sexual activity, unforeseen events). Through herbs (in pill form or as cooked concoctions of dried herbs that seem like 'magic' potions), acupuncture, moxabustion (heating by gentle burning), cupping, acupressure (acupuncture without needles, acting on the same pressure points), meditation, Qigong, Tai Chi, diet and feng shui, among others, the system or the process rather than the structure is treated. The *qi* is restored. Diagnosis is made by scanning and analysing the bodily systems without technology, by examining the tongue (colour, coatings), the pulse, the face (shape, colour), the skin (dry, red), the eyes, the emotions, the organs. This is a very complex system and further explanation is beyond the scope of this paper.⁷⁰

Interesting indicators are:

The Japanese word for disease is *byoki*, meaning *ki* in distress – close in meaning to 'dis-ease';

The Chinese word for disease is *ping*. In this system of meaning all illness is seen as disease or 'ping', whether it is a minor physical problem such as a gastric disturbance or an emotional disturbance such as worrying, and it incorporates all acute and chronic conditions such as cancer. There is only one word for all these conditions.

2.2.3.k Macrobiotics: You are What you Eat

Macrobiotics (meaning 'large life') treats the system with a very rigid dietary regime derived from Japanese patterns of eating and based on the above principles and the five elements of water, fire, wood, metal and earth. Macrobiotic 'prescriptions' differ slightly from the dietary recommendations of Chinese medicine, and Oshawa (the founder of macrobiotics) inverted yin and yang. An attempt is made through diet and lifestyle to restore the whole system to health, to bring us into balance with our surroundings and our planet and consequently with(in) ourselves.⁷¹

The basic foods of the macrobiotic diet are unprocessed, unrefined, closest to their original form, and no dairy or sugar is allowed. Major ingredients are whole grains, beans, seeds, nuts, seaweed, soya products (tofu, tamari, soya sauce) and vegetables. An important aspect to assimilating the food is chewing – 50 chews per mouthful is recommended.⁷²

2.2.3.l Vitamin Therapies

'Food is the best medicine, but we don't live in the Garden of Eden', so the saying goes. The list of vitamin supplements available is endless. Like Stacey, I found myself swallowing copious amounts of vitamins. During the chemotherapy I believe this was a very good idea, as your bodily reserves are very definitely depleted.⁷³ This is still, however, a fairly new field and the value of supplementation is open to much speculation. Those who suggest supplementation also urge a raw food and juice diet. One can find oneself spending all day

This is still, however, a fairly new field and the value of supplementation is open to much speculation. Those who suggest supplementation also urge a raw food and juice diet. One can find oneself spending all day between the organic vegetable supplier, the juicer and the vitamin shelf. By the time one has ingested these ingredients there is no place left for another morsel of food. The latest 'vitamin guru' is Patrick Holford, who has recently completed a promotional tour of South Africa. He markets his own line of vitamins and books. He is a slick salesman who talks in vague and inaccurate terms about medical conditions and the biomedical solutions. This is not to dispute the value of the information (or quality of the products) he does supply, but he is a reminder that one should always maintain a healthy degree of scepticism with regard to information. One also has to be careful when buying vitamin supplements. Some makes are artificial and may even be more harmful than a lack of vitamins in the diet.

2.2.3.m Yoga (Unity)

Yoga is an ancient Indian way of working with the body to maintain harmony of body and mind and promote efficient organ functioning. There are various styles of yoga that have all emanated from India, placing different emphases on the practice of the asanas, or postures. There are active, strengthening and restorative postures. Some styles incorporate chanting and meditation, others believe the postures are the meditation. In order to benefit from the effects of a sustained yoga practice, one should engage on a daily basis.

2.2.3.n New Age Theories (in the Age of Advice)

Some of the better-known practitioners of energetic healing, riding in the wake of disillusionment with Western medicine, have become household names and travel the world sharing their techniques with other healers and encouraging those with disease to take responsibility and be their own healers. As these discourses are gaining ground, the alternative cancer industry is developing with its own superstars and anecdotes of miraculous cures. The emphasis is on prevention of the onset of major diseases on the physical level. Clearing out the damage on an energetic level first does this, before it is too late and the damage sets in on the physical level. But then there are those who claim to be able to heal cellular damage by healing traumatic memories stored in cells.⁷⁴ As with the complementary therapies, the emphasis of 'New Age' theories is on restoring harmony to the whole system, but the responsibility is given to the patient alone, and sometimes to the partnership of patient and 'healer'. The 'cures' and healings are all so far anecdotal as opposed to those of evidence-based medicine.⁷⁵

2.2.3.o New Age Medicine: Energy Medicine and Medical Intuitives

Deepak Chopra

Deepak Chopra is a medical doctor trained in both Ayurvedic and Western disciplines. He has been Oprah Winfrey's favourite guest, along with Gary Zukav, who wrote *The Seat of the Soul* (1991) and more recently *The Heart of the Soul* (2001). Chopra's latest work ties in very nicely with the latest cultural obsession with endless youth. He has led the healthy mind, healthy body pursuit and teaches a form of practical spirituality. In an article reporting on a lecture given by Chopra in Johannesburg, Colleen-Joy Page writes:

Dr Chopra starts his lecture by calling to attention incredible, and yet largely unknown, facts about the physical world. He asserts that the mind is not local to the brain, but that the whole body is a mind, where every cell is a thinking cell, capable of communicating with all other cells faster than the speed of light, even spontaneously. Reminding us that there are 60 trillion cells in the body and that every cell does 6 trillion things per second. Being inspired by the ancient Sufi poet Rumi, Chopra begins to elegantly interweave fact with a glimpse of eternity. 'The real you cannot be squeezed into a body,' he says. He accuses the past world of having suffered from the 'superstition of materialism', and it is clear that he intends to challenge

outdated beliefs by opening modern thinking to new reality paradigms. (*Namasté* magazine Vol 12, July/August 2001: 43)

No wonder the Renaissance anatomists had trouble finding the soul!

Caroline Myss

Energetic adj. having or showing energy; vigorous. –,ener'getically adv.

Energize or –ise vb. 1. to have or cause to have energy; invigorate. 2. (tr.) to apply electric current or electromotive force to (a circuit, etc). –'ener,gizer or –iser n.

Energy n., pl. –gies. 1.intensity or vitality of action or expression; forcefulness. 2. capacity or tendency for intense activity; vigour. 3. Physics a. the capacity of a body or system to do work. b. a measure of this capacity, measured in joules (SI) units.

(*The Collins Paperback English Dictionary* 1986)

Caroline Myss is widely known for her work with the energetic body. She has a master's degree in theology and a background in journalism. She is a 'medical intuitive' who draws on what she describes as her 'perceptual abilities' to diagnose imbalance and disease. She has published many books, tapes and videos sharing her ideas and experience. She also conducts workshops for the layperson. She theorises the body through finding unity in the ancient spiritual systems, specifically Judaism (*Kabbalah*), Hinduism and Christianity, and applies these systems to the New Age body. She finds the metaphysical synthesis of the Kabbalah's Tree of Life, the Hindu chakras, the Christian sacraments, '...to demonstrate the seven stages through which one must pass in the search for higher consciousness and spiritual maturity' (Myss 1996: back cover blurb). The blurb ends with the words: 'By teaching you to see your body and spirit in a new way, *Anatomy of the Spirit* provides you with the tools for spiritual maturity and physical wholeness that will change your life.'

According to C. Norman Shealy, M.D., Ph.D. (founding president of the American Holistic Medical Association), other 'talented intuitives and mystics who have sensed the power centres of the human body, ... have all written in this field, but no one has captured the breadth and depth of our electromagnetic spiritual framework as well as Caroline. Never before has the anatomy of the spirit been so powerfully revealed. Herein lies the foundation for medicine of the twenty-first century.' He enlightens us further:

Quantum physicists have confirmed the reality of the basic vibratory essence of human life, which is what intuitives sense. Human DNA vibrates at a rate of 52 to 78 gigahertz (billions of cycles per second). Although scientific instruments cannot yet evaluate any one person's specific frequency or the blocks to the flow of such energy, two basic facts cannot be denied. First, life energy is not static; it is kinetic; it moves around. And second, talented intuitives such as Caroline can evaluate it, even though neither the human mind nor the energy system can yet be accurately physically measured. (Quoted in Myss 1996: xii)

Shealy explains that Myss tunes into the 'language of our electromagnetic being', and reads the 'effects of emotional energy, past and present' on our whole body. 'She senses deep and traumatic experiences, beliefs, and attitudes that alter the frequencies of cells and the integrity of our energy system. She reads our spirits, which are ultimately our true power' (quoted in Myss 1996: xiii). Thus energy medicine measures electromagnetic fields of the body and the vibrations of DNA. The understanding is that the seven chakras or power

centres are the regulators of the flow of life energy, representing 'the major biological batteries of your emotional biography' (Shealy quoted in Myss 1996: xiii). For Myss, each power centre has a predominant function and corresponds with the source of a specific power (1, tribal; 2, relationship; 3, personal; 4, emotional; 5, will; 6, mind and 7, spirit).

In order to heal from illness the ill person is exhorted to work through the chakras to explore where the power is eroded. This is in line with the 'holistic philosophy' of energy medicine that teaches, 'I am responsible for the creation of my health. I therefore participated, at some level, in the creation of this illness. I can participate in the healing of this illness by healing myself, which means simultaneously healing my emotional, psychological, physical and spiritual being.' If this is not done, an illness may be 'cured' but not healed, and it is then believed that 'it is highly possible, and often probable, that an illness will recur.' (Myss 1996: 47) This principle can induce a huge amount of anxiety in a patient, in that the problem with a reading of this 'principle' by a person desperate for cure, is an assimilation of a sense of committing a (punishable) sin if this advice is not followed.

Myss and Chopra share the same understanding of mind-body unity. They explore it in differing ways and the proponents that follow base their work on these principles and ideas.

Shola Arewa

Embody (im'bodi) vb. -bodying, -bodied. (tr.) 1. to give a tangible, bodily, or concrete form to (an abstract concept). 2. To be an example of or express (an idea, principle, etc.). 3. (often foll. by in) to collect or unite in a comprehensive whole. 4. Christian theol. to invest (a spiritual entity) with bodily form. —em'bodiment n.
Disembody (,disim'bodi) vb. -bodying, -bodied. (tr.) to free from the body or from physical form. —,disembodied adj. —,disembodiment n.

(*The Collins Paperback English Dictionary* 1986)

Shola Arewa is a New Age practitioner based in Britain. Arewa teaches one to work with the chakras in order that one may return from the intellect to the body in a process she calls 'embodiment'. She believes that the chakras below the diaphragm connect one to the ground, starting with the root chakra, and cannot be ignored, and that connecting with the body first through these chakras enables one to access the spiritual realm through the chakras above the diaphragm, ending with the crown chakra. It is an imbalance to live only in the spiritual domain. Therefore for Arewa, there is no hierarchy of chakras. She likens the chakras to power stations. Arewa's pragmatic approach is aimed at those dealing with the demands of twentieth-century urban life. Her methodologies, making Eastern philosophies accessible to those in the West, are published in easily readable books and find their niche in the market. The view of the body is, as explained previously, as a connected unit consisting of both corporeal and energetic matter, with access to both through the chakras. Arewa does not assume to speak of cures and healings, only of the way to your own 'truth', to being more alive, to being more comfortable in your body, through the understanding of the chakras as symbolic values and as connected 'power stations'. The chakras are also shown to correspond with the nerve plexi identified by Western science. ^{76, 77}

2.2.3.p Searching for Magic

The lack of answers or cure for a disease such as cancer and other contemporary diseases, in the ancient systems, have led most recently to a proliferation of 'New Age' theories such as energy medicine, which reinterpret Eastern ideas for the West. Energetic or pranic healing places the responsibility for healing on the ill person, encouraging or placing pressure on the ill person to take control. This is diametrically opposed to the attitude of Western medicine, which holds onto all control, yet in its own way it is very controlling – 'If you don't follow my

methods it means you don't really want to help yourself/you don't really want to get better' is something I have heard from homeopaths and others.

The danger of 'New Age' teachings is that they may put too much pressure on the cancer patient to attempt heroic responses to their disease. If they fail they become guilt-ridden that they could not achieve what they were encouraged to set out to do.⁷⁸

I have noticed a recent change in emphasis, in that patients are told that even if they don't heal on a physical level and they may still die from their disease, at least they will have achieved spiritual, emotional or psychological healing. People are being less assertive about the curative properties of their teachings. So, these discourses are liberating and release certain problems from Western discourse but they have their own set of problems and carry other ramifications.

The differences between the scientific and the 'New Age' approach to cancer are philosophical.⁷⁹ In the New Age approach, you are responsible for your cancer. It is the 'bad' things that have happened to you – emotional traumas – that have caused your cancer and therefore you can change the effects yourself, by accessing those stored traumatic memories (stored in the cells). They both centre on cells and, more recently, DNA. They both offer multifactorial explanations.

Paradox raises its head again. The ill person who turns to 'New Age' therapies usually does so either because they truly believe allopathic medicine does not have the answers and their chances of recovery are better with holistic practices, or in desperation because they have given up on allopathic medicine. Either way, the possibility of failure is even more daunting, in the former case because one's system of beliefs is challenged (you have failed yourself) and in the latter because the 'last resort' has failed ('they' can't make you better).

Brandon Bays and 'The Journey'

Brandon Bays, whose publicity material speaks of her as a 'dynamic mind-body healing expert', conducts what she calls 'Journey Work'. The technique promises to guide one 'directly to the root cause (or cellular memory) of any longstanding issue – physical or emotional'. The journey takes you to your pure essence, or to 'source'. The brochure for the Journey Intensive Weekend Workshops also offers the opportunity to: 'Discover the unique process that directly accesses your Higher Self – your Soul; Learn to finally and completely resolve issues such as ... * Chronic pain * Anxiety * Depression * Sexual Blocks * Low self-esteem * Grief * Anger * Addictions' ⁸⁰

I have attended one of these workshops and undergone a 'physical journey' and believe the technique to be a combination of Neuro Linguistic Programming (NLP) and hypnosis. Whether it can do all it claims to can only be found out after many 'Journey' processes. As with anything, to be of benefit I think it must be practiced regularly and supplemented with other practices. The tumour Bays claims to have had is not supported by any evidence other than her own testimony. The nature of the tumour is also unknown. ^{81, 82}

Barbra Brennan

A theory offered by Barbra Brennan (*Hands of Light* 1998) on auric healing is that a tumour fills an empty space and will remain there as long as the patient needs to hold on to it. The tumour will go when the patient finds a reason to accept that empty space. The implication is that the person with the tumour is holding onto 'victimology'. The tumour is seen to be storing cellular memories. Once the issues causing these memories are released the cells will let go of these traumas and will be replaced by healthy cells or will stop reproducing damaged cells and the tumour will disappear. Thus every disease or every tumour has a lesson to teach and the disease will recur as long as the lessons are not learned and as long as a state of 'victimology' is

needed. One may even have to return in one's next life to learn these lessons.⁸³ Brennan does state very clearly that she is not practicing a 'blame the victim' approach. What this would mean is that you cannot choose what happens to you, but you can choose what to do with your options.

As opposed to viewing the origin of the problem as the proliferation of cells caused by genetic and environmental factors, the tumour can be seen to be a result of energy blocks in the energetic body, resulting from a physical, psychic or emotional trauma, memory or injury. According to energetic medicine we have more than one body. These bodies make up the auric field. The energetic or subtle body consists of seven major chakras and twenty-one minor chakras, corresponding to the seven bodies of the auric field or the human energy field (HEF), which in turn correspond to the Universal Energy Field (UEF). The chakras and subtle bodies have all been seen and described and their dimensions measured in inches.⁸⁴

The human energy field is connected to the universal energy field. The ill body is one that has blockages, or channels not open, which manifest in torn or damaged chakras. The way to diagnose and treat the disease is by way of the seven chakras, which correspond to the subtle bodies. Brennan also provides graphic images of these phenomena.

The contention of these fields is that the disease first manifests on an energetic level before reaching the physical realm or body. Once they reach the physical realm they are stored as memories in the cells. Once this happens one has to work terribly hard at changing cellular memory by opening blocked channels through various applications. If one is successful, one may be cured as the cells 'melt' out of the body and are replaced by new and healthy cells. Some energetic healers, such as Brennan, claim to be able to see auras and chakras and work with them, guiding the connection with the universal energy field to repair damage that results in holes and energy blocks. The patient simultaneously has to go to work on repairing relationship, personal, emotional and behavior patterns. This happens over a period of time but the result is a successful outcome – a healthier body, disease free (this depends on what one understands of 'disease').

2.2.3.q The return to wholeness and lack of disease through rebuilding ancient memory in the DNA by attention to ancient ways of eating and being in the world

An interesting theory was explained to me at a weekend 'gathering' facilitated by Roy Littlefoot, a man who I believe has a great deal of integrity. We cooked macrobiotically, rose to welcome the sun, talked, and constructed a medicine wheel. Littlefoot's life is permanently involved with a search to return us to our ancient roots – metaphysical, cosmic, and earthly. He believes the way back to nature and a natural life is through what he calls the highest form of art – macrobiotic cooking. He believes grains are the most ancient form of food, available to humans at a time when we were connected to the earth, and that by eating these grains we will find our intuition (through the way they effect the nervous system, and the way that fire as a sun element creates a rising power), and our way back to this connection; back to wholeness and oneness. Littlefoot emphasised, in conversation, that 'with the advent of "man" came grain and fire'. He believes therefore that colon problems are the result of an inability to fully ascend, i.e. stand up straight – causing back problems leading to colon problems; due to and indicative of a failure to incorporate cooked whole grains (= 'man' + grain + fire) in the diet.

Littlefoot's belief is that through a natural way of living, and by living consciously, i.e. by attention to ancient ways of eating and being in the world, we can rebuild ancient memory in the DNA, and this is the key to the return to wholeness. He believes disease is present through ancient memory – inherited from our forebears and passed on through each generation – and that disease is not an individual but a collective problem, a symptom of no longer living with a connection to the earth. Thus his view of the causation of disease is not an individual trauma or cell memory from a current life, but rather a result of stored or inherited ancestral memories and collective trauma. He does believe, though, that eating macrobiotically for about four years can bring about these cellular changes.

His view does not contain the 'you are responsible for your own disease, you bring it on yourself' idea. Rather, disease is seen as a manifestation of an ancient global accumulation. So we are talking now about DNA, no longer small (individual) cellular memories, but large (collective) ones. For Littlefoot, the Western experimentation with science, economics, politics and medicine all constitute research to find our limitations. He believes we have reached our ultimate limit and can go no further. What this means is that we have lost our connection with the earth; created an artificial universe, which is unsustainable, and that the return of the most primitive form of life – the virus – reveals this lack of connection. The virus is a signal to us to remember our ancient past. The way back, the way to restore the memory, is through whole cereal grains, proper mineral compositions such as sea salt, and bacteria.

Thus for Littlefoot, cancer and HIV are the limit. Disease is a crisis of healing and the solution is a return to wholeness. He speaks of HIV as shrouded in mystery, as an unexplained phenomenon, which leaves people feeling powerless. To demystify is the only way through this crisis. The root to demystification is through the centre. The centre of the cell – the nucleus – is the key as it is the centre of the immune system. The way to keep the nucleus in balance is through pure foods with the right trace minerals, which come from the centre of the earth. If this is neglected, the cells decompose and become simple cells. If you change your food, you change your memory. In this way we do not remain stuck where we are now, but change the DNA pattern and keep change as the only constant. Littlefoot, proposes that we must allow for demystification by recognising that mystification is 'the way of the trickster'. This resonates strongly with my original instinct, on diagnosis, to uncover the facts of my illness and demystify the medical practice and terminology around it, as well as with Hannah Wilke's assertion that to 'strip oneself bare of the veils that society has imposed ... is to be the model of one's own ideology' (Fischer 1998: 48; see section on Wilke further on).

In addition, Littlefoot talks not of opposites but of complementaries or polarities. He believes too that we are cosmic beings on a visit to earth, and will return back through the sun (the heart). The symbol he advocates is the infinity sign as opposed to the AIDS symbol, which is a broken piece of DNA. The colour is gold, meaning reflection and representing an element of alchemy, which stands for change. He turns AIDS backwards and arrives at SDIA – 'Start Dynamic Individual Action'.

Littlefoot teaches without expecting anything in return – unusual in this age of selling knowledge. He believes in the 'cosmic plan'. He lives very simply, and travels with one suitcase containing his ritual objects such as feathers, bowls, cloths and pipe. At present he is travelling the world, living with different communities, and coordinating the ceremonial building of medicine wheels – circles built with stone in places he believes are 'gateways'. He is a global being in a very different sense of the word, absorbing lessons from all the cultures he encounters and in which he sometimes immerses himself. His name denotes a long connection with a North American Indian community with whom he lived for a long time. (See App III: 69.)

Faith healing exists at the extreme end of this spectrum. There is the practice that invokes the powers of the Holy Spirit to cast out demons such as cancer, paralysis and other forms of illness. I believe this to be a short-term act of hypnosis. The practice of deep personal faith, not in the faith healer but in God, that invokes acceptance has produced a few miraculous stories as witnessed and told to me by an immunologist. But at best the power of faith, such as that expressed by those visiting Lourdes, for example, acts not as a physical cure but as a way of finding 'inner peace' and meaning and hope in sickness. I believe that patients who exhibit an absolute faith in their doctor and the power of biomedicine experience similar benefits.

All the theories outlined above make their way into your life if you, as a cancer patient, choose to 'enter the arena' and engage with these other modalities. Mostly, through the concern and anxiety of others, information comes your way. People feel inadequate and ill equipped to help you in the face of your disease and so try to

find ways to make themselves feel better by passing on advice and all these potentially miraculous ways of 'beating' cancer, that they have heard from friends or friends of friends. You are given phone numbers of others with cancer who have recovered, as well as tapes, books, pamphlets, names of doctors, hypnotherapists and organisations. (See App III: 45–48; 72–82)

At first, out of a desire to please others, I agreed to go along with their recommendations, read the books and listen to the tapes, despite feeling sometimes reluctant and, I suppose, also with the faint hope that a miracle would be waiting. In this way I have encountered all the practices mentioned above. Early on, in the course of the disease, I was told by an anxious family member to 'look deep inside my soul' to find the source of my cancer and therefore its potential healing (this is the basic concept of New Age thinking – change your relationship to yourself). At the time, I experienced this comment as a criticism of my connection to myself, and I took it to imply that the cancer is a punishment.⁸⁵

2.2.4 Artists and the Ill Body

Nead, writing in *The Female Nude* discusses issues around contemporary commodification of the female body (surely one of the most salient indicators that we have 'lost our connection with the earth'):

Many of these issues around visibility, representation and the body are most clearly focused by those campaigning for the rights of disabled people. Across the many struggles in which disabled people are involved, the fight for self-representation has become one of the most significant. Within the mass media, people with disabilities are either largely invisible or marginalized through a limited range of social and cultural stereotypes. ... Desirable femininity has been constructed specifically in terms of both health and beauty – to be fit for life is to be fit for art. As health has become increasingly commodified, so we have been enticed to consume by the prospect of the perfectibility of the body and have been surrounded by advertising images displaying young, able and beautiful female bodies. (Nead 1992: 77)

In relation to cancer, this would imply the need to render invisible the bodies that do not conform to these ideals. The first two artists under discussion here (Jo Spence and Hannah Wilke) '...are women who, as Slavoj Zizek would put it, have assumed their own fate. They have the courage to be exactly who they want to be, or with blunt unsparing realism, show exactly who they are' (Isaac 1996: 219–21). They both had cancer, the disease itself invisible on the body but the treatments physically transforming.

2.2.4.a Jo Spence

I begin this section on artists who have worked with their own diseases with Jo Spence. When I began my own 'cancer' work I had not seen Spence's work. At the start of this research, I began to encounter references to Spence, and finally read *Cultural Sniping* (1995). There are similarities in the form taken by my first work using documentation, and reading her descriptions of her experience was full of resonance with my own. However, Spence's relevance functions with broader implications on many levels.

Within a discussion of other women artists, Isaak writes: 'In *The Picture of Health? 1982 Onwards* Jo Spence embarked on a photographic documentation of her fight with breast cancer, or perhaps it would be more accurate to say her confrontation with the medical orthodoxy and its system of representing her and her disease. These works are triumphant, not because women win the battle; for the most part they don't. They are triumphant in their challenge to society's obsession with masking loss, in their willingness to look steadily at the "disappearance that everybody denies" (Zizek 1991: 79)' (Isaak 1996: 221).

Spence writes that when she was diagnosed, she initially 'believed that I had somehow brought cancer upon myself, and only later looked at the broader environmental, political and economic profiles of illness' (1995: 130).

This is Jo Spence addressing the effect of the New Age and old myths of cancer: that you bring the disease on yourself and therefore it is a punishment for which you have to make amends by being a very good person and working very hard at changing yourself – your personality, your negative beliefs about yourself, your behaviours.

Spence worked as a photographer/activist before her diagnosis with breast cancer and turned her camera on her experience of her disease. She stated: 'It is not easy to make your journey through trauma and disease the subject of your own camera' (1995: 139–140).

I have selected the following quotations from Joe Spence's varied and extensive writings as they appear in *Cultural Sniping* in order to articulate experiences common to people with cancer and to my own experience as an artist working with the disease:

When I learned that I had breast cancer, I went through a kaleidoscope of feelings. I moved from depression to despair, then into suicide fantasies, then into anger, then back into hopelessness. The pendulum finally stopped swinging, and my feelings of being out of control began to be coupled with a powerful anger. In the shadow of my fears came a kind of rebellion. ... I decided to document the procedure of being 'processed' through the hands of the medical profession. I used my camera as a third eye, almost as a separate part of me which was ever watchful: analytical and critical, yet remaining attached to the emotional and frightening experiences I was undergoing. ... I took my thirteen rolls of film in the hospital, ostensibly for my family album. By the time I had finished, I had no clear idea what I had photographed. (Spence 1995: 130)

What she produced was a representation of her struggle with breast cancer and with the medical orthodoxy, as well as a documentation of her pursuit of alternative therapies. At the time, according to Spence, in 1982, very little work had been done on illness, breast cancer was still a fairly taboo subject and pursuing alternative treatments was quite a radical choice that brought her into conflict with the dominant discourse.

When she exhibited her work she was infuriated by gallery goers' inability to face her or the work: 'I thought, "Don't you understand that I might be *dying* – that I've put this work on the wall to help other people see that there are different ways to think about this illness?"' And additionally, 'This isn't just an artwork. This is an actual body that someone inhabits.' When she did not receive a response from people in the world of photography she said 'I began to understand that there were different audiences – the art world, the health world – but I didn't quite understand how to reach them. Art audiences didn't then have a vocabulary to talk about identity work, which is what my new work was. Everybody is quite glib about it now – we've got a vocabulary for talking about identity work' (1995: 213–4).

'If a trauma I'm representing is fresh and I haven't had a catharsis or any kind of insight or resolution from the trauma, I am literally putting my trauma on the wall. It isn't an interpretation: it's the trauma itself or an extension of it. ... The situation for dissident cancer patients is not the same as it is for people with AIDS. There is no groundswell of loving dissidents surrounding cancer patients' (1995: 214).

Spence said that she found the art world far more nurturing than the 'theoretical world of photography that

spawned me. But I didn't choose to work in a vacuum any more than I chose to have cancer. Nonetheless, that vacuum exists...' She asserts that 'the representation and politics of cancer simply do not get debated in the world of politicized photography in Britain, whereas people who do cultural work on AIDS have available the language and theory developed around the politics of homosexuality' (1995: 215).

This is how Spence saw her work around breast cancer. In some ways it is very similar to my own experience. My process of documentation also began partly due to the debilitation of the treatment. My first body of work on the subject was, as Spence says, a presentation of the trauma. I also felt I would help others through the work and was supported by the art world yet not by the health world. To some extent, I too felt I was working in a vacuum. There have been more artists working with cancer now, but they are still few and far between. In recent years the politics of breast cancer has followed the precedent set by AIDS activism and the consciousness raising is being based on women's issues. The campaign is represented by the pink ribbon, and sponsored by the Estée Lauder Foundation.

An exhibition, justified in a similar way, curated in Toronto, Canada in 1995, aimed to raise awareness of breast cancer and funding for research. *Survivors, In Search of a Voice* was the title of the travelling exhibition and accompanying catalogue. In the curatorial statement Barbra Amesbury writes: 'As the AIDS quilt was a moving symbol in the fight against that disease, so too, we felt, would this exhibition be a symbol. We envisioned that *Survivors, In search of a Voice*, would be seen by all as a monument to courage, and we hoped it would empower breast cancer survivors, their families, and their friends to lift the veil of silence that pervades this disease' (catalogue 1995: 7).⁸⁶

Ten years after breast cancer, Spence was diagnosed with leukaemia. She writes: 'This time my witness, my advocate's eye, is a hundred times keener than it was before, and I'm now using my camera as a notebook. I keep a diary. I'm watching, and I know there is no easy answer. How do you make leukaemia visible? Well how do you? It's an impossibility. It's what I went through before – a crisis of representation. ... I'm dealing with an illness that is almost impossible to represent. I have not the faintest idea how to represent leukaemia except for how I feel about it.' (Spence 1995: 215)

She adds that with the recurrence of the breast cancer and the onset of this new disease it was necessary to turn inward for the first time and to 'stop being a mother to the world ... to not have to think about the politics of leukaemia' (1995: 217). After all the energy she put into the activism of the breast cancer work she felt that this time round, all she wanted to do was garden and make tapestries.

As an artist working with cancer I face similar issues. What is the purpose of the work? What effect does the making of your own disease the subject of the work have on the artist, what toll does a desire for activism take when you are actually fighting for your survival? The physical effort, the conflict with the health care system, the criticism one invites for presenting a traumatic subject, for making others uncomfortable – these are not easy outcomes. I take inspiration from the many artists working with AIDS. In my own working process I see the artmaking process as an attempt to exteriorise the discourse, thereby empowering the self and others. Becoming a sort of protagonist in my own drama, not just the subject of someone else's investigation, is a form of empowerment. The attempt to make the disease visible both for myself and for others is one step in this process.

Contrary to the common criticism of work of this nature, it is not driven by self-indulgence, self-interest, egotism or the desire for 'exposure'. It is driven by a need to lay bare one's own pain, discomfort, fear and confusion and in confronting the extremely uncomfortable, to reduce its terrors and find workable ways in

which to deal with it. There is also a need to share one's discoveries in the hope of reducing the terror for others who are affected by illness, whether personally or through people they know and love. Angela Ellsworth writes of Hannah Wilke (in a paper e-mailed to me in July 2000): 'Accused of narcissism and self-indulgent preoccupations she courageously continued posing even into her final stages of terminal illness with lymphoma. The poses continued yet the context changed. Pointing fingers of accusation dropped.'

2.2.4.b Hannah Wilke

Wilke had always used her own body in her work, and continued to do so after she was diagnosed with lymphoma in 1987. Alfred M. Fischer writes

Recognizing for instance that 'Self-hatred is an economic necessity, a capitalistic, totalitarian, religious invention used to control the masses through the denial of the importance of a body language, which is replaced by a work ethic devised to establish slavery of the mind burdened by the awful albatross – the body...', Wilke bases her art on the body: her own. And because 'exposing the truth is like nudity,' nude is the state in which we usually find her in her art. Wilke writes in 'I OBJECT': 'To strip oneself bare of the veils that society has imposed on humanity is to be the model of one's own ideology.' (Fischer 1998: 48)

Being the 'model of one's own ideology' requires an attempt to strip down the experience and find essential truths in their 'original' form, to interpret this knowledge from an uncluttered, non-prejudiced viewpoint, and thereby to gain a position of strength. I attempt through my work to search for, access and express these 'original' truths in the laden and layered realm within which I find myself. Instead of being panic-stricken and confused by the plethora of conflicting advice/'knowledge', I try to find order in the chaos, to reach a quiet, informed place from which to make decisions about how I will manage my illness. While truths are hidden, they are not open to honest inquiry. The process of uncovering the raw experience is a starting point for reaching that elusive quiet place, which in turn is a springboard for attempted healing.

Prior to embarking on this project I was not familiar with Wilke's work, and when I discovered her work, I was struck by some obvious similarities: the need to record the physical horrors of hair falling out, drip tubes in veins, the brutalization of the body. We also share, ultimately, a celebration of the body as opposed to a commiseration of suffering or abjection. In its truest expression, knowledge is power. We both seek to empower ourselves and others by laying bare the truths of disease.

Because Wilke worked largely in the nude, and she happened to be beautiful, she was constantly accused of narcissism by critics. A different view is taken by Alfred M. Fischer in the catalogue essay:

... (... the gods punished [Narcissus] by making him fall in love with his own image). Knowing this, one wonders why the word 'narcissim' constantly pops up in the writings on Hannah Wilke's work. She stated it herself clearly enough: 'it doesn't have to do with narcissism.' It does, however, have a lot to do with love, which is the underlying theme of her entire work, as became poignantly clear in the last artistic testament of her own body fighting for the life she loved. Love of life meant for Hannah Wilke consciously experiencing life, being alive to it, enjoying it to the limit, above all, 'standing up' to all facets of it. (Fischer 1998: 44)

On the other frequent criticism of Wilke's work, the feminist charge of 'flirting', Fischer writes: 'Wilke plays not only on pain and wounds (= scars), but pleasure and delight as well: "...Gambling as well as gambling." ...Wilke does

not see any contradiction in one and the same person being both a “flirt and a feminist” (1998: 50). This resonates with the essential paradox of cancer – that it is a process of cell division and growth, as is the process through which life creates and recreates itself, i.e: that which makes life also makes death (with reference to Stacey). Wilke was a feminist but not of the school that believed the female body should be completely removed from the frame.

Laura Cottingham writes: ‘Her work encompasses satire and criticism, humor and didacticism, provocation and pathos, love and death, sentimentality and eroticism, beauty and kitsch ...’ (1998: 56).

As well as documenting her own illness, Wilke did the same with her mother, who also died of cancer. Sandra Goldman writes: ‘Wilke claimed that taking the pictures [of her mother] improved the quality of her mother’s life. In gesturing and posing for the camera, Selma Butter felt alive, felt herself in the process of creation’ (1998: 36).

Goldman adds: ‘Just as she believed she was curing her mother, she also worked at curing herself through her art, extending her life by expanding her activities. This was not a cure for the body (she and her mother both died from cancer), but a healing of the spirit’ (1998: 40). It is interesting to note that Bob Flanagan engaged actively with his disease (cystic fibrosis), and lived far longer than the statistical expectation.

It is in the delving, digging, probing, unveiling, uncovering of the layers and scrutinizing the core that personal power is gained – the power of knowledge to make sense of the seemingly incomprehensible. There is also a healing element in forcing into the open that which society wants kept hidden, because the motive for secrecy is fear. The criticism of my work as ‘morbid’ and Wilke’s as ‘narcissistic’, although coming from different dialogues, displays an inability to apprehend the need for uncovering in order to access the truth (whether that truth is palatable and socially acceptable or not). By confronting the truth, one banishes fear and reclaims the power to ‘be the model of one’s own ideology’.

2.2.4.c Angela Ellsworth

Ellsworth is a performance artist, still very much alive, who was diagnosed with Hodgkin’s Disease (a form of lymphoma) in 1993. She produced a series of solo and collaborative work around her experience of lymphoma titled *Imag(in)ed Malady* (1993 – 1998). Her subsequent body of work titled *Club Extra* (2000) looked ‘at “fitness” as it ties into health, beauty, body and institutions’ (e-mail correspondence: 2000). This work centres on Angie the fitness instructor, offering fitness classes in a museum. In this work she links the pursuit of the ideals of health and fitness to the pursuit of the art experience – both taking place in institutions dealing with beauty.⁸⁷

In a paper titled ‘Performing Illness: Crisis, Collaboration and Resistance’⁸⁸ (e-mailed to me in July 2000) about her performance pieces between 1993 and 1998 Ellsworth wrote:

The performances challenge conventions of the male gaze and medical gaze as well as attempt to take performative action against a disease that is largely invisible. ... By confronting the disfigured and diseased body in performance I will attempt to reevaluate what it means to be feminine, acceptable and controllable in Western culture. This paper explores issues of disease and disorder in relationship to gender, size, identity and race through bodies marked by illness. Addressing the precarious concept of a healthy body and a sick body I will explore the extremities of these terms as well as the moist edges where they simultaneously converge and inevitably invert.

Echoing Jo Spence's wrestling with the problem of how to represent an invisible illness, she writes: 'How does a life-threatening disease impact the experience of embodiment when the disease can't be imaged by the artist?' ... How does a performer subvert illness when the disease is invisible? How is a sick performer viewed by the audience when she doesn't look sick anymore?'

In the early '90s Ellsworth's work was informed by bodily functions such as 'sores, stretch marks, constipation and excess fat.' This was a time when she viewed herself as hypochondriac, and when she was diagnosed with cancer, 'family and friends said that I was "a perfect person to get cancer" because it complemented my fascination with the grotesque and my collection of turn-of-the-century medical tools. Other people felt my masochistic and hypochondriacal behaviours had finally caught up with me. ... The female body pushed to extremes in performance as well as re-presented in paint, redefined limits of the flesh. I invented conditions or exaggerated aspects of my own body narrative in order to take control of my own image.'

When Ellsworth was told that the tumour in her chest would have to be removed, she almost immediately 'sketched ideas for a performative action in response to the tumour removal.' She imaged putting the removed mass in a blender and serving it to friends on crackers 'for an intimate gathering at my home. I wouldn't expect anyone to do more than look at the hors d'oeuvres but the radical gesture would have been a way of asserting power over the invasive growth as well as the hands that cut it out. I made my abject body subject.' As it turned out the tumour was found to be malignant and surgery was ruled out.

To varying degrees, then, a common theme among ill artists is to confront their disease, expose it and thereby take back power from the disempowering experience of disease. *Her/She Senses Imag(in)ed Malady* is an ongoing collaborative project with Tina Takemoto that began in 1993, 'in an attempt to document, to cope with, and work through the experience of illness...' (Takemoto 1997: P9, quoted in e-mail paper July 2000)

Ellsworth writes: 'We tried to make sense out of the invisible and unknowable through the image and imagination of illness. We hoped our proactive approach might somehow make a difference and that our own perception and communication of the experience might direct the outcome.' She adds that as with Bob Flanagan, Jo Spence and Hannah Wilke, she documented her daily routines, medical procedures and bodily changes over a period of a year. 'Autobiographical photographs, while in the process of being sick, was a public and personal confrontation of the medical marks and scarring on my own body.'

The need to make photo-documentation of the illness's course is another common theme among artists living with disease. Ellsworth and Takemoto made a series of postcards using a Polaroid camera to document images as she 'trekked the inconsistent path of medical treatment. At the time, it was important for me to use the instantaneous register of a Polaroid camera. Capturing the moment and being able to view it immediately seemed critical to my process in the project. It was as if I needed to own the image before the next change occurred on its surface.'

Ellsworth and Takemoto collaborated on *Intravene Carotene*, a large-scale installation/performance piece that incorporated a thirty-foot scaffolding, yards of medical tubing filled with freshly juiced carrots, a bicycle, a vegetable juicer, flour billowing from a mechanism that squeaked and whizzed and the two artists themselves. Ellsworth writes: 'The result was an apocalyptic approach to convey the absurd attempts of curing and healing. An urgent attempt to be in the illness, perform the illness, and resist preconceived notions about being sick.' She concludes: 'By performing my illness I feel as though I am an active participant in resisting preconceived notions of cancer, with the hope that I am staving it off.'

This is precisely the impulse that drove me to document the process of my treatment, as was also the case with Jo Spence, Hannah Wilke and others. By engaging actively with the progression of one's treatment/disease, one hopes and attempts to take back the power to effect its outcome, as opposed to passively surrendering to the dictates of a medical profession which doesn't have all the answers and certainly cannot live one's own experience.

2.2.4.d Sunil Gupta

Sunil Gupta, who has lived with HIV for several years, created a series of 12 colour photographs forming diptychs, entitled *From Here to Eternity* (1999). In them he juxtaposes images with specifically gay connotations – bleak South London facades of gay clubs – with self-portraits showing him naked and dressed in various contexts. 'The descriptive sensibility and the aesthetic form elements, which speak to the intuition of the observer, impress through their extraordinary aura. ... Gupta reaches an individual expressiveness as well as a 'psychogramme' of our time, that represents a balance of a very personal and a universal feeling' (review by Necmi Gomez, quoted by Gupta in e-mail correspondence with Jane Alexander).

In another review of *From Here to Eternity*, Emmanuel Cooper writes: 'Stripping himself naked, exposing all, he pictures himself reflected in the mirror in an anonymous hotel room, anxiously taking his own image. This is no Polaroid snap of happy bedroom frolics, but a sombre questioning, Who am I? Its very honesty is both disturbing and moving, we are being shown more than the nude flesh, we are being offered an inside view, a glimpse of the turmoil within. In a hospital Gupta is seen averting his eyes while blood is drawn from an arm, apparently a test of endurance, or breathing into a machine either to test the strength of his lungs or to inhale a potent drug.' (These are images of tests and treatments for HIV.)

Thus he juxtaposes images of the 'lifestyle' with its 'consequence'. Again we have the ill artist driven to expose their 'interior', although with Gupta it is more his emotional and spiritual interior that is on view than the workings of his body's interior.

Cooper continues: 'Like the naked self-portrait Gupta appears vulnerable and exposed, taking us into his public-private domain where others are in charge. This sense of intimacy is taken even further in his self-portrait ... an enactment of his death with him lying on his bed in his bedroom, his parents' photograph on his bedside table. The blanket on which he lies bears the poignant text "If there were a pool we would be reflected in it" – the significant "we" including not only himself but also involving us in his questioning. In finding the mettle to turn the camera on his own life, to contemplate eternity, Gupta holds up a two way mirror, offering revelations that challenge and disturb...'

Gupta focuses on his position as an Asian gay man living with HIV, and it is interesting to note that, contrary to Jo Spence's assertion that there is a supportive dialogue around HIV as opposed to cancer, his feelings of isolation and alienation are apparent in his images of the coldly exclusionary building fronts with resolutely closed doors. There is a feeling of desolation, of unacceptance in these images that powerfully portrays the realities of being a gay man living with HIV. Gupta highlights the vulnerability of existence – his and the viewer's – in imagery that speaks of fear, marginalisation, isolation and mortality.

In another review, Holland Cotter writes: 'The celebratory sense of communal empowerment sometimes associated with art produced in response to AIDS is missing here. Instead, social gathering places are inaccessible, desolate, sometimes half-hidden. Tenderness is a solitary emotion, liberation takes the comfortless form of unromantic self-awareness.' He concludes: 'Generating awareness, personal and public, has propelled Mr Gupta's career for nearly two decades, as an artist, writer and curator. He doesn't make it easy to come by; it rarely has a feel-good payoff, but it is the moral spine of this fine show.' (*The New York Times*, Jan 7 2000)

In the words of Judy Freya Sibayan [e-mail correspondence to Jane Alexander January 2000], curator of Scapular Gallery Nomad (a performance art gallery or live moving gallery), where 'From Here To Eternity' was exhibited: 'I have been called a fool by those who love me. I appreciate the image for the fool is who we are as we leave the infirmed center and by placing ourselves at the periphery, we humbly endeavor to restore some form of health by inverting/subverting the perverted order.'

2.2.4.e Katherine Sherwood

Katherine Sherwood is a painter who suffered a cerebral haemorrhage in the left hemisphere of her brain in 1997. The work that arose from that experience is a combination of lithography and painting on canvas. I have extracted the following excerpts, describing the work and the process, from the catalogue essay by Juan Rodriguez (1999: n.p.):

This type of cerebro-vascular accident causes paralysis to motor skills on the right side of the body. Unable to use her right hand, Sherwood, in a matter of months, taught herself to paint with the left. These paintings are equally a testament to her courage to return to work in her studio, and to the power of her intelligence and desire to make paintings that reflect her life. ... The linear abstractions (which originate from her study of the Solomon Seals and her passionate interest in Medieval manuscripts) and thick strokes of paint are overlaid and juxtaposed against photolithographs of angiograms (X-rays of the blood vessels in the artist's own brain). ... Contrasting imagery to express meaning has been present in Sherwood's work since her early paintings of female impersonators, male nudes, nuns, Madonnas, aggressive women, and brides. ... From these early paintings one sees the unity within differences that recurs in Sherwood's work, and the prominent theme of the secular and sacred intertwined.

In both *TO RISE TO HIGH PLACES* (1999) and *KNOCK YOUR BLOCK OFF* (1998) Sherwood uses a 'squadron of rose-coloured circles filled with images of blood vessels.'

In discussing Sherwood's *BOLD OF HEART* (1998), Rodriguez comments that 'by joining together abstract painting and photo-collage Sherwood strains the boundaries of the two media, trying to unify their differences. He adds that 'one way to perceive Sherwood's paintings is as a gathering and personification of signs. By analogy, the images in her work can be seen as a collection of amulets worn around a person's neck to understand, and maybe control, the power of good and evil.' (See App III: 18)

Rodriguez continues: 'It is the nature of art, in particular the art of painting, to present the viewer with what is both seen and unseen. The act of painting, and its parallel the act of viewing, penetrates our dualistic ideas of existence: what is inside or outside, what is fluid or solid, what is visible or invisible. ... In her paintings we see the desire to know the connections and differences between the seen and the unseen, the spiritual and the secular.'

This resonates directly with my own work, in its quest to investigate the connection between the 'self' and 'other', inner and outer, hidden and obvious, subjective and universal – and the nature of 'the whole' in relation to the sum of its parts. Rodriguez talks of the 'oppositional forces embodied in her work'. These forces, and the paradoxes that manifest on digging below the 'surface', are a recurrent theme in the work of many of the artists discussed here, as well as my own. Rodriguez writes that Sherwood 'has the ability to capture the macrocosmic, as well as the microscopic, in her work. ... She identifies differences in order to gain understanding.' This, again, is a direct reflection of the urges driving my work and that of other artists living with illness, and echoes Chadwick's belief that 'famous hybrids of myth, like the Cyclops or dragons, or the Chimaera with three heads, represented creatures which

had existed and whose difference had been exaggerated by the terror and the prejudice of observers' (Warner in Chalmers (ed.) 1996: n.p.).

2.2.4.f Glynis and Sue Hillyard: Gently into the Light

Two South African sisters, a photographer and writer, have embarked on a journey of sorts together. The photographer, Sue Hillyard and her sister, Glynis, have created a photographic representation of Glynis's radiation treatment for breast cancer. Glynis has had breast cancer for ten years with five recurrences. She had a mastectomy early on, and recently, with her fifth occurrence, has had radiation therapy. Intending to write a book about her cancer, she asked her sister to take a few photographs while she underwent radiation. This became a larger documentation, with Sue and her camera accompanying Glynis to every treatment session. The result is an exhibition, *Gently into the Light*, a combination of photographs and writing by both sisters. Each photographic image has been mirror-imaged and placed side by side on a sheet of official-looking brown paper. Under the series of pairs of photographs, on the brown paper, the sisters have written a few lines each in response to the photographic image. Sue, the photographer, has written in green – representing the 'safe' green area she occupied, and Glynis, the patient, has written in red – representing the 'no entry or 'danger' area of the radiation room. The black and white photographs are accompanied by five poems Glynis has written, one for each recurrence. The work has been exhibited at a healing centre run by a GP who wishes to practice a holistic form of medicine or, as she calls it, a 'different kind of medicine.' Glynis has worked extensively with alternative modalities in combination with an oncologist, to treat her cancer. (See App III: 93)

LION IN MY TERRITORY

"Is the cancer all gone?"

"So have you beaten it this time round?"

How do I answer these questions?

*I am brought to remember
observations of animals in the wild:*

*Buck, giraffe, warthog, zebra –
any prey animal –*

*will not avoid stooping its head
to drink at the waterhole
or graze in the veld*

in case there is a predator around.

*They may never be selected to be the lion's next meal;
they could be wounded and escape;
they might be killed and eaten.*

*In a deep and unconscious way
they know there is a lion in their territory,
yet, though alert,
the fear of death does not overshadow their lives.*

*I will be that buck
with no thought of either
the chase last week through the blond-grassed savannah;
nor the likelihood of tomorrow being trapped with nowhere to run.*

*So it is, if you ask me,
"Well, do you think you've finally got rid of the cancer?"
I will answer
"There is a lion in my territory."*

Glynis Hillyard
October 2000

2.2.4.g The pain of illness in Art and Life

Bob Flanagan

The beginning of this section contains dictionary definitions of 'sick', 'sickness' and 'sickening'. Bob Flanagan was sick; he lived with cystic fibrosis his entire life. His early recollection of pain as a child in the hospital influenced his work. He remembers lying on his stomach writhing with pain and at the same time enjoying the erotic sensations felt from the rubbing of his body and penis on the bed. Thus the relationship between pain and eroticism became his method. He continued to eroticise his pain and to perform for audiences. He was also 'sick' of being called 'sick'. So he turned the label around. His assertion was that if people were going to label him 'sick', he would be sick, thus playing with the semantics of the label. For example, playing with the various meanings of the word such as: 'suffering from ill health' he would, through the performances, have the effect of making others 'sick'. He continually questioned the label, which also implies being 'mentally or spiritually disturbed' and 'delighting in or catering for the macabre: sick humour'. (The *Collins Paperback English Dictionary* 1986). The biographical film *Sick* (1997) is an excellent exposition of his work.

He merged private and public; he exposed the greenish fluids collecting in his lungs; he placed a video of his face lying in his coffin; he constructed a hospital waiting room in which he lay on a metal bed and had his girlfriend winch him up by his legs. An unexpected effect of his work was on his health – he became one of the longest surviving adults with this disease. A question that arises is whether his active engagement with his disease helped him resist it and gave him more power over it than if he had passively accepted it. As Goldman wrote of Hannah Wilke, '... she also worked at curing herself through her art, extending her life by expanding her activities' (1998: 40).

Felix Gonzalez-Torres

Gonzalez-Torres, an artist who died of AIDS in 1996, dealt with issues of 'gender and sexuality, death and loss, time and change, freedom and repression... using a clear and reduced vocabulary ... (and) ... the practice of concealing radical content under an acceptable, even beautiful veneer' (Cruz 1994: 9). Making his work widely accessible and promoting cultural awareness Gonzalez-Torres worked outside the gallery context by displaying suggestive and beautiful photographic images on large billboards. In the gallery he exhibited paper stacks of reproduced images or words, at other times individually wrapped mounds, spills or layers of sweets or chocolates that the audience could remove, intended to be takeable, replenishable and renewable and an ongoing collaboration with the public.

As Thomas Krenz describes it: 'He makes a gift of his art and, in return, hopes that those who participate will be incited to contemplate and even act on the social issues so delicately embedded in it.' (quoted in Spector 1995: ix) Even after his death the paper stacks continue to perform this function. I identify with the sensual blood and chemo curtains (1992 and 1991) that provide clues to the experience as one walks through them, but remain individually interpretable and the works that deal with the necessary bloodwork for the testing of HIV/AIDS. A series begun in 1987, it comprises graphs that chart bloodwork (the T-cell count) and which signify survival with a simple ascending line (a raised count) of which there are fewer than those in which illness (and the possibility of death) is charted by a descending line (a lowered count). (See *Untitled [21 Days of Bloodwork–Steady Decline]* 1994). For Spector, these works denote 'the abstracted body', in which 'the life spirit of a body' is incongruously translated into 'numerical sequences' reflecting the abstraction and objectification of the patient by the medical discourse and its gaze (1995: 167). Again the viewer's participation in the interpretation is demanded by the abstract nature of these works. In fact, the body is never seen, only suggested, in the work of Gonzalez-Torres.

Cuban by birth, Gonzalez-Torres was quietly, not aggressively, political in his life and his teaching and never overtly didactic in his work. He was always informed by the following awareness that 'there is never such a thing as an apolitical or inert artwork. Art always serves a function – it either furthers and helps the master narrative or it tries to disrupt it'. He encouraged the maintainance of a constant guard against the reactionary forces always ready to impose 'homophobia, sexism, racism and divisiveness' (quoted in Bartman [ed] 1993: 26). Gonzalez-Torres admitted that making artwork was an attempt to 'negotiate my position within this culture' and believed that the continuing role of the artist was to offer 'cultural critique' (quoted in Bartman [ed] 1993: 31).

David Wojnarowicz

Another artist who died of AIDS, David Wojnarowicz (1954–1992), merged his rejection by society with his work in the form of painting, collage, performance and social activism. Fineberg writes:

He had been a child prostitute on the streets of New York and had 'one of the most brilliant collage sensibilities of the late twentieth century and used it in lucid exposition of the layered interaction between nature, his personal identity, and contemporary cultural values' (Fineberg 1995: 451). In Wojnarowicz's words:

My whole life I've felt like I was looking into society from an outer edge, because I embody so many things that were supposedly reprehensible – being homosexual or having been a prostitute when I was a kid, or having a lack of education. All my life I looked at the world with a longing to be accepted, but ... the only way I could be accepted would be to deny all those things. At the moment of diagnosis [of AIDS] I fully gave up that desire to fit in, and started realizing that those places where I didn't fit in and the ways I was diverse were the most interesting parts of myself. I could use that diversity as a tool to gain a sense of who I was. (Quoted in Fineberg 1995: 452)

Again the pain of difference. In his work Wojnarowicz incorporated biological and media imagery as well as images of frogs, tadpoles, water, spirals, erotica, cartoon characters and urban decay. He is quoted as saying 'Inside my head behind my eyes are lengthy films running on multiple projectors ... the end result is thousands of feet of multiple films crisscrossing in front of each other thereby creating endless juxtapositions and associations' (Fineberg 1995: 453). These words capture the experience of his almost 'celluloid' paintings that reflect the 'endless juxtapositions' of real life, just like the reality of his life, which was like his work, challenging and uncomfortable.⁸⁹

2.2.4.h Pain, Suffering and Salvation

The exhibition entitled 'Pictures of Pain' at the Museum of Contemporary Art in Helsinki, Finland is discussed by Minna Turtiainen (in *Kiasma* magazine 11 – 2001: 15).

Turtiainen covers the belief that pain ennobles, suffering causes growth and that this leads to salvation on earth and in the afterlife: 'In the pictures depicting martyrs, the pain has been ennobled: pain is seen as a sign of the martyr's true faith which endures and suffers all.' In some cultures, she notes, pain and suffering 'are sometimes presented as a material necessity on the path to a spiritual and genuine connection with god or the universe.'

Many of the works in this show are autobiographies. When one thinks of an autobiography of pain and 'suffering' in art one cannot but help think of Frida Kahlo (about whom Helen Chadwick made a film). As Turtiainen writes of Kahlo's work: 'The self-portraits of Frida Kahlo can somehow be compared to Christian

depictions of pain. The viewers' experience is powerfully affected by the knowledge that the iron bar, which penetrated the pelvis of the beautiful, young artist as the result of a traffic accident, caused her to suffer for the rest of her life. The poor artist suffered on behalf of herself, her artist husband, the Mexican people, as well as for her art and oppressed women throughout the world. What remains are the pictures of the martyr-artist' (*Kiasma* magazine 11 – 2001: 15).

Turtiainen goes on to say that pain depicted in art is different from the pain portrayed, for instance, in entertainment. She asserts that 'art does not, unlike some computer games, merely present endless pictures of pain and violence, but goes a step further and deals with the feelings connected to pain – pain becomes the subject of the art. In this way, it has tried to get viewers to look inside themselves and, thus, become a more understanding person' (*Kiasma* magazine 11 – 2001: 15).

The works exhibited in *Pictures of Pain* deal with performance, installation and new media. Two of the artists are working with autobiography: Sirkka-Liisa Sass, 60 years old, was diagnosed with scoliosis as an adolescent. The central theme of her piece, *Vicious circle*, is of 'a body deviating from the norm, understanding of health and sickness, beauty and ugliness, good and evil and, above all, normal and abnormal. Sass has handled her history of suffering bravely, even sarcastically.' Graham Cunnington's *Pain* 'is an autobiographical account of pain and coping with it, of the struggle to take control of one's life and the rejection of the victim mentality' (Turtiainen in *Kiasma* magazine 11 – 2001: 16).⁹⁰

2.2.5 Conclusion

Health supplements in magazines are becoming ever more glamorous and more frequent. They contain information on supplements, nutrition, and exercise that may have an influence on health and aging. Advice on how to avoid cancer appears frequently. However, headlines regarding cancer are becoming less sensational and more empathetic, a welcome reflection, perhaps, of society's gradual shift to a more willing acceptance of cancer as a reality, a potential 'lion in their territory' (see Glynis Hillyard's poem, above).⁹¹

As Sontag wrote in 1989, ten years after her experience with breast cancer, thinking about cancer has evolved, 'getting cancer is not quite as much of a stigma, a creator of spoiled identity, (to use Erving Goffman's expression). The word cancer is uttered more freely.' (Sontag 1989: 15). This may be more true to the experience in North America than in South Africa and England. (As evidenced in Stacey 1997). It is true that the person with cancer is now freer than ever before to make choices in terms of treatments and approaches to their own health if they step outside of the dominant discourse and can afford to do so. The option is to move between differing discursive constructions of the body, each suspicious of the other, and to have to find the truth in all of this. In the end it seems the truth is what is comfortable for each individual. The truth lies somewhere in between!

It is also true that AIDS has displaced cancer as the most feared disease of our time and AIDS is one of the reasons offered by Sontag for the diminishing secrecy, stigma and phobia surrounding cancer. 'It seems' writes Sontag, 'that societies need to have one illness which becomes identified with evil, and attaches blame to its "victims", but it is hard to be obsessed with more than one.' (Sontag 1989: 5) This 'truth' is hard to dispute and I have come to realise that the disease belongs to the individual and to all of us at the same time. We play a part in making the person dis-eased by being so dis-eased, by commodifying health and beauty and consuming the discourse, the stereotypical narratives, and the products it sells, by rendering invisible that which challenges the dominant discourse and its taboos. Whether our insensitivity to the general ills of the environment make a contribution to the condition of cancer, will only be known in time.

In terms of Western medicine, the patient becomes the partitioned 'material' upon which it practices its own research and investigation into the human form while at the same time attempting to cure and heal (read: make whole) through the understanding it is continually gaining from those fragments. The patient is thus subjected to anatomisation and dissection with all its connotations of violence. The violence is the 'hewing into pieces', the reduction 'to a powerless jumble of fragments', of that which was once a whole organic body (Sawday 1995: 2).

The threat or the reality of violence runs through all Renaissance anatomizations, dissections, partitions, and divisions, whether we encounter the term in a medical sense or in a looser metaphorical set of registers. This is not surprising since dissection is an insistence on the partition of something (or someone) which (or who) hitherto possessed their own unique organic integrity. But dissection or anatomization is, as Foxe shows us, an act whereby something can also be constructed, or given a concrete presence. In medicine, anatomization takes place so that, in lieu of a formerly complete "body", a new "body" of knowledge and understanding can be created. As the physical body is fragmented, so the body of understanding is held to be shaped and formed. In medicine, too, anatomization takes place in order that the integrity and health of other bodies can be preserved. The anatomist, then, is the person who has reduced one body in order to understand its morphology, and thus to preserve morphology at a later date, in other bodies, elsewhere. (Sawday 1995: 2).

According to Sawday, the completion of the 'Visible Human Project' (VHP) marks the end of the culture of dissection that began with the Renaissance. 'Their new identity as electronic cadavers secured, Adam and Eve will be available to be dissected and redissected in a series of infinite demonstrations. And with that dispersal of the body and its re-creation in electronic form, the culture of dissection will, at last, have come to an end. Undoubtedly, the Medusa will survive' (Sawday 1995: 270).

As Sawday purports: no matter how deeply we investigate the inside, we will never find the Medusa, and we will never be able to kill her. Is the Medusa the elusive and mysterious nature of the soul – that which makes us breathe? Is she this elusive thing no one can find? Or is she simply the body-fear, the fear of this 'fragmented and dispersed body-interior – a profoundly ambivalent region – whose power can be somehow harnessed for good or ill.' (Sawday 1995: 9) ... (yet housing nothing else, as seen in the work of Hatoum, *Corps étranger?*)

My starting point has been the intimate, subjective and personal experience of the body that I bring to my art-making. In turn my focus on my body in the artmaking process has had an effect on my perception of my own body beyond my artmaking process. I feel I have a better relationship with my body and am more at ease with its anatomisation than I was eight years ago.

Whether there is some truth in Gray's statement that a return to the body in the broad field of contemporary art practice will 'reach far beyond the art world' (*Mail & Guardian*, April 26–May 2 1996: 36) is perhaps not such a certainty. My suspicion is that the implications may be greatest when they reach into the power base of the medical profession's hold on the body and the corpse. It is a question too of whether artists manage to change perceptions in the broader social body, or merely reflect shifts in social consciousness. Perhaps this must remain an unanswered question. Or, as Dr Jane Goodall has written, the works of artists who test the limits of the body are social experiments that may advance awareness and understanding of these limits, taboos, 'excluded possibilities', and fears (*Artlink* 1997: 15).

This is enough for art to do! Hatoum articulates: 'I don't think the language of visual art is the most suitable for presenting clear arguments, let alone for trying to convince, convert or teach.' (quoted in Archer, Brett and de Zegher 1997: 10) I do believe, however, as Gonzalez-Torres did that art can efficiently offer 'cultural critique', and in this way it does provoke if not incite awareness.

3. PRACTICE: The Art of Survival

What this continuity of cultural interest in the interior demonstrates, despite the temporal variance in the media of its expressions, is a belief that the coherence of the individual subject depends upon a stable relation of interiority and exteriority in which the interior is held from vision. To be opened up, to be known, is to be less than a whole identity, even when one is only temporarily cut up during remedial surgery. One is instead corrupted by pathological excrescence, or intrusion – the tumour, shrapnel, or evisceration – the knife (whether of public executioner, psycho-killer or surgeon). The dissolution of the interior/exterior relation is a dissolution of the subject. As Julia Kristeva asks in her study of abjection, *Powers of Horror*, 'How can I be without border?' (Chris Townsend in *Vile Bodies: Photography and the Crisis of Looking*: 1998: p 68)

My interior was 'held from vision', sometimes consciously and sometimes unconsciously. I set out to see it and part of this dissertation has contained an account of how and why I did this. This section aims to explain what I have done with it. The paradox is that through doing this, and through repositioning my experience of interiority and exteriority, I have attempted to form a coherent identity.

3.1 Introduction

Being both the subject and the object of my own investigation means my subject is very close to me and there is very little distance between it and myself. But as Jo Spence remarked of her own attempt to deal with her second cancer:

... and I'm now using my camera as a notebook. I keep a diary. I'm watching, and I know there is no easy answer. How do you make leukemia visible? Well how do you? It's an impossibility. It's what I went through before – a crisis of representation. I actually haven't got very much to say at the moment. I'm dealing with an illness that is almost impossible to represent. I have not the faintest idea how to represent leukemia except for how I feel about it. (Spence, *Cultural Sniping*: 1995: 215)

This work is a reflection of my expedition into the contours and inner realms of my own topography and the fascination with the tunnels, cross sections, formations and beautiful blights that are my morphological landscape. Applying this research to art making has required a foregrounding of certain issues over others while ordering and unifying many seemingly disparate and chaotic elements.

I see the condition as containing a duality which needs to be represented – horror and beauty. Horror at the condition of one's own body, yet awe at the magnificence of it. To see and represent the imperfect body as the continuum of life and death and as, in the Eastern systems of viewing it, the body as a microcosm of the universe, is a daunting task. I wrote this before I had fully understood the work of Kiki Smith and Helen Chadwick. Through them I see there is a way, but I don't hope to achieve this in my own work for a while. The focus in this collection of paintings is on the anatomisation of the body in Western medicine and my experience as a 'cancer patient'. The other discourses may not be apparent.

3.2 Paintings and Collages

My series of paintings do not necessarily offer a resolution of my story nor do they develop neatly. Rather they speak of the messy process of isolating and dissecting my experience, setting the various parts in paint

– as tumour tissue is set into a wax block and then sliced into thin sections. (See App II figs 5 & 6) In trying to make sense of my own corporeality I have depicted my body, as Sawday described the body, as ranging from 'a mysteriously chaotic entity' to a 'carefully stowed cabin trunk.' (Sawday: 1995: 7)

Although a resolution of sorts is achieved it is partial and momentary, just as Nead (1992: 81) says of Spence's series *Narratives of Dis-ease*: '...., it does not offer a happy ending to the narrative of disease and treatment. It is impossible to read the series as a progressive development with resolution at the climax, but to see the fragmented forms of identity being worked through is nevertheless, enabling' (Nead 1992: 81). So too, my series of paintings does not have a beginning, middle or end; there is no sequential way of reading them, much like an incomplete series of cross sections. But put the slices together, one on top of the other and there is a layered body, containing multiple readings.⁹²

In discussing 'the struggle for self-definition and self-representation', Nead takes a cue from Spence's piece, *Write or be Written Off*, and writes: 'To write, or more generally to represent, is to take power; it is to tell your own stories and draw your own lines, rather than succumb to the tales and images of others. Of course, there is a risk involved; you might not end up telling a fairytale with a happy ending, but at least you are the narrator and are in control of the means of narration' (Nead 1992: 82).

As we have seen throughout this dissertation the many artists referred to have narrated their own stories without 'fairytale endings', and have taken 'control of the means of narration.' This is the climate I have entered into.

I am unsure whether I have narrated a story or simply laid out sections/fragments/particles of my experience and my responses to this experience within a broader story of a society wishing to hide certain tales. There is a risk in the laying open of the story and crossing social boundaries. Perhaps there is a curiosity by some to play 'peekaboo' (Sawday 1995: 12), curious but too afraid to ask the tellers for their stories. One assumes the existence of an audience upon which to lay one's own experience. Is there an audience out there (public, health or art) or a disinterested social body? Is the necessity to narrate one's own story enabling only for the self? Hopefully not. Hopefully by making MY cancer visible, I make cancer visible.

On a very personal level, the paintings also function as amulets or fetish objects, aimed at warding off evil, or asking for healing/cure or simply more days of this life. (This reminds me of the Jewish festival of the 'Day of Atonement' when one asks to be written in the book of life for another year, not to be struck with disease or death. The premise on which this request is made, is that one atones for and asks for forgiveness for all the sins one has committed over the past year and even forgiveness for the sins of which one remains unaware. Even though I question this "trade off", I still like the idea of being able to ask for one more year. In some interpretations of this tradition, illness can be understood as a punishment and death as the most extreme punishment if your sins are not forgiven. I think this is a bit extreme!

What I have also had in mind is the *memento mori* for remembrance of loss, like the hair that was painstakingly braided into Victorian rings and brooches, to commemorate a dead loved one. In this way the paintings are objects of affection, in memorium for parts of myself I have lost. I have in a way created my own *memento mori* by painstakingly 'braiding' traces of loss into the surfaces. I have not yet completed the specific paintings with bits of my hair embedded. But in the small collages they have been carefully placed along with bits of reminders of 'loss' such as bandages, prescriptions, a skull and a photocopy of Holbein's *Dead Christ*.

However, as opposed to only reflecting the warning or reminder of death, I see the paintings also as *Memento vivere* (*L = remember that you have to live, a reminder of life; a reminder of the pleasure of living* [Oxford Dictionary]). I get great pleasure out of the planning and painting. This is their polarity and the paradox.

Another way of viewing the paintings is as diary pages or pages of a notebook. In this way they are a locus of my experience, drawing on all the notes in my little books that I carried with me over a period of years (see Appendix II fig 43). Each painting is a separate page, yet they overlap too. Of course there are many pages I have omitted due to lack of time, but hope over time to cover a few more. If they are ever completed, I imagine them collated as a flipbook, narrating the story of my body.

Illness has been described 'as a call for stories' (Frank 1995: 53).⁹³ and much has been written about the healing powers of the narrative and the self-narrative. A large part of the manifold and multitudinous narrative has been told through the text and the art making – other parts of the narrative are told in different situations and contexts and to different audiences. This telling acts as a healing remedy in that it aids a partial resolution for the emotions of the patient as object, (such as the indignation and anger, felt as helplessness and discomfort), through regaining a sense of control and allows an ease with the narrative. The story is retold over and over again that the actual memory fades and no longer exists in its original linear format. This is another reason that the slices of my body experience have no particular sequence. These paintings are the story as retold to myself!

The repeated image of the body in the paintings is from a drawing from a notebook I kept while having chemo. I have never been surgically opened in this region and therefore do not actually have a gaping wound in my middle. I have only two surgical incisions from the biopsy surgery to remove two lymph nodes – one of them measuring 7 cm. This 9cm incision is my largest scar. The missing head of the image denotes the body experience of the medical division, the missing arm denotes a disempowerment, although it is compensated for by the other complete arm and hand which is very busy with the process of suturing in an attempt to close the wound. In this way the paintings are an enactment of working on my own body, as distinct from the continual experience of my body being manipulated by others. I build, remove, poke and scrape the tactile medium of paint and wax, as I have been poked at, have had bits removed, have had bits grow, have been scraped bare. This is a dual process – I stitch myself closed and I manipulate the paint in the creation of the body(s). My studio is my own dissection theatre, I am my own surgeon.⁹⁴

The paintings are also the result of an act of surveillance in that I have been very vigilantly and obsessively recording and capturing minute elements of the experience with various means, then scanning the records and capturing certain scenes permanently on canvas (the film). Another way to describe it is as a collection of negatives, which can be developed and printed at any future time. I have put everything under surveillance and then created my own archive like a pack rat or a very thorough intelligence agent – all evidence is available for re-interrogation, no evidence is lost, although some might still be buried.

The serialisation of the image is also a replication, mimicking the cancer cells that replicate. The repeat is a pattern like DNA, like cells, like the CAT-scans, like the blood tests and like the projected trajectory of the illness – remission, relapse, remission, relapse.

Obviously the experience of internalising and exteriorising disease is unique to each individual but commonalities remain. When one has, or has had, cancer and chemotherapy, multiple readings of the body are/were all experienced on different levels – emotional, psychological, philosophical, physical, and spiritual. These readings are expressed in varying degrees in the paintings and the *Cross Sections II* video.

These multiple readings echo those invoked by Sawday's juxtaposition of two divergent world views. The first is the scientific belief that our bodies are designed by genetics and the second, Carolyn Walker Bynum's descriptions of medieval 'body-behaviour' as 'disturbingly unscientific phenomena: stigmata, incorruptibility of the cadaver in death, mystical lactations and pregnancies, catatonic trances, ecstatic nosebleeds, miraculous inedia, eating and drinking pus, visions of bleeding hosts.' The latter, Sawday argues, is evidence that 'the body seems to possess its own specific forms of history which are ordered by a network of social and religious codes' and is therefore 'the product of a cultural history'. Sawday asks: 'What are we to make of such a divergent sense of corporeality? Is the body a carefully stowed cabin trunk, or is it, as here a mysteriously chaotic entity? Is this divergence just a question of people's observing the body's internal processes within different cultural frameworks? Or did bodies, in some obscure fashion, behave differently prior to the advent of a scientific view of the world?' Yet he states these divergent views are united by 'a sense of interiority' (Sawday 1995: 6 – 7).

As previously discussed, the contemporary experience of cancer and 'the sense of interiority' that accompanies it, brings one into contact with accounts of similarly 'disturbingly unscientific phenomena'– the medieval experience is not so far away from the contemporary one if we listen to the evidence today from New Age testimonies which add a whole new range of 'body-behaviours'.

As discussed in relation to Hannah Wilke, it is the 'network of social and religious codes' that one has to shed in order to truly experience the bare process. The paintings may bury these in the materials, but they are a way for me to feel I am unravelling this network.

There are many images I have not yet incorporated into the paintings. The paintings have not exhausted the ideas developed in the thesis nor the polarities expressed in the phrases used by Turtiainen to describe the work of Sirkka-Liisa Sass: 'a body deviating from the norm', 'understanding of health and sickness', 'beauty and ugliness', 'good and evil' and 'normal and abnormal' (Turtiainen 2000: 15).

3.2.1 Notes on the Media and Images in the Paintings and Collages

Wax

– This material is related to the wax blocks – the first physical medical evidence of pathology – a neat way of encasing an out-of control-tissue fragment.

– And wax models (Ecorchés).

– As it was for Kiki Smith, wax as a material is good for its quality as a skin-like evocation: 'Wax [like paper] is also a translucent, luminescent material, so it always gives you some life' (Kiki Smith in Posner: 1998: 25).

– Wax is also linked to religious ritual, where for example, candles are burnt in Catholic and Greek Orthodox churches. In Mexico candles for the dead, which are now yellow or white paraffin wax, were traditionally made of yellow beeswax, and candles are different shapes and sizes, some decorated and some in glass containers.

Oil paint

– Tactile, textural, shiny, wet, gooey, drippy, stays alive for days.

Blood

– = Life and death.

– 'Menstrual blood has long been the focus of a network of taboos and phobias in western culture. Blood was (and still is) an emblem of life, particularly within a framework of Christian symbolism. But blood is also a sign

of sickness and injury' (Sawday: 1995: 10).

– My blood carries the immature B cells that are the lymphoma, on their way to the lymph nodes. It is for this signification that I have used my own blood, retrieved in test tubes from the hospital while undergoing blood tests, mixed in with the paint. Once dried it does not retain its signature colour, but turns a brownish colour. I have mixed blood with an acrylic glaze, in various consistencies of glaze and blood. When mixed with white pigment the blood leaves a trace of its presence as a slight discolouration.

Thread

– Exploited for its usual reference as suturing, sewing, joining, constructing and pattern making. The idea of pattern making is explicitly referenced in the brown paper body, which is surrounded by needles.

Herbs (in the collages)

– Along with acupuncture, herbs represent the primary experience of Chinese medicine.

Photocopies

– The process – cutting, pasting, enlarging, erasing, altering, layering, adding handmade marks to pre-existing images, losing the original, repetition, etc.

– Paper as skin – Kiki Smith talks of how paper mimics skin: 'Paper is translucent, it's luminescent, it has all these qualities that make it similar to skin' (in Posner 1998: 25).

– The photocopy also allows enlargements of details.

Acupuncture Needles

– Representative of a primary experience of a cancer patient when undergoing chemotherapy, known to be effective as an anti-nausea treatment.

– Referencing Eastern medicine.

– Balance, chi, wholeness.

– Pain by needles.

Cyanotype

– Colour: blue = x-ray film, bruising, negative image, 'blueprint' of our genetic makeup.

– The **master blueprint** (the human genome) is no more than concrete objects in the form of about 70–100 000 genes (sets of instructions). The physical manifestation of genes is the molecule of DNA, which is carried in the chromosomes of cells. Weinberg (1998) explains that human tissues are complex societies of individual cells that all arise from a single cell – the fertilized egg, which carries the master blueprint and, through repeated rounds of growth and division passes it on to the trillions of descendend cells that form a complete body. This single blueprint generates diversity: different cell types have different internal programs, i.e. express different components (genes) of the common set of instructions in the blueprint script (DNA sequences). This selective consultation of the library by embryonic cells then choreographs their future behaviour by choosing distinct fates (differentiation). In most mature tissues, cells are continuously dying and being replaced by the critically regulated regrowth of replacement cells. To understand cancer, we must understand how the inner blueprint of normal cells tells them

when they should or should not multiply and how this control system becomes deranged in the cancer cell. These complex mechanisms are currently partially – but soon to be more comprehensively – understood, through biochemical and other research now that the entire human genome has been decoded.

Plasters and Bandages

– The usual associations with wounds, mending, healing, joining, also as dressings i.e. covering body excretions, unsightly lesions, eruptions, stitches.

– 'Pinkish' bandages as fabrication of skin, a false skin. The colour and sometimes the texture mimic skin but it is always recognisable as a fake – a stand-in, a surrogate, a substitute, a proxy, a replacement skin, a skin double.

– Plasters say: 'kiss it better with a Band-Aid'.

– Micropore bandage and cottonwool are always placed over needles' points of entry and exit, to stop the flow of blood out of the vein, after chemotherapy and blood testing. I have collected too many to count. Nice and clean on the outside but once removed, a tell-tale spot or smear of dried darkened blood is imprinted on the soft cottonwool. These tape and cottonwool combinations, in the shape of an X, are not pretending to be other than what they are – no soothing pinkish colour to hide them.

Hair

– Kiki Smith was named for Santa Chiara, who, as a sign of her devotion and vow of poverty, cut off her hair. The artist considers hair to be a highly charged subject for women because it is so closely identified with sexual attractiveness. Smith views the cutting of hair as a 'renunciation ... as a form of self-mutilation. I mean, it's a combination that is empowering, in order not to fit society ... it's about resistance, but also about creation and making more possibilities.' Smith clearly relates to her namesake's symbolic act of defiance and desire to be taken on her own terms. Her images of tangled hair, which she sees as an unfolding head, represent the artist herself and her resistance to the pressure of conforming to the cultural norms of femininity' (Posner: 1998: 18).

– It is losing one's hair that is initially the most frightening aspect of chemotherapy. The thought of it sent me into hysterical crying for days. It is the sign that points to the disease.

– Hair has been an obsession for me since mine fell out during chemo. The rapidly dividing hair cells cause one's hair to seem to continue to grow after one's death. These rapidly dividing cells also cause it to fall out after the administration of certain cytotoxic chemotherapeutic agents

– Before chemo I had long hair and was advised to cut it shorter to avoid it matting as it fell out. I did this and decided not to collect my cut hair off the floor, denying myself the opportunity to be sentimental about it. Ever since I have not been able to shake off a feeling of regret at this impulse and have wished for this cast-off hair to make work with. Nor did I collect the hair that I shed, on the pillow, in the shower – pubic hair and head hair. As the last few groups of strands left my head, I did gather them carefully, bagged them in zip-lock bags, and used them in the few collages I made at the outset of this degree. I have compensated for the large volume of my own lost and rejected hair by collecting similar looking hair from the haircutter. I have experimented with setting this hair in wax but have not incorporated it into the paintings yet. I have also been collecting the hairballs that remain in the bath drain after I have washed my hair. These are all formed into neat but hairy circles by being pushed into the circular drain catcher by the pressure of the water. They have also become progressive-

ly thicker as my hair grows longer. In this way they are a record of life – they can be measured and weighed as a way of recording time. Again I have simply stored these for later incorporation into some work.

– I have recently seen an exhibition by Mona Hatoum titled *Recollection* (1995) incorporating her hairballs that she collected from combs and brushes over a period of six years and stored in shoe boxes under her bed! (See Archer, Brett, & de Zegher 1997: 88 – 104 and Warr (ed.) & Jones 2000) In the installation hundreds of hairballs float loose on the floor and windowsills. Amalia Jones describes this work as using 'discarded parts of the artist's body to evoke a nostalgic sense of absence and loss.' She says: 'Hatoum ... was using a part of her body – a dead part and in a form that is usually discarded once it has left the body – to reconfigure a physical presence, taking a variety of forms which are both ordered and disordered, from tightly controlled to floating free.' The 'tightly controlled' component is a weaving Hatoum made from hair.

– People often believe that hair retains your 'energy' even once it has been cut off. Hair is also used in a diagnostic technique to measure all kinds of properties in one's body, through a procedure that requires only a strand of hair which has been removed from the head.

– Helen Chadwick's piece, *Opal* is described by Louisa Buck: 'In *Opal* the knots of hair, suspended in clear bubbling saliva, ..., act as an abject visual and bodily counterpoint to the jewel-like aspirations of the embryos, the hair sharing with these precious stilled lifes a peculiar intermediate limbo status' (in Chalmers 1996: n.p.). One very beautiful piece is *LOOP MY LOOP*, 1991, a cibachrome transparency. Betterton describes the piece: '...a gleaming pig's intestine intertwines with golden Barbie doll hair in a braided embrace' (1996: 142). For Betterton, 'the golden hair has a dual function as a fetish object, both erotic and, in a form of *memento mori*, marking lack – the hair which was braided into Victorian jewellery to commemorate a dead loved one.' (See Helen Chadwick in 2.1.3.f)

– I have in addition collected a photographic record of my changing hair status over a period of time – before chemo (BC), during chemo (DC), and after chemo (AC). This documentation has almost reached an end, since my hair is now back to its original pre-chemo length. This process has run parallel to the time it has taken me to complete this degree. I began growing my hair the month before I registered, three years ago. I have cut it only once in the past three years. (Before I began this degree I went through various periods with the newly growing hair, cutting very short, growing a bit, cutting a bit etc.) The initial growing stage is always awkward with some very bad hair weeks and months during which time one has to be very inventive with ways of controlling an unruly mass. Directly after the hair-loss period, once I was off the particular drug (adriamycin or 'the red devil' as the chemo sisters call it) my hair began to grow again. I had hung onto the last remaining wisps, which I managed to scrape into a tiny pony tail, with the rest of my scalp totally bald. I think I slightly resembled a Hari Krishna at this stage. As it began to sprout out of the bald places I shaved it all off so that it could all grow evenly. At first it grew very fine and quite sparse, then it became incredibly thick in very tight curls like a karakul lamb, and at times I felt as if I was wearing a rug on my head. No amount of hair gel or glycerin could keep this from feeling really weird. I kept cutting it off until finally the texture normalised again. All these stages have been documented, not knowing what I was going to do with the images. They are of varying qualities – random snapshots in colour collected from my albums, black and white from a session with a photographer friend, photo-booth shots from various angles like mug shots – front, side, back – ID and passport photos, which I have now ordered chronologically. (As I write this I am working with a videographer on this sequence.)

– The interesting thing is that with the return to 'normality' of my hair, I have also experienced a return to a sense of 'normality' – to the 'who I thought I was' before the diagnosis. The period of hair growth almost feels

like a performance piece of witnessing, or a ritual. It feels as if a circle spanning six years (since the onset of chemo) has closed. Old friends have noticed this and comment that I now look like my 'old self'.

– In some ways I feel like my old self but in other ways, as Susan Sontag says of herself: 'There is something about facing a mortal illness that means you never completely come back. Once you've had the death sentence, you have taken on board in a deeper way the knowledge of your own mortality. You don't stare at the sun and you don't stare at your own death either. You do gain something from these dramatic and painful experiences but you also are diminished. There's something in you that becomes permanently sad and a little posthumous. And there's something in you that's permanently strengthened or deepened. It's called having a life.' ' She has said this now at 69, after again being diagnosed with cancer – 'a rare form of uterine cancer, diagnosed in 1998, for which the survival rate is 10% after five years.' ... ' Facing down apparently certain death, only to confront it again in a similar form, she says, forces a permanent reevaluation of your sense of self' (*Mail & Guardian*, March 28 to April 4 2002: 25). Facing it once is enough to force this reevaluation, I am sure facing it twice increases the intensity.

Hospital Images

- Needles
- Medical Objects
- Scans

New Age Images

- Chakras
- Nadis
- Subtle Bodies

3.3 Photographs

I am not a photographer but I use photographs to record or 'copy' things that cannot be constructed, or things that have been temporarily constructed for the camera. Sometimes I use the photographs of others or my own, for reference, documentation, sometimes for collage and sometimes as proof of my experience. I have not yet used my photographs in the paintings. I have also used photographs taken by photographers (such as Sue Kramer) when I am unable to do so myself.

3.3.1 Nude Descending a Staircase

The interior view I was so proud of eventually became what I realised was an interesting new version of a nude. I had an inter-neg of the CAT scan film exposed onto photographic paper, (i.e. printed it photographically) so that it could then be reproduced to any size. Reproduced and enlarged as a photocopy, it became the *Nude Descending A Staircase*. (Watching others walk unaware over my body was perversely satisfying)(See App I figs 21–25).

3.4 Video

3.4.1 CROSS SECTIONS II

In order to make this video, the static images of 69 CAT scan cross sections of my body were laid down on a video track and then animated. Apart from simply locating the tumour, the partitioned 69 views were thus reunited, made whole, and given meaning again by joining them into a smooth journey up and down my body. The spectator is invited into a moving morphological landscape that celebrates the hidden beauty of the body's interior packaging - 'a landscape simultaneously strange and intimate' (Gray, *Mail & Guardian*: April 26 – May 2 1996: 36).

Within the shifting mass – concealed from the untrained eye – is the tumour that flits past at high speed and at regular intervals.

'In this subject/object shift, the artist's own body has taken the place of a model "out there", and has become the art work' (Petherbridge 1997: 10). Of course one still needs the model 'out there'. For example, I could only see my own lymph nodes on the scan as a grainy grey image that looked like everything else. (So indistinguishable that only the radiologist could point them out to me). I still needed to see them in a 'model' or real body (cadaver).

The study of the body by artists has given scientists new ways of being creative with their materials and tools. The anatomy teacher at UCT, who assisted me in selecting, ordering and sizing the cross sections, proposed to use the video to inspire his students' interest in the study of anatomy. (Yet neither the dissected cadavers nor the video are the original true body.) The experience of interiority is still mediated when seen on a X-ray film or on a monitor – it does not have the gruesome association of the flesh/meat.

When I showed the video to someone he marveled at how compact, well organised and cleverly fitted the organs are in the frame of the body. This reaction is similar to the one related by Sawday: 'Witnessing a modern post-mortem, Michael Didbin has written: "(...). Everything seems so lovingly packaged and arranged, like a cabin trunk stowed against breakage with just those items necessary for the voyage"' (1995: 6). Yet, Sawday points out that: 'To think of the body as a "design", for example, is a peculiarly western, late twentieth-century form of response to the body's interiority, which is conditioned by a variety of technological and psychological factors: the role of modern medicine, the individual's disease history, the importance of computer technology, even the experience of "planned" systems in our everyday lives. Of course the body has no "design", but, looking into the interior, it is hard to shake off the impression that the body's internal organization is the product of careful thought, and even economical arrangement' (1995: 6).

I must say this echoes exactly my response to seeing my full body CAT scan image for the first time, as well as to the cross section images, once I had seen them moving through the sequence and had finally begun to understand what it was I was looking at. What also occurs to me is how the body accommodates a new form or growth that was not intended to be there in the first place. It allows it to fill empty space, it is quite pliable in terms of the shifting organs, and it can expand to fit. It does, however, of course have its limits when it can no longer accommodate a growth that is too large – then it bleeds or sends pain signals if, for example, the growth causes interference with the function of another part.

I also believe that by showing this video, I can provide this topography to others, and it might assist them in seeing their bodies through mine. (See App I figs 26–28)

3.5 Recurrent Themes in my Work

3.5.1 Frida Kahlo

– Although not directly apparent in my work, her work is always present. I always return to her images, exquisitely painted on small canvases, under the most adverse conditions.

3.5.2 The Grim Reaper

– The Medieval European death cults centre on the image of death as the 'Grim-Reaper', the *Santísima Muerte (Most Holy Death)*. In Mexico, this tradition was imported from Spain in the early 16th century and merged with pre-Hispanic practices involving skulls and skeletons and images of Death personified as a skeleton were carried in procession through the streets and to this day are associated with funerary rites in

Colonial Mexico. The famous engraver of popular prints, José Guadalupe Posada (1852 – 1913) developed the tradition and extended these images. Posada's skeletons, dressed in the clothing of the day 'were less the mocking harbingers of death, but rather wry commentators upon the vanities of life' (Carmichael & Sayer 1991: 58). The skeleton is a reminder that 'death revenges us against life, stripping it of all its vanities and pretensions and showing it for what it is: some bare bones and a dreadful grimace...' (Carmichael & Sayer 1991: 14). The skeleton that I have used in my paintings is a triumphant Mexican Day of the Dead skeleton who smilingly holds two skulls high above his head. (See App II fig 34)

Posada's commentators were similar in spirit to those in Holbein's vision in his *Dance of Death* (1538), as encapsulated by Kristeva: '... all of humanity is in the grip of death. Lost in the arms of Death, no one escapes its grip, ... but here anguish conceals its own depressive force and displays defiance through sarcasm or the grimace of a mocking smile, without triumph, as if, knowing it is done for, laughter is the only answer' (in Feher 1989: 249). We must laugh! Holbein also included skulls and skeletons as well as the grim reaper in a number of his paintings.

3.5.3 Skulls and Skeletons

– The Day of the Dead is symbolised by sugar skulls and skeletons.

– In contemporary Mexico the dead are buried in cemeteries but during the Day of the Dead festival it is believed the dead souls return to visit the living relatives. A feast is prepared on their behalf and they are believed to eat the essence of the food and return happily to the graveyard laden with goods.

– I have incorporated the skeleton in my work in order to make reference to Posada and Holbein where they act as reminders that no matter where we find ourselves and in what position we may be we all have death taunting us. When I have used the image of the grim reaper it refers to the Spanish image used as a memento Mori and as a signifier or bringer of death, cancer being one of its tools. Sometimes the two images are interchangeable and are both at once signifiers of death and ironic commentators on the relationship between life and death. The Mexican skeleton more overtly refers to the 'other' – the skeleton that lives inside us and is waiting to be revealed at death. An X-ray therefore has a deathly quality about it. It is the only time the living see confirmation of what they are going to become once the flesh falls off. Common to all humans is the question – is there indeed an afterlife and what is this thing called death? It remains enigmatic.

The skeleton

– Skulls and skeleton imagery through popular and historical use are accepted as Universal symbols of death (The bare facts!)

– For me, the use of the skeleton image is all of the above as well as a mocking idea – mocking others to look at me as if I were that skeleton – as well as containing that skeleton of the other – as well as wearing that skeleton on my sleeve and bearing the news that we all will die someday so don't look at me like that – mocking the fear in others – I am not afraid – I am it/ I have met it and know it already – my own bravado!

– The skeleton symbolises superstition.

– Represents the state of limbo between the two polarities of life and death.⁹⁵

Skulls

– Staying with Mexico, historical accounts tell of the attempt by the Spanish Church to have all the 'demonic' Aztec gods/idols destroyed. The symbols with which the idols were decorated were mostly incomprehen-

sible to the Spanish. 'Among these symbols there were however at least a few that were recognizable: The skulls and the bones, the universal symbols of death. In the charnel-houses of Spain there were piles of skulls and bones, decoratively arranged; even so, the piled up skulls of the tzompantli and the stone sculptures representing these structures horrified the Spaniards. The charnel-houses held the remains of those who had died a Christian death, the Aztec tzompantli held the remains of victims of dreadful sacrifice. The skull as *memento mori* was the reminder that this life is just a preparation for the true life with God after death.' This pretence by the Church is shown up by comparison with the Aztec symbols which laid the facts bare. (Carmichael & Sayer 1991: 41).

3.5.4 Memento Mori

– a warning or reminder of death, esp. a skull or other symbolic object.

– Jordanova has this to say on the *memento mori*: 'For many centuries, when it came to pictures, the skeleton was the conventional motif through which' issues of mortality and the progressive decay of flesh after death as witnessed by anatomists, life after death and questions of the quality of a life lived, were expressed. ...and 'highly realistic depictions, whether two- or three-dimensional (especially wax), which simulate life ... serve as reminders of death' (Jordanova 1997: 104–106). I believe that my paintings with wax are a form of *memento mori* as they were made with this spirit in mind.

3.5.5 Lymph nodes

– I have collected as many images as I can find in different diagrammatic and photographic modes.

3.5.6 Roses/Flowers/Petals

– 'I used roses and hands to symbolize her life; she passed from the bloom of youth to death' – Maria Antonieta Sánchez de Escamilla interviewed about an offrenda (a non-religious altar) she was making for a fifteen-year-old (ququoted in Carmichael & Sayer 1991: 117). During the Day of the Dead Festival flower petals are laid out on the grave in the shape of a cross, and strewn as paths for the dead to find their way.

– Flowers and in particular roses in the West, are symbolic of death or the transience of life. The petals are so beautiful and yet so temporary – and they visibly shrivel and decay, akin to the visible aging of the human skin.

3.5.7 Incense and Water: Purification

Two pre-Hispanic traditions that survive to this day:

– Burning of incense or copal (scented resins) = to chase evil spirits away.

– It is also called 'the super odor of the center of heaven ... and the brains of heaven' and was offered as a sacrifice to the gods (Carmichael & Sayer 1991: 145).

3.5.8 The Virgin of Guadalupe

– Known as 'Patroness of the Americas' and 'Patron Saint of Mexico' she represents the religious body:

– Along with The Virgin of Fatima and St Bernadette of Lourdes, she represents the miraculous body.

– A votive offering like the votive candles found in Hispanic culture. As Posner described Kiki Smith's *Womb* (1996): 'It suggests a votive offering presented with the hope of healing the afflicted body part' (1998: 14).

– She also represents faith and the power of faith to heal.

- Painted in dripping wax like a candle: refers to altars and 'Milagros' which are like amulets to ward off evil or to ask for the healing of that body part

- 'As Catholicism's dominant female deity, the Virgin has a large cult following that has grown around her role as the compassionate intermediary between humanity and God' (Posner 1998: 22). As a powerful and well-known icon, with her roots in Catholicism, she is universally understood.

- As Kiki Smith, who emphasised the figure of the Virgin Mary in a body of work created after 1993, said: 'One of the things about Catholicism is, it's a religion that's about making things physical, about taking emotional and spiritual ideas and making them physical. ... Catholicism uses a body model or image to address the spiritual condition' (in Posner 1998: 22). In this way Guadalupe is a direct reference to Catholicism. 'According to one critic, "A stress on the physical body has long been a key element in Catholicism. While Protestants view the kingdoms of God and man as essentially separate, Catholicism stresses the continuity of the divine and the human. All the major mysteries of Catholicism – the Immaculate Conception, the Crucifixion and Resurrection ... the Ascension and Assumption of the Virgin Mary – emphasize the role of the human body as vessel of divine spirit.'" (Posner 1998: 22).

- Thus the origins of the Patron Saint of Mexico lie in the Catholic Church, imported to Mexico with the colonists, and their missionaries who were sent to 'un-paganise' the inhabitants. The Christian church in Europe had attempted to re-focus the pagan rituals and establish celebrations for the saints instead. But they were not entirely successful and pagan practices associated with the dead persisted for many centuries. When the Spaniards arrived in Mexico they brought with them the official Catholic religion, as well as these surviving practices of early sixteenth-century Spain.

- The saints were quickly adopted and replaced the gods of the polytheistic religion of pre-Hispanic times. 'The best-documented example of this syncretism was the identification of the Virgin Mary with the goddess Tonantzin. In 1531, in a miraculous apparition at the site of Tonantzin's temple, the dark-skinned Virgin of Guadalupe, who was to become the patron saint of all Mexico, made herself known to the Indian Juan Diego' (Carmichael & Sayer 1991: 40–41). An image of either is usually placed at the centre of the altar or offrenda along with candles, flowers, burning oil, copal and water for purification. Some families have two altars, one for the saints and one for the souls. Often the Catholic Saints and Pagan gods are placed side by side on the altar. In some houses the altars for the Saints are permanent, in others they are only erected for the Day of the Dead. If they have photos of the deceased they are put out on the altar as well. The Virgin is still referred to as Tonantzin in some Indian villages of today. (The local patron deities of pre-Hispanic times were each replaced by a Catholic saint.)

- She also represents the fact that in medieval Europe 'women seemed more apt to somatize their inner emotional or spiritual states' (Caroline Walker Bynum in Feher [ed] 1989: 173).

4. CONCLUSION

Technological advances in our postmodern lives strengthen and renew the crossover of the medical and the artists' discourse. The visual products of medical technology are perfect materials for artists, as the study of anatomy and anatomical modelling was in the Renaissance. By making these materials public, our perceptual understanding of our bodies increases, and social orders are challenged, as the body is inseparable from the latter. Artists have an advantage over anatomists (who are confined by the more 'legitimate' medical power structure) in that their investigative practices are not controlled by the ethics that regulate medical experimentation, especially when assisted by doctors who are willing to risk the breaking of those codes.

The copious process of research has enabled me to understand my condition in a way that was not possible before. For example, having gained a visual literacy of the CAT scans, I can now, after every session, look at and discuss them with the radiologist, instead of confronting their mystifying abstraction in the form of the report.

The theoretical study has shed light on my need to understand the origins of cancer and the experience of anatomisation as a cancer patient, a practice that defines both biomedicine and some of the alternative discourses. The identification of a number of common threads that link the examination of the body in art and science, in particular the penetrating gaze, has resulted. Putting my body in the frame has had a twofold effect by allowing a sort of purging and enabling a sense of control.

Cultural, economic and political forces constantly mediate 'Truth'. In order to access the truth it is these forces that need to be 'stripped bare' and it is by looking for hidden histories in the social and biological arenas that the truth may be approached. The value of feminism was not only in the 'articulation of difference' it provoked but also in its legacy of challenging structures of power (not only the patriarchal) that has trickled down to all forms of theoretical and cultural practice. The contemporary artists referred to in this dissertation are either first or second-generation 'feminists' in that the latter have inherited an understanding of the importance of these challenges. These artists work with a consciousness articulated by Mary Douglas (1966) when she wrote '...all margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. ... The mistake is to treat bodily margins in isolation from all other margins.' (quoted in Bradley 1995: 5) These 'second generation feminists' do not make this mistake.

These artists' enquiries are united by their investigation of the social constructs of health, difference and acceptability – simultaneously presenting these outer surfaces and venturing to expose the duty 'to hide a secret which is the awareness of the presence of the [body] interior' (Sawday 1995: 12). The works present 'whole body' experiences in ways that are often both intriguing and alienating. Artists' responses to their ill bodies are united by these desires, as well as the desire to embrace 'Otherness' and to expose the hidden 'truths' of disease. The works encompass a range of responses, challenge and reflect social aspects of disease. For the viewer who may never have been confronted with their own interior, they explore the other, 'in the hope (or the fear) that this other might also be us' (Sawday 1995: 8) Artists are offering the possibility of vicarious living through the application of their practices to the body.

Feminism offered artists the opportunity to explore previously excluded possibilities and to render visible that which challenges the dominant discourse and its taboos. For example, Mona Hatoum is able to investigate her interest in 'the organic physiological processes of the body and the social taboos connected with' them (quoted in Archer, Brett and de Zegher 1997: 141). Art also presents a counter face to the perception of the world offered by science in its ability to communicate and explore a physical understanding of what it means

to be in a body, to be alive, that is not bound by neutrality or rationality versus irrationality. Artmaking can integrate body and mind, emotion and intellect, facilitating embodiment.

However, if we are to take Stelarc's technodeterministic beliefs seriously, we no longer exist as a duality but must add technology as a third element of being human! Art can embrace magic, fabrication and emotion and for the artist/patient artmaking can offer a form of integration. And unlike doctors, whose knowledge is 'sacred', we can share it, without feeling that we have to protect or shield anybody from our gaze, (let alone from ourselves).

Through looking at the various histories of art, the body and medicine, it is apparent that the Renaissance, feminism and new imaging technologies have given us tools we use to understand others and ourselves. The creation of scalpel-free anatomy is allowing further mapping of the interior. By reaching even greater depths into the 'body-object', however, we open up new body fears, such as images of 'the source of' our 'own dissolution' (Sawday 1995: 8). The Medusa has the last laugh! The taboos governing our interactions with our body margins are directly connected with the fear of knowledge that denies us the possession of a spirit or soul. This body fear is still greater than the fascination and it is this that contemporary artists have challenged. While artists were once complicitous in this process of fragmentation, many are now offering a view of the discomfort it produces and others are pursuing a view that signifies a return to the 'whole'.

Advances in biochemistry have afforded us an understanding of our ill bodies in a less speculative way. In terms of cancer, Western medicine offers a rational, empirical view: the cancer cell is itself not an intruder. It is only the product of a replication error of the existing DNA. The disease may be an intruder in the bubble of safety that we construct in our minds in order to live, but the cell itself is not. Sometimes we are born with an inherited faulty gene. We can live with that. But if the partner gene also becomes faulty that is when the problems begin. Only 'about 5 percent of us start life with at least one brand new mutation found in neither parent' (Nesse and Williams 1994: 94). The only real intruder may be the carcinogenic agent, causing copying mistakes. It is more a question of a betrayal from within when the replication error is overlooked by the guardians that exist in every cell.

Technology intrudes too as it travels through and collapses onto a monitor the space occupied by the body. The benefit that the computer monitor offers is a perfectly condensed view (whole and sectioned) of a vast landscape, in which the eye of the radiologist can interpret as cancerous the tissue identified by the measuring unit of the CAT scan, MRI or ultrasound. This picture is enhanced when the diverse images obtained by various devices are unified and the grey blob of the tumour as shown by the CAT scan is converted into its component parts of tissue cells obtained by the microscopic colour pictures of haematology. Representations become the reality and the visual image of the cancer offered by Western medicine enables the patient to 'see' the illness and physically locate the condition. The self-documentation and performative actions of the artist/patient complete the view – that considered unnecessary for medical investigative procedures.

It is not easy for the patient to obtain these visuals, but once they are obtained and interpreted, they offer a clear picture of the disease (and how it operates). Science has identified the even smaller components of the entire human genome but is still searching for the greater unifying theory of matter. For the patient, the ambiguity that is left by Western medicine is still the philosophical question: 'why', and 'why me?' So despite the progress of Western science, assisted by technology, there is still a lack of 'total' explanation that some lament.

The latest cultural understanding of cancer is as a physical betrayal 'of the self by the self' (Stacey 1997), which often serves as a trigger for spiritual questioning. This leads us to the New Age discourses, which believe that what fuels us does not originate in our DNA. The belief is that the challenges sent us via our physical bodies are a reason to seek spiritual 'ascension'. (Myss 1996: 78) This is the story of Job all over again! The visual image offered by the New Age discourse is of the disease travelling through the energetic body (mind, spirit) before manifesting on the physical level, occupying 'the cells' – but it is not explicit about *which* cells.

The explanations offered by 'alternative' and 'complementary' systems for cancer encompass imbalances in the systems of the body and a need for a homeostasis on various physical and metaphysical levels. Some of them banish the discomfort of the mind/body dichotomy as well as its displacement by technology. Their visual images are beautiful but largely figurative and they abstract, dissect and reduce the body in a different way. So, while this beauty balances the coldness of Western medicine (which abstracts to aid its efficacy), a partial comfort is offered from the Western anatomisation by providing a unifying perspective that was fragmented by the age of Enlightenment, when it banished the sacred. Thus the alternatives offer alleviation from the emotional (by way of reintegration) and from the physical effects of biomedicine (acupuncture relieves the nausea of chemotherapy). But they do not offer the clear 'scan on plastic' perspective that science does – the alternative view is still partial until the scientific view is incorporated.

Gombrich's theory of visual perception holds true. We have seen how artists alter traditional schema, aided by changing morals and technology, their own curiosities, against a background of shifts in consciousness of society, suggesting 'the never ending link between art and object', knowing and representation.

5. NOTES

1. In conversation with Posner, May 12 1997 (Posner 1998: 28).
2. With regard to the notion of the 'cancer personality', Sontag (1979: 62) has cynically discussed the belief that cancer is 'a disease of unexpressed energy (and anesthetized feelings).' She notes that 'there is both a fear of having too much energy and an anxiety about energy not being allowed to be expressed.' Sontag expressed her belief that it is 'as much a cliché to say that cancer is "environmentally" caused as it was – and still is – to say that it is caused by mismanaged emotions' (1979: 71). This debate around the cause of cancer still continues today between allopathic and complementary adherents.
3. Stacey gives an example of the kinds of questions she was faced with 'time and time again': 'What does your cancer symbolise to you?' She describes how through the nature of these kinds of questions she was 'urged to find a range of metaphorical meanings embedded in and embodied by, my cancer.' Her response was to 'question the use of metaphors to describe cancer as a disease, and to consider the danger (as well as the appeal) of seeing illnesses as metaphors more generally' (Stacey 1997: 25).
4. In the Japanese Obon Festival the dead are also believed to visit the living.
5. Lines from, a Náhuatl poem, an Aztec language spoken in pre-Hispanic Mexico, quoted in Carmichael & Sayer (1991: 25).
6. Further explored in 2.2.2.
7. '...traces of loss and retrieval' (Atkinson, *Electronic Mail & Guardian* 14 Apr 1998).
8. In the recent film 'Wit', the patient undergoing chemotherapy wonders what the medical profession means when they anatomise her.
9. See e-mail letter in App III:2 (American Cancer Association)
10. In Rabinow 1986.
11. 'Three-dimensional models have played an equally important part in the study and teaching of medicine, particularly in the eighteenth century, but here wax was the favoured medium ... (Wax could be easily modelled to create fantastically detailed, "realistic" figures, and readily coloured to mimic or exaggerate flesh tones, organs, veins and arteries so that the models would be both instructive and pleasing to the eye ... the leading French, Italian and British wax modellers of the late eighteenth century, ... tended to have careers as practising artists as well as servicing the needs of the medical profession' (Heller 2000: n.p.)
12. 'For example, American artist Robert Gober deals with his own sexuality in an untitled work of 1990 which seamlessly unites male and female elements in a wax torso, sealed top and bottom like a paper bag: the body as container of meanings. Artists no longer refer to "figure" drawing but to the "body", which is conceived as a cultural construct, inscribed with social, sexual and gendered meanings. Photography and new media have tended to take over from drawing as the means of re-presenting the body, but in recent years artists have become fascinated with the anatomy theatre and anatomical

museum as spectacle; Damien Hirst is one such example' (Petherbridge 1997: 10).

13. Goodall is referring to Bryan Turner, 'Regulating Bodies: Essays in Medical Sociology'. London, Routledge 1992.

14. A more detailed discussion of contemporary performance artists, and experimenton the body, is contained in 2.1.3.b.

15. The oncologist displays panic and anxiety when the patient refuses to follow their directives.

16. See Bernie Siegel's *Love, Medicine & Miracles* (1986) for a different view: He refers to the assertive patient as the 'exceptional patient'.

17. Sawday quotes Descartes as saying: 'I think this is because they usually spend some days looking at the intestines and other parts before opening the head' (1995: 156).

18. 'The organisation of material in anatomical atlases relates to profound philosophical and socio-medical discourses about the body. Most general anatomies do not follow the physical exigencies of the dissecting room, which traditionally began with the viscera and ended with the skeleton. Instead the organisation of the images reveals belief systems, for example, about the "humours", or the location of the emotions or the soul. Leonardo located the "seat" of the soul in the meeting of all the senses (*senso comune*) in the "fulcrum" of the cranium' (Petherbridge 1997: 63).

19. Sawday states that 'in that same year, Spinoza was excommunicated by the Jewish authorities of Amsterdam for expressing sympathy with Cartesianism – an irony of philosophical history since it was to be Spinoza in the *Ethics* (1678) who sardonically attacked the Cartesian doctrine of the soul's location in the pineal gland. Deyman's public excavation, then, into the skull of Fonteyn in Rembrandt's painting was an event charged with intense religious significance to those who followed the debate' (1995: 157).

20. See 2.2. for a discussion of the return to wholeness, the lack of disease, a return to unity, as opposed to partition.

21. 'The grotesque body is the open, protruding, extended, secreting body, the body of becoming process, and change. The grotesque body is opposed to the classical body, which is monumental, static, closed and sleek, corresponding to the aspirations of bourgeois individualism; the grotesque body is connected to the rest of the world.' (Mary Russo from 'Female Grotesques: Carnival and Theory', quoted in Bradley, J. 1995: 20)

22. See Kiki Smith in 2.1.3.f for her challenge of these accepted standards.

23. Cancer fits this category perfectly! It creates ambiguity and uncertainty. It breaks the boundaries, doesn't respect borders, and forces on one the stuff that is normally hidden from view. It is discussed in these terms in 2.2.

24. The figure of Mantegna's *Dead Christ* has always come to mind when I am lying on the CAT scanner bed, 'with the soles of the feet turned toward the viewers and the foreshortened perspective.' As noted by Kristeva there is a definite sympathy between the medieval view and the contemporary view of the body.

25. Atlantis Gallery (23/03/02–29/09/02), where a horrified and outraged viewer attacked and damaged one of the exhibits.

26. The website states: 'Their selfless body donations allow us to gain unique insights into human bodies which have been reserved thus far for physicians at best. We thus wish to thank the body donors.'

27. See Exhibition Guide, pamphlet in App III.

28. See 2.1.3.c.

29. See *Tale* (1992), wax, pigment, and papier-mâché.

30. Quoted earlier in 2.1.3.e.

31. The cadaver I was shown at Medical School was that of a 'pauper' – a street person who had died of TB. Apparently this is common practice in the teaching hospital where unclaimed bodies find themselves on the dissection slabs of Medical students. See App II figs 46–49.

32. They are both attributed by Goodall as being the most prominent of a small group of artists 'who bravely pursue a whole body relationship with late twentieth century technology' (*Artlink* 1997: 9)

33. Schmuhl writes that Stelarc, while in Japan, explored the interior of the body, making a series of films of the body's interior using endoscopy equipment. He inserted minute microphones into his body and amplified the sounds of his interior, creating 'acoustical body landscapes'. Expanding on his interest in physiological control of the body, he experimented with various manipulations, for instance altering his breathing rate by relaxing, or constricting veins to change their sounds. 'Further efforts to modify the body led him to the use of complex prostheses [such as *The Third Hand*], also controlled by the body, in this case through signals by the muscles.' (Schmuhl 1996: 30)

34. Donna J. Haraway proclaims in her ironic *Cyborg Manifesto*, which examines how new technologies have impacted on social relations of sexuality and reproduction: 'These sociobiological stories depend on a high-tech view of the body as a biotic component or cybernetic communications system. ... women's bodies have boundaries newly permeable to both "visualization" and "intervention"' (quoted in Petherbridge (ed.) 1997: 64).

35.a Robert Lawrence was a young British officer who was shot in the head in the Falklands in 1992. Photographs of his terrible wounds (revealing his brain) and the surgery to save him were shown to his girlfriend, who was horrified and told him never to show them to her again.

35.b The taboo, simply stated, amounts to an injunction: no one should be able to see such things of themselves and speak of them' (Sawday 1997: 14).

36. There are obviously artists who are reacting to the invasion of technology. For example, the works in an exhibition titled *Technological Bottom Feeder*, were 'created by artists who worked with "degraded" technologies like the Diana camera (a child's toy camera) and the PXL 2000 (a video camera manufactured by Fisher Price) ... a reaction to the frequently utopian and elitist perspectives on new technologies'

(*Mix* magazine 1998: 22).

37. Referring to Jean-Galbert Salvage's *Anatomie du gladiateur combattant...*, 1812, Petherbridge notes that 'Salvage, an army surgeon, discusses in his preface the difficulty of finding perfect cadavers to be fixed and dissected in the position of the Borghese Gladiator.' She describes this as a 'gruesome exercise' (1997: 72). This is yet another glaring overlap in these exercises set more than a century apart.

38. Chinese medicine, for example, reads your pulse and your tongue for signs of imbalance.

39 See Sawday (1995: 12).

40. See www.asci.org.

41. Helen Chadwick died of a virus, myocarditis, at the age of 42.

42. In a different light: 'The question of the status of the dead human body is a fraught one. It is particularly fraught since, throughout the world, many indigenous peoples have ceased to tolerate the Western habit of 'acquiring' human remains for scientific (and sometimes non-scientific) investigation' (Sawday 1995: 3).

43. See correspondence in App III pgs 19–21.

44. See article by Rosi Mestel, *Cape Times* 3 Aug 2001, in App III: 22.

45. See Bob Flanagan in 2.2.4.g.

46. 'Rereading *Illness as Metaphor* now, I thought: By metaphor I meant nothing more or less than the earliest and most succinct definition I know, which is Aristotle's, in his *Poetics*. "Metaphor," Aristotle wrote, "consists in giving the thing a name that belongs to something else." Saying a thing is or is like something-it-is-not is a mental operation as old as philosophy and poetry, and the spawning ground of most kinds of understanding, including scientific understanding and expressiveness. (To acknowledge which I prefaced the polemic against metaphors of illness I wrote ten years ago with a brief, hectic flourish of metaphor, in mock exorcism of the seductiveness of metaphorical thinking.) Of course, one cannot think without metaphors. But that does not mean there aren't some metaphors we might well abstain from or try to retire. As, of course, all thinking is interpretation. But that does not mean it isn't sometimes correct to be "against" interpretation.' (Sontag 1989: 5)

47. Stacey ponders: 'Did [my cancer] symbolise the genetic malfunctions of a post-nuclear age?' (1997: 25).

48. Conversely, Bernie Siegel describes the successful and positive use of war terminology with his patients in visualisation techniques to 'attack' cancer cells, for which he has been criticised. Another visualisation image used by his patients is of a broom sweeping the body 'clean'.

49. Doctors can't be expected to give the patient an entire medical degree in an hour, but the gap in language is actually the biggest problem. Things that doctors take for granted – such as what a lymph node is – are absolutely foreign concepts to non-medical people. Because the doctor cannot think in the patient's shoes, they make no attempt to even communicate these simple facts. Their minds are already racing ahead to the chemicals and the cells.

50. Spence continued: 'By recording such events ourselves, particularly those of us who are powerless and

marginalized by the dominant stories in circulation (e.g. in contradiction to the “happy family”) a new form of social autobiographical documentation can be put together’ (1995: 172).

51. Genes exist in pairs and ideally function identically. ‘In many cases the defective allele [version of the gene] is *recessive*, meaning that it has no noticeable effect if paired with the normal allele. If the defective allele is *dominant*, however, even one copy will cause disease.’ (Nesse & Williams 1995: 94) In some cases a defective pair may be inherited from parents – one from the mother, and one from the father.

52. See Nesse & Williams 1995: 92 – 106 for a similar explanation of cell behaviour.

53. ‘When a gene acts against the interests of the patient, the physician should act against the gene. As Oxford biologist Richard Dawkins puts it, we should “rebel against the tyranny of the selfish replicators.”’ (Nesse & Williams 1995: 106).

54. The lymphatic system operates through a network of vessels that run through the whole body from the feet to the head connected to regional glands (lymph nodes) that are concentrated in the armpits, groin and thoracic and abdominal cavities, and organs (thymus, tonsils and spleen). The lymphatics play a central role in the immune system of the entire organism. (See App II, figs 10 – 17).

55. See App III: 39, macrobiotic diet for lymphoma.

56. According to Bernie Siegel: ‘There is beginning to be an impressive amount of research to document the ways in which mind and body, brain and immune system are bound together. Although much more needs to be done to trace this incredibly intricate network of communications, the most important thing is that we know such communications do occur’ (1989: 23).

57. See Siegel (1989: 21–22) for an account of a patient with multiple personalities, and the effect of physical pain sensations experienced when switching from one personality to another. He adds (1989: 286) that ‘the value of transcendental meditation has been reported by Dr. David Orme-Johnson in avoiding a host of diseases requiring hospitalization and health care use. In Holland a group of transcendental meditators were given a 30% reduction in their health premiums because of their reduced need for medical care and significantly fewer cases of heart disease, tumors, infections, neurological diseases and other afflictions. We cannot separate our minds and bodies.’

58. See App III pg 2–3, e-mail document from USA re Cancer Association; SAJNM re fluoride.

59. See App III pg 51–54, polarity therapy brochure.

60. See 2.1.3.a Art & Anatomy: The Artist, the Surgeon and the Corpse, and 2.2.3.b and 2.2.3 h – q New Age Theories, for a discussion of the return to ‘wholeness’.

61. The chemotherapy I received was largely palliative, although it saved me from a possible thrombosis, shrank all the tumours for a year, and has kept most of them at bay for the last six years. The closest thing to a cure offered by biomedicine for non-Hodgkin’s lymphoma is a bone marrow transplant which offers 50 per cent of patients remission for an extended period of approximately five years. (See App III: 28)

62. ‘My heart would pound as we meandered through the meaningless chatter that begins most conversa-

tions. Then I would drop the bombshell and suddenly I'd have a victim on my hands myself. Who could be expected to know how to deal with information like that? These people, my friends, had no better idea than I did what "leukemia" meant. If it meant anything at all to them, the message would have come from sentimental films on television whose message was: "If you're the strongest, bravest, most loved person to ever walk the Earth, then you will put up a gallant, inspiring fight that will not be good enough." That was the only image in my mind' (Handler 1997: 14).

63. This refers directly to Sontag's discussion (in *Illness as Metaphor*, 1979) on the metaphoric and adjectival use of 'cancer' for everything that is shameful and ugly.

64. This image is central in the Mexican Cult of the Dead, and is also found in the medieval legend of the Three Living and The Three Dead (see Binski 1996: 134), appearing predominantly in sixteenth and seventeenth century England.

65. See App III pg 65, Deepak Chopra.

66. I remember clearly the absolute fear I would experience, in the early stages of managing the disease, when, while living extremely healthily, I would get something as simple as a cold. I would think if my body could not even keep a cold away how could I trust it to keep something as drastic as cancer away, when it couldn't even expel something as basic as a virus and some germs.

67. Hodgkin's lymphoma, and some forms of high grade non-Hodgkin's lymphoma, respond positively to highdoses of radiation and chemotherapy due to the fast-growing nature of the cells involved. Non-Hodgkin's low-grade lymphoma, due to the slow-growing nature of the cells, shows the lowest statistical response, but offers the longest survival rates without treatment.

68. See *Cultural Sniping* (1995) for Spence's extended descriptions. See also Stacey (1997: 42–43).

69. Previously mentioned in the Introduction 2.1.

70. See App III pg 55, Jo Spence *Moxabustion* picture, and App II fig 20, herbs etc.

71. Recommendations include walking barefoot in the morning dew, singing, joyful behavior, expressing gratitude to the earth, physical and breathing exercises, and shiatsu.

72. The macrobiotic practice requires a great deal of discipline and routine, sometimes resulting in social isolation. Arthur Frank (1995: 40 – 41) has defined four symbolic body types that take action in response to illness, and that the body approximates at different times. Of the 'disciplined body', he says, 'the disciplined body-self defines itself primarily in actions of self-regimentation; ... The disciplined body experiences its gravest crisis in loss of control. The response of such a body-self is to reassert predictability through therapeutic regimens, which can be orthodox medical compliance or alternative treatment. In these regimens the body seeks to compensate for contingencies it cannot accept.' I have experienced this myself and seen its manifestation in others. See App III pg 39–44.

73. See App III pg 56–60, including shopping list.

74. See App III pg 61–64, Brandon Bays brochure.

75. See Stacey's comments on this 'cliché' and the cultural view of cancer which sees mind and body as mutually dependent (1997: 25).

76. See App III pg 68, chakra and nerve plexus diagrams.

77. A weekend workshop with Arewa was fun, informative and unprescriptive, offering practices that are easily incorporated into daily life.

78. See *Time on Fire* (Handler 1997) for a humorous look at this side of cancer.

79. Doctors almost apologise to you that you have this disease. 'New Agers' almost wish you to celebrate it as a wake-up call!

80. 'THE BRANDON BAYS' STORY' 'Diagnosed in 1993 with a uterine tumour the 'size of a football', Brandon pioneered a self-healing process called "The Journey" which enabled her body to heal completely in just six-and-a-half-weeks. No tumour!' 'CELLULAR MEMORIES' "What I realised, "says Brandon, "is that I had stored in the tumour cells childhood memories that were too painful to face. It was as if I had literally put the painful memory into a package, and put a lid on it. Only when the issues were completed, healed, and forgiven was the tumour able to leave." See brochure, App III pg 61–64.

81. See App III pg 61–64, letter to *Argus* and Journey guide.

82. A recent programme on Talk radio with Dr Dee focused on Bays during one of her visits to South Africa. Callers, mostly accredited Journey practitioners, phoned in with remarkable testimonies to the value of The Journey and the positive effects on children and adults.

83. This is the same idea as that of the 'impure soul' (Sawday 1997: 17) mentioned at the end of the introductory section on Complementary Medicine (2.2.3.b).

84. See Barbra Brennan, *Hands of Light* (1998). See App II fig 23.

85. I reacted with a combination of indignation, irritation, amusement and of course self-doubt, thus entering the spiral of confusion.

86. A work from this exhibition by Aganetha Dyck is the cover image for Stacey's *Teratologies*.

87. See <http://asuam.fa.asu.edu/clubextra/main.htm> (See App III: 87–89).

88. Expected to be published in a special issue of *Contemporary Theatre Review*, Spring 2000, focusing on Performance of Disability.

89. For a detailed interrogation of contemporary artists and disease see Townsend, C. 1998 *Vile Bodies*.

90. See App III pgs 90–92 for full brochure text, Minna Turtiainen 'Pictures of Pain' in *Kiasma* magazine 11 – 2001 vol 4, Pia Laita (ed), Helsinki Finland: Museum of Contemporary Art.

91. See media headlines, App III pgs 94–100.

92. One can think about this too in terms of the subtle bodies that exist in layers around the physical body.

93. Frank believes that 'stories have to repair the damage that illness has done to the ill person's sense of where she is in life, and where she may be going.' He extends the meaning of this statement by referring to 'what Judith Zaruches implies when she writes of losing her map and her destination', adding that 'stories are a way of redrawing maps and finding new destinations' (Frank 1995: 53).

94. See Roland Barthes writing of the experience of gazing at images of himself in 2.1.4.f. These paintings are 'my repertoire' of images of my body.

95. The following story is told by a Mexican schoolteacher in Carmichael & Sayer (1991:119) 'I think it 's good for children to confront the idea of death, and also the idea of their own mortality. Sometimes a child feels squeamish about death, and admits to fearing skulls and skeletons. When this happens, I tell my pupils to touch themselves. 'Why are you afraid?' I ask, 'when each of you owns a skull and skeleton. We all carry death within us.' They feel themselves, and they say: 'Yes it's true, we too are made of bones.'

6. BIBLIOGRAPHY

Books

- Archer, M., Brett, G. & de Zegher, C. 1997. *Mona Hatoum*. London: Phaidon
- Arewa, C. S. 1998. *Opening to Spirit*. London: Thorsons/Harper Collins Publishers
- Arewa, C. S. 2001. *Way of Chakras*. London: Thorsons/Harper Collins Publishers
- Baltrock, T. (ed) 1998. *Kiki Smith: Works 1988–1996*. New York: Salon Verlag
- Bays, B. 1999. *The Journey: An Extraordinary Guide for Healing your Life and Setting Yourself Free*. London: Thorsons
- Bartman, W. S. (ed) 1993 *Felix Gonzalez-Torres*. New York: A.R.T. Press
- Betterton, R. 1996. *'Body Horror' in An Intimate Distance: Women, Artists and the Body*. London: Routledge
- Binski, P. 1996. *Medieval Death*. Ithaca, New York: Cornell University Press
- Brena S. F. 1973. *Yoga & Medicine*. Baltimore, Maryland: Penguin Books
- Brennan, B. 1998. *Hands of Light*. New York: Bantam
- Canguilhem, G. 1991. *The Normal and the Pathological*. New York: Zone Books
- Carmichael, E. & Sayer, C. 1991. *The Skeleton at the Feast: The Day of the Dead in Mexico*. London: British Museum Press
- Chopra, D. 1994. *The Seven Spiritual Laws of Success*. London & New York: Bantam Press
- Chopra, D. 1998. *Ageless Body. Timeless Mind*. USA: Rider (Random House)
- Clark, K. 1956. *The Nude: A Study of Ideal Art*. London: John Murray
- Day, C. A. 1991. *The Immune System Handbook: Your Owner's Manual*. Canada: Potentials Within
- Douglas, M. 1966. *Purity and Danger*. London: Routledge and Kegan Paul
- Feher, M. (ed) 1989. *Fragments for a History of the Human Body part one*. New York: Zone Books
- Fineberg, J. 1995. *Art Since 1940: Strategies of Being*. London: Laurence King Publishing
- Frank, A.W. 1995. *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago and London: The University of Chicago Press
- Gombrich, E. H. 1977. *Art and Illusion: A Study in the Psychology of Pictorial Representation*. London: Phaidon
- Haenlein, C. (ed) 1999. *Kiki Smith: All Creatures Great and Small*. Zurich: Scalo
- Handler, E. 1997. *Time on Fire: My Comedy of Terrors*. New York: Owl Books
- Holbein, H. 1887. *The Dance of Death: Illustrations and Letterpress*. London: Hamilton Adams and Co.
- Holford, P. 1997. *The Optimum Nutrition Bible*. London: Piatkus
- Isaak, J. A. 1996. *Feminism & Contemporary Art: The Revolutionary Power of Women's Laughter*. London: Routledge
- Klotz, H. 1997. *Contemporary Art*. Munich: Prestel
- Kristeva, J. 1982. *Powers of Horror: An Essay on Abjection*. tr. Leon Roudiez. New York: Columbia University Press
- Kushi, M. & Jack, A. 1984 *The Cancer Prevention Diet: The nutritional blueprint for the relief and prevention of disease*. England: Thorsons
- Kuspit, D. B. 1997. *Christian Boltanski*. London: Phaidon
- Lamers-Schütze, P. (ed) 1999. *Encyclopaedia Anatomica: Museo La Specola Florence*. Köln: Tashen
- Lamers-Schütze, P. (ed) 2001. *Encyclopaedia Anatomica: Museo La Specola Florence*. Köln: Tashen (Icons)
- Leadbeater, C. W. 1994 (c1927). *The Chakras*. Wheaton, Ill. U.S.A.: The Theosophical Publishing House.
- LeShahn, L. (Ph.D.) 1994. *Cancer as a Turning Point: Revised edition*. New York: Plume/Penguin
- Llewellyn, N. 1998. *The Art of Death*. Great Britain: Reaktion Books

- Morgan, S. & Morris, F. (eds.) 1995. *Rites of Passage, art for the end of the century*. London: Tate Gallery Publications.
- Myss, C. 1996. *Anatomy of the Spirit: The Seven Stages of Power and Healing*. New York: Three Rivers Press
- Nead, L. 1992. *The Female Nude: Art, Obscenity & Sexuality*. New York: Routledge
- Nesse, R. M. & Williams, G. C. 1994. *Evolution and Healing: The New Science of Darwinian Medicine*. London: Phoenix
- Ohashi, W. 1979. *Do-it-yourself shiatsu*. Great Britain: Unwin Paperbacks
- Petherbridge, D. (ed) 1997. *The Quick and The Dead: Artists and Anatomy*. London: National Touring Exhibitions: The South Bank Centre
- Posner, H. 1998. *Kiki Smith*. Canada: Bulfinch Press/ Little Brown and Company
- Rabinow, P. (ed) 1986. *The Foucault reader*. London: Penguin Books
- Raman, Dr K. 1998. *A Matter of Health: Integration of Yoga and Western Medicine for Prevention and Cure*. Chennai Madras: EastWest Books
- Rawson, P. 1973. *Tantra*. London: Thames and Hudson
- Sawday, J. 1995. *The Body Emblazoned: Dissection and the Human Body in Renaissance Culture*. London: Routledge
- Siegel, B. S. 1990. *Peace, Love & Healing: Bodymind Communication & The Path to Self-Healing: An Exploration*. New York: Harper Perennial
- Siegel, B. S. 1990. *Love, Medicine & Miracles*. New York: Harper Perennial
- Sontag, S. 1979. *Illness as Metaphor*. London: Allen Lane/Penguin
- Sontag, S. 1989. *AIDS and Its Metaphors*. England: Penguin
- Spector, N. 1995 *Felix Gonzalez-Torres*. New York: Guggenheim Museum
- Spence, J. 1995. *Cultural Sniping: The Art of Transgression*. London and New York: Routledge
- Stacey, J. 1997. *Teratologies: A cultural study of cancer*. London and New York: Routledge
- Stafford, B. 1992. *Body Criticism: Imaging the unseen in Enlightenment Art and Medicine*. Cambridge, Mass: MIT Press
- Steinman, D. 1990. *Diet For a Poisoned Planet*. New York: Ballantine Books
- Terre Blanche, Bhavani & Hook. 1999. *Body Politics*. Johannesburg: Histories of the Present Press
- Townsend, C. 1998. *Vile Bodies: Photography and the Crisis of Looking*. Munich: Prestel and Channel 4
- Warr, T. (ed) & Jones, A. 2000 *The Artist's Body*. London: Phaidon
- Weil, A. 1995 *Spontaneous Healing*. New York: Fawcett Columbine
- Weinberg, R. 1998. *One Renegade Cell: The Quest for the origins of Cancer*. London: Weidenfield & Nicolson
- Wolf, F., & Cassin, M. 1987. *Bodylines: The Human Figure in Art*. London: The National Gallery
- Zukav, G. 1991. *Seat of the Soul*. USA: Pan Macmillan

Essays

- Jordanova, L. 'Happy Marriages and Dangerous Liaisons: Artists and Anatomy' in Petherbridge 1997
- Kristeva, J. 1989. 'Holbein's Dead Christ.' in *Fragments for a History of the Human Body Part One*. New York: Zone, p 238 – 269
- Orlan. 'Manifesto of Carnal Art' tr. by Andrew McNiven & Stephanie Napoli in *Artlink* 1997 vol 17 no 2: 8
- Walker Bynum, C. 'The Female Body and Religious Practice in the Later Middle Ages' in *Fragments for a History of the Human Body, part one*. New York: Zone Books 1990

Thesis

Schmuhl, Fritz. 1996. *Metal and Meat: Technology and the Cyborg Futures of the Human Body*. MA thesis (unpublished): University of Amsterdam

Catalogues

- Amesbury, B. (ed) 1995. *Survivors, In Search of a Voice: The Art of Courage*. Toronto Canada: Woodlawn Arts Foundation
- Belloni E. (ed *Coordination*) Eccher D. (curator) 1997 *Christian Boltanski*. Galleria d'Arte Moderna, Bologna: Milan Italy: Charta
- Bond, A. (ed) 1997. *Body*. Australia: The Art Gallery of New South Wales: Australia: Bookman Press
- Bradley, J. (curator) 1995 *Kiki Smith*. Toronto: The Power Plant – Contemporary Art Gallery at Harbourfront Centre
- Brown, E. A. (curator) 1995. *Kiki Smith: Sojourn in Santa Barbara*. Santa Barbara: University of California
- Chalmers, G. (ed) 1997. *Stilled Lives: Helen Chadwick*. Edinburgh: Portfolio gallery.
- Cruz, A. 'The Means of Pleasure' in *Felix Gonzalez-Torres*, Ferguson, R. (ed) 1994. Los Angeles: The Museum of Contemporary Art
- Dander, D., Dik, I., Henkes, P., Tannert, C. (eds.) 1999. *Formule 2.1*. Berlin: Künstlerhaus Bethanien and Philip Morris Kunstforderung
- Hansen, E. D., Dybbol, K. & Goddard, D. (eds.) with Cottingham, L., Fisher, AM. & Goldman, S. (authors) 1998. *Hannah Wilke: A Retrospective*. Nicolaj: Copenhagen Contemporary Art Centre
- Isaak, J. A. in Ferguson, R. (ed) 1994. *Felix Gonzalez-Torres*. Los Angeles: Museum of Contemporary Art, vol 11
- Isaak, J & Lampert, C. 1995. *Kiki Smith*. London: Whitechapel Art Gallery and White Dove Press
- Kemp, M. 2000. *Spectacular Bodies: The Art and Science of the Human Body from Leonardo to Now*. London: Hayward Gallery
- Rodriguez, J 1999. 'Gesturing from Within', in *Katherine Sherwood: 1999 Adaline Kent Award Exhibition*, San Francisco Art Institute
- Steiner, R. 2000. *Wonderland*. St Louis: St Louis Art Museum
- Wáspe R., & Elger, D. 1997. *Felix Gonzalez-Torres. vol 1 (Text) & vol 2 (Catalogue Raisonné)* Germany: Hatje Cantz

Magazines and Journals

- Britton, S. (exec. ed) 1997 *Artlink*, vol. 17 no 2, Australia Henley Beach: South Australia
- Bywater, M. 'Dead Men Do Tell Tales' in *The Independent on Sunday: The Sunday Review*, 8 Oct 2000. London
- Brook, D. 'Introspecting' in *Artlink* vol 17 no 2 1997: 6–7
- Cohen, K. 1997. 'The Way of Taoist Yoga, Qigong' in *Yoga Journal*, May/June 1997: 94–175.
- Daw, R. 'Magnetic Resonance' in *Artlink* 1997 vol 17 no 2: 20–23
- Gómez-Peña, Guillermo, 'New Global Culture' in *TDR: The Drama Review* 2001 vol. 45 issue 1: 18–26
- Goodall, J. Dr. 'Whose Body? Ethics and Experiment in Art' in *Artlink* 1997 vol17 (2): 9–15
- Lanham, R. 1998. 'The Life And Soul of The Image' in: *Inscape* volume Three No. 2
- Lord, C. 2001 'From The Summer of Her Baldness' in *Art Journal* Spring 2002 vol 61 no 1: 35
- Mix Magazine* Summer 1998 vol 24 No 1. Canada
- Page, C.J. 'A Synchro Date with Deepak' in *Namasté* vol 12 July/August 2001: 43
- Theunissen, M. 1997. 'Means to an Endoscope: Art, Medicine and the Body.' In *Artlink*, 1997 vol 17 no 2: 67. Australia
- Time* October 15 2001, 'INNOvators: Time 100: The Next Wave'. 64–65
- Turtiainen, M. 2001. 'Pictures of Pain' in *Kiasma* magazine 11 vol 4. 2001, Helsinki Finland: Museum of Contemporary Art

Gallery Guide

Heller, M. (curator) *Spectacular Bodies: The Art and Science of the Human Body from Leonardo to Now*, Hayward Gallery: London, 2000

Electronic Sources

www.artthrob.ac.za

www.asci.org

[http:// asuam.fa.asu.edu/clubextra/main.htm](http://asuam.fa.asu.edu/clubextra/main.htm)

www.koerperwelten.com

www.mg.co.za (mg/art/fineart/9804/980414-cancer.html)

Films

Angelopoulos, Theo (dir & screenplay) 1998. *Mia Eoniotita Ke Mia Mera (Eternity and a Day)*. Greece (fiction)

Dick, Kirby (dir./prod.) 1997 *SICK: The Life & Death of Bob Flanagan, Supermasochist* (biography)

Fleischer, Richard (dir) 1966 *Fantastic Voyage*. (Science Fiction)

Moretti, Nani (dir & script) 1993. *Caro Diario (Dear Diary)*. Italy (Autobiography)

Van der Keuken, Johan (dir) 2000. *The Long Holiday*. Holland (documentary autobiography)

Videos

Nichols, Mike. (dir) 2001. *Wit* Screenplay: Emma Thompson & Mike Nichols, based on the play by Margaret Edson. USA: HBO

APPENDIX 1

ARTWORK: Paintings, Collages, Installation Documentation, Video Stills



Figure 1 acrylic glaze, photocopy, oil paint, beeswax on canvas

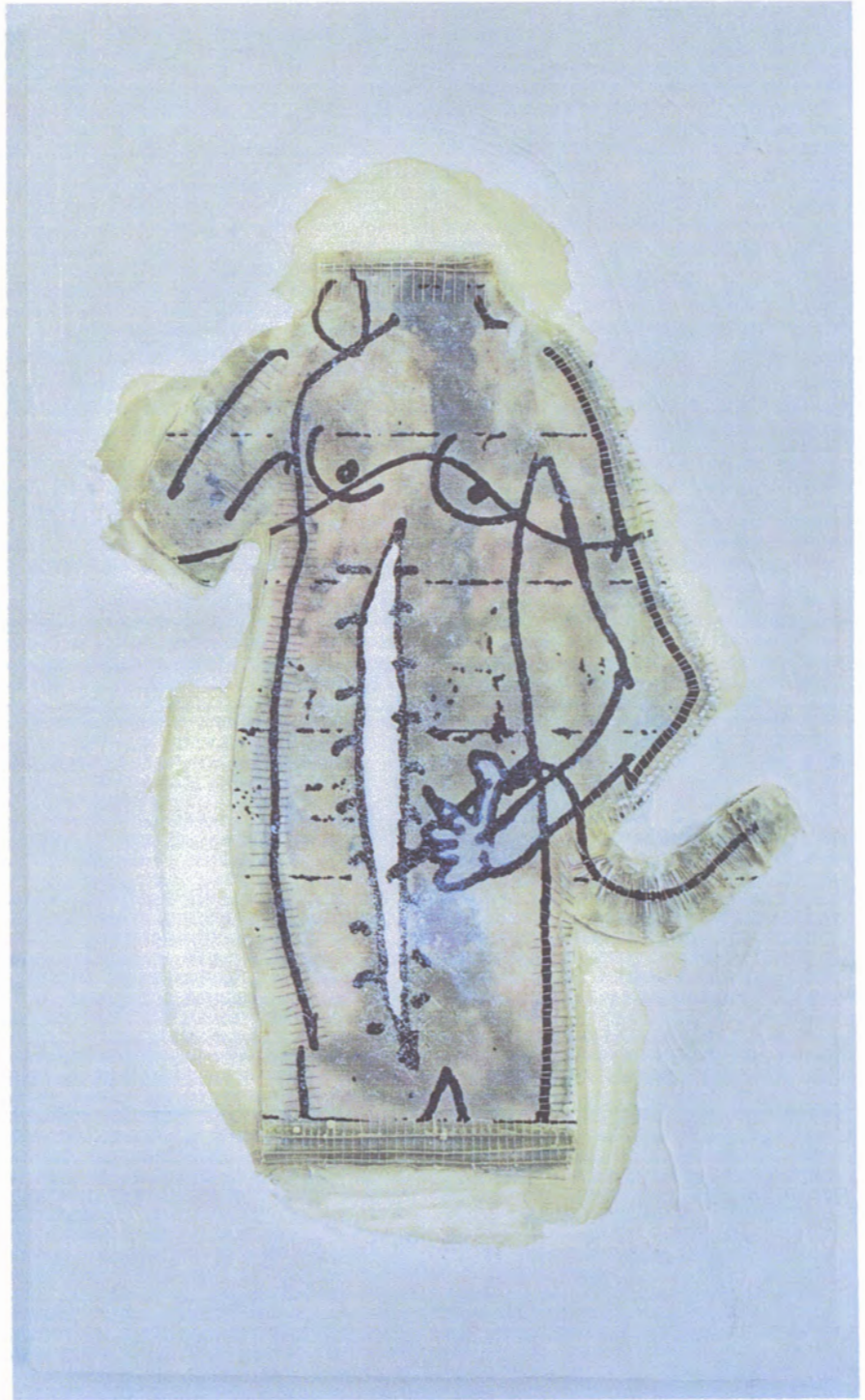


Figure 2 photocopy, pins, wax, blood, oil paint on canvas



Figure 3 tracing film, black ink, acetate, photocopy, beeswax, paraffin wax, oil paint, oil pastel on canvas



Figure 4 photocopy, paper, dental floss, charcoal, beeswax, paraffin wax, oil paint on canvas

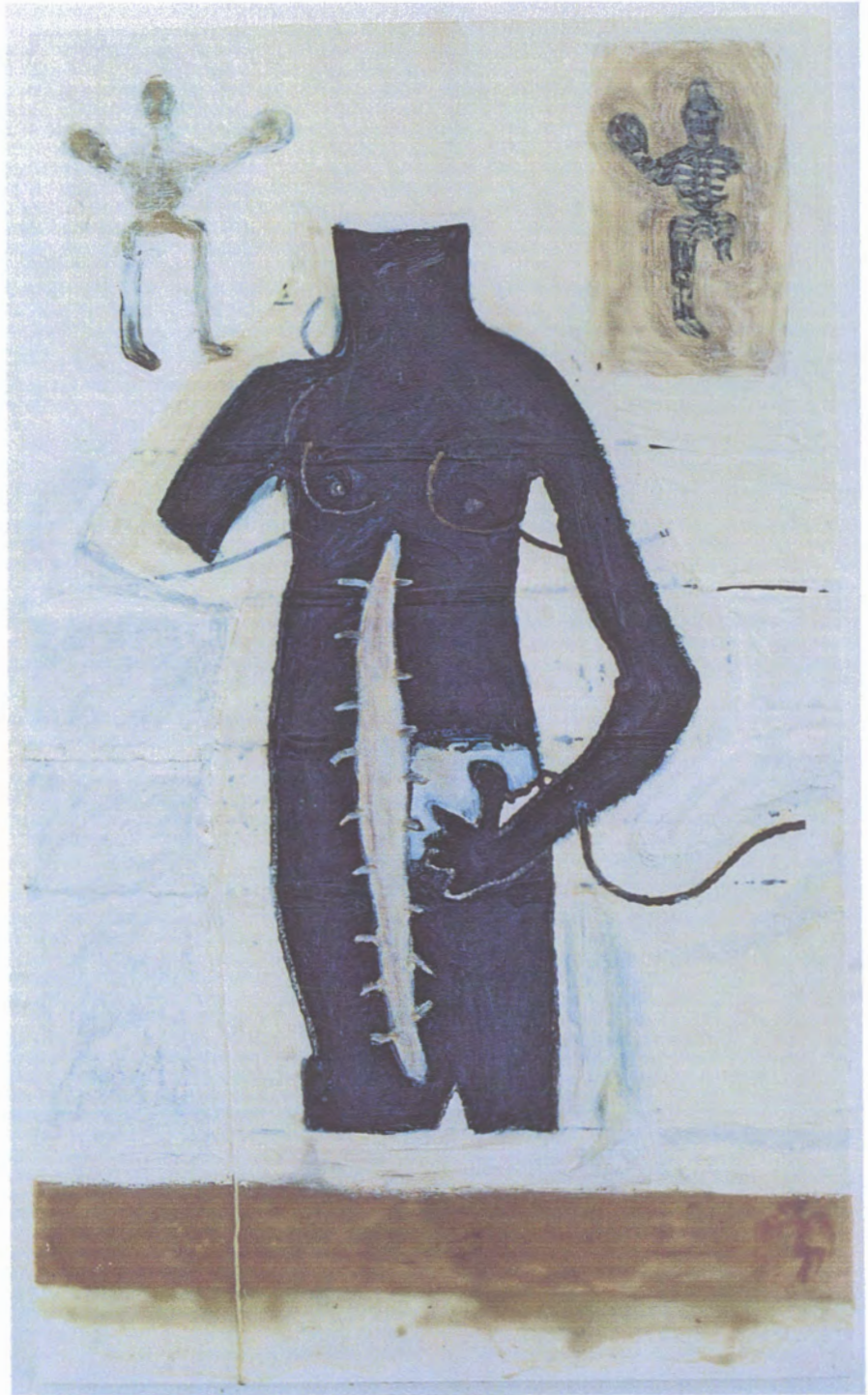


Figure 5 photocopy, paper, acrylic glaze, bandage, beeswax, paraffin wax, oil paint on canvas



Figure 6 photocopy, acrylic glaze, acrylic paint, blood, oil paint, beeswax, paraffin wax, candles on canvas

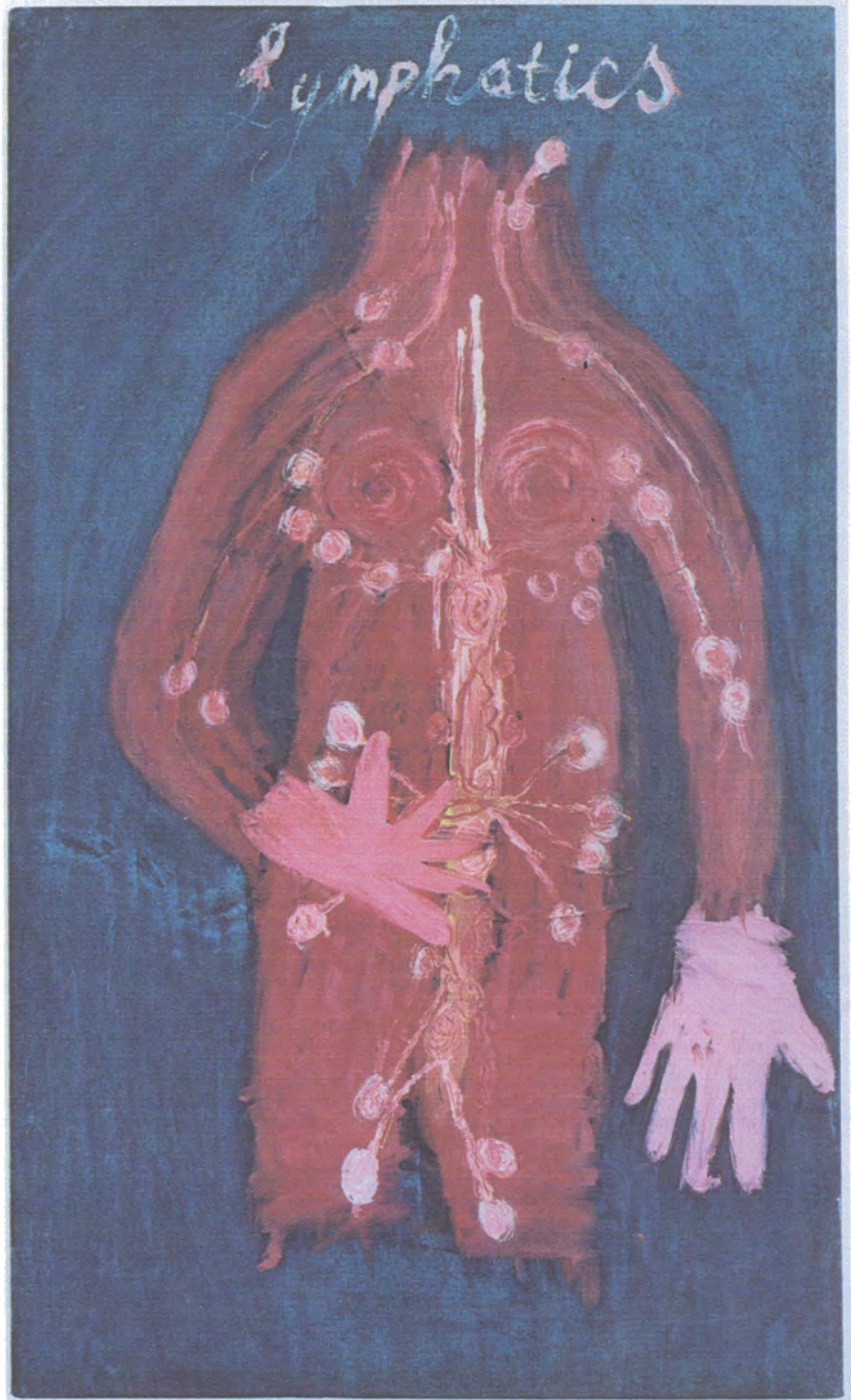


Figure 7 photocopy, paper, oil paint, beeswax, paraffin wax on canvas

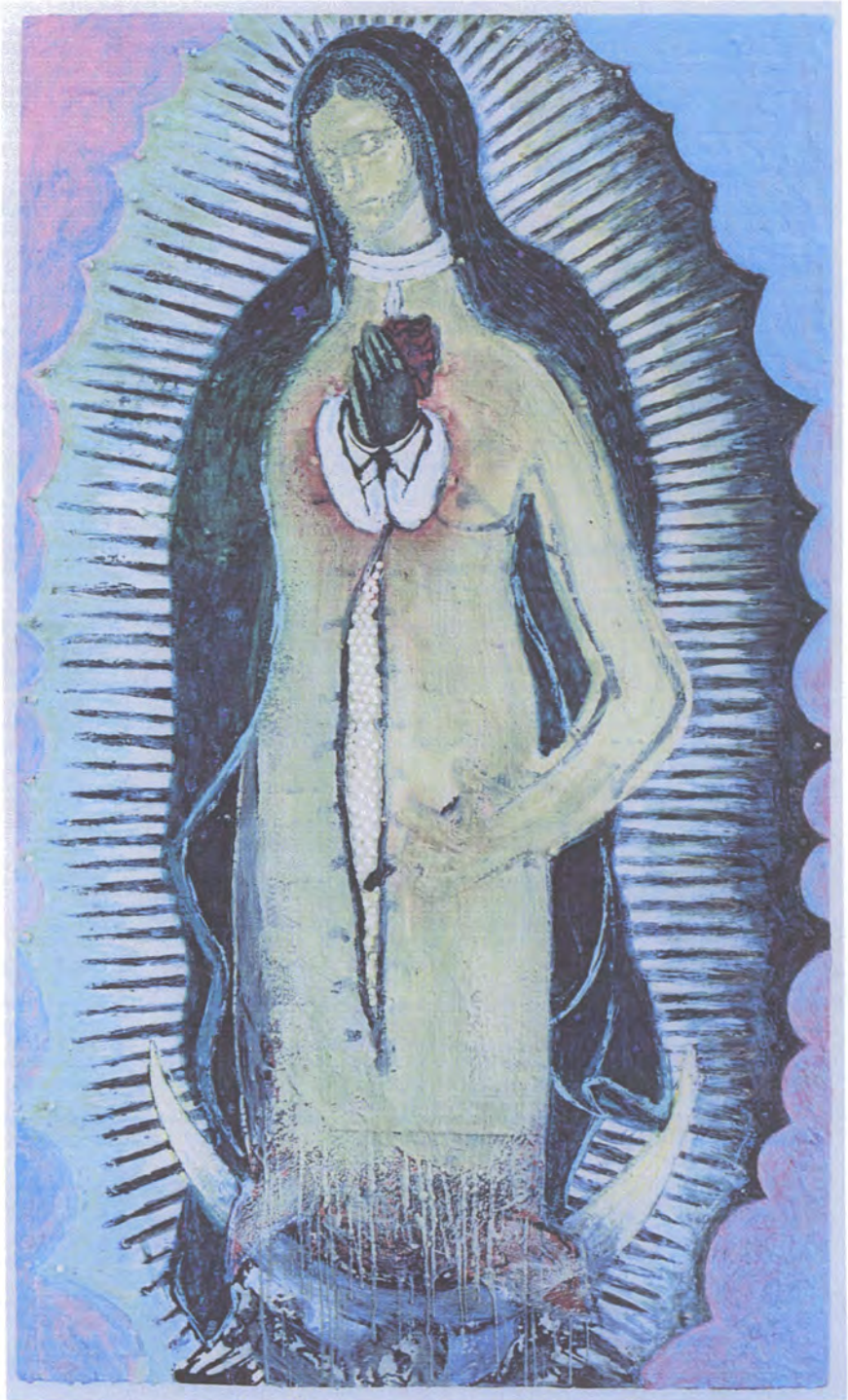


Figure 8 photocopy, paper, found objects, beeswax, paraffin wax, oil paint on canvas

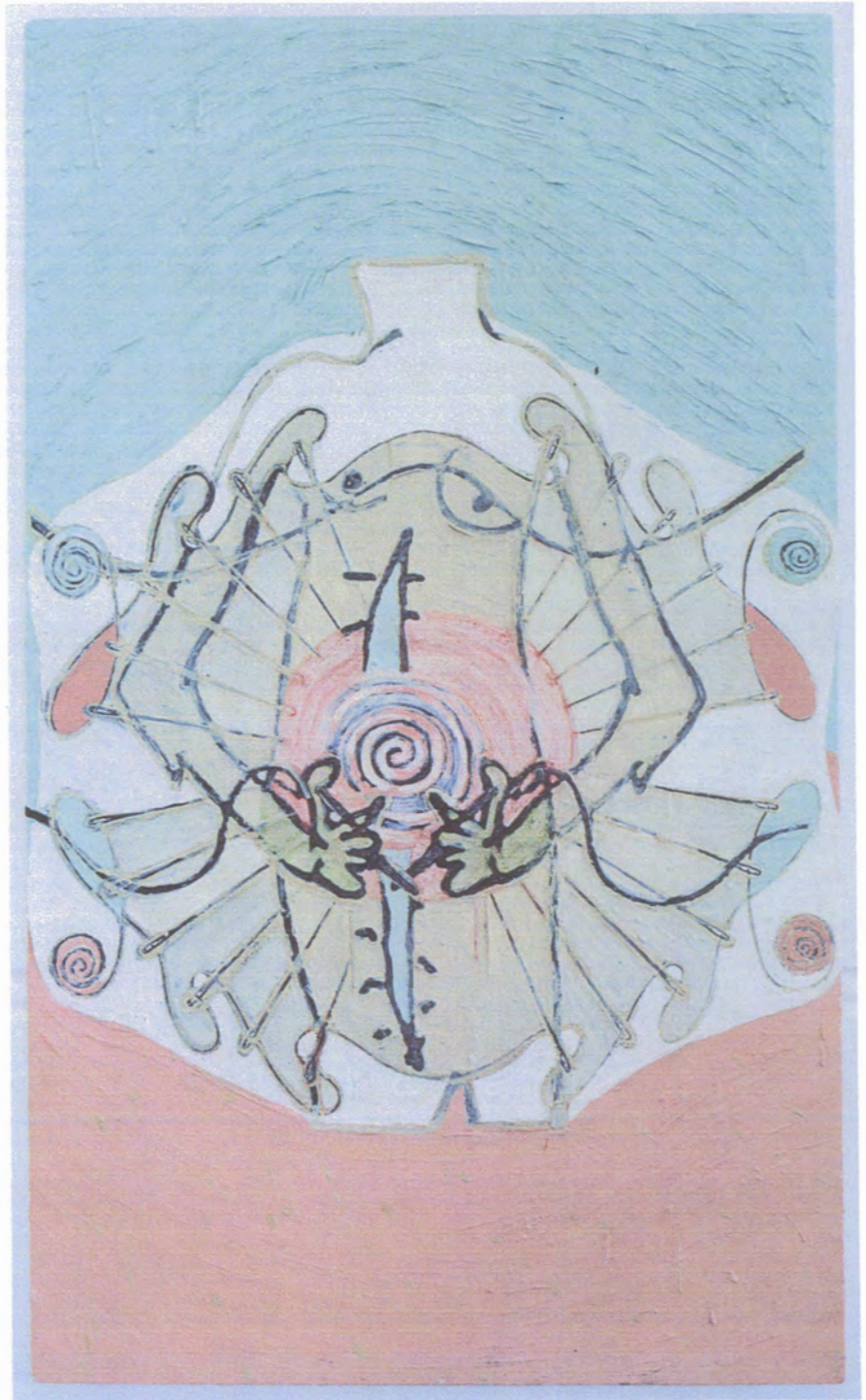


Figure 9 photocopy, tracing film, oil paint, beeswax, paraffin wax on canvas



Figure 10 photocopy, beeswax, paraffin wax, oil paint on canvas



Figure 11 tracing film, black ink, oil pastel, photocopy, dental floss, needle, micropore bandage, beeswax, paraffin wax on canvas

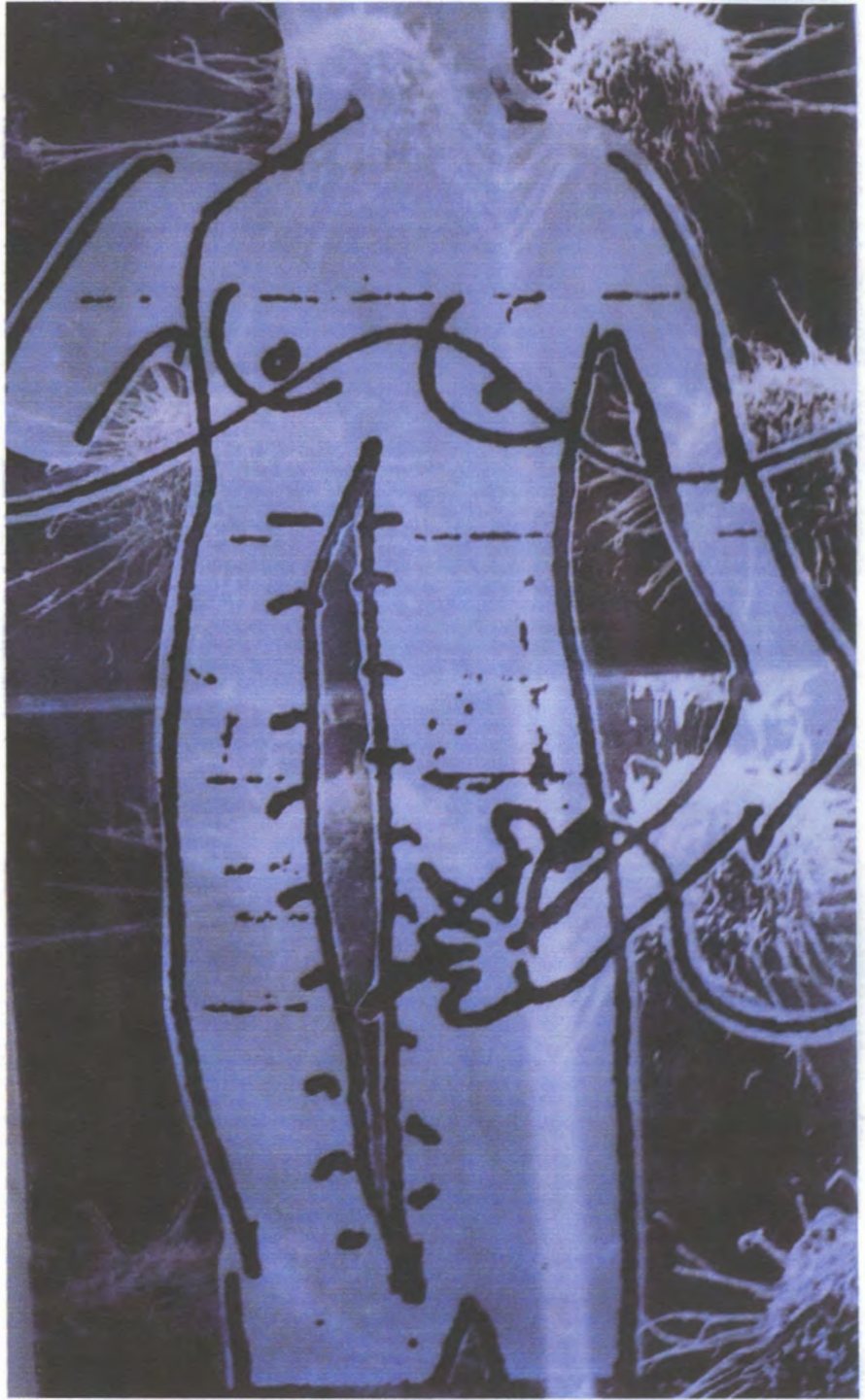
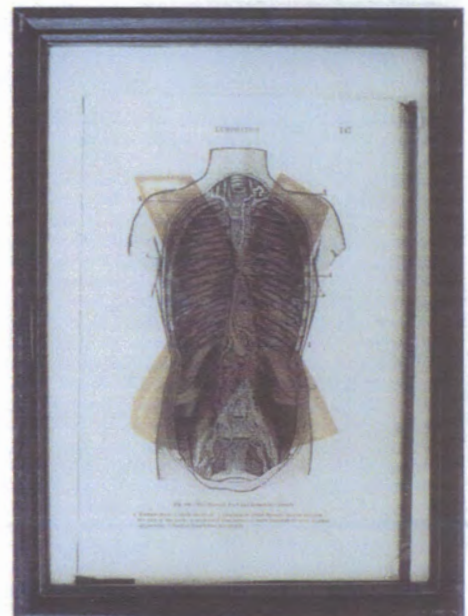


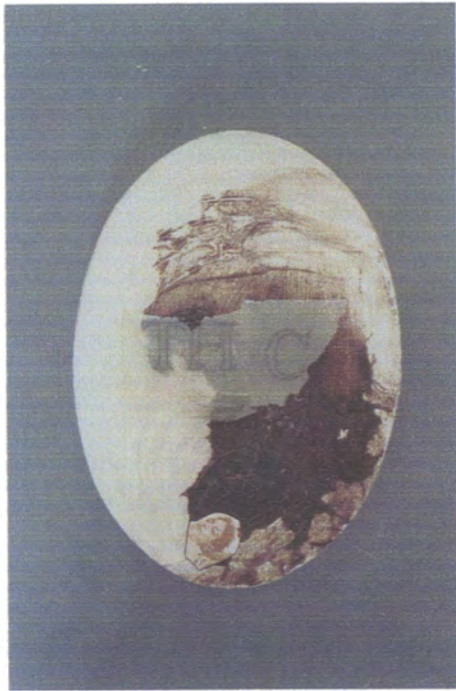
Figure 12 photocopy, tracing film on canvas



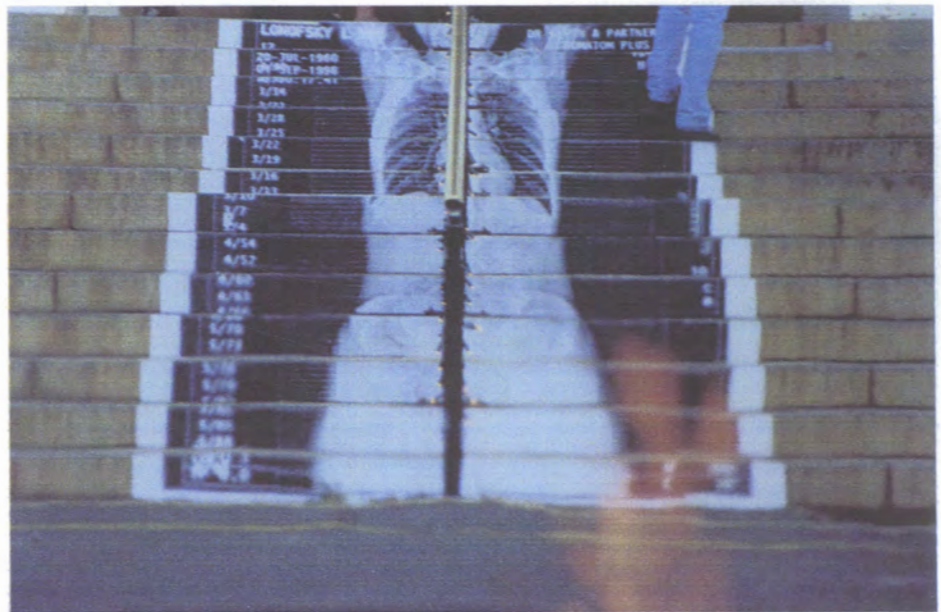
Figures 13, 14, 15 & 16 hair, paper, blood, photocopies, plastic, gauze



Figure 17 hair, paper, photocopies, plastic, kallitype print



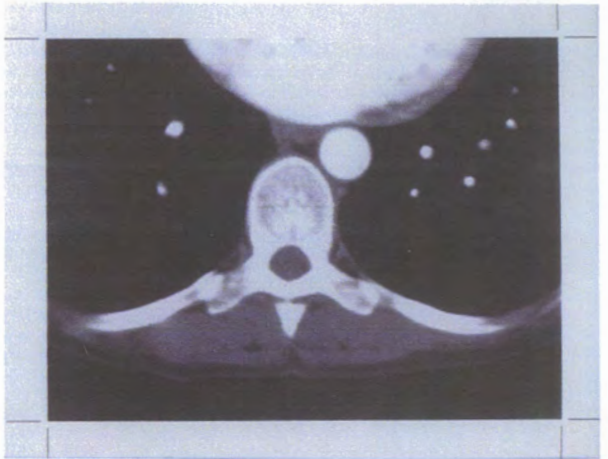
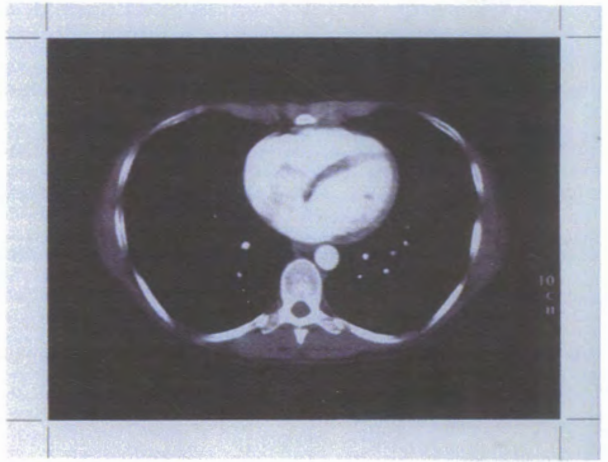
Figures 18, 19 & 20 hair, paper, blood, photographs, flowers, acrylic glaze, found object on canvas



Figures 21, 22 & 23 installation: photocopy



Figures 24 & 25 installation: photocopy



Figures 26, 27 & 28 video stills from *Cross Sections II*

APPENDIX II

VISUAL COMPENDIUM: Biographical Documentation

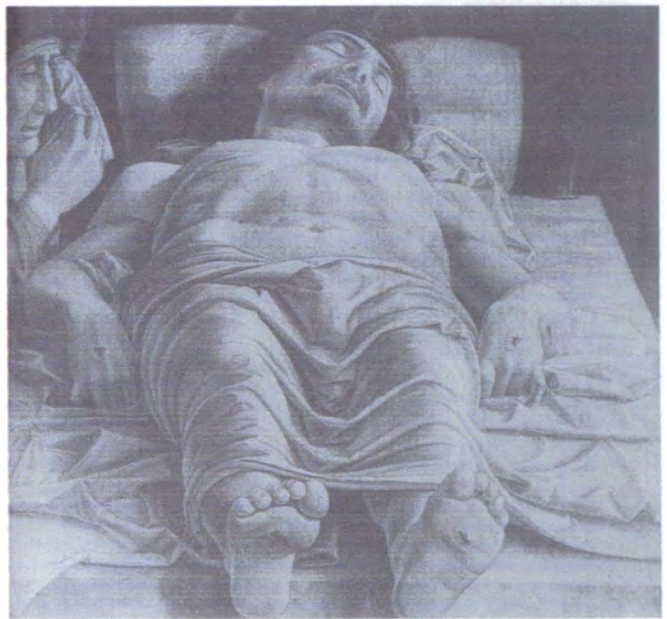
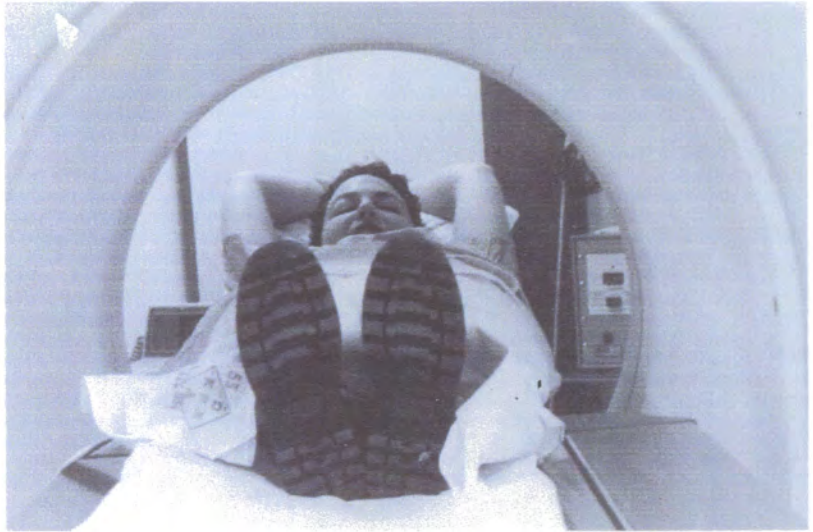


Figure 1 in CT scanner (photograph: Sue Kramer)

Figure 2 Andrea Mantegna, *Lamentation over the Dead Christ* (c. 1478 - 85)

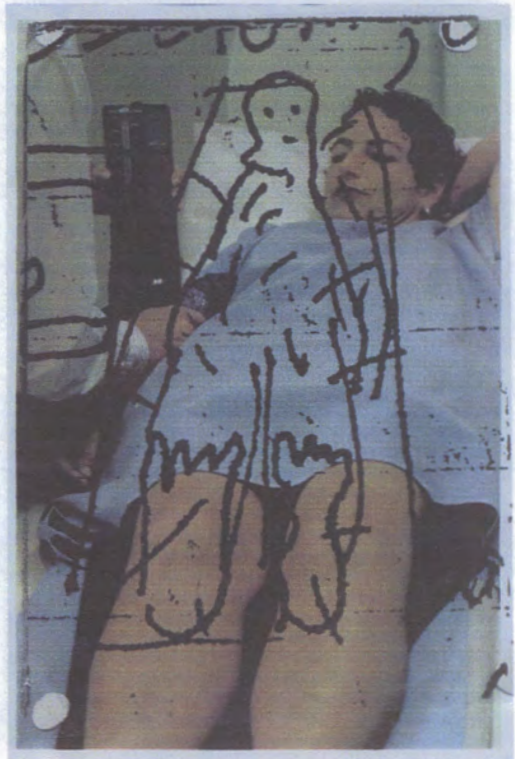


Figure 3 digital superimposition (photograph: Franz Rodenacker)

Figure 4 photograph with acetate overlay

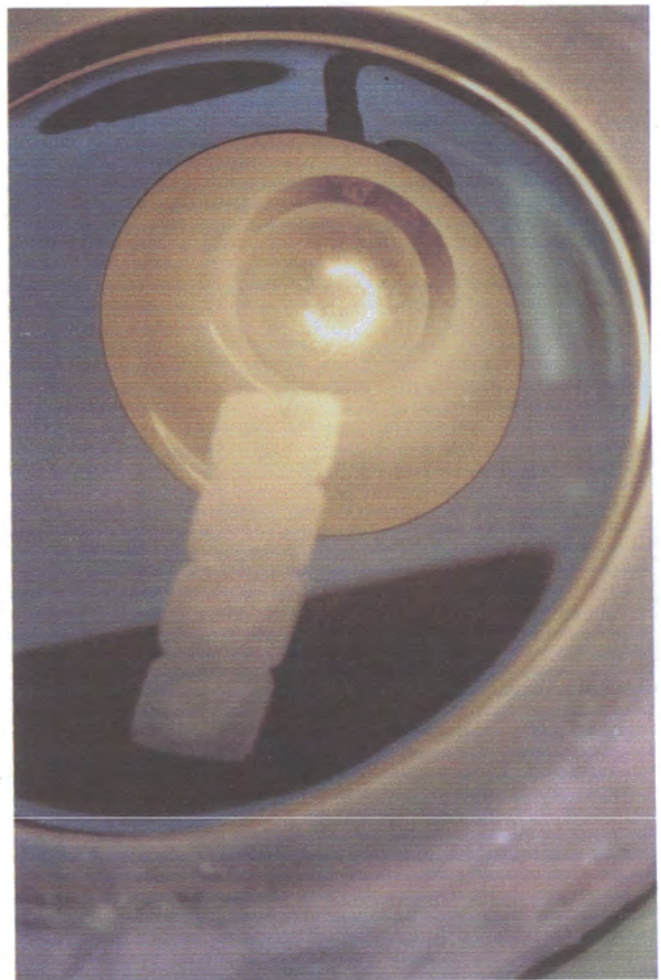
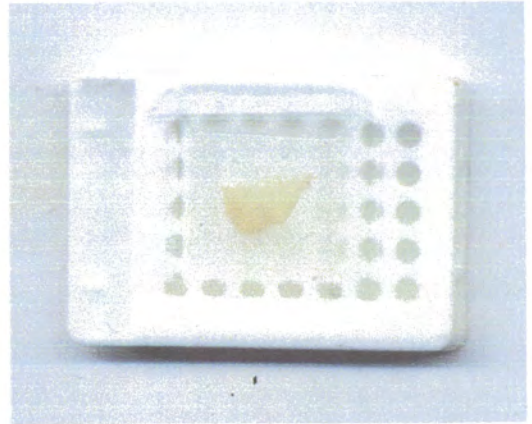


Figure 5 wax block with tumour tissue

Figure 6 ribbon of wax sections in waterbath

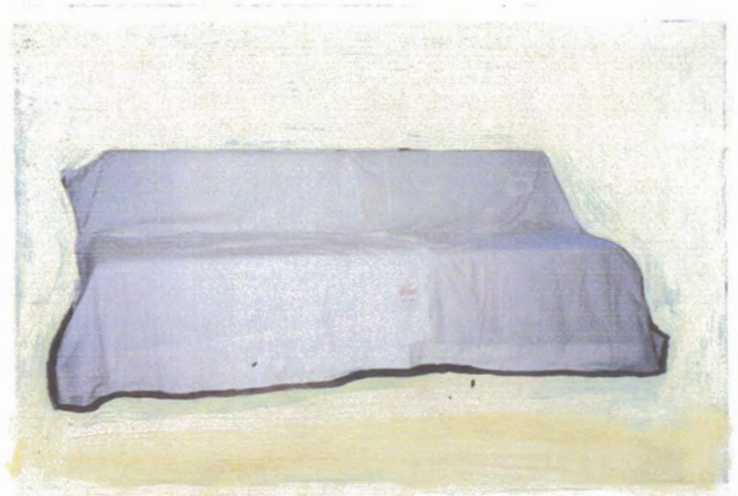
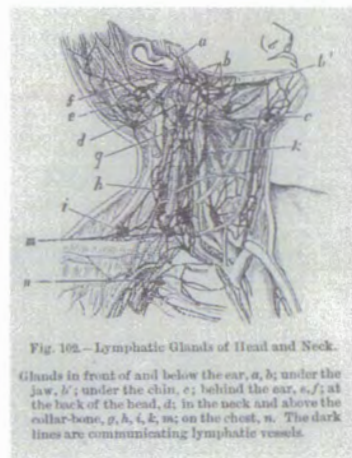
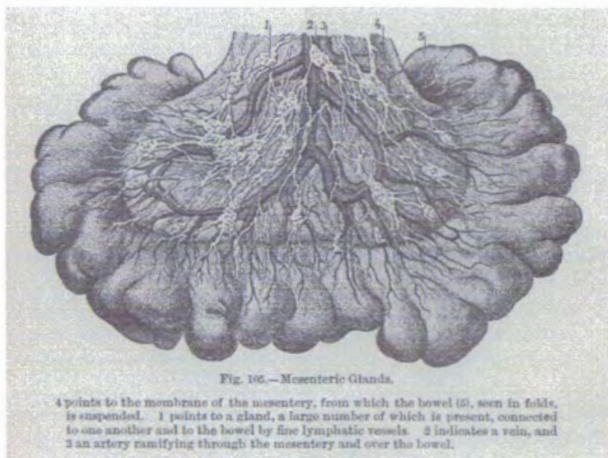
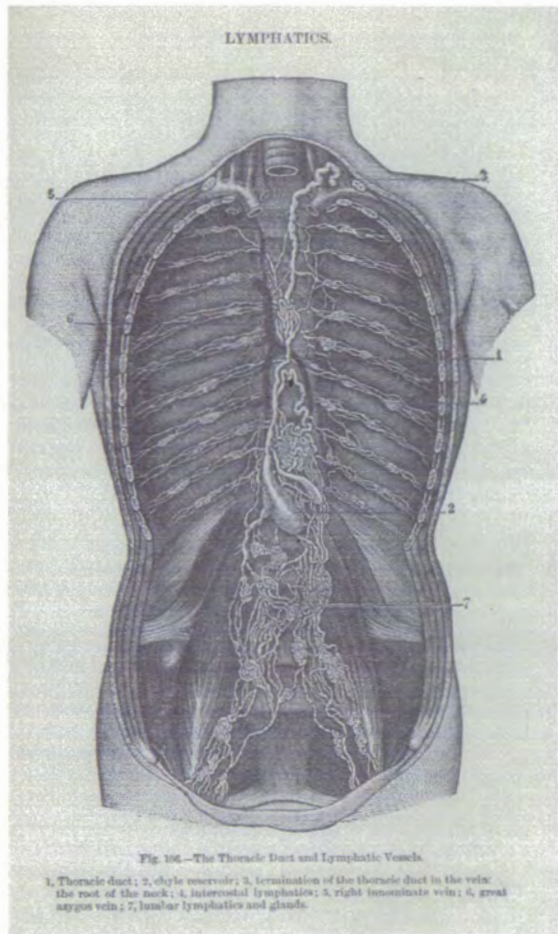


Figure 7 photograph and acrylic paint

Figure 8 photograph

Figure 9 collage with photographs



Figures 10, 11 & 12 diagrams of lymphatic system

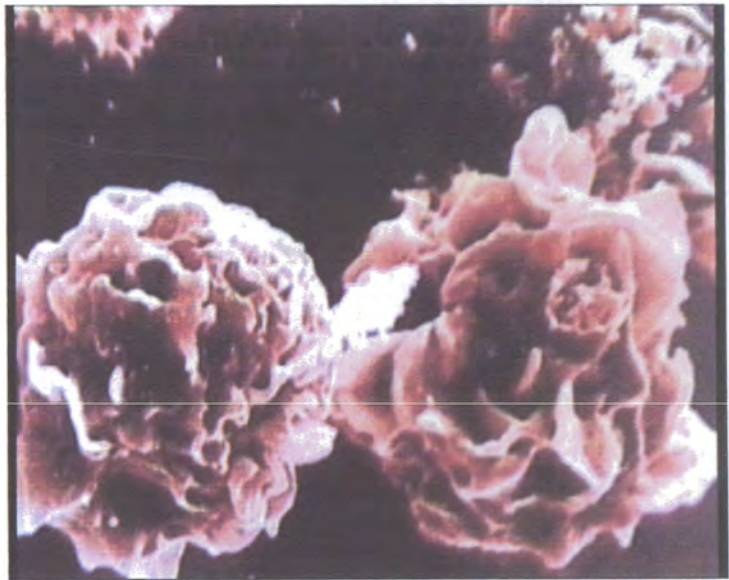
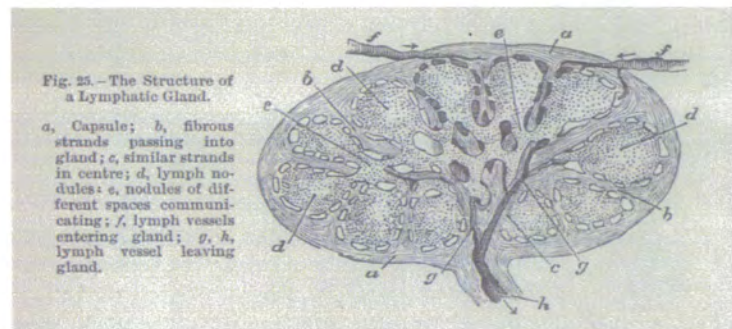


Figure 13 photograph of enlarged chain of tumorous lymph nodes in formalin

Figure 14 diagram of lymph node in cross section

Figure 15 scanning electron micrograph of macrophages

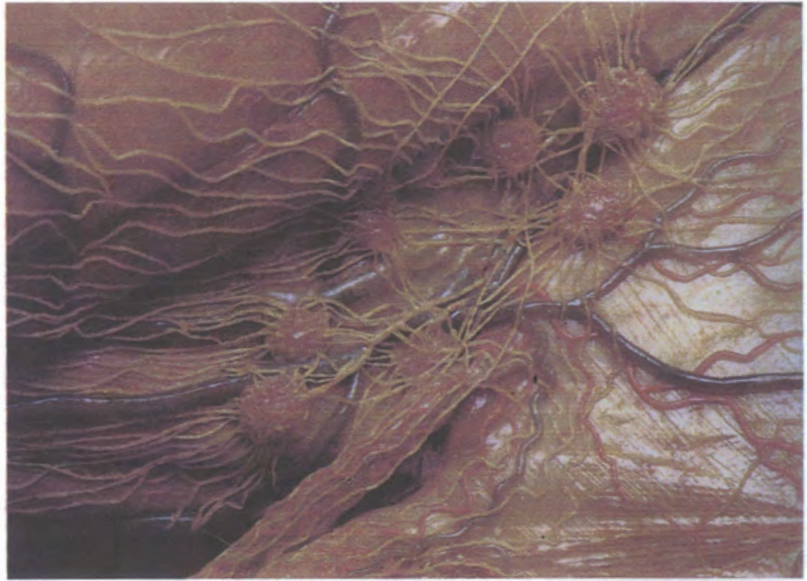


Figure 16 & 17 wax models of lymph vessels and nodes from *La Specola* Museum

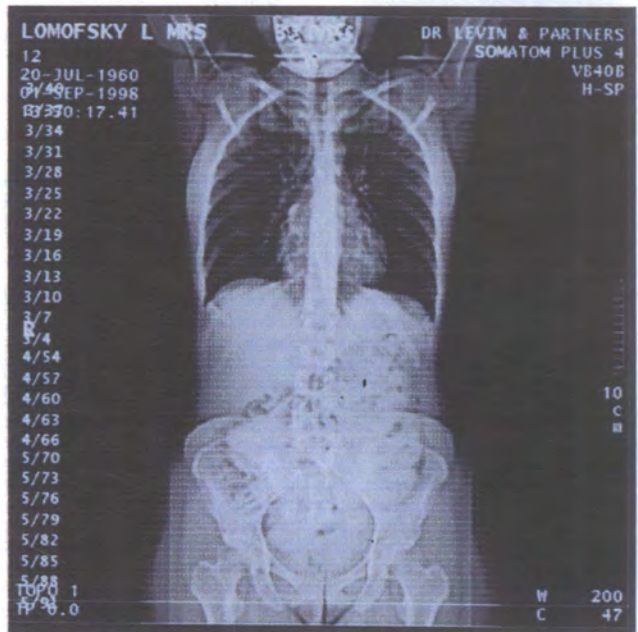


Figure 18 photographic prints of X-ray film topogram



Figure 19 shiitake mushrooms

Figure 20 chinese herbs

Figure 21 macrobiotic dish

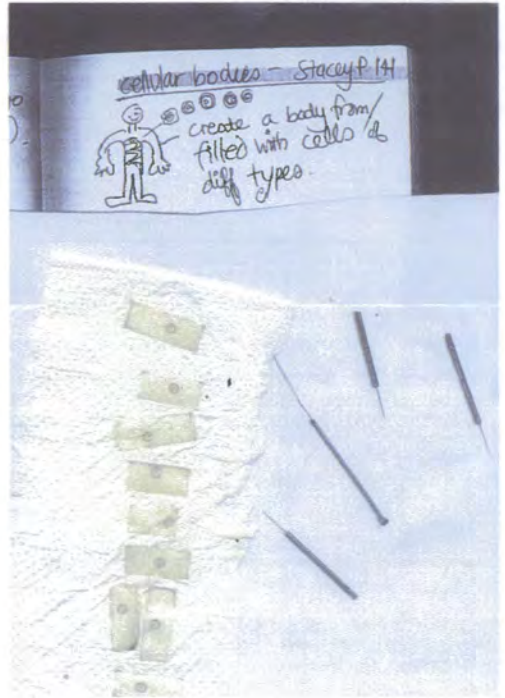


Figure 22 acupuncture needles and drawings from notebook

where the energy strands cross 14 times. (See Figure 7-2B.) They are in the following locations: one in front of each ear, one above each breast, one where the clavicles meet, one in the palm of each hand, one on the sole of each foot,

says that these tiny vortices respond to the acupuncture medicine.

Each major chakra on the is paired with its counterpart

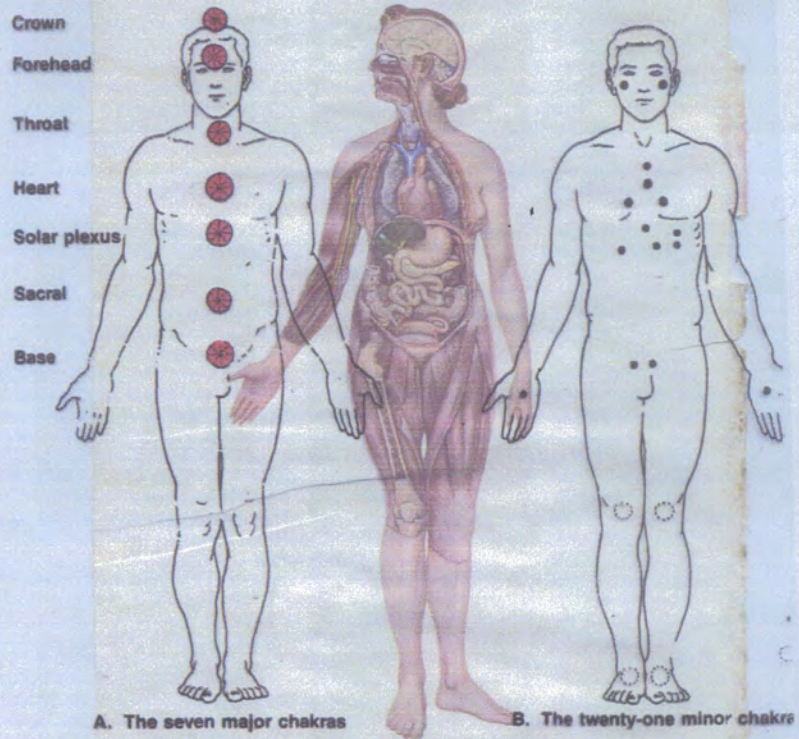


Figure 7-2 Location of Chakras (Diagnostic View)

Figure 23 major and minor chakras and acupuncture points





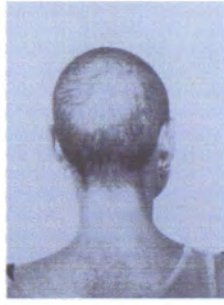






Figure 24 hair documentation 1995 - 2001

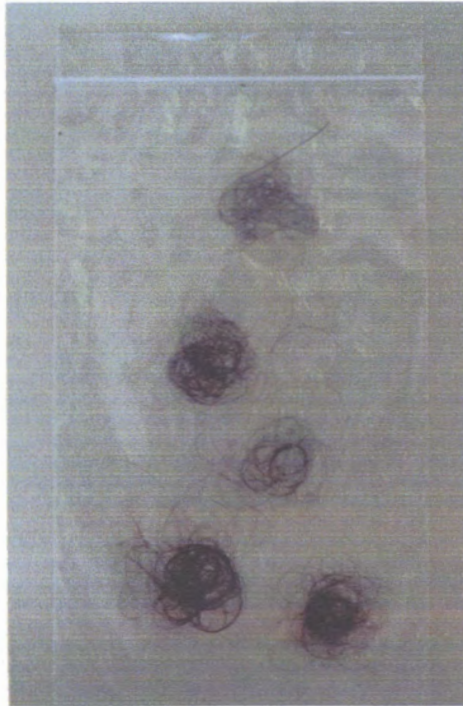
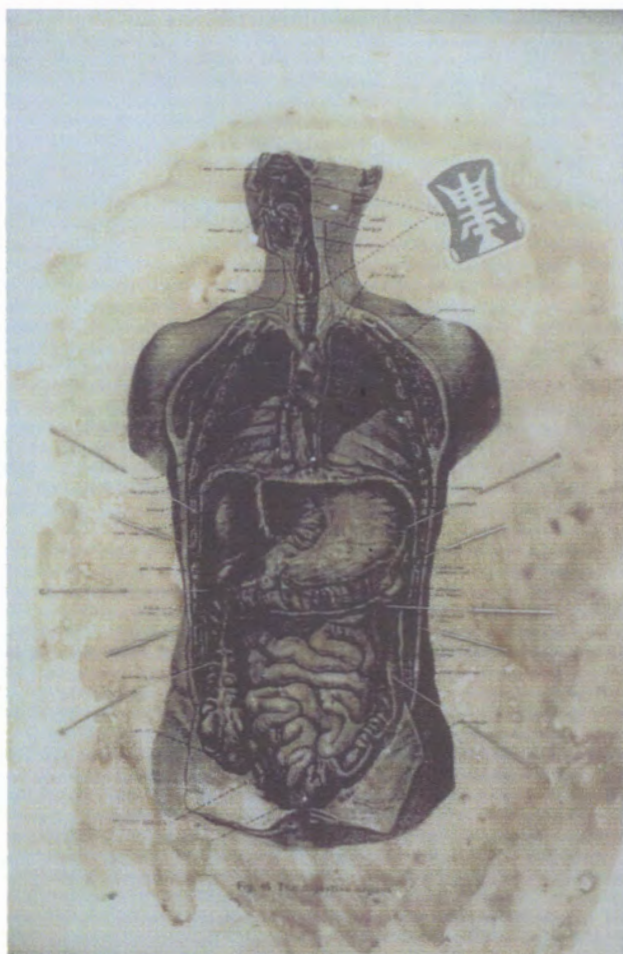


Figure 25 hair balls in plastic
 Figure 26 hair in wax
 Figures 27 & 28 pages from notebook



Figures 29 & 30 collage with blood, acupuncture needles and photocopy
Figure 31 scraperboard
Figure 32 bandage

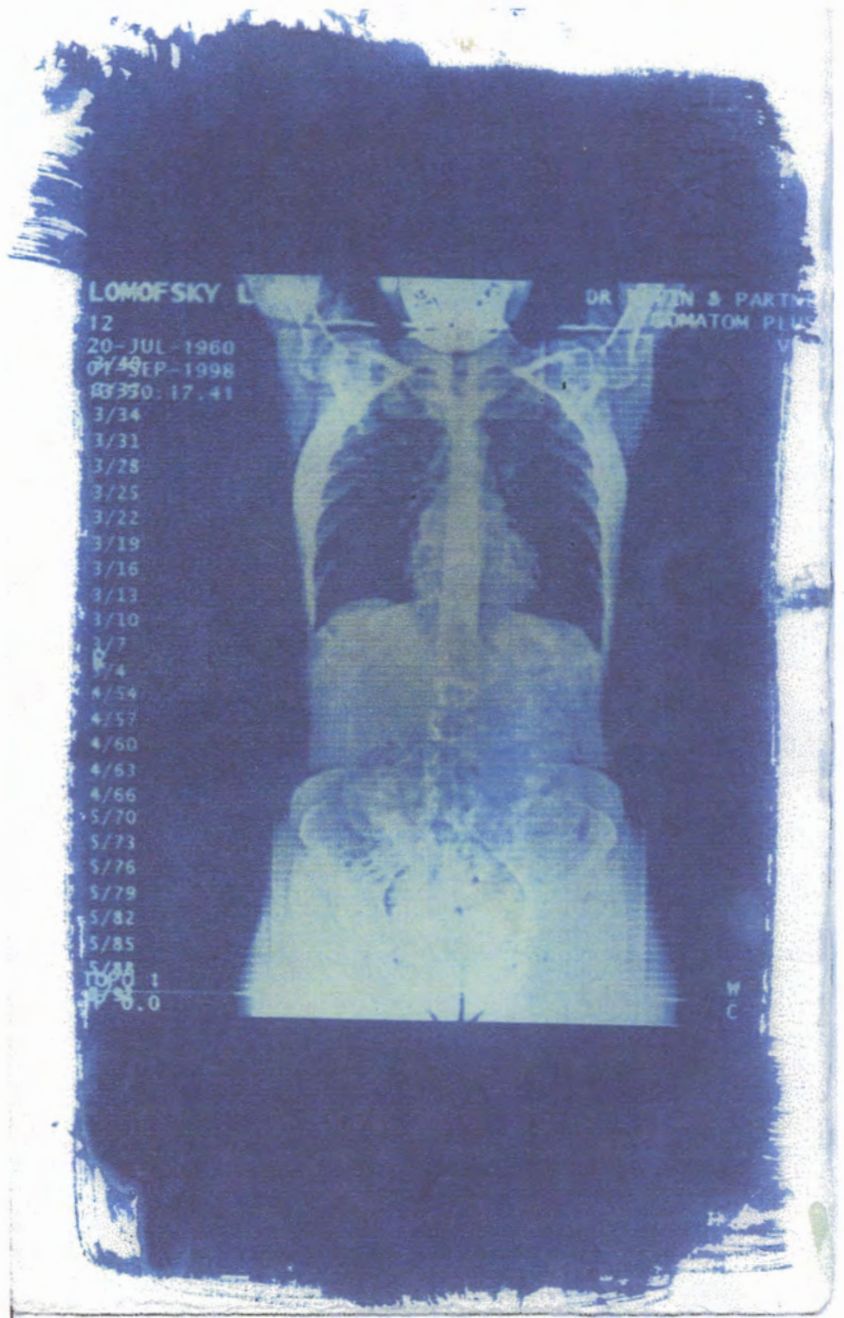


Figure 33 cyanotype

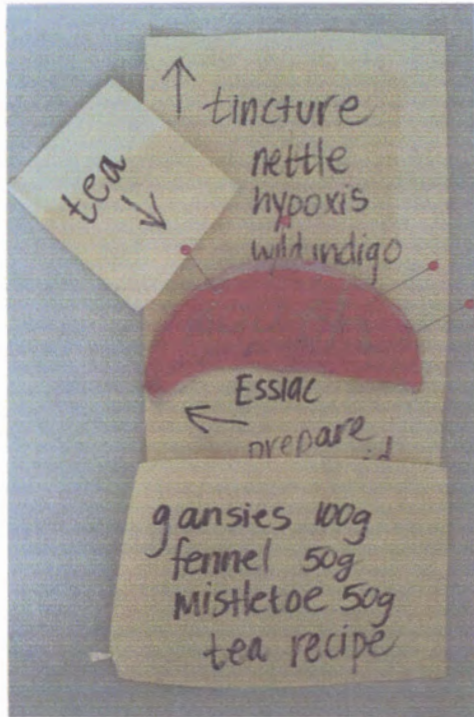


Figure 34 cyanotype

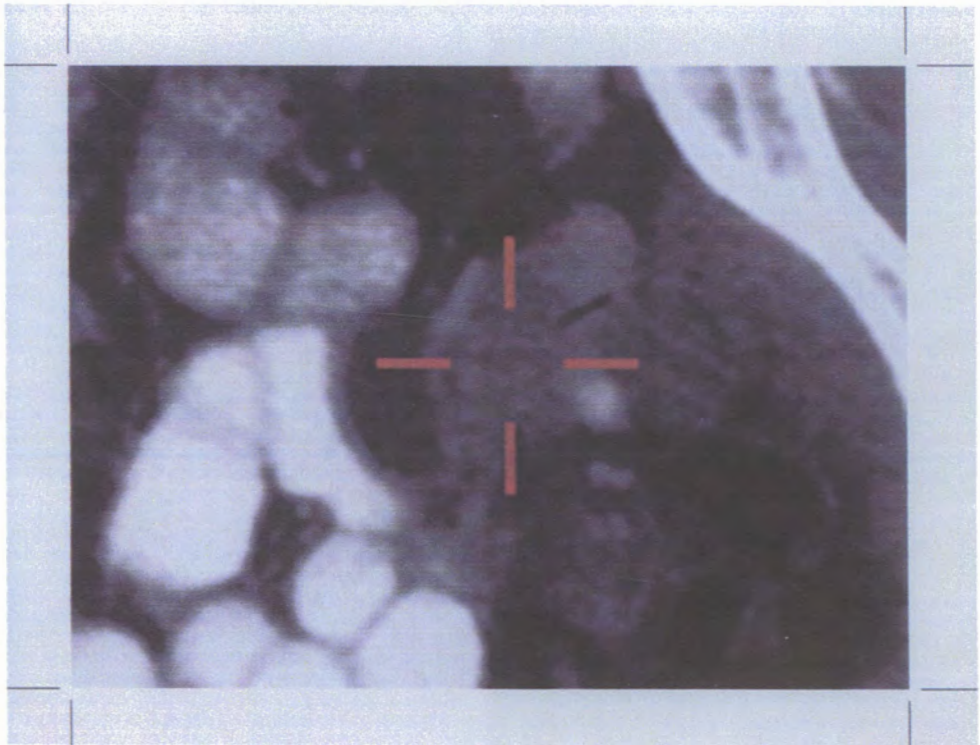
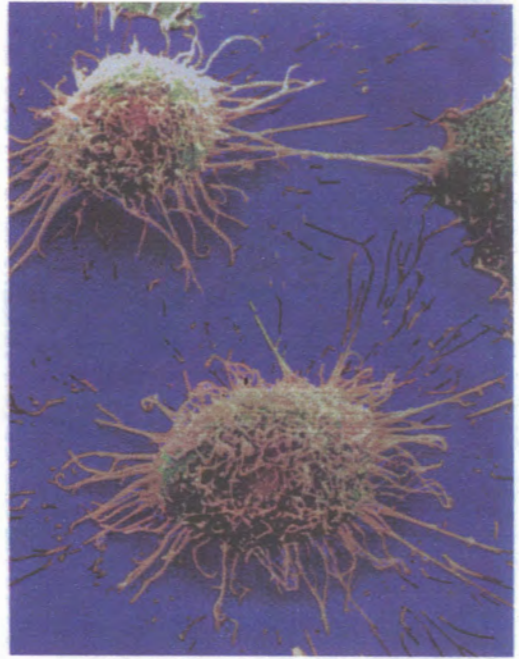
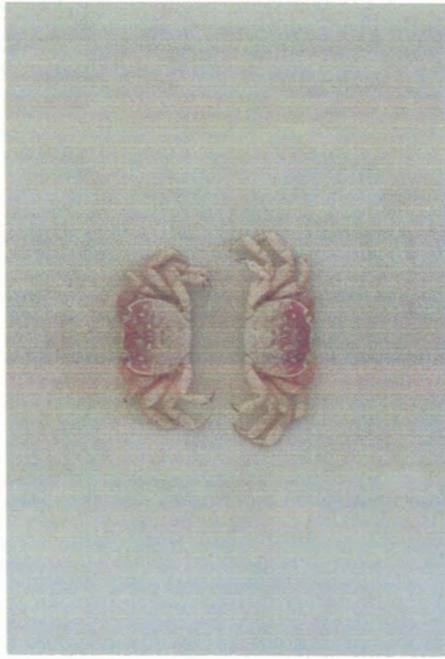


Figure 35 collage with colonic glands

Figure 36 colonoscopy



Figures 37, 38 & 39 aberrant



Figures 40, 41 & 42 cancer



Figure 43 pages from notebook

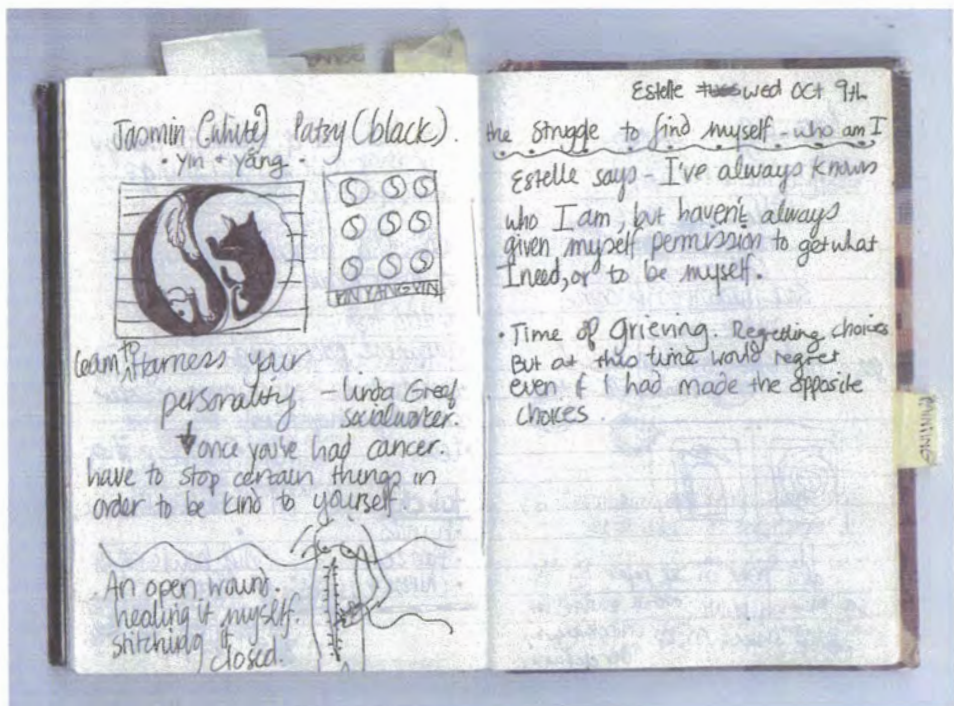
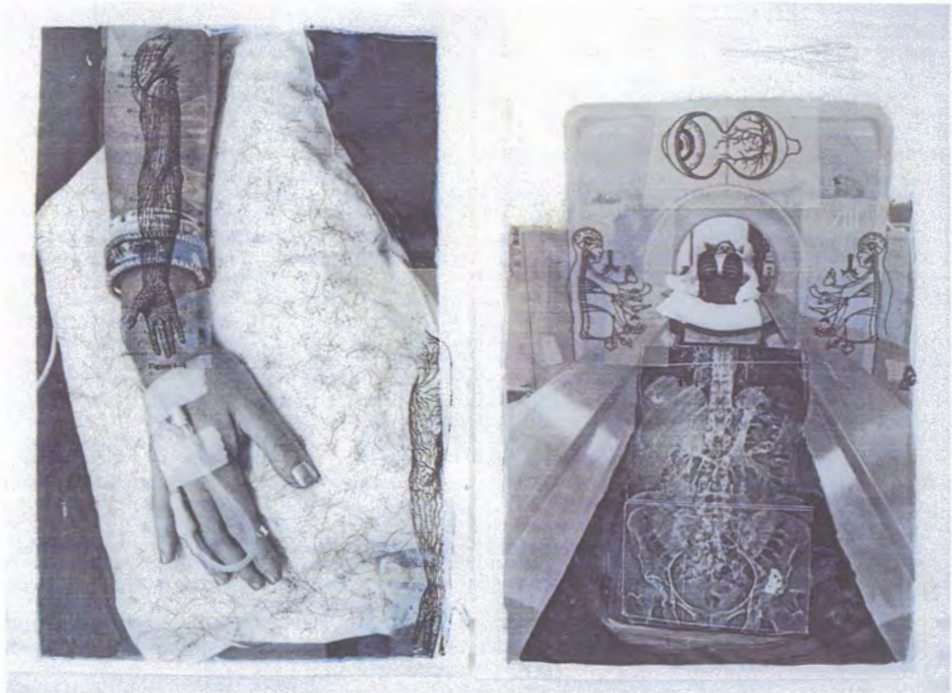


Figure 44 collage with acrylic glaze, photocopy, hair, acetate, acrylic paint on paper (original photographs: Sue Kramer)

Figure 45 pages from notebook





Figures 46, 47, 48 & 49 video stills of lymph nodes from cadaver
(camera: Koeka Stander)

APPENDIX III

SOURCE MATERIAL

Cancer Ass. of S.A.



cancer friends

VOLUNTEER NEWSLETTER FOR
PEOPLE LIVING WITH CANCER

Reg No: 05 03720 08 01 10000 002 4

SUMMER 1995 96

Declaration of Rights of people with cancer

I have the right:

1. to equal concern and attention whatever my gender, race, class, culture, religious belief, age, sexuality, lifestyle, or degree of able-bodiedness.
2. to be considered with respect and dignity, and to have my physical, emotional, spiritual, social and psychological needs taken seriously and responded to throughout my life, whatever my prognosis.
3. to know I have cancer, to be told in a sensitive manner and to share in all decision-making about my treatment and care, in honest and informative discussions with relevant specialists and other health professionals.
4. to be informed fully about treatment options and to have explained to me the benefits, side effects and risks of any treatment.
5. to be asked for my informed consent before I am entered into any clinical trial.
6. to a second opinion, to refuse treatment or to use complementary therapies without prejudice to continued medical support.
7. to have any special welfare needs acknowledged and benefit claims responded to promptly.
8. to be employed, promoted or accepted on return to work according to my abilities and experience and not according to assumptions about my disease and its progression.
9. to easy access to information about local and national services, cancer support and self help groups and practitioners that may be useful in meeting my needs.

10. to receive support and information to help me understand and come to terms with my disease, and to receive similar support for my family and friends.

Produced by CancerLink, London, UK.

From the Editor...

Dear Friends,

My sincere apologies for getting the Summer issue of **Cancer Friends** to you only now instead of December. These things happen when you're a one woman show. Now if I had more volunteers helping me, it may have turned out differently.... Things should run smoother this year though - the Cancer Association has kindly offered to assist me with the gathering of information. This will definitely ease my burden and ensure that you and I, the cancer patients, get more accurate, up-to-date articles straight from the horses', sorry, experts' mouths.

The response to the questionnaire in the Spring issue was disappointing and came mostly from professionals and not patients, as I was hoping. Thanks to those who did take the trouble to complete it. It was gratifying that all respondents found the newsletter useful. Some of the requests were for more practical tips about dealing with cancer, information on diets and nutrition, support services that are available, etc. I've noted your suggestions and will certainly try to incorporate them in future issues.

I would really like to include more personal stories about cancer patients: a positive experience that you've had, or a problem that you would like to bring to our attention. So please drop me a line to PO Box 165, Salt River 7925. Is that the postman already?? Gesundheit!

Estelle Hefer, Editor

>-----Original Message-----

>From: Patrick [mailto:paddy@mweb.co.za]
>Sent: 04 April 2001 10:14
>Subject: FW: American Cancer Society Boycott
>From: Ian Steele [mailto:iansteelc61@hotmail.com]
>Sent: 02 April 2001 06:24
>Subject: American Cancer Society Boycott

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><http://www.sightings.com/general9/cans.htm>

American Cancer Society Boycott

The American Cancer Society (ACS) is a well-known organization that presents itself as an advocate and resource for cancer victims. The ACS is a very large organization that provides research grants, public outreach, and expert advice on matters of public health relating to cancer. All this sounds great, but there are troubling truths about

- (1) who gives the ACS money,
- (2) what the ACS tells the public about the causes of cancer,
- (3) what the ACS tells the public about cancer treatment and cancer prevention, and
- (4) what research the ACS funds and what research the ACS blocks.

The ACS receives money from chemical companies and pharmaceutical companies and, in exchange, the ACS protects their political and economic interests.

Particularly, the ACS:

- (1) protects the corporate polluters that cause cancer by telling the public there is no connection between environmental pollution, food additives and cancer,
- (2) protects pharmaceutical companies by attacking natural, non-patentable, non-pharmaceutical forms of cancer treatment.

The ACS also wastes millions of dollars on excessive overhead and high salaries.

Therefore, legitimate grassroots organizations honestly trying to PREVENT cancer (e.g. The Cancer Prevention Coalition) have called for a BOYCOTT of the American Cancer Society.

The ACS is riddled with conflicts-of-interest in advocating public health. Over the last two decades, an increasing proportion of the ACS budget comes from large corporations, including the pharmaceutical, cancer drug, and chemical industries: ACS Boardmember Gordon Binder, CEO of Amgen, the world's foremost biotechnology company, with over \$1 billion in product sales in 1992. Amgen's success rests almost exclusively on one product, Neupogen, a chemotherapy adjunct. As the cancer epidemic grows, sales for Neupogen continue to skyrocket. Mr. Binder profits from increasing cancer rates. ACS Boardmember David R. Bethune, president of Lederle Laboratories, a multinational pharmaceutical company and a division of American Cyanamid Company. Bethune is also vice president of American Cyanamid, which makes chemical fertilizers and pesticides while transforming itself into a full-fledged pharmaceutical company. In 1988, American Cyanamid introduced Novatrone, an anti-cancer drug. And in 1992, it announced that it would buy a majority of shares of Immunex, a cancer drug maker. Mr. Bethune profits from increasing cancer rates and from public ignorance of the links between pollution and cancer. ACS trustees include an executive from Glaxo-Wellcome, a manufacturer of chemotherapy drugs, and an executive from Pfizer, a pharmaceutical company with investments in cancer drugs. \$100,000+ contributors to the ACS include carcinogen polluters General Electric and Dupont, and pharmaceutical companies Bristol-Meyers Squibb, Novartis, and Smith-Kline Beecham. The ACS dismisses the relationship between environmental pollution and cancer. In 1992, the ACS issued a joint statement with the Chlorine Institute in support of the continued global use of organochlorine pesticides despite clear evidence that some were known to cause breast cancer. In this statement, ACS Vice President Clark Heath, M.D., dismissed evidence of this risk as "preliminary and mostly based on weak and indirect association." In 1993, just before PBS Frontline aired the special entitled, "In Our Children's Food," the ACS came out in support of the pesticide industry. In a damage-control memorandum sent to some forty-eight regional divisions, the ACS trivialized pesticides as a cause of childhood cancer, and reassured the public that carcinogenic pesticide residues in food are

safe, even for babies. When the media and concerned citizens called local ACS chapters, they received reassurances from an ACS memorandum by its Vice President for Public Relations denying any link between cancer and pesticide residues.

The ACS's anti-prevention efforts include opposing the now-defunct 1958 Delaney Clause (which prohibited the addition to food any chemical known to cause cancer), because the law "would severely limit the use of valuable pesticides and food additives and...probably increase food costs." The ACS persists in an anti-Delaney policy, in spite of the overwhelming support for the Delaney Law by the independent scientific community. In 1977 and 1978, it opposed regulations for hair dyes that cause mammary and liver cancer in rodents. And since 1982, the ACS has insisted on unequivocal proof that a substance causes cancer in humans before taking any position on public health hazards.

In 1983, the ACS refused to join a coalition of the March of Dimes, American Heart Association, and the American Lung Association to support the Clean Air Act. Air pollutants are known to cause lung cancer. When it comes to preventing cancer, the ACS is singularly focused on 'chemo prevention' pharmaceuticals. Tamoxifen, for example, is the ACS's primary 'prevention' effort. Tamoxifen is effective at preventing breast cancer, but it is a potent promoter of Liver cancer and uterine cancer. Tamoxifen is manufactured by one of the world's largest cancer drug companies, Astra-Zeneca. The ACS ignores pollution reduction as a method for preventing cancer. The ACS attacks non-patentable, natural treatments for cancer in an effort to protect pharmaceutical companies from competition.

The ACS has maintained a "Committee on Unproven Methods of Cancer Management" which periodically "reviews" unorthodox or alternative therapies. This Committee is comprised of "volunteer health care professionals," carefully selected proponents of orthodox, expensive, and usually toxic drugs patented by major pharmaceutical companies, and opponents of alternative or "unproven" therapies which are generally cheap, non-patentable, and minimally toxic. The ACS attacked Dr Linus Pauling for treating cancer victims with Vitamin C. Well over 100 promising alternative non-patented and nontoxic therapies have already been identified. These include hyperthermia, Tumor Necrosis Factor, (originally called Coley's Toxin), hydrazine sulfate, lactile, Gersons therapy and Burzynski's antineoplastons. The ACS has attacked all of them. The highly biased ACS witch-hunts against alternative practitioners is in striking contrast to its extravagant and uncritical endorsement of conventional toxic chemotherapy. This in spite of the absence of any objective evidence of improved survival rates or reduced mortality following chemotherapy for all but some relatively rare cancers. ACS corporate benefactors sell billions of dollars of chemotherapy drugs every year. The ACS wastes and abuses charitable funds. In 1992, The Chronicle of Philanthropy reported that the ACS was "more interested in accumulating wealth than in saving lives." Fundraising appeals routinely stated that the ACS needed more funds to support their cancer programs, all the while holding more than \$750 million in cash and real estate assets. For every \$1 spent on direct service, approximately \$6.40 is spent on compensation and overhead. In all ten states, salaries and fringe benefits are by far the largest single budget items, a surprising fact in light of the characterization of the appeals, which stress an urgent and critical need for donations to provide cancer services. The 5 highest paid members of ACS each received between \$250-350K in compensation in 1998.

Conclusion: The ACS is an industry front group and is more aptly described as a 'for-profit' organization. The ACS functions to deflect public scrutiny of chemical industry pollution, and to funnel cancer victims into costly and ineffective chemotherapy. The ACS is a cause of, not a solution for, the cancer epidemic. With a lifetime risk of breast cancer of about 1 in 8, we must demand an end to carcinogenic pollution and the nefarious politics/propaganda of the ACS and cancer industry.

For information on the REAL war against cancer:

>www.preventcancer.com

>www.bcaction.org

>www.pesticidewatch.org

>For information on nontoxic alternative therapies:

>www.ralphmoss.com

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FLUORIDE – Good Teeth or another POLLUTANT?

Find out why government health warnings
are not only restricted to cigarettes

Dr Bernard Brom

MB ChB (UCT), CEDH (France), Dip Acup (Singapore)

The US government requires that all fluoridated toothpastes and mouth rinses be labelled with a warning to keep them out of reach of children under 6 years of age and that they should not be swallowed. Why is this so, and why the controversy?

Fluoride is not a nutritional supplement but a poison and by-product of industry. Like chlorine, also a poison and by-product of industry, it is being 'dumped' into our water supply. The ostensible reason for adding this poison to the water supply is to prevent tooth decay in children, despite the fact that little is known about the effects of fluoride on the rest of the body.

The shortsightedness of professional bodies is remarkable. It will become increasingly difficult to control the intake of fluoride as it increases in the food chain from watering, rain, etc. and as fluoride begins to appear in more and more products, ranging from toothpaste to drugs and cosmetics. Parents are even encouraged to give their children fluoride in tablet form.

The fluoride added to water is sodium fluoride and not the natural calcium fluoride, which is much less bio-available. Sodium fluoride is far more soluble and easily absorbed. Fluoride is more poisonous than lead and only slightly less poisonous than arsenic. It has been used as a pesticide, rodenticide, anaesthetic and in many drugs.

Fluoride does not confer any health benefits to adults, and 20 years or more of fluoride ingestion may pose significant health risks.

Opponents to fluoridization are asking if it is wise to subject adults to the possible effects of chronic poisoning in order to prevent caries in children. Is there not a better way?

Does fluoride prevent the formation of caries in children?

It seems that investigators have failed to show a consistent correlation between anti-caries activity and the specific amounts of fluoride incorporated into enamel. Since the 1970s, caries scores have been declining in both fluoridated and non-fluoridated communities in Europe, the USA and elsewhere.¹

Fluoride poisoning is linked to many symptoms and signs, of which the most well known is dental fluorosis, a brown staining and/or pitting of the permanent teeth. It is claimed that the amount of fluoride in water is insufficient to cause any problems, but in view of the water solubility of sodium fluoride (as opposed to calcium fluoride found in nature), the increasing amounts in the atmosphere and food chain, and the unreliability of the human factor (control of amounts used), it seems unwise and perhaps even unconstitutional to allow a poison into the water supply. In addition, one must always remember the possible synergistic effect with other chemical substances in the water and in the body, multiplying and amplifying the consequences of fluoride's effect on the human body. In addition, subsets of the population may be unusually susceptible to the toxic effect of fluoride and its compounds. These populations include the elderly, people with various mineral and vitamin deficiencies and those with

cardiovascular and kidney disease.

There are also insufficient data regarding safe daily intake over the long term. Industries with fluoride disposal problems are often the ones controlling the bulk of research on fluoride toxicity. This toxicity has included reports of lower IQ in children, increase in incidence of hip fractures, chromosomal damage, stomach and bowel disorders, fatigue, a decrease in calcium levels as fluoride levels increase, a possible increase in heart disease and effects on the brain. Although the possibility of toxic effects is dismissed by government agencies and most medical scientists as insignificant, one cannot dismiss the fact that fluoride is a poison, and therefore when used to prevent disease should be classified as a drug and subjected to extremely rigorous independent studies before being released into the water supply. ❖

REFERENCE

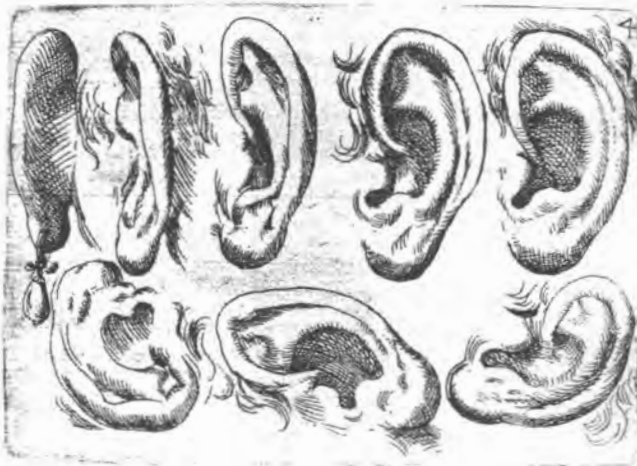
1. USA Department of Health and Human Services. *Review of fluoride benefits and risks* February 1991; 31: 7.

RECOMMENDED READING

J Hattersley. The case against fluoridation. *Journal of Orthomolecular Medicine* 1999; 14.4: 185-192.



Pietro Francesco Alberti (c. 1600)



Odoardo Fialetti (1608)



18 Rembrandt, *The Anatomy Lesson of Dr Nicolaes Tulp* (1632).

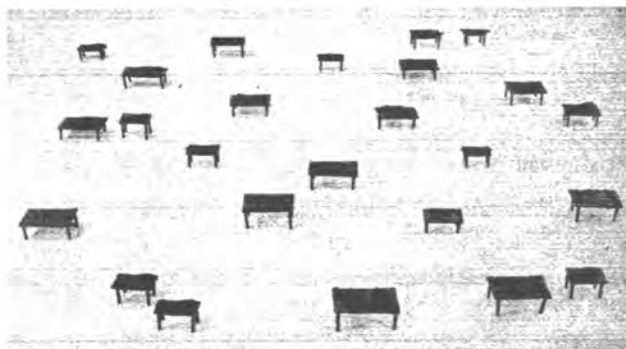


19 Rembrandt, *The Anatomy Lesson of Dr Joann Dryman* (1656).





Nervous Giants, 1987



Lymph Table (1994)



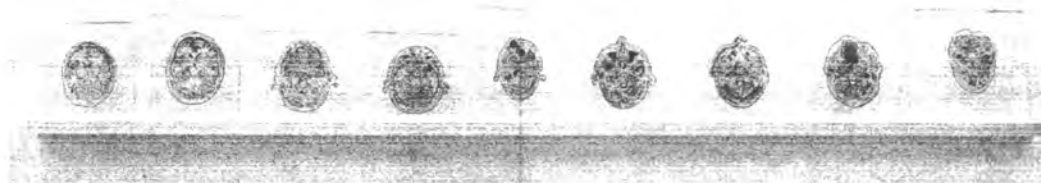
Untitled, 1990



Hair Head, 1990



Untitled (Hairdo), 1993



Cross Section of the Head, 1989

approach — are unresolved, making of this over time from one series into another. The vis- audience (who would very probably fall outside Bank Gallery, Jonathan Mebby, and ...



Perverse beauty: Helen Chadwick with her 1994 work, Piss Flowers PHOTO: KIPPA MATTHEWS

At the edge of mystery and taboo

ADRIAN SEARLE pays tribute to one of Britain's most innovative contemporary artists, Helen Chadwick

HELEN CHADWICK, who died suddenly last week aged 42, was one of the most innovative and individual artists in Britain today.

Her work was alarming, funny and deeply serious, and her reputation, which spread far outside the art world, rested on works which frequently caught the public imagination. It was Helen Chadwick who filled London's Serpentine Gallery with her chocolate fountain, which, with its 750kg of molten Cadbury's chocolate, gurgled and glooped lugubriously.

In the same year, 1994, with the help of her partner David Notarius, she cast bronze sculptures, which sprouted like phallic mushrooms, from piss-holes they made in the snow. And, in the mid-1980s, it was Chadwick whose huge cube of vegetable matter, grass clippings and kitchen waste oozed black silage over the carpet at the Institute of Contemporary Arts.

Yet she also made an acclaimed BBC film about Frida Kahlo in 1992, wrote poems, taught and lectured. Unpretentious, pragmatic, a stickler for detail, she was a delight to work with.

Much of her output found its final form in intensely coloured and brightly back-lit photographic pieces, but they always began with the physical, and with the manipulation of forms and objects from the real world. Her work focused on the body; on sexuality, disease and unease, growth and decay. Grimness and gore have lately become the motifs of cutting-edge art; yet Chadwick's lightness of touch, humour and candour distinguished her work.

As an artist, Chadwick's intention was never simply to shock, although it was always clear that she wanted to shake us up. She produced works of perverse beauty, delighting in strange juxtapositions and alarming conjunctions of materials. She sewed lambs' tongues together

and cast them in bronze; she made cheeky sculpted penises and used images of her own body cells.

She was always more at home in the personal — in the space of the body, in our own writhing interiors. Her works, sometimes literally, got under our skins, and showed us how uncomfortable, and how marvellous and strange, it is to be, in the world. Once, she painted out the yellow hearts of all the daisies growing on a lawn; she painted them black.

In the months before her death she was working at Kings College Hospital, in a unit devoted to Assisted Conception. There she made micro-photographs of human embryos for an exhibition which will open at the Barbican, in London, in May.

These works, with their manipulated images, are a meditation on both the beginning and the end of life, and in their cyclical nature, signal a kind of return.

Best adapted screen-play: Emma Thompson (Sense and Sensibility)
Best actress: Susan Sarandon (Restoration)

ing establishment would have thought them mad and given them excellent odds. Braveheart was Hollywood in essence but by no means orthodox in execution or insp...

Me, my surgeon and my art

More and more artists are using their bodies as canvas. LOUISE GRAY reports on a perverse and painful extension of self-portraiture

FOUR years from now, in an operating theatre somewhere in Japan, French multi-media artist Orlan will begin the final stage of her 10-year project, *The Reincarnation of Saint Orlan*. Surgeons will construct for her the largest nose that her face is capable of holding. As with her previous operations (at the last one, in New York, she had cheek implants put in her forehead), Orlan will be under local anaesthetic. She'll be wearing a colourful, outlandish outfit. As the surgeons proceed, she will read aloud from texts drawn from philosophy, literature, psychoanalysis: Kristeva, Artaud, Lacan. The theatre will have an audio-visual link to art galleries throughout the world. Orlan will communicate, via fax and phone, with her audience.

It's a disquietingly funny performance. At the last operation, an assistant flashed a sign to the camera: *L'Orlan nouveau est arrivé*. Afterwards, any surplus pieces of flesh will be saved, preserved and carefully mounted on texts from Lacan. Is this, the theatre of operations, a logical, if bizarre, extension of self-portraiture?

If this is art, it is art at its most shocking. It strikes at the heart of all we hold true about our physical identities in the world. But why? Because, says Orlan's agent, Dr Rachel Armstrong (a paediatrician who quit to work at the interface between art and technology), it makes a radical assertion: that we own our own bodies, we can do with them as we please.

At a London press conference, the 48-year-old Orlan cuts a dapper appearance: only a coiffure of blue hair atop a neat blonde bob and the forehead implants; standing out like large, subcutaneous kidney beans, mark her out as extraordinary. "My work is not against plastic surgery, but against the *diktats* of beauty standards which are impressed upon our bodies," she says. "Skin is a mask, a source of strangeness, and by reforming my face, I feel I'm actually taking off a mask. My work is carnal, in as much as it deals with flesh; it is blasphemous."

In recent years, a disparate group of artists have begun using the body as a source of inspiration. The body has become a landscape, simultaneously strange and intimate. By turning their gaze inwards, the body artists are discovering new topologies, new frontiers.

And nor is this some fringe activity, at the perimeters of the art world. Damien Hirst, win-



This is my body: Orlan undergoes surgery in the process that constitutes her artwork

ner of Britain's prestigious Turner Prize last year, exhibited longitudinal sections of a cow and her calf entitled *Mother and Child Divided*. Mona Hatoum showed an installation entitled *Corps Etranger*, a room in which a video of the artist's digestive system played. Hirst has spoken about his work as a response to "the paranoid denial of death that permeates our culture," which may be why a theatre piece by Ron Athey, *Deliverance*, caused so much disquiet at London's ICA in December.

Athey, a 34-year-old performance artist, was dangled from meat-hooks dug into his spread-eagled limbs. *Deliverance* is the final section of a trilogy that explores redemption and ritual, making overt links between blood, shit and other body products. Given the fact that Athey has now been HIV-positive for nine years, this systematic purging attained an especial signifi-

cance. The piece ended with Athey and the two other men in his six-strong company being sealed in body bags and buried under earth. Death, as Athey points out, is the unavoidable consequence of any kind of life.

But what about the million-dollar question: is all this art? Arguably, ever since Duchamp mounted a bicycle wheel on a stool, art's definition has grown to revolve around a notion of framing. If we, the viewers, permit the existence of this frame, then, yes, it's art. But critic Rose Jennings believes that striving to define art is insufficient. "Ask rather," she says, "whether it, the object at hand, is of a form that can contain genuinely conflicting elements? Is it interesting? Does it upset people? Why?"

Clearly, Athey has an infinite capacity to upset people. His performances are not for the squeamish. It's difficult to listen to his screams,

to watch the hooks tear his body. Has he turned his audience into sadists? Athey himself finds such performances deeply cathartic, although he concedes his audiences might not.

Cynics have suggested that, by asking questions about the body and its limits, these artists may be art's millennialist tendency. After all, Orlan's operations may be seen as a way of exerting a personal control over an impersonal technology. It is significant that such work has coincided with the collapse of our culture's belief systems. Utopian politics have failed; atheism prevails; psychoanalysis is under sustained attack. Perhaps this turning inwards more than a solipsistic response to the mysteries of human existence; perhaps it is an attempt to discover a substitute system as a palliative against the horrors of total disbelief.

Armstrong, drawing on her experience as a doctor, tells of how anatomy was once criminal activity, and says that deep-seated taboos remain. We have, as psychoanalyst Melanie Klein realised, a fascinated horror with bodies: to explore our fantasies about the body is a dangerous foray.

This is, perhaps, a reason for the unsettling power of the work from lesbian photographer Della Grace. Grace's work focuses on the body surface, as opposed to its interior. Its transgressions lie in its subject matter: drag kings, gender and pornography. Nor are these transgressions confined to her work: Grace herself has recently attained a measure of notoriety in growing a beard: the result, she says, of an ovarian cystic condition that produces enhanced levels of the hormone, androgen.

Grace's 1992 series, *Xenomorphosis*, links the fear of change with racism, homophobia and xenophobia. Her images are deliberately challenging: the naked, shaven women in her photographs stare straight out at their viewers, daring us to look. The series explores, says Grace, our fear of otherness.

Literally, xenomorphosis refers to a transmutation of something from a familiar to a foreign state. The transitions can be radical, as with Orlan; they can be as subtle as Grace's work. They may hint at tribalism or deviance, as Athey does. Whatever their form, such a return to the body is certain to have implications that reach far beyond the art world.

MTG April 26 - May 2 1996

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Hayward Gallery



Spectacular Bodies

The Art and Science of the Human Body from Leonardo to Now

Introduction

The human body is an astounding feat of engineering which for centuries man has striven to understand, artistically, anatomically and psychologically. *Spectacular Bodies: The Art and Science of the Human Body from Leonardo to Now* looks at the visual riches of the combined cultures of art and science by bringing together more than 300 objects made in the study and representation of the human body. Works of art dating from the Renaissance to the end of the nineteenth century are shown alongside medical books, models, instruments and photographs of the same period, with an emphasis on images of the mind and body visible to the naked eye. Integrated throughout the show are works by eight contemporary artists which reveal the continued influence of the historical material in this age of the X-ray and digital imaging.

The exhibition is divided into six sections. The first four sections in the lower galleries focus on the human body as a complex machine, and the two sections in the upper galleries look at the study of the human face and head as the key to understanding temperament and character.

I. Men at Work

Spectacular Bodies begins in the gallery to the left of the entrance. Here, six seventeenth- and eighteenth-century group portraits of members of the Amsterdam Surgeons' Guild are displayed, as well as engravings showing anatomy

theatres of the same period. These were theatres in the true sense of the word, with stands or seats arranged to encircle the corpse which, along with the surgeon, or 'praelector', took centre stage. Annual dissections were public affairs, accessible to anyone able to afford a ticket as well as to physicians, surgeons and students of anatomy. The surgeons could thus attain a degree of celebrity, and appearing in a group portrait commissioned by the Guild was an effective method of displaying such privileged status.

The Anatomy Lesson of Dr Sebastiaen Egbertsz, 1601-03, by Aert Pietersz, is the earliest example of what was to become a genre of portraits of Dutch surgeons over the next century. Carefully composed rather than representing real events, the paintings show the surgeons gathered around an 'anatomical' focal point. The most dramatic compositions are centred around the dissection of a cadaver, as in Rembrandt's *Anatomy Lesson of Dr Deijman*, 1656, in which the corpse's brain has been revealed, or Cornelis Troost's 1728 painting, *The Anatomy Lesson of Dr Röell*, in which the fashionably dressed Dr Röell is shown peeling back skin and muscles to reveal the corpse's knee joint.

In the next gallery space, past a case of seventeenth-century operating tools made by Cornelis Solingen, whose functional designs anticipated those of modern surgical instruments, is a new video installation by John Isaacs. Combining footage of the late sixteenth-century anatomy theatre in Padua, Italy, with imagery of a contemporary state-of-the-art operating room, the film is shot from the viewpoint of the corpse and that of the patient respectively.



William Pink after Carlini for William Hunter
*Smuggerius, (Ecorché of Man in the Pose
of the 'Dying Gaul')*, 1834 (original cast, 1775)
Royal Academy of Arts, London
Photo Paul Highnam
© Royal Academy of Arts, London, 2000

Christine Borland's work, *Progressive Disorder*, 2000, shown on the ramp leading up to the next gallery, is based on the drawings of Dr William Gowers, a nineteenth-century physician who undertook ground-breaking research into muscular dystrophy. The piece uses animation to refer to a disease which progresses from movement to loss of movement, and then to complete immobility.

II. The Divine Machine

In the eighteenth and nineteenth centuries, the three-dimensional representation of the human body was central to the study of anatomy by both artists and scientists. Johann Zoffany's *Hunter Lecturing at the Royal Academy*, c.1772, and François Sallé's monumental painting of a century later, *The Anatomy Lesson at the École des Beaux-Arts*, 1888, show the use of casts of skinned, or flayed, bodies as essential teaching aids in academic training in Britain and France. *Smugglerius*, 1834, by William Pink, is an example of one of these casts, the original version of 1775 having been taken from the corpse of a convicted smuggler which was put into the pose of the classical statue of *The Dying Gaul* before rigor mortis set in. (To be condemned to flaying, or any kind of dissection, after execution was a punishment dreaded more than the death sentence itself.) Figures were copied from this type of cast in various media – bronze, alabaster, plaster or marble – and tended to be either life-size or small enough to be kept to hand for easy reference in the artist's studio. Not only were the flayed figures, or *écorchés* as they were known, beautiful objects in their own right, they were often the subject of drawn studies, examples of which can be seen in the next gallery.

Three-dimensional models have played an equally important part in the study and teaching of medicine, particularly in the eighteenth century, but here wax was the favoured medium. Wax could be easily modelled to create fantastically detailed, 'realistic' figures, and readily coloured to mimic or exaggerate flesh tones, organs, veins and arteries so that the models would be both instructive and pleasing to the eye. The astonishing array of models brought together in this gallery, by Pinson, Zumbo, Susini and Towne, the leading French, Italian and British wax modellers of the late eighteenth century, demonstrates a high level of skill and artistic accomplishment. It comes as little surprise, therefore,

that the modellers tended to have careers as practising artists as well as servicing the needs of the medical profession.

III. The Life Within

In the next gallery is a section of the exhibition which focuses on images of women, almost all of which illustrate pregnancy, childbirth or the reproductive organs. The belief that the wonders of the female anatomy were inextricably linked to the reproductive process meant that early anatomical studies of women generally focused on obstetrics, an area of study which gained importance in the eighteenth century in the face of the continued high death rate in childbirth. The breadth of imagery in this area is remarkable, ranging from Leonardo's delicate drawings of the foetus *in utero*, to Manfredini's highly stylized life-size ceramics of expectant mothers peeling back their abdominal skin like the petals of a flower, and Jan van Rymsdyck's brutally realistic drawings for William Hunter, showing dissected corpses of women in different stages of pregnancy. The recurring image of an opening bloom establishes immediate visual and interpretative links with the flowers in Marc Quinn's *Eternal Spring (red)*, 1998, the freshness of which has been captured and frozen in silicon. Equally strong are the work's references to the ongoing quest for scientific progress in the prolongation of youth, beauty and life itself.

Capturing life was part of the motivation behind the seventeenth-century Dutch physician Dr Frederik Ruysch's invention of a new method of preserving foetuses and human body parts, the effectiveness of which has been demonstrated by the survival of the preparations, as they are known, more than 300 years later. Whatever our reactions might be to this type of material today, in the seventeenth century Ruysch's preparations were valued not only as a means of advancing medical research, but also as objects of beauty in their own right. The preparations formed part of Ruysch's 'cabinet of curiosities', which also included his other speciality: extraordinary, decorative arrangements of preserved gallstones, skeletons, arteries and veins. Ruysch believed himself to be an artist as much as a physician, and turned his home into a museum, which was open to the public and generally perceived with a sense of wonderment by fascinated visitors.

At the far end of this gallery, Bill Viola uses the simple yet loaded symbols of a bed and a beating human heart in his video installation, *Science of the Heart*, 1984, to present a contemporary interpretation of the cycle of life.

IV. Drawn from Life

From the Renaissance until well into the twentieth century, drawing, ideally directly from a specimen, was a vital element of anatomical education for both artists and medical students. In sixteenth-century Italy, Leonardo and Michelangelo were pioneers in applying a naturalistic style to the anatomical studies which informed their paintings and sculptures. In the medical world, the celebrated eighteenth-century Dutch draftsman, Jan Wandelaar, collaborated with Bernard Siegfried Albinus, his lifelong companion, to produce illustrations which went far beyond the objective representation of bare anatomical fact. The contrived poses of the skeletons and the heavily-illustrated backgrounds demonstrate the importance of artistic stylishness in designing these otherwise didactic images.

Engravings provided an effective means of disseminating information and large, beautifully-illustrated medical books were easily accessible in academic libraries. Ownership of these costly tomes was the privilege of only the wealthiest physicians and served to enhance their status and credibility.

Leading upstairs to the next part of the exhibition, which looks at the human face and head, is Katharine Dowson's blown glass sculpture of a spinal column, *Pia Mater*, 2000, which takes its name from one of the two delicate membranes which envelop the brain.

V. Humours and Temperaments

For centuries artists and scientists have grappled with the idea that mood and character can be read in facial expressions. Works of art in this gallery which reflect artists' interest in outward signs of emotion range from Franz Xaver Messerschmidt's grimacing heads, 1770-75, and Gustave Courbet's painting of a desperate man of 1844-45, to Tony Oursler's video piece, *Crying Doll*, 1993, and Marc Quinn's sculpture, *Emotional Detox*, 1994-95.

The 'science' of reading facial expressions, physiognomics, has a chequered history and Honoré Daumier



Charles Grignion after Jan Wandelaar
Muscle-man seen from the front with rhinoceros, 1747
from B.S. Albinus, *Tabulae sceleti et musculorum corporis humani*, 1747
Wellcome Library, London

exploited its comic implications to great effect in his witty lithographs. The related theory that human facial expressions can be linked to those of animals was taken up by artists such as Leonardo da Vinci in the early sixteenth century and Charles Le Brun 200 years later. Gerhard Lang's *Palaeanthropical Physiognomy*, 2000, is a contemporary response to the theory.

The Typical Inhabitant of Schloss-Nauses, also by Gerhard Lang, involved photographing the entire, albeit tiny, population of the artist's native village in Germany in 1992, and again in 2000. In its revival of the methods of the nineteenth-century scientist and inventor of eugenics, Francis Galton, Gerhard Lang's work plays simultaneously to our fascination with this type of data, and to our knowledge, with hindsight, of its potential misuse. Head-measuring devices and photographs from Galton's vast photographic

archive bear testimony to his quest to classify facial type and establish a science of human nature.

The obsessive gathering of information was common to related sciences, such as that of phrenology, which linked head size and shape to levels of intelligence and other characteristics. Phrenology attained a peak of popularity in the late nineteenth century when groups were set up across Europe, including the Edinburgh Phrenological Society, which acquired a substantial collection of life and death masks of famous and infamous men. Craniology, which concentrated specifically on the shape of the skull, led scientists such as Paul Broca in France to accumulate substantial collections of skulls. In the era of colonial Empires, this fervent categorization of types, combined with the new possibilities offered by photography, led to endeavours across Europe and America by scientists such as Thomas Huxley in Britain and Carl Dammann in Hamburg to record and classify the 'Races of Man'.

VI. Mad and Bad

Attempts in the nineteenth century to identify facial characteristics extended to the classification of 'criminal' types. Cesare Lombroso in Italy and Alphonse Bertillon in France, key figures in advancing such investigations, each created vast photographic archives in order to

pinpoint the definitive criminal forehead, jaw, eye, nose and ear. Physical appearance came to be equally important in nineteenth-century studies of 'insanity', and here, too, visual representation played a significant role. Théodore Géricault's 1821-24 series of portraits of sufferers of different types of 'monomania' – including that of child kidnapping shown here – were reputedly painted at the request of Dr Georget, medical officer at a private asylum in France. More generally, however, photography came to be the principal medium in the documentation of 'insanity' and in this Hugh Welch Diamond was a notable pioneer in Britain. In France, Dr Jean-Martin Charcot specialized in the study of hysteria in women, which was considered to be largely due to the inactivity of the ovaries. André Brouillet's painting of Dr Charcot shows him conducting a lesson at the Salpêtrière asylum in Paris, in which a female patient demonstrates the symptoms of her hysteria to an assembly of men.

In her installation, *Hysteria*, 2000, the American artist Beth B includes devices, such as an ovarian compressor belt, of the type used by Dr Charcot to treat hysterical women. The work combines references to perceived links between women and hysteria, past and present, in what is effectively a stage set, which returns us to the opening theme of this exhibition and the analogy between medical practice and theatre.



André Brouillet
Une leçon de clinique à la Salpêtrière, 1887
Musée d'Histoire de la Médecine, Paris

Spectacular Bodies

The Art and Science of the Human Body from Leonardo to Now

Hayward Gallery, London
19 October 2000 – 14 January 2001

Exhibition curated by Martin Kemp and Marina Wallace,
assisted by Caterina Albano

Exhibition organized by Margot Heller,
assisted by Sally Tallant

Architectural design by Stanton Williams Architects
Lighting design by John Johnson and Light Waves
Exhibition graphics by Herman Lelie

Front cover:

Image based on a figure by Clemente Susini, 1804,
University of Cagliari
Concept: Publicis
Photography: Masaud Golsorkhi

Guide written by Margot Heller
Designed by Herman Lelie
Typeset by Stefania Bonelli
Printed by Leycol Printers Ltd

© Hayward Gallery 2000

Catalogue

A substantial and lavishly-illustrated catalogue with essays by the curators, Martin Kemp and Marina Wallace, accompanies the exhibition. The catalogue is available from the Hayward Shop and Books Etc. in the Royal Festival Hall at a special price during the exhibition, and by mail order from Cornerhouse Publications on tel. 0161 200 1503.

Public Programmes

A varied programme of *Talks and Events* offers adults, students, children and families an exciting way of enhancing visits to the show. With every exhibition a series of free *Gallery Talks* by artists, writers and academics is open to all – and for *Spectacular Bodies* we have also invited medical professionals to give their perspectives on the show. In addition, we are launching a new series of *Conversations*, which brings together specialists from different backgrounds, including Germaine Greer, Beth B, Stephen Jay Gould, A.S. Byatt, Antonio Damasio and Jonathan Miller, encouraging dialogues across disciplines. On a more informal basis, Artist Guides are regularly on hand in the Gallery to answer your questions. For younger visitors, there are *Half-term Workshops*, and teenagers (16 and under) can now get into Hayward exhibitions free.

Events take place in the galleries, or in the Hayward Studio, located in the upper galleries, which offers reading and drawing materials and a display to complement *Spectacular Bodies*. Further resources, in the form of videos on show in The Pavilion, and an Acoustiguide audio tour (price £3.50), are also available. For information about events, please telephone 020 7921 0951. Full listings are given in the exhibition leaflet, available in the Hayward foyer.

Access

Patrons with access needs should visit the information desk in the Hayward Gallery foyer or call 020 7960 5226.

The Hayward Gallery gratefully acknowledges funding from the Gulbenkian Foundation and support in kind from Dr Sourisseaux, Lüdemann and Partner, Darmstadt, Absolute Action Ltd and Print Out Video Publishing.

Funded by
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COUNCIL
OF ENGLAND

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EXHIBITION

INVISIBLE BODY

January 21 - February 13 2000

Take 12 contemporary artists whose work explores the constantly changing world of medicine - from genetics to cell biology, HIV and eating disorders, anatomy and neurology.

Add 12 leading specialists in medical science and encourage collaboration between the two. Their task - to uncover the inspiration and ideas behind each artist's work, and to examine the role that medicine plays in contemporary culture.

Invisible Body reveals what happens when you place an artist and a scientist in the same room for any length of time. The exhibition exposes the arguments and celebrates the agreements through a diversity of visual arts.

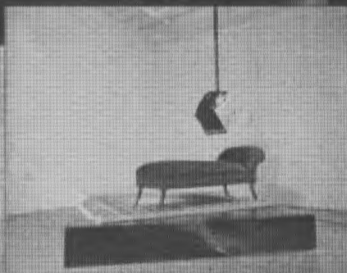
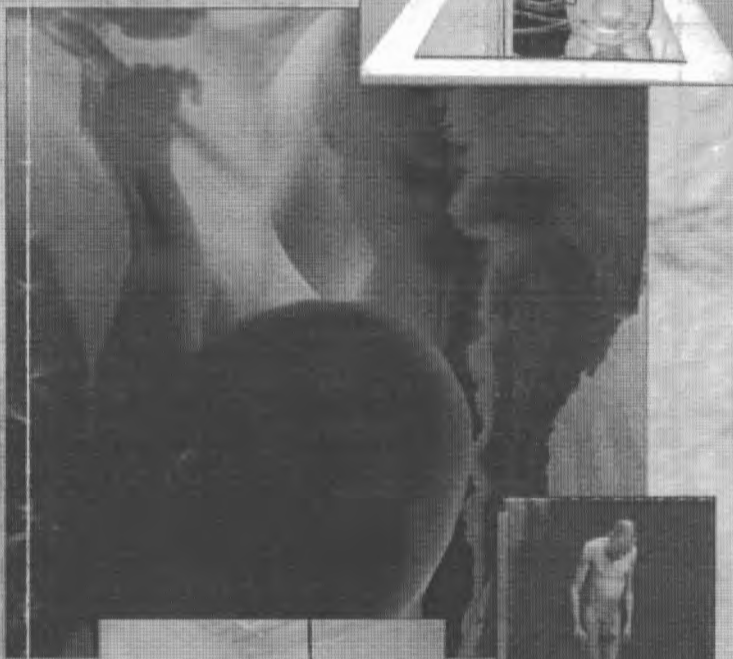
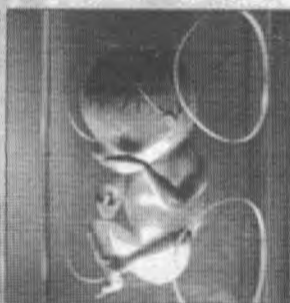
The exhibition features both the artists' original works and the interpretations produced through the collaborations, and is accompanied by a range of events offering opportunities for lively debate and discussion.

THE ARTISTS

heather barnett anna dumitriu mandee gage
paddy hartley david jones juliet mayo angela rumble
richard sawdon smith louise k wilson julia wilson
shelley wilson alexa wright

THE SCIENTISTS

kathy boursicot nicholas goddard david hopkinson michael kopelman
irene leigh alf linney caroline lynas frank marsh lorenzo pieri
anand saggarr-malik michael swash robert whittle



SYMPOSIUM

January 29 & 30

15

Invisible Body is hosting a 2 day event of talks, discussions and workshops - ideal for anyone interested in contemporary art and medical science or simply curious about what happens when the two worlds collide.

Day 1 - Saturday 29th January

Venue: Atrium Gallery, Whiteleys Shopping Centre
Speakers include:- Heather Barnett (curator, Invisible Body), The Arts Catalyst (science-art agency), and sci-art partnerships exhibiting in Invisible Body

Day 2 - Sunday 30th January

Venue: The Science Museum, Exhibition Road
Speakers include:- Denna Jones (The Wellcome Trust), Claire Cohen (sci-art researcher), artists and historians.

Cost

£60 (£40. concessions) for both days including lunch and refreshments

Book now to confirm your place by sending a cheque (including proof of concession if applicable) payable to 'Invisible Body' to:-

Invisible Body Symposium
3rd Floor Management Suite
Whiteleys Shopping Centre
Queensway
London W2 4YN

or telephone Whiteleys Customer Services on 0171 293 8844 for full details

EVENTS

ALL EVENTS WILL TAKE PLACE IN THE ATRIUM GALLERY ON THE THIRD FLOOR OF WHITELEYS SHOPPING CENTRE

For full details or to book your **FREE** place telephone Whiteleys Customer Services on 0171 229 8844

THE HYBRID LECTURES

Topical issues within modern medicine and art practice are uncovered and discussed in these informative and enlightening talks by professionals from art and science.

every Thursday evening at 7.30pm (2 hours)

27th January: *Immortality and the Unseen*

Anna Dumitriu and Steve Potts with Maurice Biriotti

3rd February: *The Senses*

Lawrence Hart and Clara Ursitti

10th February: *Medical Imaging and Genetics*

Dr Alf Linney and Prof David Hopkinson

[Hybrid originates events and exhibitions encouraging the cross-fertilisation between art and science]

GUIDED TOURS

every Sunday afternoon at 3pm (1 hour)

Performers (ex-Floating Point Science Theatre) offer you an entertaining and informative tour through the exhibition. [23rd & 30th Jan and 6th & 13th Feb]

MEET THE EXHIBITORS

every Sunday afternoon at 4pm (1 hour)

Come and meet some of the artists and scientists who collaborated for Invisible Body. The sci-art partners will give informal talks about their work and how they approached the task of working together. A unique opportunity to get first-hand insight and for you to share your thoughts and ideas with the exhibitors.

[23rd & 30th Jan and 6th & 13th Feb]

GET A FREE 3D FACE SCAN OF YOU AND YOUR FAMILY AND CONTRIBUTE TO A MEDICAL RESEARCH PROJECT

During the course of the exhibition you can participate directly in a scientific research programme concerned with **human genetics and facial appearance**, organised by Prof. David Hopkinson. It only takes 5 minutes to have a 3D face scan (which is like having a photo taken) and a couple of swabs from your cheek [which is like rubbing your tongue inside your mouth]. The scientists are looking for volunteer families, preferably 2 parents and 2 or more children, plus grandparents if possible. Children must be at least 8 years old.

In return for your help in attempting to match genes and facial features using the information gathered from face scans and DNA you will receive a copy of your 3D scan.

The scientists will set up in the Invisible Body exhibition on the third floor 12 - 6pm on Sunday 23rd and 30th January 2000.

Atrium Gallery
Whiteleys Shopping Centre
Deensway
London W12

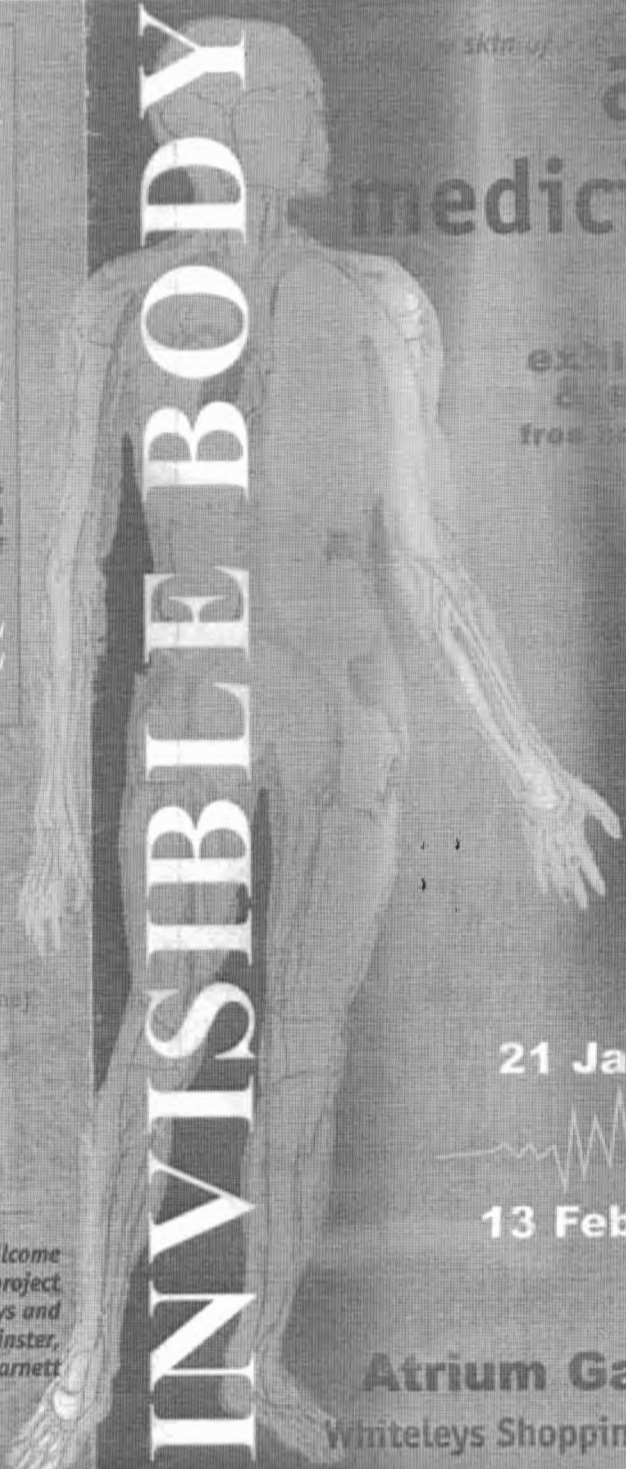
NEAREST
STATIONS: Bayswater (Central Line), Bayswater (Circle/District Line)

All details correct at time of going to print.
Please confirm dates and times of events with
Whiteleys Customer Services on 0171 229 8844
www.whiteleys.com



Invisible Body is a Wellcome Trust Sci-art project supported by Whiteleys and City of Westminster, curated by Heather Barnett

INVISIBLE BODY



skin v/ art and medicine

exhibition & events free admission

21 January



13 February 2000

Atrium Gallery
Whiteleys Shopping Centre

[PHOTOGRAPHER]

Through a Different Lens

Pick up a piece of fruit—a common red fruit, the kind that keeps the doctor away. What do you see? An apple? Not really. You see a bulbous round of apple skin. Maybe a piece of stem. What you don't see is white flesh, black seeds, core—99% of what makes an apple an apple.

For years, Catherine Wagner, like any other photographer, was limited to documenting the skin of the world. But in the early- to mid-1990s, doing a series of photographs of science labs,

Wagner, 48, was struck by how much of modern science depends on images that a camera cannot capture. To keep exploring the nexus of science and art—part of her ongoing interest in the systems people use to organize and make sense of the world—she decided that “I needed access to the same tools that the scientists work with.”

Collaborating with researchers at Stanford University and the Weizmann Institute in Israel, Wagner, whose studio is in San Francisco, began using

magnetic-resonance-imaging (MRI) machines and electron microscopes as cameras, magnifying or looking inside objects as prosaic as corncobs and as elusive as dividing cells. The resulting work, collected in the show “Cross Sections” (beginning Nov. 3 at the San Jose Museum of Art), takes the typical still life and turns it, sometimes literally, inside out.

The luminous black-and-white images are both crisply detailed and ambiguous, allowing Wagner to call attention to the leitmotifs of form that recur throughout nature: “The sharks’ teeth are like pearls,” says Anne Wilkes Tucker, curator of photography at the Houston Museum of Fine Arts. “The scallions look like some intricate body part.”

The centerpiece of “Cross

Sections” is *Pomegranate We*: an 2.5m by 12m curved, back-transparency containing thousands of interior views of pomegranate. Seen close up, the cross-sectioned fruit could be microbes; viewed as a whole, the work resembles a panorama of galaxies. When Wagner shows you a pomegranate, you see all of creation, microscopically and macroscopically. And you really see a piece of fruit as you never have before.

—By James Poniewoz

► CATHERINE WAGNER

In her San Francisco studio, with her dog Bishonen; the print *Right Brain, Left Brain* (2000), taken using an electro microscope, is one of several organ images in her upcoming show “Cross Sections”



WILLIAM MERCER HICKLORD FOR TIME

ades of the 20th century, Fukuda, 58, was in coffee country in São Paulo State, where his father had a factory that made fans. Fukuda, who has no formal art training, began his apprenticeship in his father's workshop.

convey airiness. For well-known critic Alberto Beutenmuller of São Paulo, the traditional Asian side of Fukuda's work reflects a spirit of “not wanting to lose roots or customs.”

THESE TOO HAVE MADE ART NEW



MARCEL DUCHAMP He invented conceptualism by merely pointing to things, like a bottle rack, and saying Art!



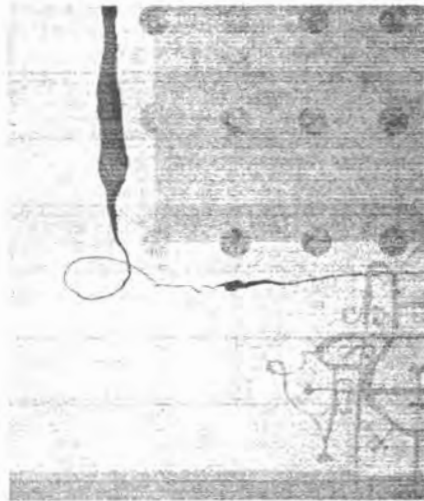
YOKO ONO With *Cut Piece*, an audience snipped off her clothes. With that, performance art made the cut



ROBERT SMITHSON Like God, he shaped whole formations of soil and water into earthworks as in *Spiral Jetty*



FROM TOP: ART RESOURCES; TRUMAN MOORE; GUY ARAUJO/ARTS AND CULTURE



Katherine Sherwood
TO RISE TO HIGH PLACES, 1999



Katherine Sherwood
KNOCK YOUR BLOCK OFF, 1998



Veronika Bromova, *Views*, 1996



Max Aguilera-Hellweg, *Untitled*, 1995

Lynne Lomofsky, 100 Bryant Street, BoKaap, Cape Town, 8001, Tel 021 4220343 Fax 021 4221458
e-mail: lmflyn01@hiddingh.uct.ac.za

Professor J.P. Cruise
Department Anatomical Pathology
UCT Faculty of Health Sciences
Anzio Rd
Observatory 7925
TEL: 021 4066162

September 10 1999

Dear Professor Cruise

Thank you for meeting with me on the 4th of August with regard to the research that I would like to conduct on your campus.

As you may remember, I am currently in the first year of a two year Master of Fine Art Degree at UCT. My field of study is the diseased body: an investigation of the normal and the pathological. In my work I am attempting to make the invisible visible. I question who looks at our bodies and wish to enable the lay person to experience disease through less prejudiced and superstitious eyes. I am aiming for authenticity without prurience. As a visual artist I have a responsibility to myself and my audience to ensure that what is reflected in my work is done so from the basis of an accurate understanding (visual and otherwise) of my field. My research requires that I have access to academic processes which are concerned with imaging the body. As such my work would benefit from the academic materials in your department by enabling me to work with scientifically accurate visual information

It is on these grounds that I approach you for access to the facilities in your department. My particular interest is in lymphomas and tumours of the lymph system.

To this end I am requesting the following:

1. A meeting with Dr Taylor in order to have the specimens and text in the museum clarified.
2. To take photographs in the museum.
3. To observe dissections of a lymph node or nodes in the laboratory.
4. To take photographs in the laboratory.
5. To observe lymphatic systems in cadavers.
6. To photograph elements of the lymphatic system.
7. To view slides in your library and obtain copies for inclusion in my personal library.
8. To allow for other unforeseen eventualities that may arise.

I would be grateful if you could assist me with creating an accurate basis for my work.

I understand that you work in a highly delicate and sensitive field with many ethical issues involved. I would like to stress that I have no interest in revealing personal identities in any way, but am rather interested in internal organs and disease. I would be happy to discuss any concerns you may have regarding the ethical use of the material.

Yours sincerely

Lynne Lomofsky



Department of Anatomical Pathology

Medical School · Observatory 7925 · Cape Town · South Africa
Telephone: 406-6162
Cytopathology Laboratory: 406-6424
Telex: 522208 · Telefax No: (021) 4481789
Head of Department and Professor of Pathology:
J.P. Cruise, MBChB, PhD, FRCPath

25 October 1999

Ms Lynne Lomofsky
100 Bryant Street
BoKaap
CAPE TOWN
8001

Dear Lynne

RE: YOUR REQUEST FOR ACCESS TO THE PATHOLOGY MUSEUM, LABORATORIES AND MORTUARY

Thank you for your letter dated 10 September, in which you outline the reasons for your application to have access to our Pathology Museum, Mortuary and laboratories. This is a highly irregular request, and we have consulted widely and sought advice from the Medical Ethics and Research Committee at UCT.

After considering all the issues, we feel unable to agree to your request. The main reasons are:

1. These areas are restricted to persons registered by the Health Professions Council and a notice to this effect is clearly fixed to both entry doors to the Museum. To admit a non-registered person would open a precedent.
2. The Ethics Committee and ourselves are categorical that all access to the Museum, laboratories and Mortuary would have to be supervised by a medically qualified person in order to interpret specimens, etc and we do not have sufficient staff for this.
3. The patients from whom material was obtained have not given consent specifically for the use to which you wish to put this material for artistic purposes.

While this decision has been a difficult one with a regrettable outcome, the matter is now closed.

With kind regards

Yours sincerely



J.P. CRUISE
PROFESSOR AND HEAD OF DEPARTMENT

Lynne Lomofsky 100 Bryant St, Bokaap, Cape Town, 8001. TEL 021 4220343 FAX 021 4221458
e-mail lmflyn01@hiddingh.uct.ac.za

23 December 1999

Professor PI Folb
The Chairperson
Research Ethics Committee
UCT

Dear Professor Folb

It was a pleasure to meet with you yesterday. Thank you for taking an interest in my situation and for offering your support.

I spoke yesterday with Dr Stubbings, my oncologist and explained to her your support for my project. She felt this was OK but had a number of personal concerns to do with her position. Her first concern was with the Medical Superintendent and the second with the releasing of information to a public venue. I said if she felt uncomfortable she should call you. She said it would be OK as long as you would provide Professor Werner with a letter. I would appreciate if this letter from yourself could request blanket access to anything to do with my body including my file, taking into account that some of the information and images may indeed be released in a public venue. In addition I would appreciate too clearing up the matter of recording by video or photographically my own experiences in the hospital without revealing identities of other patients or staff without their permission. This is a separate area in which I have experienced difficulty. When I started this project in 1995 I did get permission for documentation to take place from Ms Una Bloch.

Dr Stubbings also mentioned the possibility of arranging for me to have a lymphangiogram of my own. She said they do not do these at Groote Schuur any longer but could probably be arranged through Red Cross.

I wonder if you could also arrange with Haematology for me to make requests. For Example: photographing of slides. So far one of the technicians has been doing this for me but I always feel I am asking an extraordinary favour. I would also wish to have some wax blocks made with my own non medical materials.

I would also like to be able to go officially to medical graphics for technical support

The other area I will need to do ongoing documentation of my own experience is in radiology for eg when I have a scan or an X-Ray I would like to be able to document photographically and with video.

As requested I am enclosing:

1. A copy of my proposal.
2. Copies of letters from the University confirming acceptance and awarding of scholarships and two references.
3. In addition for your interest :
 - 3.1 My seminar paper titled *Do The Parts Make The Whole? The Anatomical Body* presented earlier this year.
 - 3.2 A text from the journal *Creative Camera* and another from an Australian art journal, *Artlink* discussing some of the issues around art and medicine and the new imaging technologies.
 - 3.3 A German book on fascinating collaborations between medical doctors/scientists and artists.
 - 3.2 A booklet on my previous exhibition entitled *CANCER WARD: LE 32*.

I would like to share the blurb from the cover of the book *BODY CRITICISM: Imaging the Unseen in Enlightenment Art and Medicine* by Barbara Stafford. Roy Porter of the Wellcome Institute for the

Jessica: pick up copies Lynne
by phone or email to return this
set of materials to her. Tell
Lynne how much I enjoyed reading
her work.
Therese. Lee. 13/01

History of Medicine, London describes the book as " An extraordinary achievement, far reaching in its theories, immensely stimulating in its individual discussions. Barbara Stafford's *Body Criticisms* is essential reading for everyone concerned with the changing role of the visual in Western culture."

The blurb states " The importance of Body Criticism lies in its own visibilizing of previously unexplored interrelationships between art and medicine not only during the enlightenment but now. Stafford also presents a strong argument for the need today to recognize the occurrence of a profound revolution - a radical shift from a text-based to a visually centred culture."

For me, one implication of this would be to nurture the 'visibilizing' of medical images for a broader public.

Thank you once again for your support

Yours sincerely

Lynne Lomofsky

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(2)

Lynne Lomofsky 100 Bryant St Bo-Kaap Cape Town 8001 TEL (021) 4220343 FAX (021) 4242355
e-mail lmflyn@hiddingh.uct.ac.za

Professor P. I. Folb
The Chairperson
Research Ethics Committee
UCT

December 6 1999

Dear Professor Folbe

RE: Application to Anatomical Pathology for access to viewing lymph nodes

I am a visual artist doing my Masters at UCT. I am also a lymphoma patient in the oncology unit at Groote Schuur Hospital. The subject of my research is the diseased body with reference to my own disease.

I requested access to certain materials in the anatomical pathology department. After consultation with your committee this access was denied. I would like to explain more clearly what exactly I am going to do with the materials I have requested access to and how I am going to use them in my work.

I would also like to make it clear that I do not intend to take any material away but would like to draw and make records of lymph nodes for my work. As a visual artist, accuracy is important and seeing the real thing is important. Ultimately I would like to make replicas of the lymph system and the lymph nodes. In order to represent and make facsimiles I need to see the lymph nodes and their tumours in reality i.e.: the colouring, the texture, the fluids that they are kept in outside the body, even the size and kind of bottles they are kept in. Thus far the only replicas I can get are in medical books and these are very stylised and schematic.

I would thus like to be able to see a real specimen in a bottle and also look down a microscope at the cell tissues.

Because I have the disease it is hard for me to visualise the parts of my body that are affected. Being granted access to these things would round off my understanding and bring greater sensitivity to my work.

I hope I have explained myself sufficiently in order that the decision to deny me access be re-examined.

Yours Sincerely

Lynne Lomofsky

From: "FOLB, PI, PETER, DR" <pfolb@uctgsh1.uct.ac.za>
To: lmflyn01@hiddingh.uct.ac.za
Date sent: Wed, 22 Dec 1999 15:48:42 SAST-2
Subject: project
Priority: normal

Val at medical graphics tel. 404 2046 will help you. Make direct contact with her. Good luck. Peter. Peter I Folb Professor of Pharmacology Director: WHO Collaborating Centre for Drug Policy

E mail: pfolb@uctgsh1.uct.ac.za
Tel: +27 (0)21 47 1618
Fax: +27 (0)21 448 6181

That healing feeling is real

By ROGER DOBSON

"They shall lay hands on the sick, and they shall recover." So said Mark in his gospel, chapter 16, verse 18. Now experts believe they have discovered medical evidence to back up his words.

The idea of a healing touch producing cures has been the source of hot debate for centuries, but researchers now believe that it can be an effective remedy for a range of conditions.

Its success is not necessarily down to divine intervention. What makes therapeutic touch or TT work is a natural chemical called immunoglobulin A, which serves as a first line of defence against invading micro-organisms and disease.

Researchers have discovered that the act of laying hands on flesh can trigger the release of these chemicals to fight disease. In the research, a team from Tennessee State University investigated the clinical effectiveness of TT by giving the therapy to patients who had never been exposed to it before.

They found the level of chemicals was higher in people who benefited from the treatment. Health improvement was reported by 59 percent of patients, and pain relief in 55 percent.

Claims for healing through touch can be found in the religious practices of many cultures. Today, those expounding the benefits of TT range from American television evangelists to lay faith healers such as Eileen Drewery, who worked closely with the England football team under manager Glenn Hoddle.

There are about 10 000 people outside the churches who claim to possess TT. They heal by a number of methods, from "holding the space" in which the patients heal themselves to stimulating the body's energy channels. - *Foreign Service*

Variation goes below skin level

CAPETOWN

3/8/2001

ROSIE MESTEL

A PAL of mine has a small slit in his neck. It's always been there, he says. Someone once told him it was a gill.

A gill? Can it truly be so? I called some anatomy experts - Dr Michael Fishbein, chief of autopsy pathology at the University of California, Los Angeles, and Ronald Bergman, emeritus professor of anatomy at the University of Iowa.

My pal, it turns out, has something called a branchial cleft cyst or sinus. And it is gill-related.

In a fish, that same structure

would end up as a gill slit. All of us, as embryos, had these little clefts or indentations: four, in a row, on each side of our developing heads.

Early in development, they usually disappear - all but one pair, which end up as our ear canals. Depending on where the opening is on the neck, it's possible to figure out which one of the clefts didn't close. I can't wait to see my pal again and investigate.

Having gill-like slits is the tip of the iceberg when it comes to human variation. None of us is alike inside our bodies. Why should variability,

like beauty, be only skin deep? Yet most anatomy textbooks don't discuss this kind of variation, says Bergman, who's been compiling a compendium of these differences for decades.

Most variabilities don't do us any harm - except, perhaps, when we're under the surgeon's knife and a vein or artery or muscle is in an odd place. For instance, says Bergman, more than 10% of us lack a little muscle in the wrist called the palmaris longus, and once in a while a surgeon trying to remove it will end up removing an important hand

nerve instead. Another tricky place is the liver, says Fishbein: The bile ducts can come out of it (or arteries branch towards it) in quite different places, sometimes leading to accidents during surgery.

Veins, Bergman reckons, are the most variable of our inner body parts.

Also variable are skeletons, knee-bones, lumbar vertebra and ribs. In the foot alone people may have various extra or different-shaped bones, forked big toes, forked little toes, or even seven or eight toes. - Los Angeles Times



TEXAS

UNIV. OF NEBRASKA MED. CENTRE
SANDRA A SASSE RN
Lymphoma Coordinator.
BMT program.

23

transplant - 1 day evaluation

- consultation + hist + physical
- pathology specimens
- CT scans.
- phone call doesn't

(402) 559 4000 page 1041

Office 402 559 7791

Fax 559 8101.

DR STEWART

- re-biopsy a node
- needle biopsy of tissue reluctant to agree that it is probably tissue instead of fluid.
- thought behind doing another biopsy is that it has been 3 yrs since the last one. so perhaps it has changed to a higher grade.
- surprised that CTOP is not working
- Fludarabine or DTAP are both acceptable forms of treatment.
- JUST TREAT IT
- If it was him he would do another biopsy + then proceed with DTAP but doesn't disagree with fludarabine first.
- Bone marrow → sibling transfer means a little more risk.

autologous transplant - not seeing results from autologous. people still continuing relapse.

no levelling off
now looking at diff ways to treat Lymphoma
now recommending - looking at allogeneic transplant

- Think that GVH that applies to Leukemia ^{new} so not so much data.
- * Graft versus Lymphoma will also apply to Lymphoma.
- * Graft versus host only doing related transplant at the moment.

Complications of unrelated transplant → too high.

NEW → protocol - ^{investigative} selection of ^{certain} cells from stem cells. (when collecting stem cells still collecting disease product) Then infusing that. CD34 positive cells



purging - cleaning. ^{this is} The opposite of purging - it is select

Statistics vary depending on individual.

- diag - LBH at diagnosis
- stage
- size
- bone marrow involvement
- auto vs allo.

Non-Hodgkin's Lymphoma Is Treatable by a New Drug

By LAWRENCE M. FISHER

SAN FRANCISCO, Nov. 26 — The Food and Drug Administration today approved a new genetically engineered drug for the treatment of non-Hodgkin's lymphoma.

The drug, Rituxan, was approved for treating low-grade or follicular B-cell non-Hodgkin's lymphoma, a slow-growing but fatal and incurable cancer of the immune system. It will be made and marketed by Genentech Inc. of South San Francisco.

In clinical trials, Rituxan was shown to be comparable to chemotherapy in slowing progression of the disease, but with fewer side effects.

Rituxan is the first of a class of drugs called monoclonal antibodies to be approved for treating cancer, but F.D.A. officials said there are at least two dozen such drugs in various stages of clinical trials. Monoclonals, which are genetically engineered copies of powerful immune system proteins, were one of the first technologies pursued by the biotechnology industry, but have until recently failed in most applications.

"To me this is a milestone for monoclonal antibody technology for this field," said Dr. Kathryn Stein, director of monoclonal antibodies for the F.D.A. center for biologicals evaluation and research.

Most impressive, Dr. Stein said, is that Rituxan is a "naked" antibody, meaning that it is not linked to a radioactive or chemical drug, but is itself an anticancer therapy.

"It really is a turning point," she said.

Because monoclonal antibodies were initially produced in mice, they caused allergic reactions in human beings, which limited their effectiveness. The antibodies now advancing in the clinic have been genetically engineered to be either chimerized, about half human, or humanized, more than 90 percent human. Rituxan follows Reopro, from Centocor Inc., an antibody for the prevention of blood-clotting in heart patients, which was approved in 1996.

"Unquestionably, monoclonals are gathering momentum," said Viren Mehta, an analyst with Mehta & Isaia in New York. "While it has clearly

A new class of treatments makes use of genetic engineering. NY TIMES 11/27/97

taken some time for the basic elements of the science to come together, we now have the second important monoclonal in a year, and this is just the beginning."

The most common side effects of Rituxan were moderate flu-like symptoms that occurred in the majority of patients during the first infusion. And unlike the typical four- to six-month chemotherapy regimen or high-dose radiation treatment, Rituxan can be administered in four infusions on an outpatient basis over 22 days.

"Although it is not a cure, we finally have a cancer agent that can be effective with less serious side effects than with conventional chemotherapy," said Dr. Myron Czuczman, assistant professor of medicine at Roswell Park Cancer Institute in Buffalo, and a main investigator of the new drug. "This is exciting news, especially for elderly patients and relapsed patients who have failed at least one standard treatment regimen."

Genentech also has a monoclonal antibody of its own invention in clinical trials for the treatment of breast cancer, and plans to develop more drugs based on this technology for other solid tumors. Monoclonal antibodies aim at proteins implicated in the cause or maintenance of cancer, so they can be more specific than a chemical drug that simply kills fast-growing cells. The more specific a drug, the lower the toxicity, meaning physicians can prescribe higher doses without serious side effects.

Rituxan works by binding to a protein known as the CD20 antigen on the surface of mature B cells and B-cell tumors. Then it recruits the body's natural defenses to attack and kill both malignant and normal mature B cells.

Drug Therapy May Aid Some Lymphoma Patients

LOS ANGELES, Dec. 3 (Reuters) — A combination drug therapy looks to be the first new treatment in 20 years for patients with a deadly form of lymphoma, researchers said today.

Conventional chemotherapy combined with Rituxan, a cloned antibody, significantly improves the chances of survival for patients with the aggressive form of non-Hodgkin's lymphoma. The study results were presented in San Francisco at a meeting of the American Society of Hematology.

"It is very exciting to find that Rituxan, in combination, is likely to save the lives of patients with aggressive lymphoma," said Gwen Fyfe, senior director of oncology at Genentech, which co-markets the drug.

With chemotherapy, only 30 percent to 40 percent of patients are cured of the cancer, which attacks the lymph system, spleen and other organs. Without successful treatment, the average life expectancy of patients is one to six years.

Non-Hodgkin's lymphomas are a group of related cancers that originate in the lymphatic system, which carries white blood cells called lymphocytes throughout the body. About 50,000 new cases are diagnosed in the United States each year and the numbers are increasing, particularly among the elderly and those infected with the virus that causes AIDS.

Interim results from the study

of 400 elderly patients, led by Dr. Bertrand Coiffier, head of the department of hematology at Hospices Civils de Lyon in Lyon, France, found that the combination of Rituxan and chemotherapy resulted in a one-year survival rate of 83 percent, compared with a rate of 68 percent for the standard combination of chemotherapy and drugs.

Sixty-nine percent of patients on the combination therapy were free of the disease, compared with 49 percent on just chemotherapy. The rates for complete remission were 76 percent and 60 percent, respectively.

Ms. Fyfe cautioned that those rates were likely to drop over time — the results apply to just one year — but said the fact that more patients responded to the combination therapy "is simply remarkable." In light of the strong results, she said Genentech and marketing partner IDEC Pharmaceuticals had suspended another lymphoma trial, although they were continuing one monitoring the safety of the combination therapy.

Rituxan, which had total third-quarter sales in the United States of \$115.5 million, is viewed as having the potential to reach annual sales of \$1 billion.

Genentech said it planned to submit the latest trial data to the Food and Drug Administration, but not for several more months.

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New drug regimen buoys cancer doctors

Low-dose chemo shows promise in unofficial tests

BY TANYA TALAGA
AND LESLIE PAPP
STAFF REPORTERS

A radical cancer treatment pioneered in Toronto and only tested in mice is now showing promising results in some patients with advanced tumours.

The treatment — a new spin on traditional chemotherapy, combined with tumour-starving drugs — is creating a buzz within Canada's closely linked community of cancer doctors.

Yesterday, 60 of them gathered at Women's College Hospital to hear more about it from scientist Robert Kerbel, whose animal studies laid the groundwork for the new approach.

"I'm dealing now with six patients in the city who are getting versions of this therapy," Kerbel said in an interview.



**'We have a feeling
that the answer
might be — in this
case — finally — yes.'**

— ROBERT KERBEL
Sunnybrook cancer
researcher

"All of them are responding, but two or three are responding dramatically."

Kerbel is the first to admit the human results are anecdotal and, without clinical trials, there is no proof the method works.

"These are single case reports," he said. "It may all relapse very soon. But it looks like there might be something to this."

Instead of zapping advanced cancer in mice with massive doses of chemotherapy, Kerbel has shown that giving small, frequent doses, plus a tumour-

starving drug, stops the disease.

"Researchers like myself have been curing cancer in mice for a depressingly long time," Kerbel told assembled doctors and scientists yesterday.

He described how researchers have long been frustrated by the failure to translate animal cures into human success.

"We have a feeling that the answer might be — in this case — finally — yes," said Kerbel, head of cancer biology re-

☛ Please see There, A24

The Toronto Star
Sat, Feb 26, 2000
PAGE 1.

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'There might be something to this'

Continued from A1

search at Sunnybrook and Women's College Health Sciences Centre.

The therapy doesn't depend on experimental drugs unavailable to doctors. Instead, existing chemo drugs are used in a reduced, non-toxic way, coupled with medicine already on the shelf that can interfere with a tumour's blood supply. That is why doctors can start treating cancer patients immediately, without waiting for human trials.

It is not known how many people across Canada are receiving this treatment. But those dying of cancer, who have tried everything else and failed, are being offered a combination of low-dose chemo and cancer starving drugs by some oncologists who have heard of Kerbel's work.

"We are just at that tantalizing stage where there is suggestive evidence," said Dr. Donald Sutherland, an oncologist at Sunnybrook. Sutherland is treating a few patients with the new approach, and one is seeing a remarkable turnaround. Cancer had spread to her liver and she was failing on conventional care.

Based on Kerbel's results, she was given low dose chemotherapy along with Celebrex, an arthritis medication that also happens to interfere with a tumour's blood supply.

Tests tracking the disease show significant improvement and Kerbel says she now goes jogging outside.

But Sutherland said it's impossible to tell whether her recovery is strictly due to the new treatment.

He warned that this was just one case and clinical trials are needed.

Scientists know history of cancer research is full of promising breakthroughs that fizzled

"People's desire for hope can lead them into all sorts of folly."

But if the woman's situation keeps improving, "it will be hard not to be excited," he added.

"This is a shot in the dark but the medicines we use aren't likely to cause them any particular harm."

Dr. Sylvain Baruchal, an oncologist at The Hospital for Sick Children and head of the hospital's new agent and innovative therapy program, is also treating patients. An 18-year-old whose aggressive bone cancer was not responding to treatment was given low, daily doses of a common chemotherapy drug called vincristine combined with a tumour-starving agent.

"Now she is enjoying her life," Baruchal said. Rather than being ridden, she is travelling and even skiing.

Again, this is just one case. "We need to be very cautious because we don't want to generate false hope," he said.

Dr. Michael Pollak, a cancer doctor at Montreal's Jewish General Hospital, said the approach "is worthy of investigation, but I'm not going to count my chickens before they're hatched."

Pollak has patients on low-dose, tumour-starving regimes but has yet to see dramatic results.

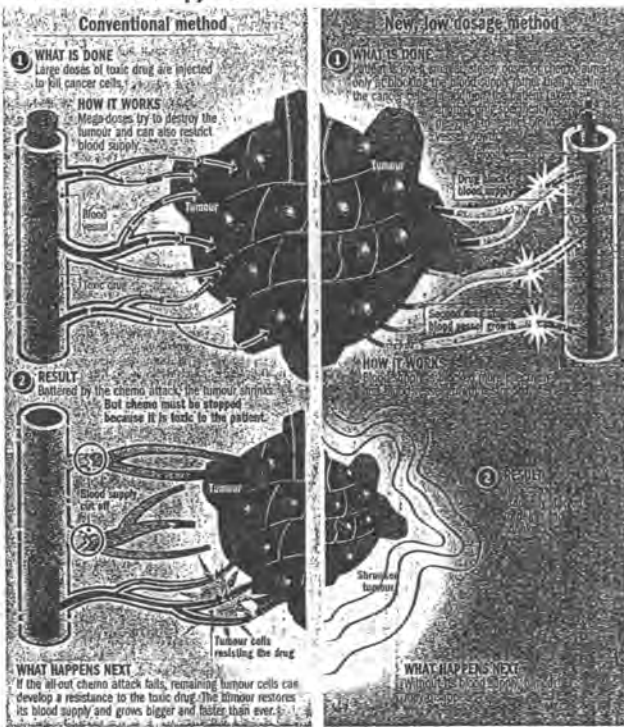
"I've seen some patients who have not benefited," he said.

That evidence, too, is anecdotal and it doesn't mean the method is without merit, he added.

"It would be irresponsible not to pursue this," he said.

"It would be nice for humanity if this approach actually did work. It would be a nice for humanity if this approach actually did work."

How chemotherapy works



'It would be irresponsible not to pursue this. It would be nice for humanity if this approach actually did work. It would convert cancer to a chronic, non-life threatening disease. It's of potentially great importance.'

— Dr. MICHAEL POLLAK
Montreal's Jewish General Hospital

would convert cancer to a chronic, non-life threatening disease. It's of potentially great importance."

Kerbel says clinical trials could be under way as early as this spring. "It doesn't depend on getting some new experimental drug from a company."

For decades, cancer treatments have been based on toxic chemotherapy drugs, usually given at the "maximum tolerated dose," meaning the highest doses possible without killing the patient.

The aim is to poison the genetically damaged cells that form tumours. Because of their potency, the drugs can only be given for short periods. Patients need time to recover from devastating side effects, including hair loss, vomiting and fatigue.

Sometimes it works. But all too often, the tumours become resistant to drug therapy and hope is lost.

Kerbel's work represents a departure from the usual pattern. Instead of directly killing tumours, he targets cancer's supply system.

Tumours can't grow without building a network of rogue blood vessels to carry the oxygen and nutrients they need to survive.

Kerbel says this network is vulnerable to several weapons, such as traditional chemotherapy in small doses and drugs engineered to hit newly formed blood vessels.

Dramatic evidence of that comes from pediatric oncologist Dr. Giannoula Klement. Working in Kerbel's lab, she has erased tumours from mice suffering from neuroblastoma (a nerve cancer), using vincristine and an experimental tumour-starving drug.

That one-two punch succeeded in keeping cancer away, even after the treatment was stopped, and proved far more effective than either of the two drugs used alone.

"I thought, ah, it's probably not going to work, but let's just try it anyway," Kerbel said. "It worked beyond our wildest imagination. And again, it all in mice, but it did work."

Similar research is under way by famed cancer scientist Dr. Judah Folkman of Harvard University.

Kerbel's work elaborates on findings from Folkman's lab, showing the immense promise of low-dose

approach and starving tumours.

Low-dose chemo — by itself — has been used and experimented with for years, but lacks the power to stop cancer. "It's the combination that's key," Kerbel said.

So far, those receiving this treatment do so as a last resort. It is important that people with treatable cancers follow the advice of their oncologists, he said. "It may be that after a year or two, some toxicities will begin to emerge," Kerbel said.

"That's one of the things we really have to watch out for."

The history of cancer research is full of promising breakthroughs that fizzled, disappointing scientists and people suffering from the disease.

"There's a part of me that says, 'Don't go overboard. You don't want to get your hopes up too high,'" Kerbel said. "But my intuition is that this is going to work in some patients."

"When I say 'work,' I don't necessarily mean 'cure.' But if you can take a person who is going to die in five weeks and, maybe, keep them alive for another five years — that would be a pretty amazing achievement."

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Scientist: This was my calling

By LESLIE PAPP AND TARYA TALAGA
STAFF REPORTERS

A decade ago, Bob Kerbel was close to despair.

Despite all his efforts, and those of the world's most brilliant scientists, there seemed no way to beat cancer.

Hundreds of drugs had been tried; more were in development. But all seemed limited by cancer's amazing ability to mutate and ultimately resist what science threw at it.

"I became very discouraged," says Kerbel, a researcher at Sunnybrook and Women's College Health Sciences Centre.

"I was wondering: Is this an insurmountable problem? How long is it going to take?"

Then, in 1990, a question from a graduate student led him to a groundbreaking insight. The student wondered whether there was any strategy that could stop cancer's power to mutate into drug-resistant forms.

Kerbel knew that Boston researchers were looking at ways to starve tumours by depriving them of their blood supply.

Suddenly, a "light bulb switched on," he says.

This starvation strategy, he realized, could halt cancer's insidious power to rapidly develop drug resistance, since it involves an attack on normal blood vessel cells, which are slow to breed resistant varieties.

He discussed his idea with Dr. Judah Folkman, the world renowned cancer researcher at Harvard who originated the cancer-starving approach. Folkman was impressed.

Kerbel published his idea in the journal *BioEssays* in 1991, sparking new excitement among researchers.

Kerbel, trained as an immunologist, had a limited awareness of tumour-starving drugs in 1990.

"Up until that point, I wasn't in the field. But, I thought, 'I'm going into this big time.' And that's what I did."

Now Kerbel is pioneering a new concept: using these tumour-starving drugs in combination with small, frequent doses of existing chemotherapy medication.

His tests on mice have shown that the approach shrinks and erases tumours without giving rise to drug resistance.

A handful of people are already be-

ing treated in Toronto, with promising results.

Plain speaking, and given to excitement, Folkman has his hands full. Kerbel, 54, finds it hard to contain his excitement. "This is almost mind-boggling. Even I am astonished."

Blessed with an inquisitive mind, Kerbel decided early to go into science. He spent his summers growing up in Toronto around Bathurst St. and Eglinton Ave., he dreamed of becoming a researcher and professor. But he harboured doubts.

"To be quite honest, I didn't think I had the perseverance or intellectual ability to really make it."

That changed after Kerbel graduated from the University of Toronto and went to Queen's University, in Kingston, to specialize in immunology.

"I loved it. I realized within about six months that this was my calling. I really seemed to thrive on it."

As years passed, Kerbel became more intrigued by cancer research. "I sort of drifted out of immunology."

He served as a professor at Queen's before moving to head the division of cancer and cell biology at Toronto's Mount Sinai Hospital in 1985.

Five years later, he switched to Sunnybrook while he oversaw a 12-person lab conducting various cancer-fighting experiments.

Over the past decade, he has kept close contact with Folkman.

About 2½ years ago, Folkman called him with some news: His Boston lab had succeeded in eliminating cancers from mice using two tumour-starving drugs — angiostatin and endostatin.

The advances brought a frenzy of media activity, and inflated hopes that cure for cancer was at hand. Progress has been much slower than expected.

Kerbel's intuitive, combining low-dose chemotherapy with tumour-starving drugs, is showing early promise.

"I don't want to get my hopes up too high," he says. "But I'm thinking there's something to this business. This is something to pursue."



MEETING OF MINDS: Pediatric oncologist Dr. Giannoula Klement chats with Robert Kerbel, Sunnybrook Hospital's head of cancer biology research in the lab in Toronto.

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NATION

FDA Gives Approval To Anti-Cancer Drug

Associated Press

WASHINGTON — Thousands of patients with an incurable type of non-Hodgkin's lymphoma won their first new weapon in a decade Wednesday.

The Food and Drug Administration approved a novel, genetically engineered drug to attack the immune system cancer with far fewer side effects than standard treatment.

Rituxan is not a cure, but the FDA said it has an "excellent" success rate in shrinking tumors safely.

The approval makes Rituxan the nation's first anti-cancer monoclonal antibody, a long-awaited biotechnology in which specially manufactured antibodies bind to cancer cells and trigger the immune system to do the killing instead of toxic chemicals.

One patient who tested Rituxan called the approval something to

celebrate this Thanksgiving.

"Even though my type of lymphoma is still considered incurable, Rituxan has renewed my hope of raising my three children," said Dr. Wendy Harpham, a Richardson, Texas, physician who failed other treatments before Rituxan therapy put her cancer in remission.

About 240,000 Americans have non-Hodgkin's lymphoma, a cancer of the lymph system that targets vital white blood cells. Many patients are successfully treated. But about half of them have an incurable form called low-grade non-Hodgkin's that causes repeat relapses over six or seven years.

These patients try high doses of chemotherapy, radiation and bone marrow transplants that can cause severe side effects, particularly when these treatments also kill healthy cells that get in the way.

Rituxan, on the other hand, is made from a genetically engineered mouse antibody designed to be a

more specific treatment. Scientists don't know exactly how it works, said FDA monoclonal antibody chief Kathryn Stein. But ultimately these antibodies zero in on the white blood cells involved in non-Hodgkin's lymphoma and trigger their death.

"This is the first of what we hope will be many monoclonal antibodies for tumor treatment," she said.

In a study of 166 patients with advanced cancer, 48 percent had their tumors shrink by at least half. Six percent of patients had complete remissions. Half the successful patients remained stable for more than 11 months, a rate that Stein called "excellent."

Rituxan therapy does not require hospitalization. Manufacturers IDEC Pharmaceuticals and Genentech Inc. say Rituxan, known chemically as rituximab, will be available within a month. A complete course of four weekly transfusions will cost roughly \$9,000, comparable

to many chemotherapies.

Rituxan has some risks. It can kill healthy white blood cells as well as cancerous ones, meaning patients could suffer infections although no unusual rates have appeared so far, said Dr. Peter McLaughlin of the M.D. Anderson Cancer Center, the drug's lead investigator.

Additionally, most patients have temporary and mild flu-like symptoms, such as fever and chills, one to two hours after the first infusion, as their bodies learn to recognize the new antibody, he said.

So few side effects make Rituxan a prime candidate to give to lymphoma patients in addition to chemotherapy, hoping for a one-two punch against the disease, McLaughlin said. Doctors already are studying how well such a combination could work, as well as the feasibility of giving it to earlier patients instead of waiting until they relapse.

Bone marrow therapy offers hope for cancer

New transplant less toxic to immune system

BY REBECCA BRAGG
STAFF REPORTER

MONTREAL — A Canadian scientist who has been treating patients suffering from blood-based cancers with a revolutionary new therapy involving bone marrow says she is very excited by the results so far.

The treatment is "radically different," said Dr. Megan Sykes, formerly of Toronto but now an associate professor at Harvard University in Boston, after making a presentation at a conference on transplant medicine.

But preliminary clinical trial results among 15 patients at Massachusetts General Hospital with non-Hodgkin's lymphomas, all of whom had experienced relapses of their disease despite many bouts of chemotherapy and radiation, have been "extremely encouraging" to date, she said.

The method involves a revolutionary way of using bone marrow to fight blood-based cancers.

Under the technique, bone marrow transplants are not used, as is now the case, to simply replace the bone marrow of the recipient.

'The bone marrow cells from the donor can educate the immune system (of the recipient).'

— DR. MEGAN SYKES

Rather, the transplanted bone marrow co-exists with that of the sick person — a far less toxic procedure.

Drugs that suppress the immune system — used to allow a recipient to accept bone-marrow transplants — often have extremely toxic side effects on



MEGAN SYKES

healthy tissues.

But in the work Sykes has been doing with Thomas Spitzer, director of Massachusetts General Hospital's bone-marrow transplant unit, mild "conditioning" drugs are used to prepare the recipient's bone marrow to accept a transplant.

The result is that "the bone marrow cells from the donor can educate the immune system (of the recipient) so that it thinks the bone marrow donor is self" and not launch an attack on the foreign tissue, Sykes said.

"Later on, we give these patients infusions of immune cells from the original donor that then attack the lymphoma without attacking the normal cells of the host," she explained.

Theoretically, if an organ from the same donor were grafted into a recipient whose immune system had been pre-educated by bone marrow to accept the tissue, the transplant would be tolerated by the body without requiring any immunosuppressive drugs, said Sykes, 40.

The longest-standing patient in the ongoing clinical trial of the therapy is now "doing very well" after 14 months, she said.

The theory behind the treatment of the 15 patients is based on a scientific concept called

"mixed chimerism."

As applied to bone marrow transplants, "mixed chimerism" means that two types of human marrow are induced to co-exist within the recipient, a state "that can quite reliably be achieved without any of the traditional toxic treatments that are required for a conventional bone marrow transplant," Sykes said.

And once a sick person's immune system has been persuaded to accept the bone marrow of a healthy donor, the implications go far beyond bone marrow transplants.

"Bone marrow is just a tool to make the immune system of the recipient accept other tissues from that donor without needing immunosuppression," Sykes said.

A graduate of The University of Toronto's medical school, Sykes went to the United States in 1985 to work for the National Institutes of Health, which still supports much of her research.

'Megan Sykes is the example of the star who got away.'

— DR. CALVIN STILLER

Dr. Calvin Stiller, a professor of medicine at the University of Western Ontario in London and a world-renowned expert in clinical transplantation, predicts that the work she has done will be seen in future as "forks in the road" for transplant medicine.

"The principles coming out of her experiments will allow us to establish a new curriculum for our immune system and re-teach it what 'self' is."

Stiller emphasized that he wants Sykes to come back to Canada to continue her work. For too long, Canada has served as a "farm team" for major American universities, which entice the best away.

"Megan Sykes is the example of the star who got away."

WORLD NEWS

Genome map points route to cancer cure with leukaemia wonder-drug

SAN FRANCISCO: The success of a drug targeting a rare form of leukaemia - one of the blood and bone marrow - and the human genome map have given scientists the tools to cure every known form of cancer, the man who led the discovery team said.

The end of cancer could take about 40 years, huge effort and a lot of funding, Brian Druker

said at a Leukaemia and Lymphoma Society panel here.

Druker has achieved near-celebrity status as the US and Drug Administration's speedy approval on Thursday of Gleevec, proven to cure chronic myeloid leukaemia (CML) by thwarting the malfunctioning enzyme that causes the rare form of blood cancer. Clinical trials

have also proven Gleevec remarkably effective at treating some gastrointestinal tumours.

Dressed in a black suit hanging loosely on his lanky frame, he told of patients who went from planning funerals to returning to normal lives after a few days on the drug.

"If we can do it with Gleevec and CML, we can do it with every form of cancer," Druker

said. "It is not going to be tomorrow, but we are on the right track."

The mapping of the human genome provides researchers with a guide of where to look for cancer-causing defects in genes and enzymes.

"Leukaemia treatments have always led the way in all cancer treatment," said Druker, a haematology programme leader

at the Oregon Cancer Centre and a professor of medicine at Oregon Health Sciences University. Standard treatments will be used with Gleevec in entrenched CML cases.

Druker expects researchers to take 10 to 20 years to identify the right targets for cancers including more prevalent forms such as lung, breast, skin and prostate.

"We are going to cure cancer, but it is not going to be one cure," he said. An array of drugs could take up to 10 years to develop.

"We have the character of the parts, now we have to figure out what is broken," Gleevec proved itself so quickly, even Druker and his research team were surprised - Sapa-AFP

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Cancer

"Cancer treatments abound in the world of alternative medicine, most of them much less toxic than radiation and chemotherapy, but none of them works reliably for large numbers of patients. If

there were a reliably effective alternative treatment for cancer, we would all know about it soon enough."

-- Dr. Weil


If, after looking at these frequently asked questions, you still need to know more, ask Dr. Weil [here](#).

Frequently asked Questions

- [Eating to Combat Breast Cancer?](#)
- [At Risk for Testicular Cancer?](#)
- [Skinny on Skin Cancer?](#)
- [Concerned about Colon Cancer?](#)
- [Testing Time for Prostate Cancer?](#)
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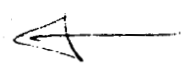
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Featured Question

Does "C" Hinder Cancer Treatment?

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Today's Question:

Is Non-Hodgkin's Lymphoma Always Fatal?

Q: I'm curious about non-Hodgkin's lymphoma, as a friend has been recently diagnosed. What can you tell me about it?
 -- Anonymous

A:

(Published 2/15/99) Both King Hussein and Jacqueline Kennedy Onassis have recently succumbed to non-Hodgkin's lymphoma, a type of cancer that has doubled in incidence since the early 1970s to the point where more than 60,000 Americans will be diagnosed with the disease this year. But there are about 15 different types of non-Hodgkin's lymphoma, each of which is identified by a specific type of cancer cell. Some of these malignancies are very aggressive and some are very indolent, progressing slowly over the years and sometimes not even requiring treatment. Non-Hodgkin's lymphoma is much more common than Hodgkin's disease, which was named after the British doctor who first described it and which tends to develop in patients between the ages of 15 and 40. Non-Hodgkin's lymphoma usually occurs between the ages of 30 and 70. In general, the outlook for those with Hodgkin's disease is more favorable than for those with non-Hodgkin's lymphoma. Obviously King Hussein and Jacqueline Onassis, both of whom died within a year of being diagnosed, were unlucky enough to develop very aggressive cases of this malignancy.

No one knows why lymphoma is becoming more prevalent, but exposure to pesticides and other environmental toxins and to certain infections may be responsible. A study done by the

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Tomorrow

Tomorrow: Reduce Blood Pressure With a Plate of Potassium?

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Today's Poll

Do you think students get too much homework?

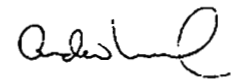
Yes

American Cancer Society linked non-Hodgkin's lymphoma in women to frequent use of black hair dye, but risks are highest among people with HIV, those with the Epstein-Barr Virus or transplant patients who are taking immunosuppressive drugs, suggesting a possible viral cause.

No
 Not sure

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Lymphoma affects the cells in the lymphatic system, which is part of our immune defenses. The most common symptom is a painless swelling of the lymph nodes in the neck, armpit, groin or abdomen. Other symptoms include fever, night sweats, fatigue, indigestion, abdominal pain, loss of appetite and bone pain. The five-year survival rate for non-Hodgkin's lymphoma is 51 percent, up from only 31 percent in 1960. When non-Hodgkin's lymphoma is caught early it often can be treated with radiation; more advanced cases require chemotherapy or a combination of chemotherapy and radiation. This is definitely a case where conventional medicine offers the best chance for survival. While I have heard of a few people recovering from non-Hodgkin's lymphoma by using purely alternative methods, I do not recommend those alone.



Dr. Andrew Weil

Email this article to a friend. **Printing?** Use this version.

Cases of non-Hodgkin's lymphoma have doubled and no one knows why. Tell us your theories in the Boards.



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Immunity

Your immune system is your interface with the environment. If it is healthy and doing its job right, you can interact with germs and not get infections, with allergens and not have allergic reactions, and with carcinogens and not get cancer. A healthy immune system is the cornerstone of good general health. Its problems are of two general sorts: underactivity, which predisposes to infections and cancer, and overactivity, which predisposes to allergies and autoimmunity. Although the advent of AIDS has made us very conscious of immunity and its failures, most people I meet do not have a clear picture of what the immune system is. I often hear references to the "autoimmune system." There is no such thing; autoimmunity is a disease process in which the immune system attacks the body's own tissues.

The immune system is hard to understand for several reasons. First of all, it was not recognized as a functional unit of the body until recent years. It is a sobering fact of modern medical history that doctors labeled many of the organs of the immune system "functionless" throughout most of this century, giving surgeons license to remove them with abandon. The medical profession has removed or destroyed countless tonsils, adenoids, appendixes, thymus glands, and spleens in the belief that these structures were useless, not worth the space they occupied. Second, the components of the immune system do not hang together in any neat arrangement that makes it easy to picture the whole, as we can picture the digestive system or the vascular system. Finally, the operations of the immune system are immensely

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Q&A

Today's Q&A

add to section on immune system

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intricate.

Let me try to cut through the complexity and tell you what I think you need to know to protect your body's defenses. The immune system comprises the tonsils and adenoids, the thymus gland, the lymph nodes throughout the body, the bone marrow, the circulating white blood cells and other cells that leave blood vessels and migrate through tissues and the lymphatic circulation, the spleen, the appendix, and patches of lymphoid tissue in the intestinal tract. The essential job of this system is to distinguish self from not-self, to recognize and take appropriate action against any materials that ought not to be in the body, including abnormal and damaged components. For example, it can seek out and destroy disease germs and cells infected by germs, as well as recognize and destroy tumor cells.

In deciding what belongs in the body and what does not, the immune system pays particular attention to details of protein chemistry, because of all the molecules that make up living organisms, proteins are the most distinctive and the most specialized.

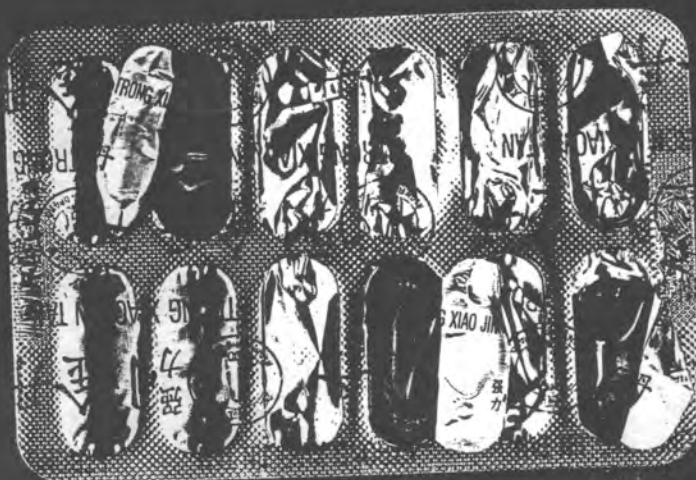
Like the nervous system, the immune system is capable of learning. It analyzes its experiences, remembers them, and passes them on to future generations of cells. Because its tissues are very active and very involved in processing information, its cells divide very rapidly and so, as you learned in the last chapter, are unusually susceptible to injury by types of energy and matter that can alter (mutate) DNA. All of the recommendations I gave you for decreasing your risks of cancer also hold for protecting your immune system. Please follow them.

Here are some further guidelines:

1. Do Not Allow Infections to Persist

One of the greatest strains on the immune system is an infection it cannot eliminate. Never ignore such symptoms as unexplained fevers, night sweats, or tender, swollen lymph nodes ("glands") they can indicate a hidden infection.

One area of the body where infection often goes unnoticed is the mouth.



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- Radix Aconitidis 3.125g
- Buthus sinuatus 3.125g
- Buthus sinuatus 3.125g
- Radix Trichosanthis 3.125g
- Radix Platycodonis 3.125g
- Rhizoma Pinelliae 3.125g
- Radix Rehmanniae 3.125g
- Fructus Forsythiae 3.125g
- Eggs of Notarchus leucifrons (Griffin) 3.125g
- Herva Menthae 3.125g
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- Thapsalia 3.125g

Actions & Indications:
Used internally as a remedy to slay and diminish serofulous swelling and indicated in the treatment of scrofulus.

Directions & Dosage:
3 pills once, three times daily.



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白朮 三月 黃藥子 三月
熟地黃 三月 川芎 三月
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Note: Not for pregnant women.

tea - boil up for 1 1/2 hrs in an open pot.
 cook down to 1 cup of fluid. → put 3 pots on stove. 1 pack in @ pot. (5)
 bring to boil all at once. Put remainder in jar. refrigerate.*
 * 1 pkg = 4 cups of water - soak herbs for a few minutes before boiling. Bring to a high boil for 15 minutes.
 REBOIL AGAIN FOR NEXT DAY.
 Reduce heat to soft boil. (herbs must move around).
 Reduce water down to 3/4 - 1 cup.
 don't burn herbs. (ie: not 1/2 cup).

MORNING BETTER
 give energy

will help make body strong.

powder → work on bones. remove unwanted tissue growth.

* put herbs in 3 sep plastic bags + refrigate. Boil again. little less water (3/4 cups) boil again for 1hr - 1hr 15 min.
 ie: 2 - 2hrs boiling less p/west.

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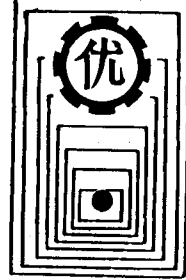
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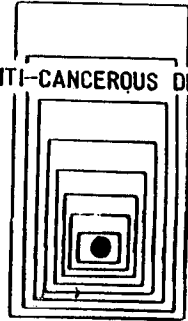
DIRECTIONS AND DOSAGE:

Take orally, 4-8 tablets each time, three times daily. It can be used with along the operative therapy, radiotherapy, or chemotherapy.

STORAGE:

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MENUS FOR CANCER PATIENTS

The following suggested meal plans are for people with cancer. They do not include pickles, condiments, and special side dishes or special beverages which should also be prepared. Check the dietary recommendations for each particular illness.

More Yin Cancer (Mouth, Esophagus, Upper Stomach, Breast, Skin, Leukemia, Lymphomas, Hodgkin's Disease, and Tumors in the Outer Region of the Brain)

	Breakfast	Lunch	Dinner
SUNDAY	Vegetable Miso Soup Soft Brown Rice Bancha Tea	Brown Rice Cabbage-Roll Tempeh Arame Bancha Tea	Brown Rice Miso Soup Nishime Style Carrots, Onions, Lotus Root, and Burdock Steamed Kale Bancha Tea
MONDAY	Miso Soup Soft Barley Bancha Tea	Brown Rice with Wheat Berries Steamed Tofu with Miso Dressing Boiled Watercress Salad Bancha Tea	Brown Rice and Rye Miso Soup with Chickpeas Steamed Cauliflower and Broccoli Boiled Wakame and Onions Bancha Tea
TUESDAY	Vegetable Miso Soup Whole Oatmeal Steamed Rice Kayu Bread Bancha Tea	Sweet Rice Sautéed Burdock and Carrots Grain Coffee	Brown Rice Buckwheat Soup Azuki, Kombu, and Squash Boiled Chinese Cabbage Bancha Tea

	Breakfast	Lunch	Dinner
WEDNESDAY	Miso Soup with Millet Soft Brown Rice Bancha Tea	Brown Rice Seitan Stew Hiziki Boiled Daikon Bancha Tea	Brown Rice with Barley Miso Soup with Azuki Beans Colorful Soybean Casserole Steamed Mustard Greens Bancha Tea
THURSDAY	Miso Soup with Daikon and Wakame Soft Buckwheat Bancha Tea	Millet with Vegetables Natto Boiled Salad Bancha Tea	Brown Rice Tamari Broth Soup Lentils with Onions and Celery Steamed Parsnips and Parsley Amasake
FRIDAY	Miso Soup with Barley Steamed Rye Bread Bancha Tea	Rice Ball with Nori Steamed Kale Grain Coffee	Brown Rice Carp and Burdock Soup Boiled Salad with Daikon, Cabbage, Onions, Carrots, and Watercress Bancha Tea
SATURDAY	Vegetable Miso Soup Brown-Rice Cream Bancha Tea	Whole Oats and Barley Azuki Beans Steamed Watercress Bancha Tea	Brown Rice Miso Soup with Squash Dried Daikon with Kombu Boiled Sauerkraut and Scallions Grain Coffee

DAILY DIARY

DAY & DATE: THURSDAY NOV 23 95 TIME UP: 8:20 HOURS OF SLEEP: 7
 WEIGHT: 56 kg DAILY AVERAGE NUMBER OF CHEWS PER MOUTHFUL: _____
 BREAKFAST: Time 9 am Food Miso soup w onions, carrot, daikon, wakame + rice porridge
 LUNCH: Time 2 pm Food bully kintill soup, rice, hijiki, parboiled salad
 DINNER: Time 8:30 pm Food miso soup, rice, cauliflower
 SNACKS: Time 7 pm Food rice cakes x 3
 DRINKS: Time _____ Drink banhcia tea, Echinacea tea, water
 FOOD CRAVINGS: _____
 ENERGY LEVEL (AM): Excellent Good Fair Low
 ENERGY LEVEL (PM): Excellent Good Fair Low
 MENTAL CONDITION: Clear Confused Spacey Agitated
 Other _____
 EMOTIONAL CONDITION: Joyful Worried Sad/Depressed Afraid Angry
 Other content
 URINATION: Color: Yellow Light Dark
 Frequency: _____
 BOWEL MOVEMENT: Firm Hard Loose Odor: _____
 Float Sink Frequency: _____
 SEXUAL ENERGY: Excellent Good Fair Low None
 COMMENTS ABOUT THE DAY: wake up with energy
 GOALS FOR TOMORROW: _____ TIME TO BED: 12 pm

* Cucumber Shopping list

* apples/pears * apple juice

* raisins granola
toasted seeds
nuts

fields
* carrots
* oats

* Cameraland miniprints

Rice cakes
oats
eggs
sprouts

Tofu cream
* tofu x 3
* mint

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 (F) - Istruzioni per l'uso:
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 (R) - Application recommandée:
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 (DK) - Anbefalet brug:
 2 gange dagligt 1-2 kapsler, 1 time før eller 1 time efter måltiden.
 (FI) - Suositeltava käyttö:
 2 kertaa päivässä 1-2 kapselaa, 1 tunti ennen ateriaa tai 1 tunti aterian jälkeen.
 (NO) - Anbefalt bruk:
 2 ganger daglig 1-2 kapsler, 1 time før eller 1 time etter måltiden.
 (Finnish) - Käyttöohjeet:
 2 kertaa päivässä 1-2 kapselaa, 1 tunti ennen ateriaa tai 1 tunti aterian jälkeen.
 (Swedish) - Användningsanvisning:
 2 gånger om dagen 1-2 kapslar, 1 timme före eller 1 timme efter måltiden.



Good for the heart and blood vessels

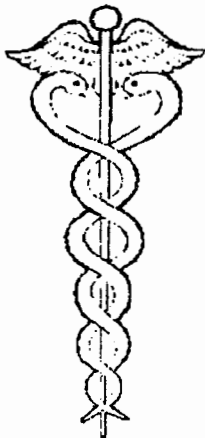


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WHAT'S IN THE HOXSEY TREATMENT?

by S. Edgar Bond, B.L.M.D.

Modern Theory of Cancer

The difficulty of those administering remedies for cancer and such allied conditions, is in not realizing cancer is first and always a systemic disease and failing to understand the manifestation we term cancer as not the cause of the systemic disturbances which are present as a result of such a visible lesion.

We are attempting to cure cancer by more and more X-ray force, chemotherapy and surgical elimination of the local manifestation when we should begin at the root cause and eliminate it by means of systemic eliminants. If we do not change our methods of attacking cancers and attack it as a systemic disease, we will have an increasing number of cancer fatalities.

In addition "scientific medicine" in theory and practice is bound to the theory it takes a poison to "kill" disease and thus cannot see any virtue in natural medicines of botanical origin which build and strengthen nature's fighting forces and enable it to better resist diseases as well as cure diseases. Natural medicines do not kill the patient with an overdose but build vitality.

Out of an experience of over fifty years, we are preparing to analyze each ingredient which experience has firmly established.

The following is the 16oz Hoxsey Tonic as analyzed by the A.M.A. Laboratories. Each 5cc contains:

Potassium Iodine	150mg
Licorice	20mg
Red Clover	20mg
Burdock Root	10mg
Stillingia Root	10mg
Berberis Root	10mg
Poke Root	10mg
Cascara Amarga	5mg
Prickly Ash Bark	5mg
Buckthorn Bark	20mg

We submit the following analysis of each in its clinical and laboratory findings. Each discovered by the bedside use and confirmed by recoveries from diseased conditions as evidence of its value in such diseases as cancer, both internal and external.

Potassium Iodine

Potassium Iodine is an alterant tonic influencing the glandular system, the serous and mucous membranes. It cures specific ulcerations, scrofulae, ophthalmias, goitres, severs pruritis, exzemas and warts. The Potassium side (Pot Ash) is made from wood ashes as lye and is a strong alkali and brings with its chemical combination, iodine, these same qualities. With iodine as a base, there are formed many combinations which are included in various medications. If given in continuous doses, it is so potent as to create a rash or

other skin lesion, evidence that it reaches every cell of the body as an eliminant rather than merely as an expectorant in a coryza.

Trifolium Pratense — Red Clover

The common red clover is gathered when in perfect bloom. It is a stimulating alterant influencing the capillary circulation to better distribution. Its use promotes healthy granulations in indolent ulcers, scaly and pimply skin. In elderly persons, it influences the dry skin to more normal condition and induces better protective moisture and perspiration.

Burdock Root — Arctium Lappa or Lappa Major — Roots and Seeds

The root is a soothing alterant. The seeds are the same but more active and somewhat oily. Eclectic physicians rely on this drug in blood dyscrasias and usually combine it with more stimulating or diffusive drugs if used in syphilitic cases. It is a persistent tonic alterative, relieves lymphatic congestions, inflammations of the skin and influences the alvine (relating to abdomen or the intestine) structures. It is of value in rheumatic conditions especially in the inflammatory stages of such diseases, aiding in cleansing the system of its accumulations. Here the seed with its natural oils is of value.

Cascara Amarga — Honduras Bark Picramnia, Etc.

This bark is little known by modern physicians yet it is one of the best stimulating alteratives we have in the botanical field. It is of special value in gummy tumors, chronic eczemas, chronic catarrhs, gonorrheal rheumatism, secondary syphilis, localized tubercules and general blood disturbances. In fact, this drug seems to stimulate the kidneys and skin in such a manner as to eliminate the accumulated virus through these emunctories as it improves the appetite and digestion.

It has been long known that the addition of berberis aquifolium, and xanthoxylum adds to these properties due to their diffusive and stimulating properties.

Xanthoxylum Flaxineum — Prickly Ash

This drug made from the bark, seed or berries is a positive diffusive stimulant which produces better arterial and capillary circulations. This property is unlike that of capsicum, in that it is more lasting and more agreeable to the taste. It arouses the skin, is diffusive, reaching to cold extremities, stimulates salivary and lymphatic glands, serous and mucous areas.

Of value by itself yet it is often combined with Phytolacca root when it becomes even more effective in rheumatisms, scrofulae, syphilis, congestions and paralysis. A vehicle made from ripe berries, possesses similar values but much milder in clinical values.

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Phytolacca Decandra — Poke Berries

This plant is common to our woods and fields, easily recognized with its stems of long black berries which are largely eaten by robins to condition them for their long flight south. Both berries and the green root are used. Phytolacca influences all the deep structures and relieves congested or inflamed areas. It is a stimulating, relaxing, alterant which influences all serous, mucous and glandular structures. It enables the physician to relieve the system of excess accumulations of fats and filth within and give to the patient more muscular solidity. It is a persistent remedy so is used in orchitis, mammary ovarian and scrofulous abscesses. It will avert body and cartilaginous swellings and is of great value in rheumatisms.

Stillingia Sylvatica

The root of this plant is used which also is a positive, stimulating, alterative especially adapted to chronic cases where its persistent properties are useful.

Its use with other and less stimulating drugs is urged for in large doses it is cathartic and even emetic and may leave within the bowels a burning sensation.

Like many of the foregoing drugs it is an alterant to the glandular system and is used in secondary syphilis, exzemas, ulcers, scrofulae and malignant eruptions.

Rhamnus Frangula — Buckthorn

This is the European variety which is a mild, stimulating, laxative, cholagogue which in large doses becomes a cathartic of moderate impression. Its addition to any alterative medications gives persistent values toward easy elimination of toxic impurities in

any system without any of the usual cathartic disturbing cramps. In such action it is a tonic laxative rather than that of drastic disturbances.

Glycyrrhiza Glabra — Licorice

This root is usually used as a vehicle to cover up any bitter, tonic medications, but the profession have of late discovered it is more than a mere covering for bitter taste. It is a demulcent and gentle laxative yet somewhat stimulating to the entire internal and digestive mucous membranes. This is now emphasized as a valuable addition to any combination of drugs designed to use in inflammatory ulcerations and many other indications in digestive disturbances.

Is it a "Shot Gun" Prescription?

Perhaps one may be accused in such a combination as using a "shotgun" prescription. But when one analyses it he finds each has its purpose and reaches diseases especially in cancers which are many sided from many angles as an eliminating alterative, blood builder and mildly stimulating factor in urging the system to eliminate its accumulations of its pathology and rebuild.

Each drug is one which gives positive elimination returns which we term alterative in action. Should there be no other argument for their efficiency than of their elimination properties, it should enable one to reach the conclusion that there is in our formulae the needed properties to treat disease.

Also, there is in it tonic properties which build in the system greater assimilation and strength from foods consumed.

Distributed by the

FOUNDATION FOR ADVANCEMENT IN CANCER THERAPY, LTD.
BOX 1242 OLD CHELSEA STATION
NEW YORK, N.Y. 10113
212-741-2790

GENERAL INFORMATION

The clinic is open from 8 a.m. to 4 p.m., Monday through Friday, except legal holidays of the United States and the following Mexican holidays: February 5, March 21, May 1, September 16 and November 20. Closed the last weeks of December.

PATIENT MUST BE HERE AT 8:30 A.M.

No appointment is necessary. We do request all patients to arrive at the clinic before 9:00 a.m. without breakfast and having had a laxative the night before. This prepares them for tests and examinations. The laboratory x-rays and physical examination charges run between \$400 to \$900 dollars. The charges must be covered on the day you are here. The Hossey Treatment, for as long as necessary, is \$3,500 dollars. A down payment of at least 30% toward the treatment must be paid on the first visit.

The examination is normally completed in one day, however, the patient should be prepared to remain overnight, if necessary. There are motels and hotels available at reasonable rates.

No Passport is necessary when crossing the border into Mexico. After crossing the border there are yellow Taxis for hire that will bring you to the clinic. The fare is usually \$6 dollars per person, but it is wise to arrange with the driver on the price before getting into the taxi.

If you are driving, take Interstate 5 or 805 south to San Ysidro off ramp to access road, left 2 blocks to International Motor Inn (formerly Motel B). They have transportation to the clinic to your room. International Motor Inn & R.V. Park, 190 E. Calle Primero, San Ysidro, CA 92073. Phone (619) 428-4486.

If flying in: Take a taxi from the Airport to E.Z. B Mctel, 3333 Channel Way, San Diego, CA, phone (619) 223-9500. In the afternoon or evening call Mrs. Leona Rogers at telephone number 226-8655 for transportation.

CLINIC TELEPHONE NUMBERS:

- (0115266) 84-90-11
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Closed Saturdays, Sundays,
U.S. Holidays
Feb. 5, March 21, Good Friday, May 1,
May 5, September 16,
November 20 and last two weeks
of December for vacation.

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VITAMINS AND MINERALS—Vitamin A (100,000 I.U. daily for a while), Vitamin C (with bioflavonoids), very healing, B-complex (extra B12), E (used internally and externally). Multi-mineral supplement (burns heal faster when minerals are present), calcium and magnesium (balance), potassium, sodium, selenium, copper, zinc.

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Other

HERBAL COMBINATIONS—Bone (increases healing), Infections, Nerve and Relaxant combinations. Lower Bowel cleansers will help prevent infections.

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SINGLE HERBS—Aloe Vera (very healing), Chickweed (will purify the blood), Comfrey (heal and restore damaged tissues), Garlic, Horsetail (contains silicon), Marshmallow (acid or fire burns), Oatstraw, Red Clover, Slippery Elm (internal and external), Witch Hazel, Yarrow.

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SUPPLEMENTS—Aloe Vera Juice (decreases bacterial infections and speeds healing), Evening Primrose, Salmon Oil, Chinese essential oils (externally), Redmond Clay (make a paste), Tea Tree Oil (external).

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AVOID—High sugar diet, sweet drinks, cortisone creams, ice water, acid foods (accumulates too many toxins in the body). Don't use butter or margarine, will cause burn to penetrate deeper.

CANCER

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There are many different types of cancer. Some spread quickly and others take years to develop. The bloodstream and lymphatic system can take cancer cells to different parts of the body. Cancer is a severe disorder of the immune system, where the replication processes of the cells go haywire and reproduce wildly and invade other organs and tissues. This is known as malignancy.

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ause

The basic causes of cancer are those environmental, dietary and stress factors that allow normal cells to get out of control. Cancer is a risk all of us take because we cannot be at a well level all the time. Air pollution, pesticides, food additives and drugs all contribute to the degree of health we can maintain at any one time.

ter).

NATURAL THERAPY—Blood purification and Nervine therapy, also the Lower Bowels and Liver should be the main concern. The nervine herbs will help strengthen the nervous system, which is connected to the immune system. The nerves help one cope with everyday stresses. When your nerves are strong and healthy the body can handle diet changes. The National Academy of Sciences validated what many nutritionally-oriented physicians have been saying for years: there is a connection between diet and cancer. The United States government has found evidence that there is a strong connection between diet and health, and now the American Cancer Society says that diet is a major cause of cancer. We can no longer deny the link between diet and cancer.

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FOODS TO HEAL—A change of diet is necessary. Crucifers protect against cancer (cabbage, broccoli, brussels sprouts, cauliflower) because they encourage the formation of indol in our intestine which can help prevent colon cancer and some other cancers. High fiber diets will also protect against cancer. Foods rich in potassium: beans (sprout first), whole grains (best sprouted), wheat grass juice, almonds, sunflower and sesame seeds, lentils, parsley, blueberries, coconut, endive, leaf lettuce, oats (thermos cooking), potatoes (baked with skin), carrots, peaches, fresh fruits and vegetables. Buckwheat, brown rice and millet (easy to digest and assimilate).

VITAMINS AND MINERALS—Vitamin A (protects against bladder cancer), B-complex vitamins (fortifies the nerves), C (with bioflavonoids) (protects against all cancers), antioxidant, destroys, neutralizes and protects against additives, detoxify viruses and carcinogens which cause cancer, D, helps the body to use calcium, vitamin A and minerals. E, free radical scavenger (works with selenium), Multi-mineral, with extra calcium, magnesium, magnesium, selenium, silicon, zinc.

HERBAL COMBINATIONS—Blood Purifier, Bone, Candida, Cleansing, Digestion, General Cleanser, Glands, Immune, Lower Bowels, Nerves.

SINGLE HERBS—Key Herbs: Burdock (blood cleanser), Garlic (natural antibiotic), Capsicum (cleans the blood), Chaparral (cleans the blood and eliminates toxins), Echinacea (blood cleanser), Kelp (cleans and nourishes the blood), Lady's Slipper, Pau D'Arco (protects the liver and cleans the blood), Red Clover (cleans the blood), Suma (strengthens the whole body).

SUPPLEMENTS—Acidophilus, Liquid Chlorophyll, Blue-Green Algae. Salmon Oil and Evening Primrose Oil, Herbal teas containing Red Clover and Chaparral. Pau D'Arco Tea.

AVOID—Refined grains and sugars, fried foods, and additives. Food colorings, coffee, tea, cola drinks. Avoid meat which is dead matter, cutting fats and eliminating salt-cured, salt-pickled and smoked foods such as sausage, bacon, ham, smoked fish, bologna and hot dogs. Fluoride in water and toothpaste is linked to bone cancer. Breathing unhealthy air causes cancer, the toxins in the air are called "particulate matter." Obesity increases risk of colon cancer.

Smoking causes lung and mouth cancer. A high fat and meat diet can cause colon cancer.

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A CANCER CASE HISTORY

By Lou Diaz

In 1978 I was diagnosed with a malignant form of lymphoma. My story began long before 1978, and some of this history is directly related to my contracting cancer. As a child I constantly had throat problems. My resistance was poor and I was prone to strep throat, tonsillitis, colds and flu. I was given the standard inoculations as a child and I ate the standard 1950's American "balanced" diet which included lots of dairy, fats, sugars, soft drinks and junk food. In response to my frequent throat infections, my tonsils were removed when I was in the 4th grade.

In the 5th grade I began to have a severe problem with my right elbow joint. It swelled and became quite painful at irregular intervals. This problem would persist for a few weeks at a time and then would depart as mysteriously as it had arrived. Over time, the frequency, duration, and intensity increased to the point where something had to be done. I visited an orthopedic surgeon. X-rays indicated a cyst which was eating out the bone inside the joint of my right elbow. Surgery was performed to scrape out the joint, and bone was grafted from my right hip to fill the hole eaten out by the cyst. This was never diagnosed as a cancer and the problem seemed to go away with the surgery.

My diet remained unchanged and so did my general health. I continued to suffer a high incidence of colds, sore throats and flu. In about 1975 I began to have a similar swelling and soreness in my left wrist. As in the 5th grade, it came and went. I had to wrap it in an ace bandage and could not move my wrist so much as a fraction of an inch without intense pain. At first, the problem surfaced every 4 months or so and would last a few weeks. When it became worse, I consulted a physician. I was diagnosed as having gout. The "cure" prescribed by my doctor proved to be ineffectual, so I consulted another physician. I told him my history and the gout diagnosis, and he confirmed the diagnosis. His "cure" was similarly ineffective. By sheer coincidence, I met another physician (in 1978), who took one look at my severely distended wrist (the size of a tennis ball), and insisted that I check immediately into the hospital. A biopsy was performed on my wrist, and the diagnosis, confirmed by two independent laboratories, was a malignant form of lymphoma in the bones and lymph system. A second biopsy indicated that I had lymphoma in my lymph nodes in my left armpit. I was subjected to a battery

of tests to see if I had cancer in other locations. Dye was injected into the lymph nodes in my feet and pictures taken on a CAT scan. I drank various radioactive concoctions and again had images taken. I had taken so many radioactive isotopes that I was able to pin the needle on a "geiger counter" located in the nuclear medicine waiting room. I was a pretty hot number!

My left wrist bone was almost totally consumed by the cancer and I was unable to move it. It was the consistency of soft mush. I was given a series of radiation treatments to my left wrist and arm. This reduced the mass so that it appeared more normal, but the wrist remained sore and weak. The radiation burned all hair from my arm and caused the skin to dry and crack. This was followed by one treatment of chemotherapy, which consisted of Prednisone, Oncovin, and one or two other chemicals, the names of which I have long forgotten. The chemotherapy produced a three day migraine accompanied by nausea. I was given codeine to help alleviate the pain in my head and wrist. During treatment I was given minimum feedback or explanation despite my numerous questions and obvious interest in treatment and side effects.

It was at this point in my treatment that I discovered FACT. I consumed books, networked with recovered cancer patients, contacted clinics, obtained literature and attended the annual FACT convention in Detroit. I promptly put all conventional treatment on hold pending further investigation into the alternatives. I was simultaneously encouraged and petrified by my discoveries. My background as an engineer had trained me to investigate symptoms and trace them back to the root cause(s). The alternatives made so much sense to me. On the other hand, I was scared of veering from the advice of medical professionals who had had years of scientific and medical training. My life was at stake! This left me in a severe emotional quandary as I sat on the fence and gathered additional information. Nonetheless, I decided to take responsibility for all future decisions as to modes of treatment. It was my body and my life. No longer would I relinquish these decisions to others and follow blindly.

I wrote out a three-page list of questions and made an appointment with my oncologist. I gave him a 90-minute exam and insisted on clear answers to my many questions. He was patient and accommodating.

By the end of the interview, I was leaning strongly toward alternative treatments. When I told him this, he became very defensive and upset. He related examples of three or four members of his immediate family who had died of cancer and how he had done everything in his power to save them. He would not consider these "so-called alternatives" which he considered quackery. His track record (which he claimed was above average), helped me to decide in favor of alternative treatment. Two years after leaving his care and adhering to metabolic therapy, I was offered a promotion by my company on the condition that I obtain a clean bill of health from my original oncologist. I visited him and after a thorough examination, he declared me totally free of cancer. What amazed me was that he never once expressed any curiosity as to how I had done it! Amazing.

I began my metabolic program by following the Kelley plan and followed it to the letter. I consulted him totally via mail, through fluid samples, a massive questionnaire, medical reports, etc. After about 6 months I decided to attend the John Richardson Clinic in Berkeley, California. His program had many elements in common with Kelley's, and I discovered that most of the successful alternatives I had become acquainted with shared many similarities. Let me suggest a few of the common principles which I followed in rebuilding the immune system and in reestablishing the integrity of the body.

1. Whole, natural foods, largely in their raw, organic state, were used abundantly. This included vegetables, fruits, nuts, grains, etc. All additives, preservatives, refined sugar, white flour, adulterated meats, soft drinks and junk food were avoided.

2. The body needed cleansing inside and out to assist in the elimination of waste products and toxins. Various methods were used including high enemas, flushes and purges.

3. Liberal quantities of freshly produced carrot juice were consumed. I typically drank 1-2 quarts daily, usually a combination of carrot juice mixed with celery juice. I would often add other juices such as spinach or beet. This was an important part of the program.

4. Supplements were added to my diet to help correct my specific deficiencies. I took pancreatic enzymes, liver supplements, bone supplements, and numerous others. These supplements must be tailored to the specific needs of each individual patient. The assistance of a knowledgeable professional is indicated. Seek guidance from FACT.

5. A "take charge attitude" helps reduce stress

and improve attitude. These factors are shown to make a significant difference in a patient's ability to recuperate. Imagery, relaxation, and a positive outlook seem to assist the body in restoring normal functioning of the various glands and organs.

6. Exercise as appropriate for the condition of the patient is important. The goal is to get oxygen and blood pumping to nourish cells and assist in elimination. It is not appropriate for very sick persons to wear themselves out. Moderation is in order.

7. The assistance of a professional health practitioner well-versed in biological alternatives is highly recommended. FACT is the best source for guidance in selecting a practitioner. A tested and proven practitioner can keep you on the right track.

8. Stay involved. Hippocrates said, "Physician, heal thyself." It is your body and your life. Your feedback combined with an appropriate practitioner is a good combination.

I'd like to comment on one more piece to the puzzle. I am convinced that emotional problems and severe emotional trauma often play a significant role in causing cancer. I believe this was very true in my case. I have worked very hard to eliminate suppressed anger and resentment from my life. This is why I feel so strongly about people getting involved in their own treatment. Somehow, when you become actively involved, attitudes change and this affects the body's chemical and electrical processes in a very positive manner!

I have not had any recurrence of cancer as of this date (Dec. 1992). My wrist bone has grown back completely and functions fairly normally, though it remains somewhat deformed and weak from the devastation wrought by cancer and radiation treatments. Since full recovery, I sometimes stray from my diet and revert to foods and habits that are not conducive to health. When I do not feel well, or if my wrist hurts a lot (sometimes due to weather changes), I clean up my act and go back to a healthier diet and follow the steps outlined above. Of course, the best course is to stay on a health-giving diet all the time. I have learned that my body has some inherent weaknesses, and that going back to the standard junk food diet leads to problems. I also find that my health is impaired during periods of severe emotional stress, especially in conjunction with a poor diet.

The good news is that I now have confidence that I can rebuild my body's health, defenses, and immune system, thus going to the source, rather than attacking symptoms. That, in essence, is what FACT is all about.



A Typical Case History

The medical doctors said, "We will have to remove your right lung or you will not last three months. You have cancer of your right lung."

I had been in the hospital over a month with double pneumonia and in spite of the efforts of the doctors, through the use of antibiotics, the lung refused to heal.

After many x-rays and sputum tests, the results showed malignant cancer of the lungs.

I phoned my wife and she said, "Check out of the hospital and come home; Suzanne has called Mr. Tobe's office in Canada and he has recommended Dr. Max Warmbrand of Stamford, Connecticut, and he has agreed to look at you, although he makes no promises."

Suzanne is my daughter who was very worried about my condition.

After battling doctors, nurses, and even the chaplain (who tried to convince me to have the lung removed), I finally was able to check out of the hospital. This was in June 1974.

The next day my wife drove me to Dr. Warmbrand's office. I could not drive; in fact, I was hardly able to walk. My heart was also in bad condition.

Dr. Warmbrand said, "Mr. Mott, all your life you have lived to eat and drink. Whiskey, beer, wine. Your body is completely deteriorated. Are you now ready to change your way of living and eating? In other words, are you ready to eat to live by rebuilding your whole body?"

He said, "Your body is a wonderful machine and will rebuild itself if you give it the chance. But you must make up your mind to take my advice and don't cheat. If you are ready to do that, I will try to help you."

What could I say? The medical doctors had given me three months at the most.

When this happened, I weighed 255 pounds. I would eat three or four steaks a week for my principal meal, always a big roast of meat on Sunday, loved spaghetti, meat balls, chicken and all Italian Foods, plus a pint of brandy a day,

one or two six-packs of beer a day depending on the weather, always a fifth or two over the weekend, coffee, tea, doughnuts, cake, candy, white bread, sugar, etc.

I said to Dr. Warmbrand, "There's nothing I can do but give it a try. I have only three months, according to the M.D.s."

"O.K.," said Dr. Max. "No beef, pork, veal, chicken, cold cuts, or fish. No white bread, cake, doughnuts, candy, sugar or sweets, alcohol, coffee, tea, soda drinks, no milk, eggs, cheese or other dairy products. No beer or wine."

I looked at him and said to myself, "Oh, I see, he is going to save time and expense by having me kick the bucket immediately."

I said to him, "What can I have? There's nothing left."

His answer was, "What does a steer or cow or horse eat? They grow hoofs, horns, teeth, and grow massive in size. How many cancer operations do you hear performed on these animals?"

He said, "Number one, you can eat all the fruit you want, a few almonds, a large glass of carrot juice in the morning. During the day, have a chlorophyll drink or lettuce, celery, carrot tops, beets tops, any greens available in season, and a salad for lunch with nothing on it, you can have honey or orange juice on the salad. For evening meals, have a large salad of lettuce, celery, peppers, tomatoes, onions, any greens in season, with a baked potato and avocado. Get plenty of rest, and take a hot bath with epsom salts every night. Keep your feet warm, and do a few exercises that I will give you."

My wife was taking this all in and agreed to give me the described food, and without her following this to the letter, and watching and waiting on me, and preaching to me 100% of the time, I know that I would not have made it.

I stayed on this diet faithfully and after 2 months, I started to feel much better. My strength started to return and people started to

tell me that I looked better. I sure felt a lot better, and after three months started to drive the car and do a little work around the house.

Each month I felt stronger and people who saw me when I looked, as they later told me, "like walking death," could not believe I was the same person.

My weight went to 175 pounds in a period of six months and has held at this weight, although Dr. Warmbrand is after me to get down to 165 pounds. My heart showed great improvement.

I still stayed 100% on Dr. Warmbrand's advice.

On June 21, 1975, one year later, I entered the same hospital and after x-ray and examination, the doctors found that my lungs are clean and show no evidence of cancer. They compared these with the x-rays taken the day I left in 1974 that showed a mass on my right lung that was tested, looked at, and x-rayed. My lung was

now clean.

The sputum samples are now negative.

I told them of Dr. Warmbrand's method of treating the body, but all they said was that I have had a 100% remission. I reminded them about their recommending removal of my lung, but I did not receive any answer.

I am grateful to God, to many people who were praying for a miracle, to Dr. Warmbrand, to my wife, without whose help, work and advice, in no way would I have been able to make the change.

However, with the advice I received, I never will go back to the old way of eating meat, fish, or cooked food that kills the enzymes that are necessary to keep our whole body healthy.

This is my happy story, thanks to the good doctor, Max Warmbrand of Stamford, Connecticut.

Richard A. Mott

Distributed By :

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A Recovered Cancer Patient—Betty Fowler



Following is a transcript of a tape of Betty Fowler, a recovered cancer patient, speaking at the Annual Cancer/Nutrition Convention of the Foundation for Advancement in Cancer Therapy which was held at the Biltmore Hotel in NYC May 29th & 30th, 1979. The transcript has been edited in order to adapt to a written presentation, but it in no way changes the meaning of the material.

MC: Betty Fowler was Director of the Leonard Fowler dancers in the Fowler School of Practical Ballet here in New York. A native of Chicago, Mrs. Fowler attended Straton Business College there and Columbia University in New York. She is married and has a daughter. She's been active in the Girl Scouts and has served in various administrative capacities in the fields of publication and dance. I suspect that Betty's most proud credential, however, is her successful struggle with cancer. She's going to tell us something about that struggle today. It is my pleasure and pride to introduce Mrs. Betty Fowler. Please welcome her.

Betty Fowler: My name is Betty Fowler and I'm a recovered cancer victim.

When I first heard the three words, "You have cancer," my first thought was, "I'm going to die." My second thought was, "Why me?" It was a sentence of death by painful means.

When I was 37, I had a partial hysterectomy. Shortly afterward, I went to our family physi-

cian with pain in my abdomen. He found a cyst in my womb area. He removed the cyst by cauterization, but I still felt rotten.

I also had attacks of myositis and facial neuritis. I continued to have pains in my abdomen. I went to the dentist because my gums bled every morning, often at night and sometimes during the day.

When I was 23 I had developed a pyelonoidal cyst in the fifth month of pregnancy. For two months I received X-ray treatments on a weekly basis. In my seventh month, the cyst was cut and drained. One week before delivery, it had to be cut and drained again. But three months after giving birth I had an operation to remove the cyst. The cyst would not heal. It drained for 2 1/2 years.

Two years after the partial hysterectomy, the brown mole on my left cheek started to throb and enlarge. I saw a skin specialist and had the mole excised. A biopsy was performed. The diagnosis was "non-malignant." When I was 40, I noticed a small growth under my left breast. I saw another specialist and had the growth removed and biopsied. Diagnosis was "non-malignant."

In 1969 a growth developed under the arch of my left foot. The doctor said it was a tumor and surgically removed it. This, too, was biopsied and declared "non-malignant." At the same time the skin specialist removed some small growths on my face, my forehead and my right wrist.

My eyes were deteriorating and I could not focus. My gas problem which had plagued me earlier became worse. I began to suffer with muscle weaknesses and bad cramps. My hair began to turn gray and the texture changed from soft to brittle. My face started to itch 24 hours a day.

It was excruciating. So I made an appointment with a surgeon who had previously operated on my face and done a good job. He said, "You must go into the hospital. We'll do the surgery in the morning and you'll go out that same day." I had to undergo a series of X-rays and many other tests.

In the hospital I had a section between my lip and chin cut. The operation was done with local anesthesia. I got the results of this biopsy:

"Cancer." I was in continuous pain. "It may have metastasized," the doctor said. "You may have cancer in the mouth somewhere." He recommended that I should see an oncologist.

The oncologist suggested the Mohs technique: special chemicals would be put on my face and where an area revealed cancer, the specialist would cut. For several reasons I decided not to follow this path.

I went to a health food store which had often posted notices of health meetings and found a book called, *New Hope for Cancer Victims* by William Donald Kelley. The first four pages of the Kelley book got me very excited. Dr. Kelley described the symptoms a cancer patient has, and they matched mine—every one, except for the hernia.

I begged and pleaded with the owner of the health food store to help me find a way to Dr. Kelley. I told her, "I have cancer. I have just come from having a biopsy done." Then she said, "Here is the phone number of Ruth Sackman. She's a beautiful person. She helps cancer victims day and night." I went to a phone booth and called Ruth Sackman and made an appointment with her at 2 o'clock that afternoon.

Mrs. Sackman helped me to understand a different concept in treating cancer and to connect with Dr. Kelley. I had my first Kelley test in January of 1972. I found out that my cancer was painful from the beginning because it involved a nerve. I also found that I had serious nutritional deficiencies. Dr. Kelley established a nutritional program for me.

Now, the Kelley program is not at all similar to any program devised by the medical establishment. At the very beginning and for about 6 months, I took enemas every two hours during the day and for a whole year my husband got me up at 3:30 in the morning to give me an enema.

Before going on the Kelley program, I spent one year following the criteria of the medical establishment. I wanted the miracle they write about. I wanted the silver bullet drug. Something that I could either swallow or else, a shot. Something that would make the cancer go away. I found

out there was no silver bullet to combat cancer. The prescription for me was nutrition.

I did not feel better at first on the Kelley program. I felt worse. I had more severe stomach aches. I had more gas than when I first went on the program and I felt weaker than before. I was also more nauseous than before. My body ached. Every day was like living with flu-like symptoms. My brain felt sluggish. I often had a fever.

I had abused my body most of my life and now that I was dislodging poisons which were trying to find a way out, I was going through reactions or flare-ups and all this was part of the healing process. This is very important.

Every single place where I was cut, an eruption came out—a big one, like a boil. I woke up one morning and the blue blob on my chin spit out pus, drained that day and the next and then stopped. Intermittently, until I was healed, the blob opened and drained. At one point I broke out in a rash all over my face and body, another aspect of the healing process.

The following year I saw Dr. Kelley for a retest. I went to a specialist in New York and he said, "My goodness, that's the largest mucous cyst I've ever seen." It took three visits to this specialist to remove the cyst; it was that big. Isn't it wonderful that my cancer changed? Isn't it wonderful what the nutritional program did?

Fighting cancer the nutritional way means work. It means taking enemas, drinking carrot juice, and eating salads with plenty of greens. It means eating fruits and vegetables. It means taking supplements and stopping them when you begin to get toxic symptoms. It was very hard.

It also means adhering conscientiously to the basic biological principles and not cheating. I started the nutritional program in February of 1972 and I've been on it ever since. I have a retest when indicated. My last test was great.

I hope I've inspired those of you who might have cancer here to follow a good nutritional program, whether it be Dr. Kelley or some other non-toxic therapy. I hope my talk has given you strength, courage and faith to follow a nutritional program. *

Hy Radin - Cancer Survivor - 23 Years Later

I always believed faithfully in our medical profession. Just listen to your doctor, "Don't worry, we have a major pill for everything." So I ate hot dogs, smoked, and boozed. Being in the advertising business didn't help. I helped advertise, promote, and market drugs, junk foods, petroleum, and services. There were many times my clients and I wound up in a bar in town or on a flight where we indulged in the niceties of life.



Hy Radin in the FACT office

At 35 years of age, I blew up like a balloon to 198 lbs. (I was only 5 feet, 7.) Lo and behold, I had become a diabetic.

Of course, I got the best doctor with a fancy Park Ave. address. "It's easy," the doctor said, "don't worry, we have the best drugs now. You don't need insulin; we have a magic pill. I'm putting you on Orinase." He didn't warn me about the side effects, and what do you know, after many years I got arteriosclerosis. It suddenly dawned on me that I had better start learning not to blindly trust these doctors who don't warn you about these unknown causes or side effects. Anytime I get a drug now from my doc-

tor, I make sure I get the sheet of warnings from my pharmacist. He *must* give it to me. I read and study it.

The doctors I've met have known nothing about nutrition. The diet I got from my doctor was a printed sheet from a dietitian and, if you have been in any hospital, you have seen the worst food in the world, prepared usually by a dietitian. The food is lousy; there is no other word for it, and it lacks the nourishment the body requires.

Well, 17 years later I had pains in my back so I went to another specialist, one who took care of football players and fighters. He diagnosed it as a torn muscle. I had to see him 2 or 3 times a week for about 6 months. I left his office on Oct. 17, 1967 and collapsed in the street.

I got a cab and went to my family doctor. He immediately put me into Lenox Hill Hospital, and after x-rays and biopsies, I finally got the message: I had cancer in my spine and had to have surgery as the cancer was eating my 4th and 5th vertebrae. I was warned that this must be done immediately or they would not be responsible if I never walked again. Well, after surgery, I had 10 double shots of cobalt (200 rads) and chemotherapy.

Only a cancer victim would know my feeling. I was completely devastated. Why me? I went through more pain because of the spinal surgery and those bad miserable doctors who never gave me enough pain killers. It was so bad that I welcomed death! Somehow I managed to leave that hospital after 36 days of torture. They said I was terminal and couldn't last 3 weeks.

I have a friend, Lou Kashins, who had been after me for 20 years to go "natural" - all vegetarian - and follow Dr. William Howard Hay's program. What did I have to lose now? I started this therapy myself because I couldn't find a doctor who had enough guts to monitor me. After six weeks, I found Dr. Maxmillian LeWitter, who then went over my records and said, "Yes, I like this program; I know of Dr. Hay and his work." He didn't change anything I was doing except to cut down on the huge amounts of Vitamin A and D that I was using as this was in the danger zone.

Basically the program used was very simple. It had two parts: 1) a purge lasting 3 days and 2) nutrition lasting the rest of my life. I want to tell you it worked. I knew about two months later that it was working! Hey, I was still alive, my eyes cleared, and my pains disappeared - all without drugs. And my energy was coming back. I was walking again without crutches.

For someone like me who was basically a meat and

potatoes man, this was a new life style. I can say it was not easy. I had to change my life style of eating completely! My diet for one year was strictly vegetarian, but I ran into some problems and had to go into proteins like fish and eggs. I added fish (5 oz.) and eggs, soft-boiled or poached. When I ate eggs one day, I had fish the next.

There were no substitutions of junk foods and no coffee, tea, sugar, salt or spices. You must stick to the diet! Read the book, *How to Always Be Well* by William Howard Hay, M.D.

I had two enemas and 2-8 oz. glasses of carrot and celery juice a day. I finally cut down to one enema and one glass of carrot and celery juice a day, then finally no enemas and no juices. This is part of the detox program. As I felt better, I started to slowly get my strength back. Finally, it worked; there was no cancer detected after one year.

Now, 23 years later the cancer reactivated. In early June, 1990, a growth on my left jaw coming from the parotid gland appeared. The doctors wanted biopsies, surgery, etc. I said, "No," and went on the Dr. William H. Hay program again.

It's now 5 months later and I feel great. The growth has become slightly smaller. I'm hoping it will disappear entirely. I'm sticking to the program, playing golf weekdays, weather permitting, and I know that I have the cancer licked again.

And do you know what? I test my urine every morning and for the past 2 months the tests show *no* trace of sugar at all! Only a diabetic will know what I mean. I've taken no insulin or drug of any kind for 23 years. And believe it or not, I eat at least 7 or 8 pieces of fruit a day.

Usually, I start breakfast with a large piece of watermelon. A half-hour later I eat more fruit with plain yogurt or cereal with nuts and seeds. Lunch is often a fruit salad with nuts and seeds. Dinner is generally fish (about 5 oz.) and a vegetable salad with nuts and seeds. I have a snack between breakfast and lunch, between lunch and dinner, and sometimes between dinner and bedtime.

Yes, the Hay Therapy has taught me many things: Stop what's causing the problem because "cure" is never anything less than removal of the cause or causes, whatever these may be, and anything that does not meet these specifications can be nothing more than palliative at best. And keep in mind that internal filth or toxicity is the only cause of most disease.

I have had other problems like cataracts in both eyes. After going to my ophthalmologist, I asked if he knew of Dr. Bates' natural therapy for better eyesight without glasses, curing cataracts and glaucoma. He

laughed and said, "Don't go to quacks." So I walked out and tried a natural way myself and dissolved the cataracts. I can't believe that I was so blind for so many years and accepted everything my doctor said!

Remember, I'm talking about myself and some of my experiences. As far as I'm concerned, I advocate eating raw foods when I'm sick. This has reduced my fatigue and restored my energy.

If your will power is strong enough and you give nature every ounce of cooperation, you would be surprised at the satisfactory results that follow. Unfortunately, most of us seek pain-killing remedies for instant relief instead of the slower and more tedious but decidedly more certain and permanent methods which aid nature in cleaning and rebuilding the body in order that our lives may be longer and more vital.

Yes, this is 23 years later. I'm 76 years old and still full of vim and vigor. I've run into some problems in trying to extend my diet. I couldn't handle regular milk, so I went to soy milk, and boy, did I get it! My body reacted violently. I had the runs and then the opposite, constipation. I found that soy milk is very acid and contains about 17% more phosphorus, about 400% more sulphur than human milk, both these elements being acid-forming. What I'm trying to say is that once you take a good food like soybeans and then process it to death, you don't have the same natural product. It's like taking an orange and juicing it; instead of eating the whole orange with its vitamin C and bioflavonoids, you're getting mostly citric acid which destroys the vitamins necessary for a good life.

Good benefits can be obtained by juicing raw vegetables as they contain all the minerals, enzymes, chemical elements, vitamins, calories, and amino acids. What a life you can get! Try it, you'll like it!

Hy Radin, going for the year 2000!

The human body cannot be made dependably or permanently well unless the surplus toxins are removed from the blood and tissues. At least seventy-five per cent of all symptoms, diseases, and discomforts disappear with the removal of toxins. No one can expect full health unless he lives in a manner to keep his toxemia below the saturation point and his vital energy high. All people are more or less toxic, but only those who are ill are pathologically toxic. The changes wrought in tissue by repeated and violent physiological disturbances often result in permanent alteration of organic structure, and real disease is always represented by pathological alteration.

- Dr. G. S. Werger



The iris of the eye is studied by the technique called iridology, as explained in the chart below.

Alternatives

Alternative therapies are for the most part still suspect in conventional medical eyes; indeed, several of them are commonly regarded as no more than quackery – except by the patients who seem to benefit from them. The medical profession, however, is properly cautious, secure in the knowledge that it has science and proven safety records behind it; physicians' reservations are deeply felt. Yet overall, in both physicians and public there is a growing awareness that conventional medicine does not hold all the answers, and techniques such as osteopathy have become recognized medical practices.

Drug treatment in particular has contributed to this disquiet because although drugs are a strong weapon in the fight against disease and pain many have harmful side effects.

Furthermore, drugs are often used to control symptoms rather than to prevent or cure disease. Drug treatment, however, like surgery, has the advantage that it can be understood in conventional scientific terms, and this is crucially important to those trained in that tradition. Because the mysticism and ritual that seems to surround some alternatives makes them unacceptable to a scientist from the start.

The alternative approach

There are so many different alternatives that to regard them as a whole can be of only limited value. One characteristic many share, however, is that the interrelationship, or coordination, between the healer, the patient, and the method

used is much closer than is usual in orthodox medicine. Although the variety of alternatives is vast, their modes of action can be broken down in three major categories.

The first category includes techniques that manipulate the body's "energy" – a characteristic that is difficult to understand, but which certainly seems to exist. It has been effectively excluded from Western medical concepts, but in some Oriental philosophies it is known as "prana" or "chi," which translates best as "life force."

The second category works on the physical body as conventional drugs and other treatments do. These therapies either alter the structure of the body – as does osteopathy for instance – or alter the chemicals within the body, as occurs in orthomolecular therapy or herbalism.

The third category has a mental or psychological approach. Examples include biofeedback, or work on a paranormal or psychic level – faith healing.

Acupuncture

Acupuncture is one of the oldest forms of medical treatment and has been practiced in China for centuries. Classical acupuncturists believe that the body remains healthy so long as its energy or force (*chi*) flows freely along well-defined channels known as meridians. Blockages in these channels are the cause of ill health, and the insertion of needles into points along these channels, or application of heat at these points (moxibustion) allows the energy to flow once more, encouraging the restoration of health.

Acupuncturists decide where to insert needles either by assessing the qualities of six pulses at each wrist, which represent the major organs of the body or, if they are treating pain, by needling points lying along the meridians that cross the painful area. Pain is often successfully treated with acupuncture but many other conditions can be helped too – notably hay fever and depression. Belief in acupuncture is not needed for it to be effective, although some people – for unknown reasons – do not respond to treatment. Techniques are still developing and recent advances include electrical stimulation of needles, ear acupuncture, and the use of acupuncture in anesthesia.

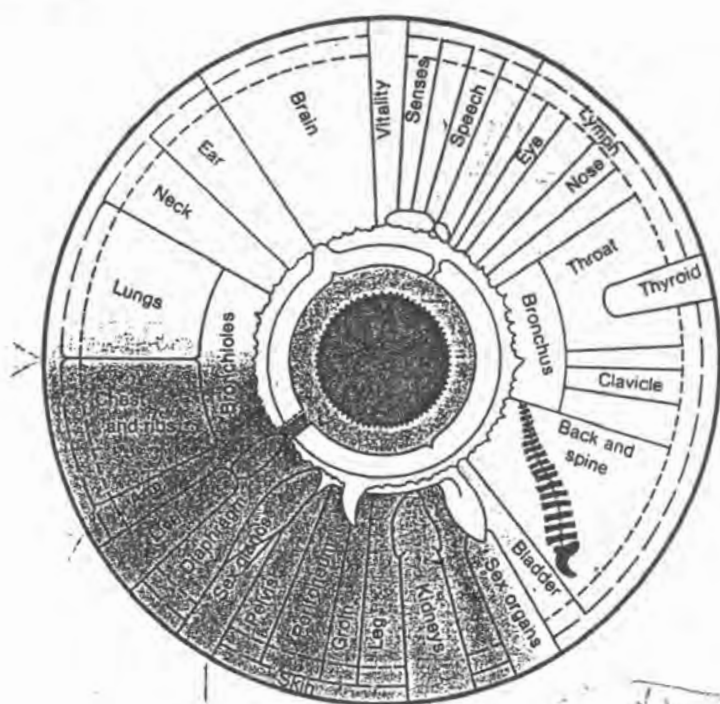
Homeopathy

Homeopathy originated in the 1750s when a German doctor, Samuel Hahnemann, noticed that the effects produced by a substance taken by a healthy person corresponded to the sufferings of a sick person then this substance, homeopathically prepared, could provide a useful cure. His homeopathic preparations were made by repeatedly diluting and shaking the substance.

Why does this system work, even when the degree of dilution may be so great that the physical presence of the original substance is virtually undetectable? Many homeopaths believe that every substance has both physical and energetic characteristics "vibrational energy" which

Iridology claims to interpret the color and condition of segments of the iris in terms of the state of health of various parts of the body. This simplified chart is for the right eye (the left-eye chart is basically a mirror image of this one). For example, by studying the right-hand sector of the eye at the four o'clock position, an iridologist can possibly diagnose ill-health in a person's back or spine.

Iridology chart (right eye)



Widdology: Water failed!

EPSON STYLIX Young Muller 588632

Ice a week 1 cup 2.5. + 1 cup

Apple Cider Vinegar. Soak for

20-30 minutes. Hot hot water

Evening

* Muffin Sprouts

Supplement

* Webster's K

Bonaca Calcium

* Ginger +

1 daily

* Nasturtians +

lemon E-co

* Avoid Dairy + Bread

May/cale

Eye Cakes

by vfr

+ Macular Edema

Rye loaf

take 3x morning

Brown Rice

take 3x afternoon

Willet

Fenugreek Tea daily

Kidney + Digestion

Isabella: 439-09157 Widdology

Olive oil Treatment

750ml Olive oil

250ml Lemongrass

Spice Tea: 3-4 drops of

Olive oil, Massage with 1 tsp

Lemongrass. Repeat every 15 minutes

My and friend 750ml (Good)

Apple - 1 tsp Epsom salt in

glass of warm water

Eye: Many have a great photo

with Olive Oil + fresh hot water spray

Apple Sprouts

Throat about Colonic Irrigation

DEY SKIN BRUSH - lymphatics

Attends up towards the heart

look/ handle her

51

-Dr. Randolph Stone

Life is a song. It has its own rhythm of harmony.
It is a symphony of all things which exist, in major and minor keys of Polarity.

NEW YORK OPEN CENTER POLARITY THERAPY PROGRAM

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POLARITY THERAPY
PROGRAM



*Become a nationally-registered
Associate Polarity Practitioner*

Energy is the Foundation of All Life.

Modern scientific research is just beginning to document this simple truth which has been the basis of Eastern medical traditions for thousands of years, and it is revolutionizing how we think about our health. Polarity Therapy is on the cutting edge of this revolution—bringing the study of energy out of the esoteric realm of quantum physics and nuclear particle acceleration into, quite literally, the palms of our hands.

Just as there are subtle electromagnetic forces which bind the parts of an atom together, there are subtle patterns of energy which create and sustain all living things. This "life energy" expresses itself not only through our physical bodies but also through our thoughts, feelings, personal relationships, and everyday experiences. Polarity works with life energy in all of its forms, using a comprehensive system of bodywork, exercise, nutritional guidance, and verbal counseling to bring body, mind, emotions, and spirit into a state of balance, harmony, and vibrant health.

Developed by Dr. Randolph Stone (1890-1981), an osteopath, chiropractor, and naturopath who sought to integrate Eastern and Western approaches to healing into one unified system, Polarity includes elements of many healing modalities, such as reflexology, acupressure, craniosacral balancing, yoga, and Ayurveda. But Polarity is more than just a collection of techniques—at its heart is a set of principles about the balance and flow of life energy which Dr. Stone believed to be the underlying essence of all healing arts. This is attested to by the growing number of health care professionals, such as nurses, chiropractors, physical therapists, creative arts therapists, and massage practitioners, who are successfully incorporating Polarity Therapy into their work.



Through the Open Center's Polarity Therapy Program, you will learn how to work with the whole person, combining bodywork skills with techniques for addressing the mental and emotional aspects of health. Our curriculum, designed by the International Polarity Wellness Network, has been developed over 15 years and is accredited by the American Polarity Therapy Association (APTA). This curriculum is unique in its focus on hands-on learning, its in-depth exploration of the body/mind relationship, and its emphasis on personal growth.

The program is open to bodyworkers and other health care professionals as well as to anyone wishing to enhance their own healing and growth process. It is designed so that courses may be taken separately or as part of our 165-hour associate-level program. Graduates of the full program are eligible to join the APTA as

Associate Polarity Practitioners, the first level of training recognized by the APTA, and to continue on for advanced Polarity training* at the New York Open Center as well as at any of the many Polarity Wellness Network schools throughout the US and Europe. Students who have taken Polarity Wellness Network classes elsewhere are also welcome to complete their training through the New York Open Center.

*The APTA recognizes two levels of Polarity education: the first, requiring a minimum of 155 hours of APTA-accredited training, leads to registration as an Associate Polarity Practitioner (APP); the second requires an additional 460 hours of accredited training and leads to registration as a Registered Polarity Practitioner (RPP).

POLARITY THERAPY
PROGRAM

Basic Polarity I

introduces the basic principles of energy flow. You will learn the Polarity General Session, a complete bodywork protocol for balancing the flow of life energy. Emphasis is placed on developing the art of touch and understanding the relationship between body, mind, emotions, and spirit in the healing process.

Instructor: Anne Seham, RPP

Basic Polarity II

is an in-depth exploration of Polarity energetics and the expression of life energy through the Five Elements—Ether, Air, Fire, Water, and Earth. You will learn bodywork sessions for balancing each element and the basics of Polarity exercise and nutrition. Emphasis is placed on self-discovery—for it is through understanding the activity of elemental energies in our own lives that we are able to work with these energies in others. (Prereq: Basic I)

Instructor: Lisa Schimski, RPP

Polarity Reflexology

explores the relationship between Polarity Energy currents and reflex points on the feet, hands, and ears used to stimulate and tonify glands and organs and release tensions throughout the body. The protocols taught can be used either on their own or combined with other techniques within a Polarity session.

Instructor: Lisa Schimski, RPP

Basic Polarity Counseling Communication Skills for Bodyworkers

focuses on the body/mind relationship. It combines Polarity energy principles with techniques drawn from NLP, Gestalt, Bioenergetics, and others. Emphasis is placed on integrating verbal work with bodywork and on exploring the energetic meaning of physical postures, movements, and responses.

(Prereq: Basic I; enrollment in Basic II)

Instructor: Anne Seham, RPP



Evaluation & Preparation for Practice

introduces you to the practice of Polarity at a professional level and gives you an opportunity to integrate verbal and non-verbal skills learned in other classes to energetically assess your clients' needs and establish a healing intention for your work. Other topics include: guidelines for effective recordkeeping and how to energetically prepare and care for oneself as a practitioner. (Prereq: Basic I & II; Basic Counseling)

Instructor: Gary B. Strauss, MS, RD, RPP

Polarity Clinic

gives you an opportunity to work with clients under the guidance of senior practitioners and teachers. Discussions following each practice session address issues related to establishing a successful practice, such as scheduling, session strategies, time management, handling money, self-evaluation, etc.

(Prereq: Basic I & II; Basic Counseling)

Supervision

is an opportunity to review techniques and to discuss issues that come up during your practice with clients. Each supervision group, led by a senior practitioner, is limited to 8-10 students. In this small group setting, students present case studies, benefit from in-depth peer and instructor feedback and support, and develop a clearer vision for their work.

(Prereq: Basic I & II; Basic Counseling)

Program Policies & Completion Requirements:

Basic Polarity I and Polarity Reflexology may be taken by anyone regardless of previous training or experience. Prerequisites for Basic Polarity II and Basic Polarity Counseling may be waived for those with previous bodywork training with the permission of the instructor.

Students intending to participate in the professional portion of the program (Evaluation, Clinic and Supervision) are expected to practice regularly, complete all class assignments, and attend all scheduled classes (or make prior arrangements with the instructor to make up for any time missed). Requirements for successful completion of the full program also include: 30 documented Polarity sessions given (including clinic sessions), 5 sessions received from Registered Polarity Practitioners, and the recommendation of your teachers.



For further information on program costs, registration and class schedule (including upcoming mini-workshops and free introductions), please check the enclosed information sheet and The New York Open Center catalogue, or call Wellness Services at (212) 274-1829.

Primary Faculty

Lisa Schimski, BA, RPP, has been practicing the art of Polarity since 1986. A graduate of the New York Polarity Wellness Center, her background also includes a BA from Sarah Lawrence College and years of intensive study in the fields of anthropology, medical sciences, naturopathic and Oriental medicine, and massage. She has taught extensively at schools throughout the U.S. Along with her private practice, she is the program director for the Polarity Program.

Anne Seham, RPP, is a graduate of the New York Polarity Wellness Center. In addition to her private practice in Brooklyn Heights, she has taught extensively at the New York Polarity Wellness Center and at other schools throughout the greater metropolitan area.

Gary B. Strauss, MS, RD, RPP, has been teaching Polarity for over 15 years and has trained thousands of students throughout the US and Europe. Gary founded Polarity Healing Arts of Santa Monica in 1986. He has been honored by the American Polarity Therapy Association for his contribution to Polarity.

Guest Teachers

Thea Keats Beaulieu, BA, RPP, holds a degree in English and Dance from the University of Wisconsin. As a principle dancer for the Isadora Duncan Dance Company of New York and San Francisco, she has traveled around the world and has taught extensively throughout the US and Europe. She is the author of *The Color Love Journal*.

John Beaulieu, ND, PhD, RPP, is the founder of the New York Polarity Wellness Center and the International Polarity Wellness Network. He has taught extensively throughout the US and Europe for over 20 years and is author of *Music & Sound in the Healing Arts* and *The Polarity Therapy Workbook*. He is also co-author of the APTA's Standards for Practice.

All faculty are certified Polarity Wellness Educators and APTA-Registered Polarity Practitioners.

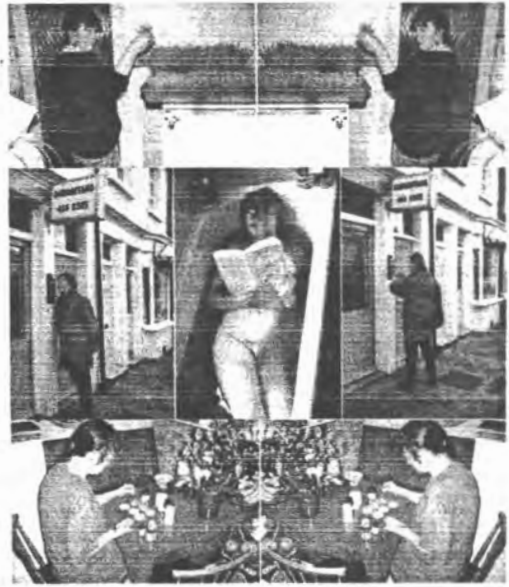
Jo Spence



Jo Spence/Maggie Murray
Alternative Health Treatment
Using Traditional Chinese Medicine, 1984



Jo Spence/Rosy Martin
Infantilization, 1984



Jo Spence/David Roberts
Epic Journey from the Leukemia Diary Series, 1991-2

2 tablets Monday 25 SEP

Orthadren C - 6 today.
10 tomorrow

if get diarrhea call
took 2 + 2 + 2 before bed.

Colloidal Silver - Tablespoon
p/day

for 1 week.

Then 1 teaspoon a day
till bottle finished.

Adrenucleo - 6 per day
till bottle finished

SOD's → 20 per day
control's free radicals.
minimum 8 per day ^{Anti}oxyme

Cats Claw - 6 ^{Monday 25} per day
then 10 per day
NB aloe - 6 per day

shark cartilage - 4 per
day
then 8 per day

algae -
2

COQ10 3 per day

Fatty Acid Liquezyme
2 in each juice

Unseed Oil - Natural
remedies store - Evelyn
Lymph Liquezyme - 3 teasp
per day

~~ENZIMUNE~~ **ENZIMUNE** 619752

Blue green Algae 619876

Antioxyme 619020

Orthadren C 627623

Lymph Liquezyme
629266

Fatty Acid Liquezyme
619817

Adrenucleo 619604

Enzyme - 6 ^{Monday 25} or
SEP
* 8 per
day

Selenium - 2 per day

e - 3 per day
2

multi vit - 2 per day

Beta Carotene

3

B compound 3

	Lymph Liquezyme 3 tspn p/day	Fatty acid Liquezyme 1 in e juice	Enzyme* 8 per day	Antiozyme* (SOD) 20 p/day OR 8 per day	Adrenocor 6 per day	Vitaminic + other supplements
MON	3 tspn ✓	2 tspn ✓	4✓ + 2✓ (6)	3✓ + 2✓ (5)	2 + 2✓	
TUES	✓ + ✓ + ✓	1 + 1	2✓ + 2✓ + 2✓ + 2 (8)	2✓ + 3✓ + 3✓ + 2✓ (10)	2✓ + 2✓ + 2✓ (6)	
WED	/	/	/	/	/	/
THUR	/	/	/	/	/	/
FRI	/	/	/	/	/	/
SAT	/	/	/	/	/	/
SUN	/	/	/	/	/	/
MON	→ only 3 per day of everything					
SAT	12 OCT					
SUN	Finished					

• ENZYME • BLUEGR ALGAE • ANTIOZYME • C

	e 3 p/day	orthadren C 10 per day	B compound ?	Beta Carotene ?	multivitamin 2 per day	Selenium 2 per day	Week 2 Colloidal silver 1 Tbsp p/day + 10 p/day til bottle finish week 1
MON	2✓ + 1✓ (3)	4✓ + 2✓ (6)	3✓	4✓	2✓	2✓	1 Tbsp ✓
TUES	① + 1✓ + 1✓	3✓ + 3✓ + 2✓ + 2✓	1✓ + 1✓ + 1✓ (3)	1✓ + 1✓ + 1✓	1✓ + 1✓	1✓ + 1✓	1 Tbsp ✓
WED	/	/	/	/	/	/	/
THUR	/	/	/	/	/	/	/
FRI	/	/	/	/	/	/	/
SAT	/	/	/	/	/	/	/
SUN	only 3 p/day of everything						

25 SEP 95

	Blue Green Algae 4 p/day	Cats Claw 6 per day then 10 per day	Shark Cartilage 4 per day then 8 per day	Alo 6 per day	Powder 2mg 3x p/day	tea 1 cup p/day
MON	2✓	2✓ + 2✓	2✓ + 2✓	2✓ + 2✓	∅	✓
TUES	1✓ + 2✓ + 1✓	2✓ + 2✓ + 2✓	1✓ + 1✓ + 1✓ + 1✓	2✓ + 2✓ + 2✓	x1. x2	✓
WED		⊕	⊕	⊕		
THURS						
FRI						
SAT						
SUN						
MON						
Sat	→ only 3 p/day of everything			6 p/day	4 p/day	

LIST OF PRODUCTS FROM ENZYME PROCESS

① ENZYME - SHARK CARTILAGE 619607

9190732

② ENZYME 619752

9163777

③ Colloidal Silver 607615

434727

④ Anti Oxime 619620

cell phone
083275279

⑤ Aloe Vera capsules 619868

CULEMBORGS
hill lepm
old railway
arriving at
old station

⑥ Adrenuco 619604

⑦ catsclaw root 619825

⑧ B+ 619639

ENZ 9
NATURES
CO Q10
30mg → 3 per day

⑨ Lymph liquezyme

is this a different
products.

⑩ fatty Acid Liquezyme 619817

⑪ Vitamin C - Orthadren C1000 627623

⑫ KLAMATH (Blue green Algae) 619872

Thymus Liquezyme

⑬ ALSO GELATIN CAPS. + VITAL CATALOGUE + Address BOOK

Do Zinc
o Vit C
o B Vit

gSH

Fatty acid deficiency - dry skin
irritable bowel
concentration

Fish oil, linseed
calcium, mag, zinc → immune function.

↑
exhaustion

Patrick Holford - Optimum Nutrition

WFC - 3-6 g p/day - cancer.

Vit A - lungs, night vision (carrots)

B - insulin, mechanism of cells, adrenalin

VM24 - R15

Organic vitamins → food state → molecular size
1. cellolition 2. microplasma technology - vitamins for
cancer absorption



cod liver oil - vit A, E in it.

Flax seed, linseed - concentration, memory,
dry skin.

* Barley grass - immune boosting
energy
(carries a huge range of vitamins)

* take supplements

- vitamins a little before food.
- minerals better taken w food.

disease is part of life.

antioxidants - prevent free radicals formation
ACE selenium prevent inst of cancer.

MINERAL AND VITAMIN CHART

- See Page 21 for an explanation of antioxidants
- legumes — beans, peas, lentils
- wholegrains — brown, unsifted or unrefined grains such as maize, millet, sorghum, rice, wheat, barley, oats and rye

Nutrient	Food sources	Use in the body	Symptoms if deficient
Vitamin A	all yellow and orange fruit and vegetables, alfalfa, milk, garlic, green vegetables, egg yolk, liver	to make white blood cells, for vision, healthy skin, teeth and bone development, protection against infection, antioxidant	eye problems and night blindness, sensitivity to light, scaly and dry skin and hair, poor teeth and nails, colds
Vitamin B ₆	sunflower seeds, wholegrains, seeds and nuts, cabbage, eggs, leafy green vegetables, alfalfa, banana, liver, legumes, chicken, meat, fish	breakdown of protein and fats, production of antibodies and red blood cells, production of protein and nerve transmitters, antioxidant	tiredness, anaemia, irritability, depression, sore tongue, nausea, muscle twitching, dizziness, skin problems, nerve problems
Vitamin B ₁₂	seafood, liver, kidney, heart, sardines, wholegrains, tuna, yogurt, eggs, cheese, meat, chicken	formation of red blood cells, affects white blood cells, maintains nerve and gastrointestinal tissue	tiredness, anaemia, confusion, numbness, nerve problems, ringing in ears, dementia, memory problems
Folic acid	kidney, liver, nuts, legumes, eggs, green vegetables, wholegrains, avocado, oranges, fish	works together with Vitamin B ₁₂ , aids red blood cell formation, for cell division and growth	diarrhoea, sore red tongue, anaemia, heartburn, fatigue, confusion, depression, dementia
Vitamin C	guavas, sweet peppers, alfalfa, leafy green vegetables, oranges, potatoes, all fruits, tomatoes	builds healthy bones, teeth and gums, helps fight infection, helps iron absorption, antioxidant	bleeding gums, bruise easily, slow to heal, anaemia, muscle and joint pain, frequent colds
Vitamin E	vegetable oils, nuts and seeds, wholegrains, eggs, legumes, dark green vegetables, alfalfa	increases disease resistance, protects fats and vitamins A and C from oxidation, prevents aging, treats scar tissue, antioxidant	tiredness, dry hair, leg cramps, infertility, muscle weakness, impotence, nerve problems, heart disorders
Zinc the mineral most deficient in people with HIV/AIDS	leafy green vegetables, seafood, oysters, nuts, meat, pumpkin seeds, milk, liver, wholegrains, egg yolk, garlic, chicken, fish, legumes, popcorn	protects the immune system, needed for digestive and immune system enzymes, muscles, wound healing, vitamin A metabolism, antioxidant	slow growth, loss of smell or taste, loss of appetite, diarrhoea, prostate gland problems, poor wound healing, skin problems, ringing in ears
Selenium	brown rice, nuts, seafood, liver, egg yolk, onions, garlic, alfalfa, meat, wholegrains, milk	prevents oxidation and breakdown of fat and other body cells, antioxidant	weakness, pancreas damage, impaired growth, heart problems
Magnesium	seafood, legumes, nuts, seeds, wholegrains, avocado, dark green leafy vegetables, avocado, potato skins	for muscles, nerves and the release of energy from fats, proteins and carbohydrates	spasms, cramps, tremors, constipation (strained bowel movements)
Iron vitamin C helps the body to take up the iron in food	meat, liver, kidneys, eggs, green leafy vegetables, seeds, wholegrains, legumes, potatoes, nuts, apricots, alfalfa, fish, seafood	needed for oxygen exchange in the blood, needed by enzymes	headaches, tiredness, irritability, pale colour, dizziness

Yan - contractive

Carrot = orange part = contractive
green part = expansive

Fried rice = left over.

rice balls - very nice for beach etc.

• NO TEMPURAH

67

Claim of cancer cure misleading

I am writing with reference to your recent article in the Life section: "Your inner journey to health" (Wednesday, April 12).

I feel it is important to point out the dangerous misconception implied by misrepresentation in the article and to spell out its effect.

The feature reports that Brandon Bays, author of the book, *The Journey*, (Thorsons 1999), claims to have healed herself of a life-threatening tumour. Your article states that she related her story of healing her cancer to the Cancer Association of South Africa in Mowbray.

Having listened to her interview on SAfm, read her book and attended her seminar, I noted with interest that not once was it specified that her tumour was cancerous. Neither does she state in her book or media appearances that she has ever been diagnosed with cancer or a malignant tumour. Nor does she state that she has not. There are other conditions that could be present in the way she describes her own condition, such as a benign tumour, a fibroid, even an ovarian cyst.

The fact that Ms Bays uses a vagueness of terminology, talks of her tumour/growth/condition, while the word, cancer, had been purposefully excluded in relating her own story, is a careful concealment of the truth. The effect is to lead people to make the assumption, as did the Cape Argus journalist, that the tumour was cancerous. The result was that by unquestionably supporting Ms Bays, the Cape Argus implied that her claim to have healed her own cancer was valid.

Why is this important?

To people with confirmed cancers, hearing stories of people who have succeeded in banishing this disease from their bodies by whatever method is extremely important. On one hand it is a story of hope and yet, on the other hand, if one cannot achieve the vanishing of the cancer as she claims to have done, it becomes a burden of failure, inadequacy and impotence.

I think it is fair to assume that most of us who live with the disease feel the same way. To allow a misconception such as the one perpetrated by your article without refutation is disrespectful and downright cruel. The fact that Ms Bays does nothing to allay this type of assumption, and has not refuted the obvious misleading information in the article, leads one to question her integrity, if not her claims.

I would appreciate a follow-up to this story. I would also expect that our leading newspaper would be more alert and diligent in fact-checking and not allow this sort of misrepresentation to creep into what are supposed to be thoughtful and factual articles of interest.

I would like you to print this letter as a caution to people who are vulnerable, particularly those who live with this disease. The world is filled with latter-day snake-oil salesmen prepared to sell us the cure to whatever ails us. The fact that the Cape Argus has unwittingly exaggerated personal and unfounded claims should make us all doubly careful as to where we put our energy and resources in trying to stay well.

Lynne Lomofsky
Bo Kaap

JOURNEY INTENSIVE WEEKEND WORKSHOPS 2001

JOHANNESBURG

DATE: Sat/Sun 21/22 April, 2001

VENUE: Theatre on The Track, Kyalami

COST: R1 250,00 (incl VAT)

CAPE TOWN

DATE: Sat/Sun 28/29 April, 2001

VENUE: Lord Charles Hotel, Somerset West

COST: R1 250,00 (incl VAT)

JOHANNESBURG

DATE: Sat/Sun June 30/July 1, 2001

VENUE: Theatre on The Track, Kyalami

COST: R1 250,00 (incl VAT)

AT THE JOURNEY WORKSHOP:

- Discover the unique process that directly accesses your Higher Self - your Soul.
- Be guided directly to the root cause (or cellular memory) of any longstanding issue - physical or emotional
- Learn to finally and completely resolve issues such as...
* Chronic pain * Anxiety * Depression * Sexual blocks * Low self-esteem * Grief * Anger * Addictions

ABUNDANCE RETREAT GAUTENG

JULY 6-8 2001

A joyous and healing weekend residential retreat with Brandon Bays for *Journey graduates only* at the elegant Kievits Kroon Manor House and country estate (20 minutes drive from Johannesburg and Pretoria).

Friday night, July 7th: Discover your silent saboteurs: deep-seated blocks preventing you from manifesting abundance in your life.

Saturday July 8th: Brandon will lead you with brilliance and ease to the point where you can finally release whatever is blocking you in a powerful Journey Process.

Sunday July 9th: From this new-found freedom, visionquest and brainstorm your heart's deepest desires and an action plan for the future.

Abundance Retreat grads often manifest VERY QUICKLY after this workshop: be prepared!

JOURNEY ADVANCED SKILLS ONE-DAY WORKSHOP:

Johannesburg

DATE: Sat 5 May, 2001

VENUE: Theatre on The Track, Kyalami

COST: R650,00 (incl VAT)

Brandon shares the advanced skills that make her own Journey one-on-one processes so powerful including the "Designer Journey Process".

NLP & POWERSKILLS OF COMMUNICATION

the ultimate user-friendly NLP workshop
with U.S.A author & communication expert

Dr Bob Bays

Date: Fri 6-10pm, Sat & Sun 9am-7pm

June 1,2,3, 2001

Venue: Delta Environmental Centre, Johannesburg

COST: R1 250,00 (incl VAT)

Learn the potent skills that Dr Bays taught in the Mastery Programmes of Anthony Robbins for 12 years. Create instant rapport and communicate effectively at home and in business; change old fears and limiting beliefs with the "six-step-reframe"; persuasively present your point of view; break through resistance in any situation. Dynamic and entertaining, Bob Bays makes self-transformation easy and fun.

BOOKING

CALL THE JOURNEY: 021-6839451 or
083 999 2330 or

email: indabalo@iafrica.com


Or Booking forms on
website: www.brandonbays.com

Credit card facility available

PROMOTION BY CARYL MORGAN
083 444 88 18

Journey to Freedom

with
BRANDON BAYS
dynamic mind-body
healing expert & author of


"The Journey"

AS SEEN ON CARTE BLANCHE

"BRANDON BAYS IS ONE OF THE MOST DYNAMIC AND
INNOVATIVE TEACHERS IN THE MIND-BODY
HEALING FIELD TODAY."



ANNOUNCING: THE JOURNEY 2001 (APRIL-JULY) WORKSHOPS!

623

Due to the overwhelming response to The Journey in South Africa, Brandon Bays has expanded her April - July tour to include several new workshops previously available only in the UK or Australia.

April 21/22	Journey Intensive	Gauteng	R 1 250,00
April 28/29	Journey Intensive	Cape Town	R 1 250,00
May 5	Advanced Skills	Gauteng	R 650,00
June 1/2/3	Dr Bob Bays : NLP & Powerskills of Communication	Gauteng	R 1 250,00
June 30/July 1	Journey Intensive	Gauteng	R 1 250,00
July 6/7/8	Abundance Retreat*	Gauteng	R 3 500,00

**Includes two nights' accommodation & meals at the elegant Kievits Kroon Manor House and country estate. For Journey Graduates only.*

Each workshop stands alone - but also forms part of the overall requirements for accreditation as an internationally recognised Journey Therapist.

WHAT PEOPLE SAY

The Journey weekend has totally changed my life. The Journey is a way to access and reconnect with Source. Jan Walker, Gauteng

"I had suffered for 25 years with serious migraine headaches. After undergoing Journey processing the headaches have completely stopped! I feel great!" Nicki Hancock, UK

"I never believed 28 years of back pain could actually leave. Not only has it gone, but so has my need to smoke and drink" Noreen Clarke, UK

"I am finally free from years of depression and enjoying a healthy life at last" Ronnie Westby, UK

"Making money used to be hard work. Now I'm amazed at how effortlessly I'm attracting everything I want" Ben Drake, UK

"Brandon filled the room with an aura of peace, joy and stillness; but above all, her purity and love radiate to everyone in her presence" Peta Heskell, UK

TO QUALIFY AS A JOURNEY THERAPIST

You need to have attended the following workshops:
Abundance Retreat: Trainer Training (the night prior to the retreat)
then qualify you to attend the one day Life Purpose workshop
with Brandon which takes place in Australia, July 14, 15, 16, 2001

THE BRANDON BAYS' STORY

Diagnosed in 1992 with a uterine tumour the "size of a football", Brandon pioneered a self-healing process called "The Journey" which enabled her body to heal completely in just six-and-a-half-weeks. No drugs. No surgery. No tumour!

CELLULAR MEMORIES

"What I realised," says Brandon, "is that I had stored in the tumour cells childhood emotions and memories that were too painful to face. It was as if I had literally put the painful memory into a package, and put a lid on it. Only when the issues were completed, healed and forgiven was the tumour able to leave."

DRAMATIC CHANGES

Life continued to shake Brandon's world apart as she describes in her dramatic best-selling book "The Journey" (Thorsons/Harper Collins). But each time she used the process to heal, let go and move on. She moved from America to the UK where her Journey work there and internationally has helped thousands to change their lives.

Are You Ready for a New Life?



Then you're ready for *The Journey* Intensive Workshop with world-renowned mind-body healing expert **BRANDON BAYS**

BACK IN SOUTH AFRICA BY PUBLIC DEMAND!
As seen on "Carte Blanche"

In 1992 Brandon was diagnosed with a basketball size tumour and found herself catapulted into a remarkable, soul searching and ultimately freeing, healing journey. Only 6 1/2 weeks later, she was pronounced textbook perfect — no drugs, no surgery—and no tumour!

The Journey was pioneered by Brandon Bays from her own dramatic personal experience. At this unique, powerful and experiential weekend you'll

work at the deepest level, directly with your 'body-memory' to clear long held emotional and physical blocks.

Chronic pain simply vanishes. Anxiety, depression and sexual blocks disappear. Self-esteem, grief and anger issues dissolve, addictions fall away and illnesses resolve and heal.

The results are profound and lasting.



BOOKING NOW OPEN FOR APRIL 2001 JOURNEY WORKSHOPS!

- You'll discover the unique process that directly accesses your Higher Self — your Soul.
- You'll resolve and heal old emotional wounds that limit your real potential.
- You'll get to the root cause of self-sabotaging behaviour — and let it go.
- You'll learn practical tools with which to create real freedom in all aspects of your life.
- You'll heal cell memories that can cause physical blocks and diseases.
- You'll begin living life as a true expression of who you really are!
- You'll get off 'automatic pilot' and let your 'inner genius' take charge of your destiny.

**CALL THE JOURNEY NOW:
0 21 - 6 8 3 9 4 5 1**

For more details/booking form:
Website: www.brandonbays.com
or email Caryl Morgan in Cape Town:
indabalo@africa.com

JOURNEY INTENSIVE WEEKEND WORKSHOPS

COST: R1 250,00 Early-bird booking price: R990,00 (only until 30 Nov 2000)

JOHANNESBURG: Sat/Sun 21/22 April, 2001 CAPE TOWN: Sat/Sun 28/29 April, 2001

plus, plus, plus: Abundance Retreat Weekend: July 2001

Apply the Journey process to clear your blocks to abundance in health, work, relationships and money!
(For Journey graduates only; also consists towards future accreditation as a Journey therapist).

The Ten Steps to The Physical Journey

Read slowly and carefully. Whenever you see "...", pause and give your partner sufficient time to fully experience and answer your questions.

1. Guide your partner into **Source**. (Sheet PJ2)
2. Take **shuttle ride** with mentor on **Journey of Discovery**. (Sheet PJ3)
3. Walk around and **explore** the region. (Sheet PJ4)
4. **Uncover** emotion and associated memory or people. (Sheet PJ4)
5. Guide partner through **Memory Process**. (Sheet PJ5)
6. Guide partner through **Campfire Process**. (Sheets PJ6 / PJ7)
7. **See** how region has changed. (Sheet PJ7 cont.)
8. Take **shuttle** back to:
 - a) **doorway where we started** (for all workshop processes).
 - b) **different part of body** (not for workshop processes).
9. If **Journeying** to a different part of body - repeat steps 2 - 8 (go back to Sheet PJ3 last paragraph)
10. **Guide** partner back to **waking consciousness** (Sheet PJ8)

Thank your partner and share your experiences of the process. Get up, walk around a little, (quietly please, others will probably still be processing!), get a glass of water - then switch.

a synchro-date with Deepak

Colleen-Joy Page Was There

a MAN WITH A MESSAGE - just add inspiration, humour and a wealth of knowledge and you have the acclaimed Dr Deepak Chopra. This man's humility and presence drew 5 thousand people around South Africa to his seminars. Within moments of his talk, it became clear that he was not here to dazzle us with fancy footwork or theatrical rhetoric, but was here with a simple and timeless message from soul, but packaged in a style that is accessible to business people and academics alike.

Dr Chopra is a bridge from the left to the right brain, from logic to abstract, the measurable to the immeasurable. His background in science and medicine wins him the credibility that takes him to otherwise inaccessible markets and it is here that he brings stories of magic, mystery and spirit to audiences around the world and Namasté was there.

On Human Rights Day, 21 March, Namasté attended the Deepak seminar at the Sandton Convention Centre. This popular event was hosted by Creative Life, sponsored by 702 and drew an audience of over 3000. It is said that Dr Chopra's work is changing the way the world views physical, mental, emotional and social wellness and this is easy to see. The 3000 delegates that packed the Convention Centre in Johannesburg experienced Dr Chopra's winning formula of taking practical spirituality into mainstream science and business.

Dr Chopra starts his lecture by calling to attention incredible, and yet largely unknown, facts about the physical world. He asserts that the mind is not local to the brain, but that the whole body is a mind, where every cell is a thinking cell, capable of communicating with all other cells faster than the speed of light, even spontaneously. Reminding us that there are 60 trillion cells in the body and that every cell does 6 trillion things per second. Being inspired by the ancient Sufi poet Rumi, Chopra begins to elegantly interweave fact with a glimpse of eternity. "The real you cannot be squeezed into a body," he says. He accuses the past world of having suffered from the "superstition of materialism", and it is clear that he intends to challenge outdated beliefs by opening modern thinking to new reality-paradigms.

His seminar hinged around a term he has coined,

"Synchro-Destiny". Using quantum physics as the basis of his reasoning, he draws metaphoric parallels between the subatomic world of quanta, and the macro world of human lives and destiny. Using colourful personal stories, Dr Chopra defines Synchro-Destiny as:

- A conspiracy of improbabilities
- Orchestrated by a-causal relationships
- Orchestrated in a non-local domain
- Causing an expansion of the Self
- Manifested through intention
- Life transforming
- Facilitating the joy experience and the desire to share this joy
- Opening you to the meaning of your existence and purpose
- Ultimately unveiling the inseparability of the inner and outer worlds



Dr Chopra believes that our thoughts and memory do not come from the physical self, but originate in the soul. "After all" he says, "the body is only recycled dust". 99,999 percent of the physical body and the entire universe, at a subatomic level, is in fact empty space. Dr Chopra asks, "What is the nothingness from whence we come?" He names the nothingness as soul. In the world of soul nothing is random; nothing is isolated; reality is multi-dimensional; the universe is conscious, alive and intelligent. Meditation is sighted as crucial to our ability to access this world of soul.

The key to aligning with your personal Synchro-Destiny is awareness and learning to see the world with more than the eyes of the flesh and mind but with the eyes of the soul. When you are in a room filled with hundreds of minds you become aware of the few that are disappointed at the simplicity of his message. You also become aware of the minds that are new to any level of this work and it is with awe that we watch businessmen and women opening to magic of soul.

Thank you to Creative Life, we look forward to your continued growth and success. Visit Creative Life's website to find out about their upcoming events: www.creativelife.co.za or email cordev@mweb.co.za

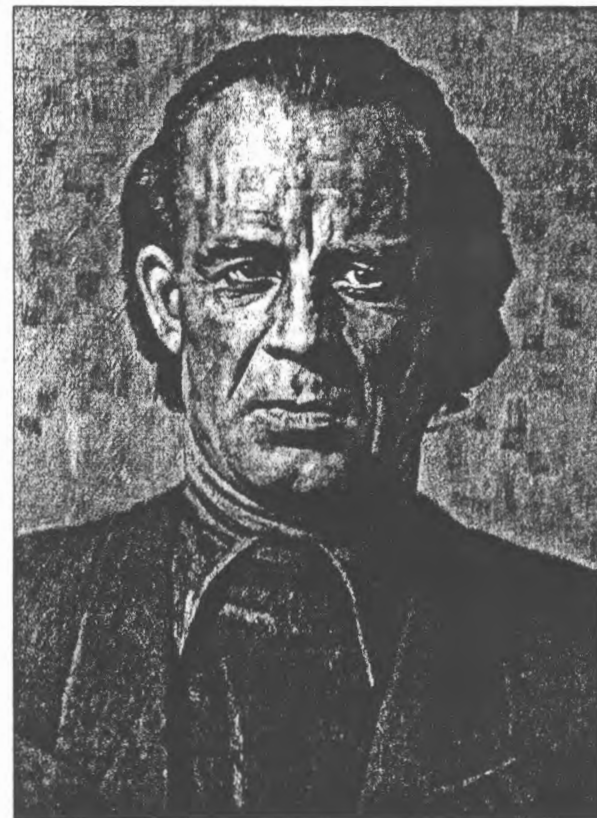


Healing **the Spiritual Way** **Medically Provable**



**AN EXPLANATORY PAPER
OF THE MEDICAL SCIENTIFIC GROUP OF SPECIALISTS
OF THE BRUNO GRÖNING CIRCLE OF FRIENDS**

Bruno Gröning *helps the suffering mankind*



*"Whoever had the high luck to get back
his health through me, is to thank
GOD
from the depth of his haert at all times
I am just His tool and servant"*

2000

Engl.

Infoschrift MWF
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Mind, Emotion, Body and Spirit: from Suppression to Healing

The anatomy of the Body-Mind-Spirit system

Dr Alta Smit

MBChB (Wit), BSc, THysc (R.A.F.S), AB 1ker (E.N)

Introduction

Disease is always purposeful. It is a message the body sends us to heed certain things that are causing an imbalance in our equilibrium. This message is given on physical, emotional, mental and spiritual levels, but we often do not heed the message because we do not know how to listen to it – or as we have learnt in modern medicine, if you shoot the messenger (the symptom), the disease will apparently go away. This is of course seldom true, as the disease mostly goes underground. Both patient and doctor alike mostly ignore this process of going underground. There is a very distinct progression of the disease process on each of these levels, but because we view the process as a series of random events, we seldom put two and two together. Only when we stand back can we recognise the pattern of progression and regression in the physical, emotional, mental, and spiritual bodies. The body will follow the same pattern towards healing as it followed in getting sick, and only by recognising and facilitating this natural process can we achieve total healing. This is not a totally new concept – the ancients described such a process a long time ago. However, in our modern quest to treat the symptom, we ignore the overall message.

The physical body

When an invader threatens the physical body, be it virus, toxin or injury, the body will mobilise the same 'army' every time as a unit in order to restore the balance. We have spoken of this defence system before as including the immune system, the hypothalamus-pituitary-adrenal axis (HPAA), the liver, the gut and the connective tissue (tissue between the cells, which is often the battleground). When this army is mobilised it secretes certain products that result in symptoms, which we see as disease. For instance, when one gets food poisoning the gut lining opens secreting chloride and other ions into the gut. This results in a shift of water, which attempts to wash the invader away, and we get diarrhoea. The body will use only what is necessary to eliminate the toxin, and as the invader goes deeper into the body it will employ bigger guns. Sometimes, as we shall see, the defence process can be so severe that

it damages the person's own tissues, and in this case suppression must be employed (including cortisone or chemotherapy) to buy time for the organism so that it can regroup. There is therefore a strong case for an integrative medical approach. The one cannot do without the other.

Order of disease progression

Constantine Hering, a contemporary of the father of homeopathy, postulated a law which describes patterns of healing in the physical body. He stated that disease resolves from the inside out, from the top of the body to the bottom, from the deeper organs to the more superficial, and very important, in the order it started. Take eczema for instance. It is on the skin, so it is on the outside of the body, therefore relatively less severe. If suppressed, it goes to deeper organs, e.g. the patient develops asthma. If it goes from the trunk to the legs, it is getting better, if it started after say flu which was suppressed, one can expect the same flu to return at some stage in the healing process. More recently Hans Heinrich Reckeweg has put this into a more modern version, in the so-called table of homotoxicosis:

Fig. 1 Table of Homotoxicosis

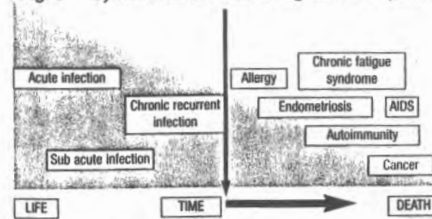
	Excretion	Reaction	Deposition	Impaired Cellular Enzymes	Degeneration	Cancer
Physical Body						

Biological Cut → SUPPRESSION

Reckeweg describes six phases. As the body has to mobilise more defence systems and as the toxins go deeper into the embryological layers of tissues, it becomes more difficult for the body to clear the invader, and sometimes it can only compensate. The more to the right of the table, the more we may need to support the body with allopathic therapy while we are helping the body's innate healing process with natural therapies.

If we use the immune system as an example, it will look as follows:

Fig. 2 Syndromes of immune regulation: Physical



We all get an acute infection at least once a year unless we are very free of toxins and feel well. The first sign that the body cannot cope is when the infection is protracted and does not clear in due time. This will also worsen if the excretion phase, say in a common cold, is suppressed. The body will then move into the reaction phase and mount an inflammation, say sinusitis, or bronchitis. If this is suppressed and the body cannot clear the infection, it will result in a deposition of toxins, and the body will continually try to clear it, causing chronic recurrent infection. At this stage the body crosses what we call the biological cut and starts to react inappropriately to innocuous toxins, and allergy ensues. The next step is chronic fatigue syndrome (CFS) or endometriosis, where cellular immunity has been impaired and the immune system has become chronically imbalanced and activated, yet is unable to fight off deep viruses such as the Epstein-Barr virus (glandular fever virus). Accordingly these viruses reactivate. They do not cause CFS, but this is again a sign that the immune system is unbalanced. The next step down the line is autoimmunity, with the immune system now attacking the body. The last phase of immune dysfunction is cancer, where the immune system can no longer clear aberrant cells. (However, this is only one of the mechanisms involved in cancer.) Using exclusively natural therapies the immune dysfunction will reverse this path towards healing. For instance, CFS patients often cannot remember when they last had a common cold with a streaming nose, yet they all have allergy, and all went through a stage of chronic recurrent infection even if it was years ago. If one starts to heal, the same pattern will emerge, and so we are very glad when a CFS patient presents with an increase in the allergy, followed by infections and lastly by epidemic colds like everybody else, i.e. an excretion phase.

Therapies which may be valuable to support and facilitate this physical healing process are, for example, clinical homeopathy (often complex or drainage therapy), acupuncture, herbal medicine, naturopathy or other therapies. It is important to note that the body will go through the same physical regression if one works from the top down, i.e. if one works on the emotional body or the spiritual body. Thus, a patient in a grief phase may get a chest infection with lots of mucous at the same time.

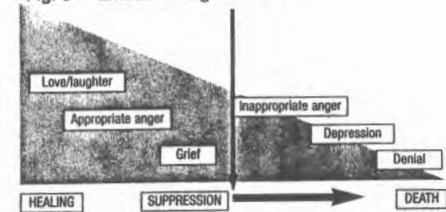
The emotional body

This is the system whose language we understand the best, as we react to the world and to others. However, society dictates behaviour, often to the detriment of the body's own emotional healing. How often do we suppress appropriate anger, as if it is not 'nice', or suppress grief because it is a shame to cry, especially men? The first thing we do after bereavement is to prescribe a tranquilizer, so that we do not see the grief.

Suppression and healing in the emotional body also follow a very distinct pattern. Until a patient with chronic disease gets angry, he or she will not heal. The anger may initially be inappropriate, as it will bring out all the old suppressed anger when the same occasion presents itself, but it must be seen in the context of healing (one can always say

sorry afterwards with honesty and integrity). All natural therapies will induce this emotional healing process, and it should not be suppressed but supported. Again, if it threatens to overwhelm, or if we want to buy time, sometimes drugs are necessary. The emotional 'disease' pattern is illustrated below:

Fig. 3 Emotional regulation



There may be an overlap of some of the phases and two phases may occur together, as the emotional body deals with several suppressed emotions at once. The emotional body may also try to communicate with us via the physical body, and the ancient Chinese made several references to this. Suppressed anger goes to the gall bladder (we even say 'it galls me'), suppressed grief goes to the lungs, worry to the spleen, etc. Think of the woman who develops asthma after the death of a child for instance. Systems of energy healing such as high-dilution homeopathy; neurolinguistic programming (NLP); hypnotherapy; acupuncture; Reiki; and African, Inca and North American medicine (to mention only a few) can offer tremendous help in facilitating this healing process. Healing will, however, follow the regression process, so expect to start crying and become angry!

The mental body

In my view we are 'over mentalised' in our society, which often hampers healing as we suffer from 'analysis paralysis'. The Internet hugely encourages this and we analyse every theoretical aspect of disease, while our emotional and spiritual bodies desperately try to communicate, and get ignored.

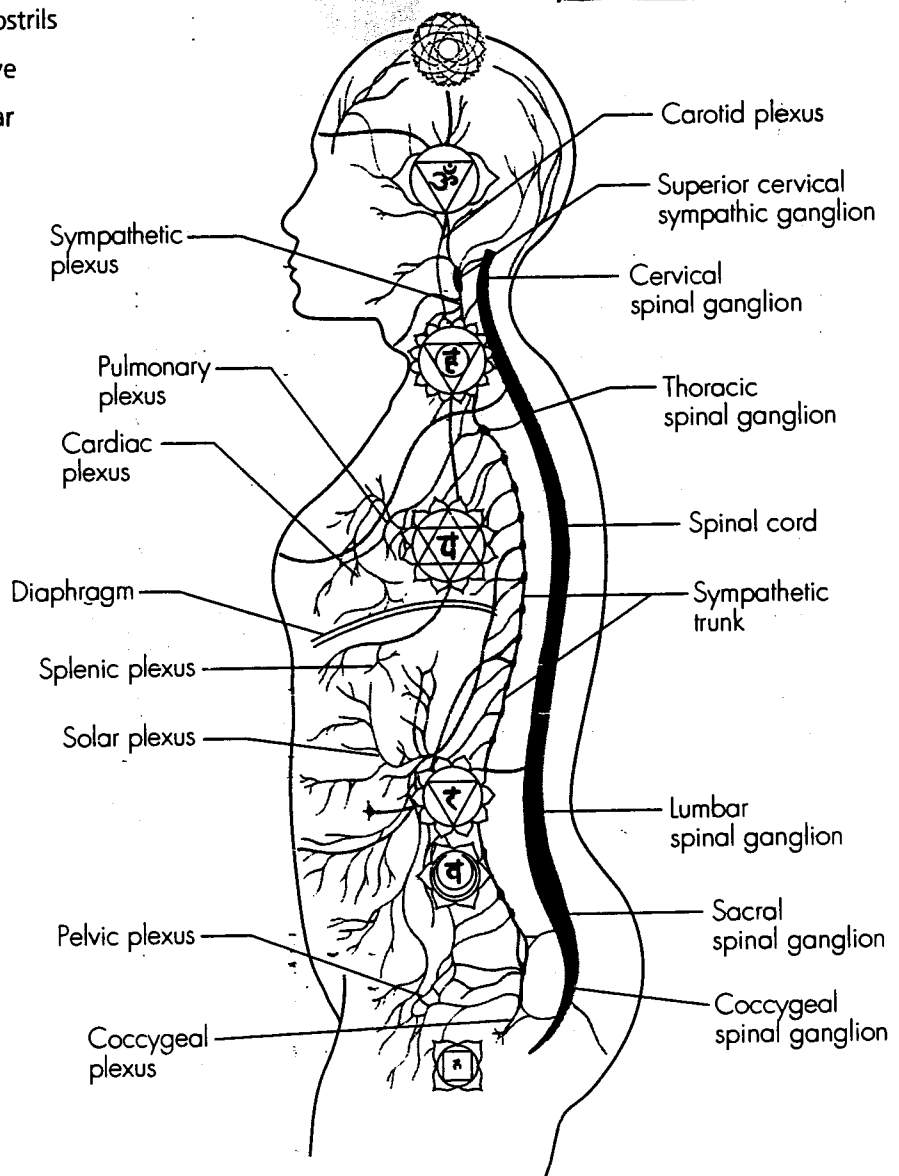
THIS ARTICLE IS CONTINUED ON PAGE 59 WITH A DESCRIPTION OF THE SPIRITUAL BODY



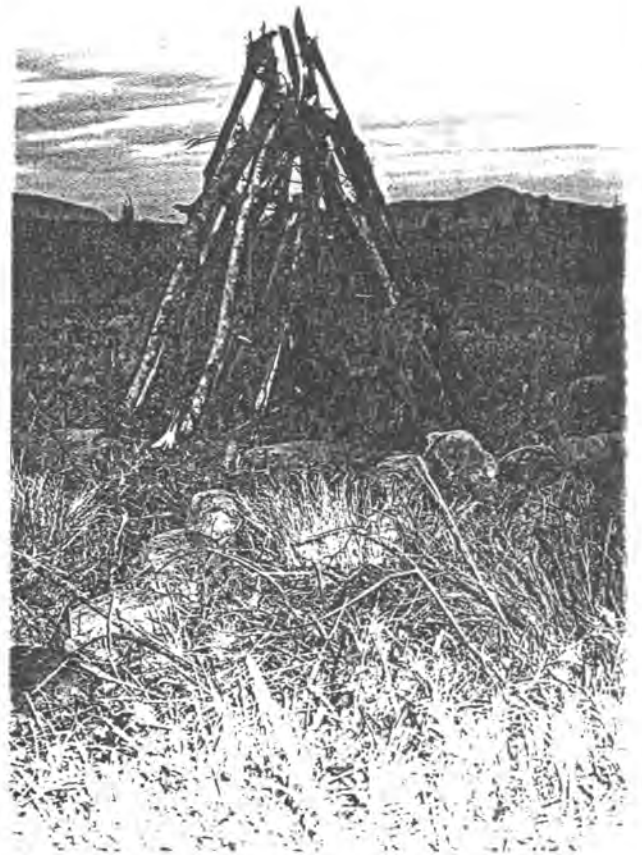
'main' nadis: Nadi means stream or energy pathway; it is the channel through which energy travels. According to yoga and Ayurveda, there are 72,000 nadis in the human body. Chakras arise where many nadis meet. This is mirrored in the nervous system: a plexus is a place where many nerves meet. The main nerve plexuses in the body are situated at the same location as the seven major chakras. There are 14 principal nadis, of which the aforementioned three are the most important. Ida represents negative energy, Pingala positive energy, and Shushumna neutral energy. ~~The ten~~ primary nadis correspond to 10 gates of the body:

- 3 right and left nostrils
- 5 right and left eye
- 6,7 right and left ear
- 8 the mouth
- 9 genitals
- 10 anus.

P. 67 opening to spirit

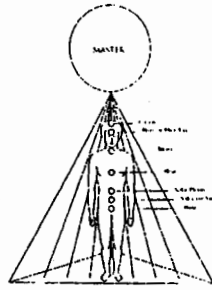


Chakras and corresponding nerve plexi



Setting your Three Dimensional Crystal Triangle Exercise

1. Relax and quieten all vibrations within yourself. Take three slow, deep breaths, inhaling all that is good and exhaling and releasing all physical, emotional and mental tensions.
2. Align yourself with all of life and all of creation, to all vibrations in the Universe, with Love in your heart. Align yourself to the Rays at the Eagle Heights Centre.
3. Draw a molecule of energy from the central shaft, and place it at your feet. See this molecule of light slowly expand outwards to form the shape of a triangle, large enough for you to sit or stand in, and strong enough to hold your weight.
4. From each corner of the triangle, draw up a line, bringing them in to form the apex of the triangle at least 30cm above your head, so that your soul star will be enclosed. This Triangle contracts and expands as you move, is not restrictive in any way, and is large enough to encompass all of your bodies. Adjust your triangle so that the base is at least 30cm below your feet, enclosing your earth-star.
5. Fill each plane of your triangle with clear quartz crystal.
6. Ask your Master or Guide (or the Universal Creative Force of Love and Light) to join you at the apex of your triangle. Visualise this as a ball or ellipse of golden light.
7. Feel the rays of pure Gold Light pour down from your Master or Guide. Fill your triangle completely with his/her Love and Light. Feel it permeate through every cell and atom of your being. Visualise your Master's rays pouring down onto you, cleansing each level of your aura—your Mental Body, your Emotional Body and your Physical Body. Visualise the Light and Love of the Master's Rays penetrating and filling each cell and atom of every part of your body. Cleanse the spine, the blood, the lymphatic system, the nerves—every cell of your being.
8. Affirm that the crystal triangle protects you from all negativity as all that passes in through the sides of the three dimensional walls are automatically harmonized and uplifted with Light and Love. You move through all places bringing Light and Love, according to the Will of God and the Laws of Nature.
9. Identify with the Soul, by repeating the Soul Mantra three times: I am the Soul, I am the Light Divine, I am Love, I am Will, I am Fixed Design.
10. Call on the soul to merge with the personality—bringing spirit into matter.
11. With your breath, project a White Light now out into your aura, forming a cocoon or bubble of white light around you. Feed the bubble of white light for a few moments, to make it strong. Expand it out to cover your local community, then project it out over your country, then your region, then the entire world, covering the world with the spiritual protection of the White Light of Power.
12. This bubble of white light will erase negative energies wherever it is lurking or attached. The negative energy will have its parasitic existence removed with your personal input of the White Light of Power.



Chakra Cleansing Exercise (To follow setting of Crystal Triangle)

1. Draw down Universal Love and Light through the top of your head, through the Crown Chakra, down to the base of the spine to the Base Chakra. Visualise this chakra as a ball of red light (vitality), pulsating slowly, gently, rhythmically, releasing its impurities through the apex of your triangle. As it is cleansed, see it becoming brighter and brighter, giving you strength and vitality.
2. Draw down the Universal Love and Light again through the top of your head down the spine into the Spleen Chakra, which is situated approx 5cm below the navel. Visualise this chakra as a ball of orange light (wisdom), pulsating slowly, gently, rhythmically, releasing its impurities through the apex of your triangle. As it is cleansed, see it becoming brighter and brighter. This is the energy of pleasure. Feel the pleasure that this energy brings you.
3. Draw down the Universal Love and Light again through the top of your head down the spine into the Solar Plexus Chakra, which is situated approx 2.5cm above the navel. Visualise this chakra as a ball of yellow light (earthing), pulsating slowly, gently, rhythmically releasing its impurities through the apex of your triangle. As it is cleansed, see it becoming brighter and brighter, bringing you happiness. Enjoy the happiness this brings you.
4. Draw down the Universal Love and Light again through the top of your head, down the spine into the Heart Chakra, which is situated in the centre of your chest. Visualise this chakra as a ball of green light (healing), pulsating slowly, gently, rhythmically, releasing its impurities through the apex of your triangle. As it is cleansed, see it becoming brighter and brighter. This is the energy of love, compassion, peace and hope. Bask in this energy.
5. Draw down the Universal Love and Light again through the top of your head, into the Throat Chakra. Visualise this chakra as a ball of blue light (Will of God), pulsating slowly, gently, rhythmically, releasing its impurities through the apex of your triangle. As it is cleansed, see it becoming brighter and brighter. This is the energy of communication. Absorb this energy.
6. Draw down the Universal Love and Light again through the top of your head, into the Third Eye or Brow Chakra. Visualise this chakra as a ball of indigo light (ceremonial), pulsating slowly, gently, rhythmically, releasing its impurities through the apex of your triangle. As it is cleansed, see it becoming brighter and brighter. This is the energy of spiritual enlightenment. Use this energy to foster your spiritual growth.
7. Draw down the Universal Love and Light again through the top of your head, into your Crown Chakra. Visualise this chakra as a ball of violet light (Divinity), pulsating slowly, gently, rhythmically, releasing its impurities through the apex of your triangle. As it is cleansed, see it becoming brighter and brighter until it sparkles like a thousand petal lotus, radiating its energy to the rest of the Universe. This is the highest spiritual energy in the human energy system. Feel yourself become one with this energy.
8. Now your whole being is filled with this radiation of Universal Love and Light. Ask your Soul to draw nearer to your cleansed form, in Harmony, Peace, Attunement and Protection.
9. Send your radiation of Love, Peace and Harmony that you have created within yourself out into the Universe. Embrace your loved ones, friends, all of humanity and all of Creation with this Love and Light.
10. You are ONE with the Universe, you are part of all that surrounds you. All that you come into contact with, all vibrations are synthesized and harmonized as they pass through the sides of the crystal and contact your cleansed and purified forms. The crystal protects you from all negativity because all that passes in through the sides of the three dimensional wall is automatically harmonized and uplifted with Light and Love. You move as a channel of your Master's Illumination and Love and Light according to the Will of God and the Laws of Nature.

About the Three Dimensional Crystal Triangle:

The three dimensional crystal triangle protection exercise was channeled through Elizabeth Kruger as an aid to humanity.

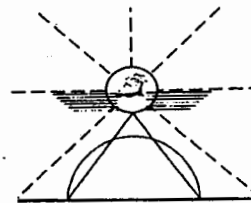
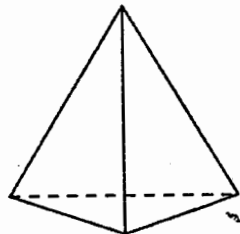
The Three Dimensional Crystal Triangle provides protection from negative energies. From the moment that the triangle is placed around you, you are instantly in the Universal Cosmic Light.

For best results, the triangle protection exercise should be used every morning and evening, and before participating in meditation. Reinforce your triangle when you meet someone with whom you feel uncomfortable. The triangle becomes stronger over time, and should be used more frequently when first starting to use it. You should be able to feel the difference within three months, however, the triangle will not become solid for around 12 months.

The triangle will protect you from negative energies, allowing only positive energies to penetrate. Negativity is only able to enter your triangle if you allow it, however, negative energy can still penetrate the triangle until it has reached it's full strength, therefore, perseverance and daily attention to the triangle is essential.

The triangle will move as you move, turning and self-adjusting continually, according to the balance required by your electro-magnetic field (aura).

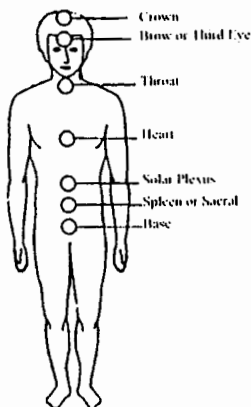
Each person needs their own individual triangle, therefore if you wish to protect your family, each person must have a separate triangle to gain individual protection. You may set triangles for your family members if they are unable or unwilling to do so themselves.



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168 Macdonell Road
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Qld 4271
Australia

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Email: spirit@eaglehtsctr.com.au
Web Site: http://www.eaglehtsctr.com.au

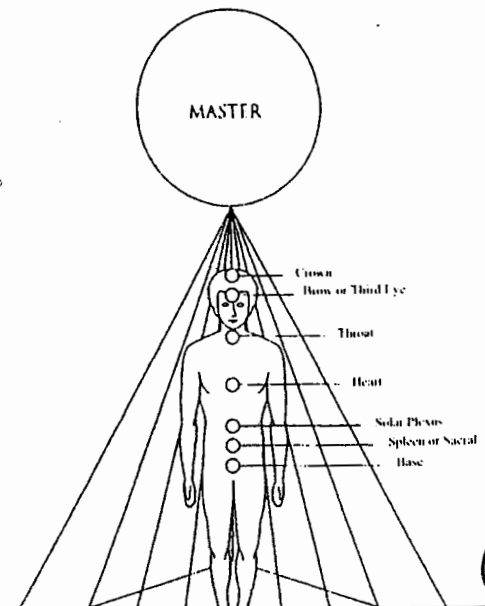
Triangle Protection And Chakra Cleansing and Alignment



The Seven Primary Chakras

Chakras are centres of consciousness and energy vortices within the human energy field. The word chakra is a Sanskrit word for "wheel" or "life force centre". They control one's emotional, mental, spiritual, physical and energetic well-being. The soul works cooperatively with our body, through the nervous system and brain, by managing the energy currents that provide us with life. Chakras receive the vital life force energy and distribute that energy to our human energy field as well as to the physical parts of the body nearest each chakra.

Well-being and balance on all levels is attained when the chakras are balanced and working efficiently with each other and with the whole system. It is generally understood that the first chakra is the root or base chakra, working upwards toward the seventh chakra—the crown chakra.



**Do Not Throw It
Try Him
In CAPE TOWN**

DR. SURAIMA MUHUSEN



Hlalohn

I have used
A lot and
Did not change



Stop Suffering Like that one

Not all can do it as he can

HEAL

Young but Powerful

Stop Suffering By Dr Sharief Maliki Ali

Diseases, Like

Domestic Problems

He is here to pay attention and to heal, treat and solve whoever has problems using spiritual powers as well as typical African and Arabic Herbs. He can also tell you all your problems before you say anything to him. Consultation fee payable is R100-00. He can treat (heal) over 40 diseases at a reasonable rate. Some of the diseases / problems he can solve are:-

Insanity, Diarrhoea, Bewitched People, One with bad luck, Men's penis which cannot erect powerfully, Women with pregnancy problems, Vomitting all the time, Asthma, Women who cannot produce, Gonorrhoea, Lack of strength in the body, To be like at work, Prevent thieves from attacking homes, shops and cars, Education, Promotion, Pressure, Diabetes, Customers attraction, Court cases, Tuberculosis, Demand debts, Removal of misunderstandings with anybody, To bring back a lost lover, Cancer, Misfortunes, Swollen body, etc...

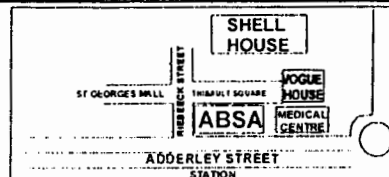
Hy is hier om aandag te skenk, te genees te behandel en op te los wie ookal probleme het deur die gebruik van spirituele kragte sowel as tipiese Afrikaaner en Arabiese kruie. Hy kan ook al jou probleme vertel voordat jy enigiets aan hom te se. Konsultasie fooie betaalbaar is et R100-00. Hy kan 40 kwale behandel (genees) teen 'n redelike tarief. Sommige van die kwale / probleme wat hykan oplos is:-

Verwansigheid, Pune op die maag, Vervloekte mense, Ongelukkige persone, Mans geslagsorgaan met verslapping, Probleme met verwagte moeders, Braak deur die mond, Asma, Vroue wat nie kan voortbring, Dodelike siektes, Tekort aan yster en vitamieni, Te bevredelik by die werk, Beheer aandoening van diewe, Edukasie, Hoer rank, Bedruk, Aandag, Gehore by die hof, TB, Vermaning van geld, Verkeerde aanmaningsmaak, Terugkeer van verloofde, Kanker, Misverstand, Verminkte Liggaam, ens...

Ulapha ukuzokunyanga, aphilise, asombulule neengxaki zabantu esebenzisa amandla omoya amayeza ase Afrikaanse Arab, Ukuxelela ingxaki zakho ungekamxeleli. Ukubona nge R100-00 Unyanga izifo ezingphezu kwamashumi amane ngethutyana. Ezinye zezizifo / Ingxaki zezizo:-

Ukuphambana, Ukurhuda, Abathakathiweyo, Ubudoda, Obungaqunelwa ngokupheleleyo, Abantu abanengxaki yokumisels (pregnancy), Ukugabu, Isifuba (Asthma), Abafazi abangazaliyo, Igcushuwa, Ukuthanwa emsebenzini, Ukuqanda abaghekezi ezindlini, motweni njl, Ezemfundo, Unyuselo emsebenzini, Iswekile (Pressure), High blood pressure njl njl, Umntsalane kubathengi, Amatyalala emthetho, Isifo sephepha (TB), Amatyalala evenkile, Ukungavani phakatha kwabantu, Izithandwa exalahlekayo, Umhlaza (Cancer), Amashwa, Imizimba edumbileyo njl njl.

Room No. 201
Vogue House, Thibault Square
Riebeeck/Adderley Streets
CAPE TOWN
Cell: 082 539 6057 -



Working Hours
Mon - Sun
8 am to 7 pm



PARASITE KILLING PROGRAM DETAILED INSTRUCTIONS

from the book THE CURE FOR ALL CANCERS by Hulda Regehr Clark, ph.d N.D.

Black Walnut Hull Tincture:

Day 1 (this is the day you begin; start the same day you receive it)

Take one drop four times. Put it in a beverage like water milk or juice. The timing does not matter. The drops can be 1 hour apart if you start at 6:00 p.m. They can be 4 hours apart if you start in the morning. Take them before meals or on an empty stomach.

Day 2 Take 2 drops four times as above.

Day 3 Take 3 drops four times.

Day 4 Take 4 drops four times.

Continue increasing in this way till you have taken 20 drops four times. After this, continue taking 20 drops once a day for 3 months. If you get interrupted, don't start over, just continue. The flukes will be dead by day 5. Don't get interrupted before day 6. After 3 months switch to Maintenance Parasite Program.

Wormwood Combination capsules:

Day 1 Take 1 capsule before supper (with water)

Day 2 Take 2 capsules before supper

Day 3 Take 3 capsules before supper

Continue increasing in this way to day 14. You take the capsules all in a single dose (you may take a few at a time until they are gone). Then you do 2 more days of 14 capsules each. After this, you take 14 capsules twice a week, such as on Monday and Thursday forever, as it states in the Maintenance Parasite Program. Try not to get interrupted before the 6th day, so you know the intestinal flukes are dead. After this, you may proceed more slowly if you wish. Many persons with sensitive stomachs prefer to stay 2 days on each dose instead of increasing every day. You may choose the pace after the sixth day.

3. Cloves. Fill size 00 capsules with ground cloves: if these are not available, use 0 or 000. In a pinch, buy gelatin caps and empty them or empty other vitamin caps

Day 1 Take one capsule 3 times a day before meals

Day 2 Take two caps 3 times a day

Days 3, 4, 5, 6, 7, 8, 9: Take 3 caps 3 times a day. After day 10, take 3 caps once a day for 3 months. Then take 3 caps twice a week forever, as in the Maintenance Program.

MAINTENANCE PARASITE PROGRAM

Twice a week (any two days will do) take:

1. Black Walnut Hull Tincture: 30 drops once a day on an empty stomach, like before a meal.
2. Wormwood Combination caps: 14 caps once a day on an empty stomach.
3. Cloves: 3 caps once a day on an empty stomach
4. Take ornithine and arginine as needed, if available. May be difficult to find in Canada (amino acids sold separately)

You may take these at different times in the day or together. The only after-effects you may feel are due to dead parasites. If this maintenance treatment gives you any noticeable after-effects on the same day or next day, it means indeed you killed something, and you shouldn't wait 3 more days to resume killing it. Go after it immediately with the high dose program for three days in a row. You will know it is gone when there are no after effects from the high dosage program.

HIGH DOSE PARASITE PROGRAM

Do this at least twice a year while on the maintenance parasite program. Take for three to five days in a row.

1. Black Walnut Hull Tincture: 30 drops twice a day on empty stomach.
2. Wormwood Combination caps: 14 caps once a day on an empty stomach.
3. Cloves: 3 caps three times a day on an empty stomach
4. Ornithine and arginine (500 mg) as desired

CHILDREN'S PARASITE PROGRAM

Children follow the same parasite program as adults, but do not increase their dosage beyond one day for each year age. For instance a six year old would not increase beyond day 6. Children still stay on the parasite program for the same length of time. Maintenance also consists of their highest dosage twice a week, and a high dose program is three to five days of their highest dosage.

You may take these at different times in the day or together. There are NO side effects to these herbs at these dosages.

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PROPYL ALCOHOL POLLUTED PRODUCTS

THROW THESE OUT

*SHAMPOO - even health brands

*HAIR SPRAY and MOUSSE

*COLD CEREALS

*COSMETICS (unless the label does not have any "prop" ingredients)

*store bought and bottled water

*store bought fruit juice

*rubbing alcohol

*mouth wash

*all shaving supplies including after shave

*carbonated beverages

*decaffeinated coffee, (Postum, herb tea blends) single herb teas OK

*white sugar

BENZENE POLLUTED PRODUCTS

*flavoured food (yogurt, Jello, candies, throat lozenges, store bought cookies)

*cold cereal

*hand cream, skin cream, moisturizers

*toothpaste, including health brands

*beverages including bottled water and store bought water

*Vaseline products (noxema, vick's, lip therapy) chap stick and hand cleaners

*Tea Tree oil products (Melaluca)

*Cooking oil and shortening (use olive oil butter and lard)

*Ice Cream and frozen yogurt

*chewing gum

*personal lubricant, flavoured pet food for both cats and dogs

CHORIONIC GONADOTROPHIN URINALYSIS

Immuno-Diagnostic Test for Cancer

ROY CUISON, M.D.
6005 Medical Arts Bldg.
University of Santo Tomas
Manila, Philippines

UPDATED
DIRECTIONS FOR URINE TEST

1. From an early morning urine take 100 cc (3.5 oz.) and add 400 cc (14 oz.) of acetone (from a paint store or apothecary) and 15 cc (0.5 oz.) of alcohol, either rubbing or ethyl. Stir and mix well.
2. Let stand in refrigerator for 2 hours until sediments are formed. Throw off about half the urine-acetone mixture without losing any sediments. Filter the remainder through coffee filter paper or laboratory filter paper.
3. When filtration is over, dry the filter paper with its sediments. Fold and send by air mail to my Manila address. Send \$35 to Erlinda Suarez, 631 Peregrine Dr., Palatine, IL 60067. Send a xerox copy of money order or cashier's check to my Manila address.
4. Make sure the name of the patient is on the envelope along with his/her address. Give sex and age of patient and one sentence about patient's symptoms or diagnosis.
5. PRECAUTION: No sexual contact 4-5 days for females before collecting urine for the test. For males, 18-24 hours is needed. Do not send urine of pregnant women.

INTERPRETATION OF READINGS
of Chorionic Gonadotrophin Urinalyses

<u>Index</u>	<u>Int. Units</u>	<u>Reading</u>	<u>Interpretation</u>
0	zero	(-)	Negative
1-3	1-49	(±)	Doubtful
4	50-400	(/)	Faintly Positive
5	401-999	(//)	Definitely Positive
6	1000-3000	(///)	Moderately Positive
7	3001-5000	(////)	Markedly Positive
8	5001-10,000	(/////)	Very Markedly Positive
9	over 10,000	(/////)	Excessively Positive

Foods That Fight Cancer

You'll be surprised at how many may provide protection

By JEAN CARPER

DIET is now considered a major weapon against cancer. The US National Cancer Institute estimates that about a third of cancers are linked to diet, and recent research indicates that what you eat may help reduce your risk significantly. Cancer develops over a long time, which means you have years—usually decades—to hinder or promote it. Researchers are finding that what you eat may interfere with cancer growth at various stages. For example, certain foods can block the chemicals that initiate cancer. Antioxidants, found in some vitamin and minerals, can snuff out oxygen free radicals, substances that are thought to make cells more susceptible to cancer, and can even repair some of the cellular damage that has been done. And some food—wheat bran in particular—has been shown to block precancerous cells

A recent review of 170 studies in 17 nations reveals that people who eat the most fruits and veg-

etables have about half the cancer rates of those who eat the least. That includes cancers of the lung, colon, breast, cervix, oesophagus, oral cavity, stomach, bladder, pancreas and ovary. In fact, some research suggests that frequent consumption of fruits and vegetables can cut the risk of lung cancer, even in smokers. "It is almost mind-boggling," says Tim Byers, an epidemiologist, "that ordinary fruits and vegetables can be so effective against such a potent carcinogen as cigarette smoke."

One of the most studied antioxidants in vegetables and fruits thought to protect against cancer is beta-carotene, concentrated in deep-green, yellow and orange vegetables such as carrots, sweet potatoes and spinach. Fruits high in beta-carotene include apricots and melons. In test-tube studies at

disease. In animal studies, soybean constituents have been found to block colon, skin and other cancers by possibly slowing the growth and division of cancer cells.

Dried and canned beans—chickpeas and lentils, and kidney, pinto, navy, black, pink and white beans—contain possible anti-cancer agents as well. A study of Seventh-Day Adventists showed that those who ate beans weekly were 40 per cent less likely to die of pancreatic cancer than those who ate them less than once a week.

Wheat Bran. Wheat bran may lower the risk of colon cancer. A double-blind study of patients at The New York Hospital-Cornell Medical Centre found that two 28-gram servings of wheat-bran cereal a day caused premalignant colon polyps to shrink within six months. Most remarkable, say researchers, is that such a small amount of food could have such an impact within a short period, illustrating that dietary intervention may work even after precancerous warning signs have appeared.

Low-Fat Milk. While the saturated fat in milk seems to promote certain cancers, another substance in milk may combat them. Researchers discovered that drinkers

of whole milk, about 20 per cent of total daily energy intake, had a 50 per cent lower risk of stomach, colorectal, lung, breast and prostate cancer. But they also had a 20 per cent higher risk of coronary heart disease. It is likely that the milk's fat is not the cause of the cancer risk, but rather the calcium and vitamins A, C and D (present in whole milk, too, but apparently less effective) may act as anti-cancer agents in ways not yet understood.

TO OBTAIN the most cancer-protective compounds from your diet, strive for five or more servings of fruits and vegetables daily, advises the US National Cancer Institute. One serving means half a cup (115 grams) of most cooked or raw fruits or vegetables, one cup (about 225 grams) of raw leafy vegetables, one medium piece of fresh fruit, or 170 millilitres of fruit juice or vegetable juice. The ideal diet is low in fat and kilojoules, high in fibre, and includes a variety of nutrient-rich foods such as fruits, vegetables, whole grains, beans, seeds, nuts and, if desired, low-fat animal proteins.

CONDENSED FROM FOOD—YOUR MIND'S MEDICINE © 1991, JANE O'NEILL, HUFFINGTON

Reprints of this article are available. Send a self-addressed stamped envelope to: Reprints, 130 Strand Street, Cape Town, 8001

FOODS THAT FIGHT CANCER

cell progression. A recent German study found that ajoene, a garlic compound, is toxic to malignant



cells. Garlic may also antagonize existing cancer by boosting immune functions, according to researchers at Loma Linda University School of Medicine, California. Their study on mice found that garlic's sulphur compounds increased the activity of macrophages and T-lymphocytes, two components of the immune system that destroy tumour cells.

Citrus Fruit. "Eat oranges, grapefruits, lemons and limes as often as possible," says toxicologist Herbert Pierson. He calls citrus fruit an all-round cancer package, because it possesses every class of natural substance (carotenoids, flavonoids and others) that individually have neutralized powerful chemical carcinogens in animals.

Citrus fruit may be particularly effective in reducing the risk of pancreatic cancer. One study found that in a group of Swedes, those who ate citrus fruit almost daily reduced the risk of pancreatic cancer by a half to more than two-

thirds, compared with eating citrus fruit less than once a week.

Cruciferous Vegetables. Cruciferous vegetables, such as cabbage, cauliflower, Brussels sprouts, broccoli, kale, mustard greens and turnips, may reduce the risk of breast cancer. In fact, researchers found that feeding animals cabbage and collard greens (also a cruciferous vegetable), with a low-fat diet, reduced the incidence of mammary cancers. Eat cruciferous vegetables raw or lightly cooked. Overcooking may destroy the indoles, compounds found in these vegetables that may protect against cancer.

Cruciferous vegetables may also work to head off stomach and colon cancer. Research has revealed that men who ate the most cruciferous vegetables had a 70 per cent lower risk of colon cancer than those



who ate the least.

Soya Beans. Soya beans contain at least five compounds believed to inhibit cancer. In fact, one of the compounds is chemically similar to the drug tamoxifen, routinely used to treat oestrogen-dependent breast cancer, and now being tested in a large clinical trial to see whether it can prevent the

Harvard University, beta-carotene had a direct toxic effect on cells taken from malignant tumours. It also reduced the growth of lung-cancer cells and altered the pro-



teins needed for tumours to grow. Research also shows that beta-carotene can change in the body to retinoic acid, a substance used in clinical trials to treat certain types of cancer.

Here are some of the foods that contain cancer-fighting chemicals: **Tomatoes.** A compound in tomatoes thought to reduce cancer risk is lycopene, the pigment that makes tomatoes red. An antioxidant also found in apricots and watermelons, it destroys certain cancer-triggering oxygen free radicals.

Having little lycopene in your blood is associated with a higher risk of pancreatic cancer, according to a study at Johns Hopkins University. People with pancreatic cancer showed lower levels of lycopene than healthy individuals. Those with the least blood lycopene had over five times the risk of pancreatic cancer as healthy people with the most blood lycopene.

Lycopene is present in tomato products, including tomato paste and even tomato sauce.

Green Vegetables. A recent Italian study showed that dark-green leafy vegetables lower the risk of many cancers. Spinach, broccoli, kale (a type of cabbage) and dark-green lettuces are chock-full of antioxidants, including beta-carotene, folate and lutein. A good rule of thumb: the darker the vegetable, the more antioxidants within.

Pungent Preventives. A whole host of chemicals thought to have cancer-inhibiting properties have been identified in allium vegetables, which include garlic, onions and



scallion. Animal studies show that many of these chemicals block carcinogens that have been linked to colon, stomach, lung and liver cancer. A study at Pennsylvania State University found that feeding rats various garlic extracts, and preparations reduced mammary tumours by as much as 71 per cent. In humans, studies suggest that those who eat more onions and garlic are less prone to gastrointestinal cancer. Research suggests that garlic compounds may even interfere with can-

A BALANCED DIET

The following diet can stimulate biological changes, therefore, it is best to change from a conventional eating pattern to the new diet gradually to allow the body to become accustomed to the change.

This diet can displace poor quality material which has accumulated in the cells with better quality material. The displaced material is a waste product which the body might need help eliminating or the body may become toxic. The most recommended procedure by doctors using nutritional programs in their practice is to use enemas or laxatives for colon cleansing. Toxicity is to be **avoided**.

Foods to eliminate from the diet: coffee, tea, sugar, white flour, white rice, milk, oils, liquor, fried foods, meat from animals that have been raised with hormones or antibiotics, citrus, vitamins that are not indicated for you specifically, salt, cocoa, over-processed foods, foods with additives. Drugs are to be **avoided**.

Foods to use: Raw vegetables (some in the form of juices, made by using a vegetable juice extractor), fruit, whole grains, lightly cooked vegetables, sweet potatoes, white potatoes, beans, clabbered milk or yogurt, about 46 grams of protein for a female or 56 grams for a male, small amount of poached fish, nuts, herb teas, nut milks, vegetable soup, avocado, sprouts. About 70% of the diet should be raw, especially vegetables.

SAMPLE MENU

Breakfast: A glass of mixed vegetable juice (mostly carrot). Fruit with clabbered milk or yogurt. Thermos-cooked cereal (with soaked raisins or dates) or an organic egg, soft-boiled or poached only.

Lunch: Mixed vegetable juice. Salad (use a variety, such as, cabbage or lettuce (not iceberg), grated beets, apple, nuts or cheese, etc.). Baked potato or beans a half-hour after the salad. Fruit for dessert.

Supper: Mixed vegetable juice. Salad. Small piece of fish. Soup.

Snacks: Dates filled with raw almond butter or unroasted nuts rolled in coconut. Raw nuts and seeds. Nut milk. Ripe frozen banana blended to simulate ice cream.

EAT ONLY WHEN HUNGRY. DO NOT OVEREAT.

SUPPLEMENTS:

Before meals: 3 pancreatic enzymes (GR)*

With meals: Green Life (SB)*, 3 or 4 tablets each meal or Dr. Bernard Jensen's Whole Life Food Blend, 1-2 tsp. per day

After meals: Pancreatrophin (SP)*, Hepatrophin (SP)*, Thymus (SP)*

* GR - General Research Laboratories. *SB - Sonnebrand. *SP - Standard Process Laboratories.

Book recommendations: *Recipes for Life* by Ann Wigmore, *Eydie Mae's Natural Recipes* by Edie Mae Hunsberger, *Seeds and Sprouts for Life* by Bernard Jensen, *Diet and Salad Suggestions* by Dr. N.W. Walker, *Fresh Fruit and Vegetable Juices* by N.W. Walker.

Use distilled water (no fluoridated or chlorinated water should be used)

Use stainless steel cookware or pyroceram. **DO NOT USE ALUMINUM!**

ALKALINE FOODS LISTED IN GREEN

FOOD CHART

ACID FOODS LISTED IN RED

CLASS ONE Protein (Cell Builder)	CLASS TWO Mineral Salts or Digestive Juices Percentages Indicate Carbohydrate Value		CLASS THREE Carbohydrates—Starches and Sugars (Muscle Energy)	CLASS FOUR Hydrocarbons—Fats and Oils (Nerve Energy)
<p>A. Fish Proteins Chicken Duck Turkey Lamb Beef Venison Gelatin</p> <p>Fish Flounder Haddock Halibut Salmon Mackerel Pike Tuna Trout Crab Lobster Shrimp Oysters</p> <p>Non-Fish Eggs Yolks (6 oz.) Whites (1 oz.) 2 Whole Eggs (4 oz.)</p> <p>Dairy Products Yellow Cheese Cream Cheese Cottage Cheese Goat's Cheese Goat's Whey</p> <p>Nuts Almonds Almond Butter Soybeans Peanuts Peanut Butter Macaroni</p>	<p>5% Fresh Vegetables Artichokes Asparagus Beet Greens Broccoli Cabbage Cauliflower Celery Cucumber Dandelion Greens Egg Plant Endive Kale Leeks Lettuce Mushrooms Onions (Green) Parsley Peppers (Green) Radishes Rhubarb Sauerkraut Spinach Squash (Summer) Swiss Chard Tomatoes Watercress</p> <p>10% Beans (Green) Beets Brussel Sprouts Carrots Kohlrabi Okra Onions (Dry) Pumpkin Rutabaga Soybeans Squash Turnips</p> <p>15% Artichokes (Jerusalem) Corn (Green or Frozen) Lima Beans (Green) Peanuts Peas (Green or Frozen)</p>	<p>5% Fresh Fruits Grapefruit Lemons Limes</p> <p>10% Blackberries Blueberries Cantaloupe Cherries Cranberries Gooseberries Honeydew Melon Huckleberries Muskmelon Papayas Peaches Raspberries Strawberries Tangerines Watermelon</p> <p>15% Apples Apricots Currants Figs (Fresh) Grapes Oranges Pears Pineapples Youngberries</p> <p>Note: Fresh fruits cooked become a starch and change to Class Three.</p>	<p>A. Natural Sweets 20% Persimmons Bananas Sugar (Raw) Molasses Maple Sugar Sorghum Honey</p> <p>Dried Fruits Prunes Apricots Apples Currants Dates Figs Peaches Pears Raisins</p> <p>B. Fresh Natural Starches Corn (Dried) Cocunut Chestnuts Potatoes (Irish) Potatoes (Sweet) Yams Water Chestnuts Squash (Hubbard)</p> <p>Dry Starches Barley (Unpolished) Buckwheat Wheat, Whole, Flour Dry Corn Meal Popcorn Oats, Steel Cut. Rolled, Whole Rice, Unpolished, Polished Rye, Whole, Grits, Flour</p>	<p>Avocado Ripe Olives Soya Bean Oil Butter Cream Olive Oil, Peanut Oil Vegetable Oils</p> <p>Nuts 1 1/2 cup Brazil 2 cups Cashew (Roasted) 1 cup Filberts 1 1/2 cup Hickory 2 cups Pecans 1 cup Pine 1 cup Walnuts (Black) 1 1/2 cup Walnuts (English)</p> <hr/> <p>MISCELLANEOUS CLASS</p> <p>Spaghetti</p> <p>Legumes and Lentils 1 cup Black Eyed Peas 1/2 cup Kidney Beans 3/4 cup Lentils 1 cup Lima Beans 1 cup Navy Beans 1 cup Split Peas 1 cup Garbanzo Beans 1/2 cup Pinto Beans</p> <p>Note: Legumes and lentils are high in protein and carbohydrate. Dark beans are higher in protein and the white bean is higher in starch. Do not cook or serve meat with beans or lentils. Potatoes, rice and other heavy starch foods should not be served with them.</p>

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APPROXIMATE NUTRITIONAL CONTENTS OF IMPORTANT JUICES

U. S. Dept. of Agriculture Chart

	BET (Red)	CARROT	CELERY	CUCUMBER	Remaine LETTUCE	PARSLEY	RHUBARB	SPINACH
PROTEIN %	1.6	1.1	1.1	0.8	1.2	3.5	0.6	2.1
FAT %	0.1	0.4	0.1	0.2	0.3	1.0	0.7	0.3
CARBOHYDRATE %	9.7	9.3	3.3	3.1	3.0	9.0	3.8	3.2
CALORIES PER PINT	220	217	89	84	94	283	115	115
CALCIUM %	0.140	0.225	0.390	0.050	0.345	0.350	0.220	0.390
MAGNESIUM %	1.130	0.100	0.140	0.045	0.065	0.160	0.085	0.250
POTASSIUM %	1.770	1.540	1.460	0.700	1.650	1.50	1.625	2.685
SODIUM %	0.485	0.385	0.645	0.050	0.100	0.200	0.125	0.445
PHOSPHORUS %	0.210	0.205	0.230	0.105	0.140	0.130	0.090	0.230
CHLORINE %	0.290	0.195	0.465	0.150	0.390	0.090	0.180	0.330
SULPHUR %	0.090	0.110	0.140	0.155	0.130	0.120	0.065	0.180
IRON %	0.004	0.003	0.003	0.002	0.007	0.016	0.003	0.013
SILICON %	0.009	0.007	0.008	0.013	0.018		0.006	0.020
MANGANESE %	0.008	0.0005	0.0014	0.0013	0.0064	0.008	0.0013	0.0042
COPPER %	0.001	0.007	0.001	0.016	0.0003	0.015	0.0005	0.001
IODINE % Parts per billion.	230	180		500	650			400

Oxalic Acid is a relatively prominent factor in Rhubarb, Beet, Chard and other vegetables of so-called goosefoot family.

TOMATO	WATERCRESS	APPLE	COCONUT	GRAPE	GRAPEFRUIT	LEMON	ORANGE	PINEAPPLE	POMEGRANATE
0.9	1.7	0.1	1.4	1.3	0.4	0.9	0.6	0.4	1.5
0.4	0.3	0.2	12.5	1.6	0.1	0.6	0.1	0.3	1.6
4.0	3.3	12.5	7.0	19.2	9.8	8.7	13.0	9.7	19.5
112	109	250	700	462	200	210	265	207	472
0.055	0.785	0.035	0.120	0.055	0.105	0.110	0.120	0.040	0.030
0.065	0.170	0.040	0.100	0.045	0.045	0.045	0.055	0.050	0.020
1.335	1.435	0.640	1.500	0.530	0.805	0.615	0.905	1.350	1.600
0.060	0.495	0.055	0.180	0.025	0.020	0.030	0.060	0.080	0.250
0.145	0.230	0.060	0.370	0.050	0.100	0.055	0.090	0.055	0.050
0.145	0.305	0.025	0.600	0.010	0.025	0.030	0.025	0.255	0.068
0.070	0.835	0.030	0.140	0.045	0.050	0.045	0.050	0.045	0.040
0.002	0.015	0.002		0.0015	0.0014	0.003	0.002	0.002	0.004
0.009		0.006		0.002			0.0007		
0.0012	0.0036	0.0003	0.0017	0.0001	0.0001	0.0002	0.0003	0.006	
0.0005	0.005	0.0008	0.0009	0.0005	0.0003		0.0008	0.0004	0.0005
350	180							200	120

Chemists advise against use of same where there is evidence of calcium deficiency.

Fundamentals of Mistletoe Therapy*

R. LEROI

Mistletoe therapy for cancer has been one of the first methods to be not solely directed against malignant cells, but also intended to effect a change in the whole organism subject to cancer.

Why is mistletoe so particularly suited to this purpose?

The white-berried mistletoe, *Viscum album*, has a number of unusual characteristics. A semiparasitic, spherical plant growing on a number of different host trees, it avoids direct contact with the earth, shows no geotropism, and follows its own rhythm in the cycle of the year. The mistletoe needs light in order to exist, it will germinate only if exposed to light, growing towards every ray of light within the tree, and photosynthesis is so intense that chlorophyll is formed even inside the branches, in the embryo and in the cortical bundles. Apart from water and mineral salts, the mistletoe takes only traces of organic substance from the host. Being partly heterotrophic and partly autotrophic, it therefore comes half-way between plant and animal.

Animal-type features are also to be found in the constituents of this plant. Apart from choline and acetylcholine, mistletoe contains numerous free amino acids, and particularly also arginine, normally found in fish sperm and mammalian livers; on the other hand, glutamine and asparagine, two typical plant amino acids, are absent.

The basic histone-type proteins of mistletoe have attracted particular interest as they are powerful cytostatics. Vester¹ has shown that they have a specific action on malignant cells. It appears that these mistletoe proteins do not act as antimetabolites or mitotic poisons, but function as specific repressors in the misrouted nuclear information mechanism, by selective inhibition of mRNA. The toxicity of these proteins does increase with purification. On the other hand, the polysaccharides, lipids and arginine contained in mistletoe also have antitumour activity.

Using completely different methods, Prokop², Luther³ and Franz⁴ found heterophile antibodies called lectins in mistletoe extracts that have a specific affinity to tumour cells. Under the electron microscope it has been possible to observe labelled lectins agglutinating and destroying tumour cells in blood samples. This led to further immunological studies, and investigations carried out by Bloksma⁵ have shown that the mistletoe preparation Iscador primarily stimulates an immune response at cellular level, whilst reaction at the humoral level is minimal. Rentea⁶ established that stimulation

*A paper read to the 1978 Baden-Baden Cancer Congress

of the thymus occurs, with a dramatic increase in thymocytes. Together with the hypertrophy of the T-cell-dependent paracortical zones in lymph nodes, this confirms that stimulation of tumour-active cellular immune reactions takes place.

Today, a number of immunological and cytostatic elements are frequently combined. In the mistletoe, this combination exists already, confirming that Steiner⁷ was right in suggesting that this plant be used for cancer therapy. It is important that the full plant extract is used, for nature herself has created a model here, avoiding one-sided action on the part of the individual tumour-active constituents, and hence their toxicity, by combining them in a biological whole.

If cancer is regarded as a disease involving the whole organism, with the tumour merely the tangible end-stage of precancerous states that have persisted for years, it is possible to describe this disease as a profound disruption of the balance between forces imposing form on the one hand, and cell proliferation on the other. Having immunostimulant properties, supporting the inherent form-processes, and also cytostatic potential, the mistletoe presents itself as the ideal therapeutic agent.

At the Hiseia Research Institute founded by Alexandre Leroi, we are endeavouring to manufacture Iscador from mistletoe in such a way that even with preservation, the total effective composition is retained and indeed enhanced. The drug is tested in vitro and in vivo. In vivo studies have shown reduction in size of the tumour and connective tissue encapsulation with a broad lymphocyte wall (RES stimulation).

From the very beginning, however, clinical use has been the focus of our interest, being fully aware, of course, that the results of animal studies cannot be directly applied to man, a being endowed with spirit and individuality. The observations made on Iscador therapy have however confirmed a specific mistletoe action.

Postoperative treatment for cancer cases with 12 primary tumour locations to date, carried out at 19 hospitals, has brought a significant improvement in survival rate compared to untreated controls. In the treatment of tumours in different sites, we have seen 25-100% regressions in 15-20% of cases, depending on the nature and extent of the tumour.⁸ Salzer⁹ reported cessation of pleural effusion and disappearance of malignant cells in 50 cases of carcinoma pleurae treated with intrapleural injections of Iscador repeated a few times. From the patients' point of view, particular value attaches to situations where inoperable tumours

that prior to treatment had shown rapid progress remain stationary for years with Iscador therapy, and patients are able to live almost symptom-free lives, without the side effects of cytostatics that are often so hard to bear. In these cases, it has been possible to stabilize the increasing imbalance between cell proliferation and form principles. It has been of particular interest to note that malignant tumours of the bladder and rectum regressed via semi-malignant stages. Such observations indicate abnormal cell structures reintegrating step by step into the form-principles of the organism.

Clinically, temperature levels are raised, and in addition there is an increase in lymphocytes and erythrocytes as well as enhanced hormonal and enzyme activity. From the patients' point of view, important aspects are an improvement in general health, deeper sleep, better appetite, the relief of tension and depression, and also increased initiative. Thus the human being as a whole responds, and there are no toxic side effects.

Iscador therapy can also be combined with cytostatic and radiotherapy. Operable tumours are of course surgically treated, following a short course of preliminary treatment.

Follow up care at the Lukas Clinic involves keeping records of all patients and following them up, whether they continue on Iscador therapy or not. To date, the case material covers about 7,000 patients, with all relevant clinical data. In view of the many different types and stages of cancer, it is only now, however, that treatment results can be assessed for the separate groups.

Steiner's mistletoe therapy has proved its value. 36 preclinical and 24 clinical papers as well as the extensive case material confirm its positive effect. Despite the undoubted success of chemotherapy, conventional methods still leave one helpless in many cases of malignant disease, and this clearly makes it our duty to continue the work with mistletoe therapy.

Literature

1. Vester F. Über die kancerostatischen und immunogenen Eigenschaften von Mistletoeproteinen. *Krebsgeschehen* 1977/5.
2. Prokop O. Über die Befestigung der Protectine und Lectine u.a. von *Viscum album* zur Erkennung von Zelloberflächenstrukturen. Based on a paper read to the Congress on "Molekulare Basis der Malignität", Vienna, October 1974. Published in: Wolf O. *Die Mistel in der Krebsbehandlung*. Frankfurt a.M., 1975.
3. Luther P. et al. Isolierung und Charakterisierung von Inhaltsstoffen der Mistel (*Viscum album* L.) II. *Acta biol med germ* 1977; 36:119-125.
4. Ziska P., Franz H., Kindt A. The lectin from *Viscum album* L. Purification by biospecific affinity chromatography. *Experientia* 1978; 34:123.
5. Bloksma N. *The Influence of Iscador on the Immune Response in Mice* (preliminary report) Rijksuniversiteit Utrecht, November 1976.
6. Rentea R. *The Modulation of the Immune Response by Viscum album Proteins, Iscador*. University of Chicago 1976. In press.
7. Steiner R. *Spiritual Science & Medicine*. 20 Lectures given in Dornach, Switzerland, 21.3-9.4 1920. Tis. 2nd ed London: Rudolf Steiner Press, 1975.
8. *Dokumentationsübersicht für das Viscum album-Präparat Iscador*. Arlesheim (Switzerland): Society for Cancer Research, 1978.
9. Salzer G. and Müller H. Die lokale Behandlung maligner Pleuraplässe mit dem Mistletoepreparat Iscador. From the Ludwig Boltzmann Institute of Clinical Oncology, Vienna. *Prax Pneumol* 1978; 32:721-9. Engl. translation entitled "Local Treatment of Malignant Pleural Effusions with the Mistletoe Preparation Iscador" obtainable from Society for Cancer Research, Arlesheim, Switzerland.

Author's address: Dr. Rita Leroi, Society for Cancer Research, Kirschweg 9, CH-4144, Arlesheim, Switzerland.

23 YEARS OF A DEADLY WAR

In 1971 President Nixon launched this country's longest war, the WAR ON CANCER. Twenty-three years later, the incidence (number of cases per 100,000 people) of cancer and cancer deaths are up in the U.S. Here are some grim statistics reported in the San Jose, Ca. Mercury News 6/19/94.

1. Despite many billions of dollars, the cancer case rate is 18% higher in 1994 than it was in 1971.
2. The death rate, even adjusted for an aging population, is up 7%.
3. One in three Americans will get cancer during his or her lifetime. This year, 1.3 million new cancer victims will be added to the 8 million in this country who have heard their doctors pronounce the dreaded words, "It's cancer."
4. By 2000, cancer will surpass heart disease as the No. 1 cause of death. Is cancer an implacable, devious, complicated foe or is it a "systemic disease?" Is a tumor a form of waste that has lodged somewhere in the body? If so, does winning the WAR ON CANCER involve the following?
 1. Drinking and bathing in pure water free of cancer-causing chemicals such as fluoride and chlorine.
 2. Eating only whole, non-chemical, natural foods in harmony with one's functional metabolic type discovered by completing a HEALTHEXCEL SURVEY.
 3. Detoxifying with enemas, special cleanses, colonics, colemas.
 4. Replacing fluorescent lights (linked to malignant melanomas, N.Y. Times 8/17/82) with full spectrum lights, available at many hardware and health food stores.
 5. Coping with electromagnetic fields which can disturb the endocrine gland system by wearing a Teslar watch. Teslar watches are available from Rose Waldram, P.O. Box 457, Spokane, Wa 99015; 509/927-2559.
 6. Taking supplements that match one's functional metabolic needs.
 7. Breathing clean air.
 8. Installing an air purifier in the home to combat indoor pollution.
 9. A cheerful, positive attitude.
 10. Managing stress.
 11. Healing crises. A cancer patient may go through periods of what seems like an acute illness. Symptoms are varied and may include nausea, fever, bodily aches and pains; a feeling as though their cancer is growing. The solution to a healing crisis is to
 - a. Increase detoxification procedures and
 - b. Slow down the mass movement of poisons into the bloodstream by cycling off supplements and eating cooked vegetables in harmony with one's functional metabolic type.

In other words, increasing detoxification procedures, cycling off supplements and eating cooked vegetables matching one's functional metabolic type will slow down the process of tumor elimination just enough so there is less of a shock to the body from dumping its own poisons. When the symptoms vanish, the cancer patient can resume his/her metabolic program.

-----CLIP & MAIL----- 7-8/94

Enclosed is \$170 for a COLEMA BOARD.
 Enclosed is \$200 for a HEALTHEXCEL SURVEY + HAIR ANALYSIS PACKET.
 Note: Hair analysis is available only with the purchase of a HEALTHEXCEL SURVEY. Hair analysis is an additional \$25 payable to the lab.

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 Address _____ City _____ State _____ Zip _____
 Please make check payable to BETTY FOWLER, ELA and mail check and coupon to BETTY FOWLER, ELA, West 5615 Lyons Court, Spokane, WA 99208-3874.

MARK YOUR CALENDAR

Don't miss FOUNDATION FOR ADVANCEMENT IN CANCER THERAPY (FACT) Convention Sat., Sun., Oct. 1 and 2 at the Clarion Hotel, 901 Spring St., Elizabeth, NJ 07201. The weekend features well-known speakers on noninvasive therapies plus talk by Ruth Sackman, president and cofounder of FACT on the right and wrong alternative concepts in cancer therapy. For information write FACT, P.O. Box 1242 Old Chelsea Station, New York, NY 10113; 212-741-2790.

HEALING CRISES

Diet and supplements compatible to one's metabolic type, determined by completing a HEALTHEXCEL SURVEY, daily enemas, colemas and/or colonics, and special cleanses help dislodge waste and poisons from cells and tissues of the body.

Waste and poisons are carried by the bloodstream to the eliminatory organs: bowels, kidneys, lungs, skin, nasal passages, ears, throat, bronchi, genito-urinary organs.

As organs and systems of the body become crowded with debris, the host may experience one or more of the following symptoms: a cold, flu, boils, ulcers, open sores, kidney and bladder infections, perspiration, fever, diarrhea, menstrual discharges, itching, hemorrhages, mucus, nasal drips, etc. These are healing crises symptoms.

Healing crises are necessary in order to overcome cancer. I know this from personal experience. I was diagnosed with cancer in 1971. In 1972 I got on a nontoxic nutritional program. In 1974 I was declared cancer-free by an M.D.

Some cancer patients feel pain in their kidneys, bladder, bowels with a healing crisis and believe the organ in question is now malignant. On the contrary. The organ in question is usually the strongest eliminative organ in the body and nature is using it as an outlet for waste.

When a healing crisis occurs it is important to STOP supplements and INCREASE DETOXIFICATION PROCEDURES. Through detoxification -- more enemas, more colemas and/or colonics, more special cleanses -- the body dumps waste and poisons.

Do not suppress the healing crisis symptoms with drugs. Drugs accumulate in the body. Our organs were not made to handle drugs and they get stored in fatty tissue and other parts of the body.

A healing crisis shows there is enough energy in the body to eliminate waste. A healing crisis may last from three to five days, sometimes more. If the healing crisis lasts longer it is because the body is weak and it is just going to take a little longer to get well.

After each healing crisis the host can look forward to feeling better. The host becomes stronger after each healing crisis.

One resumes their metabolic diet and food supplements after each healing crisis. And, of course, keeps up with detoxification procedures.

The day does come as it did for me -- after more than two years -- when healing crises become history.

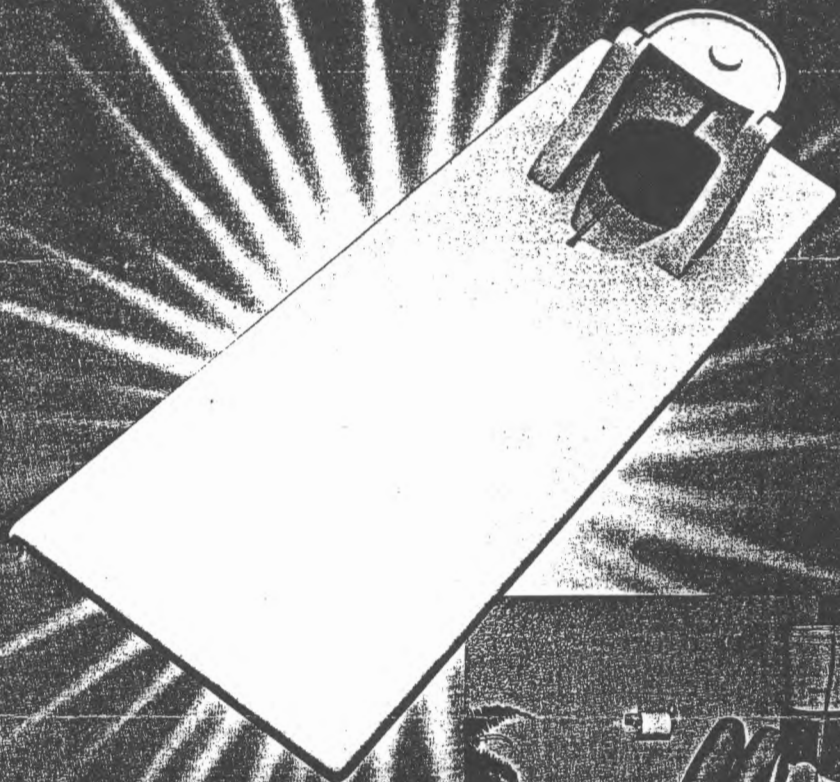
However, some may experience slight healing crises once in a while thereafter, but they last a short time -- from one to three days -- pass and leave the host healthier. Remember: detoxify through each healing crisis.

-----CLIP & MAIL----- 9-10/94

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Care of the Colon



COLEMA BOARDS INC.

THE COLEMA BOARD




- Each board comes with 2 disposable plastic tips.
 - Easy to Assemble and Store.
 - 15 1/2" wide, 45 1/2" long, WEIGHS: 14 lbs.
 - Plastic covered, enabling easier cleaning.
 - PRIVATE, SIMPLE and SAFE to use.
 - EFFECTIVE and INEXPENSIVE.
 - GRAVITY FLOW - No pressure or distention of the colon at any time.
 - Bowel evacuations and emptying of bladder done at will without removal of tip, turning off the water or getting off the Board.
 - Pencil-like tip enables full sized stool elimination without the removal of the tip. Likewise it allows the elimination of the enormous amounts of 3 to 30 ozs. of accumulated hardened mucous which we too frequently find.
- YOU WILL BE AMAZED AT THE SIZE AND TYPES OF HARDENED MUCOUS EXCRETIONS YOU WILL ELIMINATE.**
(Our system saves all this type of elimination for your personal examination.)
- SEE - FEEL - and EXAMINE with rubber gloves unbelievable quantities of material that is not fecal matter - IT IS NOT YOUR FLESH - yet it is flesh-like without blood or nerves but built up in your colon over the years. YOUR astonishment will CONVINCe you to continue our type of colon irrigation until all is eliminated.
 - The WHOLE FAMILY of all ages and sizes can and should use it. Commercially it would cost approximately \$280.00 to take the number of colonics needed in a 7 day cleansing program (14 in all - morning and evening for 7 days) Hence, you pay for your Board twice over for one individual's program in One Week. Most everyone needs to REPEAT this program at least FIVE times, 7 weeks apart to get back to normal health.
 - THE FULL SAVINGS are enormous for it is available to the whole family at all times.

ORIGINAL COLEMA BOARD	\$170.00
FOLDING COLEMA BOARD	\$220.00
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(Each Board comes with two disposable tips)

WE DO NOT SUPPLY THE FIVE GALLON BUCKET as they may be purchased at restaurants or bakeries for \$1.00 to \$2.00.

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A PERSONAL RESPONSIBILITY

Acceptance and realization that HEALTH CARE is truly a personal responsibility, is a MUST if we, as Individuals are to meet our basic health needs and achieve that goal of RADIANT HEALTH.

Through research and experimentation, there is NOW available to all of us some basic tools and knowledge that makes the acceptance of the care of the body a wonderful and challenging experience. We can be confident that our personal efforts will be rewarded many fold on our journey to RADIANT HEALTH - But, it must all start with the FIRST STEP.

THE AGE WE LIVE IN

If we lived properly, there would be no need to concern ourselves with the function of the bowel. However, most of us are not living right, we do not eat the right foods, we do not get the right exercise, fresh air, and sunshine.

There are so many things we are not doing right, we can't expect our bowel to function properly. The result is that all our attentions are directed towards treating the physical problems that are products of bad living habits. This in turn has given rise to major demands upon our doctors and hospitals, and has created a crisis in the field of health care that is growing worse daily. Hospital care and medical attention have become so costly that it has all but made such care unavailable to a majority of people of this country and yet astoundingly a majority of the people in the country are sick according to the statistics of our government. The staggering growth of hospitals, rehabilitation centers, and convalescent homes tells us clearly that the present approach to our health problems is just not working. Because of the age in which we live, each of us must take back the responsibility for our own personal health care.

PREVENTION IS NEEDED

Colon cleansing and healthy bowel management certainly are basic and essential to the prevention of disease and to the development of good health. The basic purpose of the colon as an organ of elimination is to collect and dispose of toxic waste from all parts of the anatomy. The colon is essentially the sewer system of the body. If waste is allowed to accumulate, then surely innumerable ailments, sicknesses and disease will follow. No sewage system of any kind is immune from trouble if debris is allowed to clog up somewhere along the line. GOOD HEALTH care and PREVENTION of disease must include a program of colon cleansing. This is certainly one area that has been neglected by all concerned. The illness crisis has become so acutely dangerous that this is the one field which is open to the individual himself. Our experience over the last four years has been more gratifying than any of us dreamed possible. YOU too will be most gratified by YOUR results if you go on the Cleansing Program and use the COLEMA BOARD.

AT LAST — A KEY TO THE FIRST STEP

Place the working end of the Board over the toilet. BUT drop an ordinary kitchen colander (which you purchase for this specific purpose) in the toilet bowl first. PLACE the head end of the BOARD on a chair. If space in your bathroom is not available, you may use any other room with the working end over another 5 gallon bucket and the head end on a chair. The bottom of the 5 gallon liquid flush bucket should be from 20 to 24 inches above the surface of the BOARD or 8 to 10 inches above the top of the porcelain tank of your toilet. (THIS IS IMPORTANT, as the higher you place the bucket, the more water pressure you will get in the Colon). But, you must not have it too high for we do not want too much pressure.

The COLEMA BOARD and associated parts (BUCKET NOT INCLUDED in the package) represent a major advance for those who accept the responsibility for getting involved in their own healing process. Not only does it make the colon cleansing possible in the privacy of your own home but the kitchen colander which you placed in the toilet under the "exhaust" end of the Board catches the hardened mucous - the real cause of most of your troubles. Old hardened fecal matter will go through the holes of the colander but hardened mucous will not. When the 5 gallon water bucket is empty, flush the toilet which washes away the fecal matter, then lift out the colander, hold it under the faucet until contents are clean, then dump contents out on a newspaper or paper towel. Then get your fingers into the contents. KNOW - SEE - FEEL and carefully examine that which has probably been the cause of your long slow buildup of toxins all through your life. In the privacy of your own bathroom "KNOW THYSELF".

A HEALTHY COLON .. A LIFETIME PROCEDURE

Curing and healing do not exist outside the body. They exist only within. ONLY the same power that built the body has the ability to heal it. Even then, the body can do this only if it is not interfered with or hampered by those who seek to "cure" some particular symptom of ill health. Real cures lie in removing the underlying CAUSE OF the discomfort, namely the toxicity that prevents NATURE from healing itself. The body is truly self-preserving, self-defending, self-repairing, and self-healing. From childhood through adolescence the personal care (or lack of it) of the Colon will determine the healthful condition of the body. Caring for the colon from a very early age and keeping it well cleansed is certainly one of the fundamental ways of avoiding illness, sickness and disease. Keeping the drainage clear from childhood is the real solution to HEALTH, HAPPINESS, and a LONG FRUITFUL LIFE.

LETTERS FROM SATISFIED USERS

"We don't know how many take the time and effort to tell the RESULTS and to Thank You! ...Well, our results were outstandingly fantastic. We've neither been the same - my wife nor myself, 68 and 78 years respectively. No one will ever believe what is inside them, perhaps for 30 to 40 years, until they do the job right, get it out, and carefully examine it. Astounding and unbelievable. But, seeing is believing..... Just to encourage you and say, THANK YOU! ..C.M., Oregon.

"Am using the COLEMA BOARD with ease now. I wish to congratulate you on a product that works so efficiently and easily. I had just finished the old fashioned 7 day cleansing program method when the news of the COLEMA BOARD ARRIVED. I ordered at once, received it promptly and used it just as promptly, even though I had so recently used the older method. That makes it possible for me to say that the COLEMA BOARD produced such additional results that it was unbelievable, especially since I thought I was already cleaned out. It's great! I'd sooner part with my toothbrush." E.M., Florida.

"I also wanted to let you know that I completed my First 7 day cleansing program and got superlative results.....I passed about 2 quarts of "junk" during the week including one specimen that was close to 2 feet long (all in one piece) that I passed two days after I broke the fast. UNBELIEVABLE ...This Board is tremendously helpful and certainly does make for a much easier and more efficient cleanse than does the regular enema...I am very happy with it as I am with the entire "IRONS PROGRAM".....B.D., Holyoke, Mass.

"The best money I ever spent, except for my marriage license.".....G.N., Texas.

"I can't believe I could harbor all this corruption inside of me and still be able to function as well as I did. My complaint wasn't so much my bowels (I was always constipated). I had arm and leg pains in all my joints, hands, elbows, shoulders, knees, real bad and getting worse for the last 10 years. I am glad to say that although I am still passing all the corruption the aches and pains are letting up and I can work now with more freedom of my muscles than I have had in a long time. I have tried many things (no medicine). This is the only thing that has helped me - COLONICS. Hope I haven't bored you but I am so glad I sent for YOUR BOARD.".....M.L., New York.

HOW TO TAKE AN ENEMA

Equipment required is an enema bucket or bag. If the tube attached to the bucket or bag has a bone end, a 20-inch colon tube should be added. A very convenient plastic bucket is available from L & H Vitamin Company, 37-10 Crescent Avenue, Long Island City, N.Y. 11101, (Telephone: 800-221-1152). It doesn't need a colon tube.

One should be relaxed and comfortable. The most comfortable position is flat on one's back, or stomach, if preferred. Since it might be difficult for some people to get up from a prone position, then, taking a hands and knees position will achieve the same effect of having the colon in a flat position. This is so as to get the water to flow back to the transverse colon. When the bucket is filled, place it higher than the body.

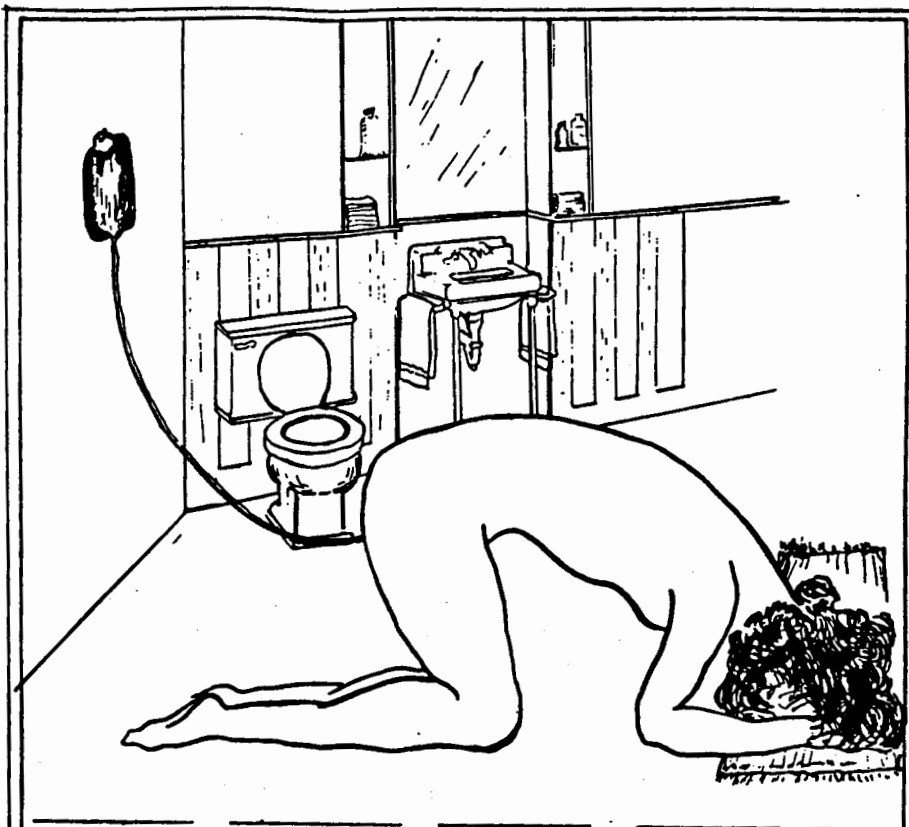
Fill the bucket or bag with water at body temperature or below. Do not use soap. Lie down on a bath rug or large towel near the toilet if it is convenient. The tip of the tube can be lubricated with any edible oil. Insert the tube into the rectum and allow the water to enter the colon to the point that the bowel signals that it wants to evacuate. Get up and sit on the toilet letting whatever waste is ready to be eliminated to start emptying the colon. Usually this signal starts when about 2 or 3 cups of water have been taken.

After the first elimination, fill the bucket again and allow the water to enter the colon a second time. Repeat this procedure until you feel the elimination is complete.

The colon will usually take about one quart of water and possibly more. Each system is different and one's individuality should be taken into account. The enema should always be done comfortably without stressing the colon.

It is helpful if you can raise the buttocks so that the water, through gravity, reaches the transverse part of the colon. In this way, more of the colon can be cleaned. The technique duplicates a high colonic but not quite as effectively, so should not be considered a substitute.

Distributed by:
Foundation for Advancement in Cancer Therapy, Ltd. (FACT)
P.O. Box 1242 Old Chelsea Station
New York, New York 10113
Telephone: (212) - 741-2790



This is the **KNEE-CHEST POSITION** when taking a
HIGH ENEMA

Use a 30 inch thin Rectal Tube so the water will flow directly way inside the Colon.

The **KNEE-CHEST** position helps the water to flow in by gravity into the Transverse and Ascending Colons as it leaves the Rectal Tube. It will thus reach the farthest parts of the Colon with less effort and greater efficiency.

It is much more beneficial to use the juice of 1, 2, or 3 lemons in 2 quarts of water, than to use any-thing else. We never use soap, salt, bicarbonate of soda, &c. We use only lemon and water, or just plain water, neither hot nor cold - just comfortably tepid. To lubricate the tube we use K-Y jelly.

To BECOME YOUNGER keep the Colon **CLEAN !!**

H. W. Walker (17)

Dr. B.W. Digby

ND. DO. M.R.S.Hom. U.K

Registered Homœopath

P.R. no. 0804053

Name lyn homofsky

Address 2, Glen Manor
10, Glen Crescent, Oranjezicht.

Medical Aid No. _____

Date	Address	Amount	
<u>22/8/97</u>	Treatment. digestive disturbance	150	-
	Medicines- Carcinosin 200/m	25	-
	Phye 30	35	-
	lycopodium 30x	35	-
<u>Paid 22/8/97. O. Digby.</u>		<u>R245</u>	<u>-</u>

8, Broadway Ave., Newlands, 7700, Cape Town.

Ph. (021) 683 7355

SUMMARY

We could review and detail additional methods, but I would like to again emphasize the importance of combined treatment, the objective being to reach the best possible results.

Each method is feasible, on condition that it is implemented in a professional manner. The tumor must be surgically removed in order to avoid damaging the human body's essential activities and to avoid metastases. Therefore, surgery, chemotherapy and radiation are highly recommended, parallel to treatment which reinforces the immune system, according to selection of the various methods outlined in this article, hoping to reach total recovery in as many patients as we can.

It is unnecessary to mention that this article is not intended as a medical indication, and one should consult with the doctor using any of these specific methods.

Excerpt from paper entitled
Cancer treatment based upon
principles of natural medicine:
NON-TOXIC treatment.

Club Extra Installation/Performance by Angela Ellsworth

JANUARY 29 - MARCH 12, 2000

ARTIST RECEPTION WITH PERFORMANCE

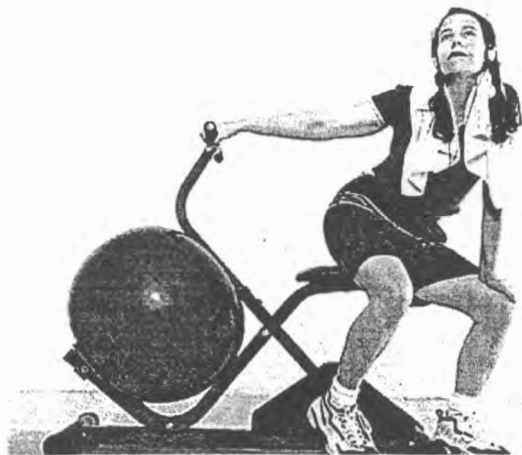
January 28, 2000

7-9 P.M.

Matthews Center - Experimental Gallery

The night will include two-hours of high energy workouts organized by
Club Extra's Fitness Coordinator
Angie

please dress appropriately if you wish to join the workout sessions
Please Note: Individuals workout and use equipment at their own risk.



Angie, *Club Extra's Fitness Coordinator*
photo courtesy of Barlow and Straker, Phoenix

Club Extra

"Beauty" is spandex on a perfectly toned thigh, perspiration on an upper lip, sweaty underarms of live artists in action. A fitness club, a performance venue, and an art museum are all spaces of objects and subjects of beauty. All share the promise that their institution might help us transcend the physical to the ethereal. We sweat, we critique, we long to be a part of these institutions of absolute beauty.

Club Extra is inspired by the similarities between health fitness clubs and art museums. We become members, bring friends, grapple with beauty, carry attitude, and gaze at what we want

(or wish we had) while trying to achieve profound aesthetic connections. The vaporous sweat of art enthusiasts and health fanatics will fill the space of a major art institution.

Club Extra Operates on Three Different Levels

Special one-hour exercise classes will be held in the Experimental Gallery of the Arizona State University Art Museum throughout the exhibition. Participants are invited to work off "Art Ass" or observe others work it off for them. The classes will be complete with an instructor, loud music, gatorade and a towel girl/boy. "Angie," the Fitness Coordinator of *Club Extra*, will facilitate all classes and club activities. Angie doesn't have a degree in cardiovascular performance, but she knows how to "turn it on" and she wants others to reach that higher state of performance.

While riding a stationary bicycle or developing inner thigh muscles, participants can listen to "Walkin' to Concepts" and "Sweatin' for Academia." Participants not interested in "collaborative" performance can visit the interactive installation and check out a headset of "Theory-on-Tape."

Using the strategy of local fitness clubs, there will be brochures and free membership opportunities at major sites around the Tempe/Phoenix area. Temporary membership cards will be distributed in the exhibition invitation.

Complimentary Temporary Membership Card

About the Artist

Angela Ellsworth currently resides in Phoenix, Arizona, where she is a visual and performance artist. She received her Master of Fine Arts in Painting and Performance from Rutgers State University of New Jersey in 1993.

Her recent projects include: performance/installation at the Salt Lake Art Center for *Out of the Closet* which also included three of Ellsworth's mixed media works; performance/installation at Barlow & Straker in Phoenix with Tina Takemoto as *Her/She Senses* entitled *Squeak and Clean*; and *waist/waste room*, a performance for the opening reception of the Arizona State University Art Museum exhibition, *Art on the Edge of Fashion*.

Ellsworth's writing will be published in the upcoming performance book, *Women's Comedy: Cross-Cultural Perspectives on Gender and Humour*, edited by Lizbeth Goodman (Cambridge: Polity Press) and an issue of *Contemporary Theatre Review* on performance and disability with a paper entitled *Performing Illness: Crisis, Collaboration and Resistance*.

ASU Art Museum Presentation

Organized by John D. Spiak, *Club Extra* will be installed in the 2,400-square-foot Experimental Gallery of the Arizona State University Art Museum at Matthews Center.

Duration

Club Extra (January 29 - March 12, 2000) is open from 10 am to 5 pm, Tuesday through Saturday. Special one-hour exercise classes will be offered during the run of the exhibition. *Club Extra* will be open from 1pm - 5pm on Sunday, March 12, to accommodate attendees of the Performance Studies International Conference that will take place March 9 through March 12 on the ASU campus.



Support

The exhibition at the Arizona State University Art Museum is supported in part by L.A.P. (Live Art Platform) and Friends of the Arizona State University Art Museum.

Please Note: Individuals workout and use equipment at their own risk.

Performances by Angela Ellsworth at ASU Art Museum

Actual Odor at Token City reception

waist/waste room at Art on the Edge of Fashion reception

For more information contact John Spiak at spiak@asu.edu or 480.965.2787.

Click here for
CURRENT EXHIBITIONS AND EVENTS
See what the ASU Art Museum is up to.

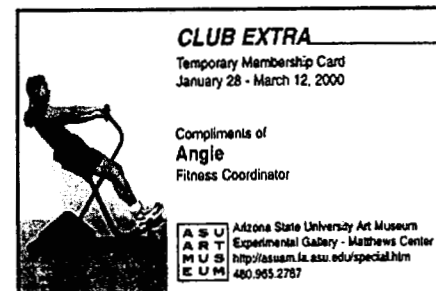
More Museum Information	Access Arizona Artists Online	Current Exhibitions	Museum Marketplace	General Museum Information
Membership Information	Return to ASU Home Page	Educational Activities		Info about this Website



Club Extra

Installation/Performance by Angela Ellsworth

TEMPORARY MEMBERSHIP CARD



print and cut-out your temporary membership card

RETURN TO CLUB EXTRA

Click here for
CURRENT EXHIBITIONS AND EVENTS
See what the ASU Art Museum is up to.

More Museum Information	Access Arizona Artists Online	Current Exhibitions	Museum Marketplace	General Museum Information
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DIS/FUNCTIONAL - TOKEN CITY RECEPTION



Angela Ellsworth - *Actual Odor*

For the duration of the opening, Ellsworth wore a dress soaked in her own urine for seven days prior to the event. The dress was hung out to dry on the seventh day. While wearing the cocktail dress she cooled herself with an accessory hand fan which was stenciled with the word "actual" on one side and "odor" on the other. Ellsworth mingled casually with other exhibition viewers and for long periods of time she sat quietly fanning herself in the close quartered projection space of *Token City*, the computer generated subway installation. Other times she positioned herself under hot spot lights in order to generate more heat from her body for utmost odor. Exhibition visitors clearly caught whiffs of her dress but couldn't determine from where the smell was coming.

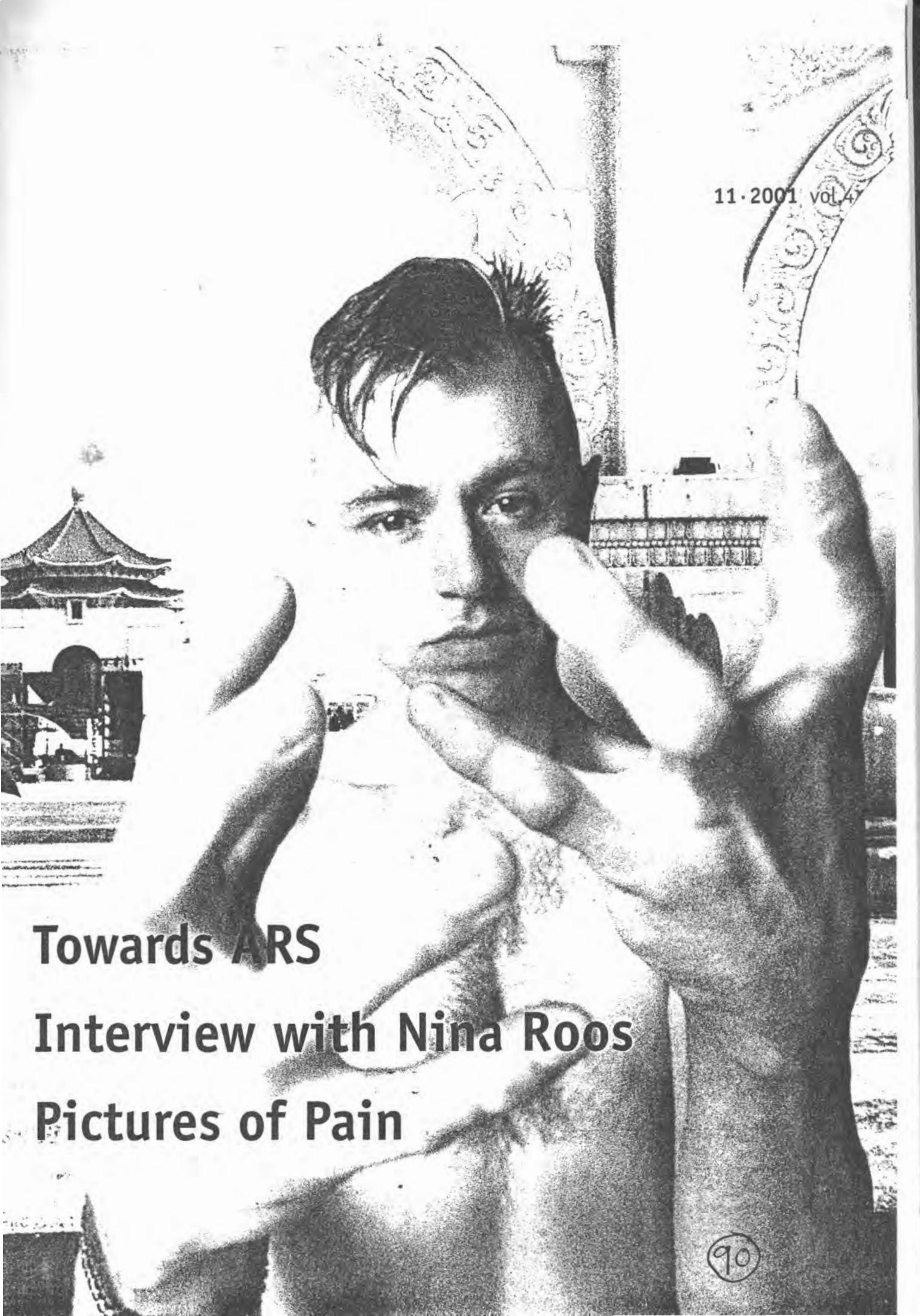
Ellsworth's *Actual Odor* responded in a literal way to *Token City* by questioning the virtual experience of subway. Visceral responses in any metropolitan subway often outweigh the visual experiences. By bringing an olfactory catalyst to the exhibition, Ellsworth provided an overall subway experience for exhibition visitors.

Performances by Angela Ellsworth at ASU Art Museum

Club Extra Performance/Installation

waist/waste room at Art on the Edge of Fashion reception

More Museum Information	Access Arizona Artists Online	Special Exhibits and Events	Museum Marketplace	General Museum Information
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11 · 2001 vol. 4

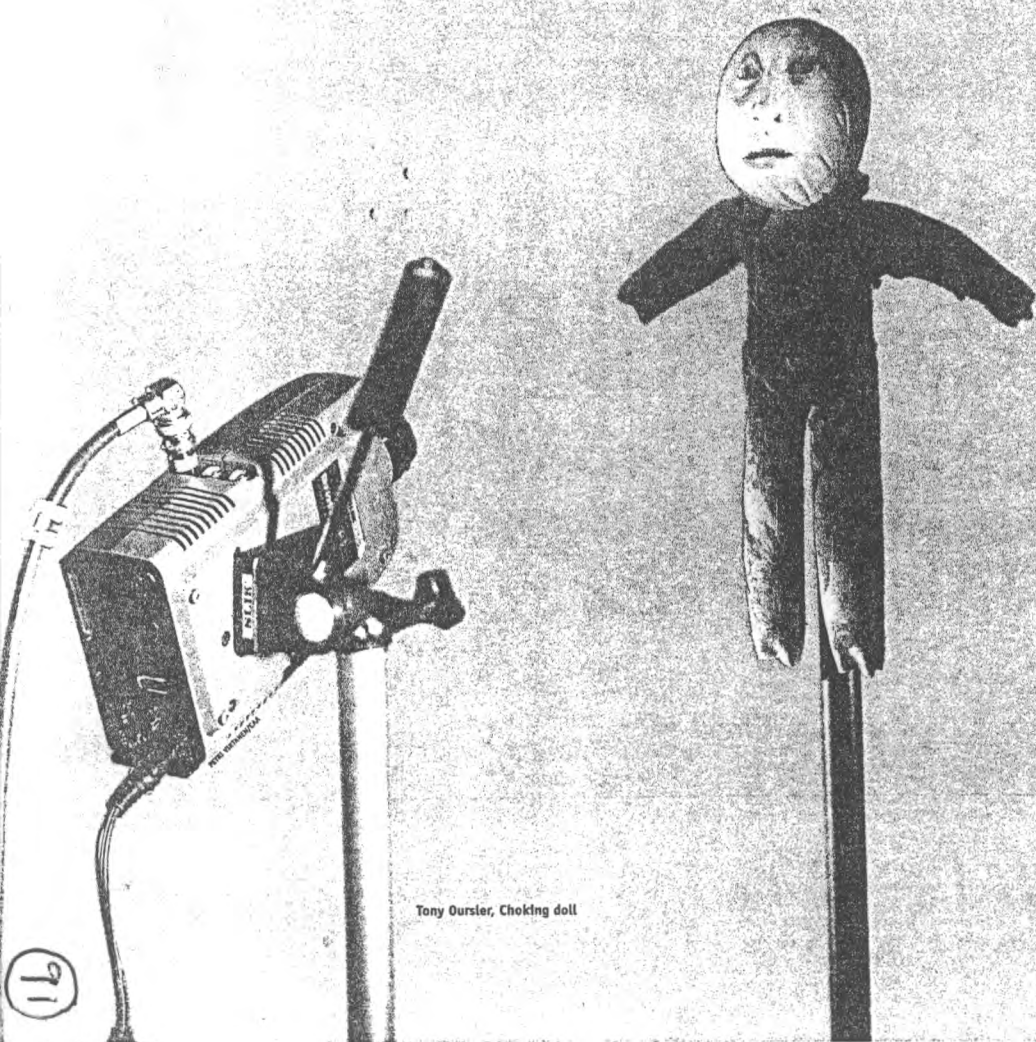
Towards ARS

Interview with Nina Roos

Pictures of Pain

What's it all about when a work of art deals with pain? What sense is there in an artist deliberately hurting himself or making pictures of painful subjects?

Pictures of Pain



Tony Oursler, Choking doll

Marten de Vos, The Crucifixion

DOES IT HURT?

– representation

Pictures of pain and aching, suffering and death have been created at least as long as pictures of the pursuit of divinity, happiness, motherhood or beauty. In Western art, one of the most important pictorial themes is Christ stretched out on the Cross. If the artists of today create pictures about pain, there is nothing new about it. In the pictures depicting martyrs, the pain has been ennobled: pain is seen as a sign of the martyr's true faith which endures and suffers all. 'The correct' reality is the reality of God's spirit, the material world is fleeting and secondary. In the same way as physical suffering. This way of thinking reflects an idealistic concept of reality absorbed by the Christian faith from Platonism. Christ's Passion is different from the martyr's suffering. He suffers as the Saviour of all mankind in the role of God made flesh. It is a noble suffering upon which depends the fate of the world. In other cultures, pain is also sometimes presented as a material necessity on the path to a spiritual and genuine connection with god or the universe.

The self-portraits of Frida Kahlo can somehow be compared to the Christian depictions of pain. The viewer's experience is powerfully affected by the knowledge that the iron bar, which penetrated the pelvis of the beautiful, young artist as the result of a traffic accident, caused her to suffer for the rest of her life. The poor artist suffered on behalf of herself, her artist husband, the Mexican people, as well as for her art and oppressed women throughout the world. What remains are the pictures of the martyr-artist.

The confrontation of pain presented in ennobled art is traditionally seen as noticeably different from the pain depicted, for example, in entertainment. Art does not, unlike some computer games, merely present endless pictures of pain and violence, but goes a step further and deals with the feelings connected to pain – pain becomes the subject of the art. In this way, it has tried to get viewers to look inside themselves and, thus, become a more understanding person.

IT HURTS!

– presentation: real pain

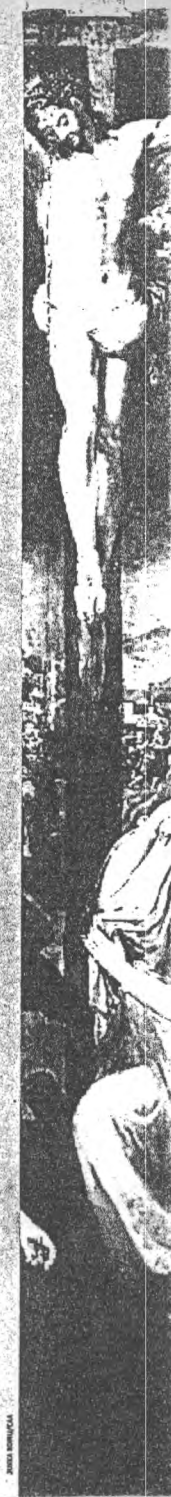
Throughout time there have been people who live on behalf of others in human society. These scapegoats, through their own lives, give other members of society the chance to experience real pain without having to feel it. Such a role has been played by shamans or beggar monks, flagellants, fakirs, escape artists or a bohemian artist dying of tuberculosis on the Left Bank of the Seine. The use of real pain as artistic material is found particularly amongst performance artists. Today, religion alone is not sufficient to justify the use of pain. Scapegoats can also be found not just in sports and art, but also in the name of entertainment: for example, on TV shows volunteers place themselves in dangerous situations.

When an artist experiences something on behalf of others, he may expose himself to danger or pain, not being content with merely painting pictures of flayed martyrs. Chris Burden had himself shot in the left arm. 'I didn't try to commit suicide, I'm not a sadomasochist nor am I certifiably insane', he has stated. It may also feel unreasonable that a top athlete subjects himself to life-threatening danger in order to achieve top result.

The thought of feeling pain troubles many people. Pain is to be avoided. Artists can show others what a feeling of pain or real fear of death looks like. They can also tell how it feels. In using pain as an element of art, the intention might be to shock the viewer – but without destructive consequences. If the viewer examines his feelings either alone or with someone, he may be better able to face pain in his own life. At least he knows how the sight of pain or fear has earlier affected him.

The use of real pain as an artistic element appeals to the viewer's empathy and, through their own body, to identify: 'Ow! That must hurt!', which is completely different from looking at a painting in which Judith severs Holofernes' head. It is just paint on a canvas and it is not even certain if the story is true. Prodding the viewer to compare what he sees with his own experiences can be the beginning of working through the psychological process.

continued on the next page



DAVID BURNETT/ICA

FESTIVAL OF PAIN
Klasma 3-6 May

Thursday 3 May
2pm Estradivammaiset *Lintukoto*,
Café Klasma

Friday 4 May
2pm Seminar on the audio description,
Seminar room
4pm *Daily Bread*, Klasma entrance hall
5pm *Pain in Art*, lecture, Seminar room
7pm NVA: *Pain*, Klasma Theatre

Saturday 5 May
12 noon Stand Up Comedy course, Paja
(advance registration)
3pm Meet the Artist - Sirkka-Liisa Sass,
Seminar room
4pm Estradivammaiset *Lintukoto*
7pm NVA: *Pain*, Klasma Theatre

Sunday 6 May
7pm NVA: *Pain*, Klasma Theatre

Tickets
Pain: 90/70 FIM
Others: Free admission



SIRKKA-LIISA SASS
IN A VICIOUS CIRCLE

Sirkka-Liisa Sass was diagnosed with scoliosis as an adolescent. Now over 60, Sass has drawn on her own personal and case histories to create art. Scoliosis, its treatment and apparatus are the concrete subjects of the exhibition. The first version of the *Vicious circle* exhibition appeared in Pori Art Museum in the spring of 1999. The exhibition has new elements in Klasma's Kontti even though the central theme is the same as in Pori: a body deviating from the norm, understanding of health and sickness, beauty and ugliness, good and evil and, above all, normal and abnormal. Sass has handled her history of suffering bravely, even sarcastically.

Sirkka-Liisa Sass
Vicious circle
Kontti
26 April - 17 June



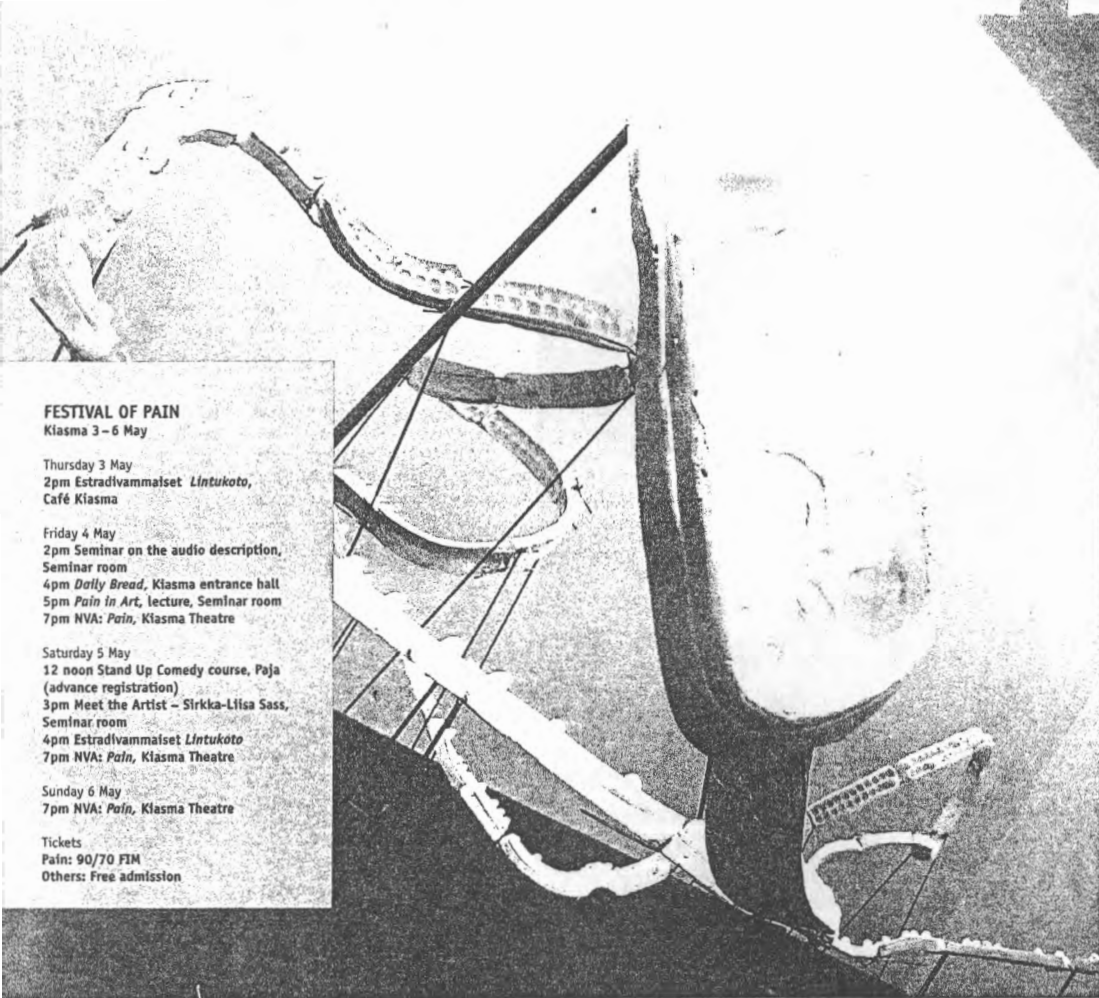
PAIN ON THE STAGE

Pain is a monologue written and performed by **Graham Cunningham** and based on his life with chronic rheumatism. *Pain* tells about imagination, will-power and hatred, which has caused Cunningham to search for answers about how to live with a crippling disease. It is an autobiographical account of pain and coping with it, of the struggle to take control of one's own life and the rejection of the victim mentality.

Pain is a multimedia work which captures the viewer and forces him to listen. The arresting and personal account gathers around it an energetic sound, light as well as a 3-D world of pictures.

NVA is a Glaswegian group founded by **Angus Farquhar**, the director of the performance, which has specialised in organising mega site-specific events and performances.

NVA: *Pain*
Klasma Theatre
4, 5 and 6 May
at 7pm



PETER LAGUSKA



Tiina Ketara, *You and I*

Graham Cunningham

PAINFUL?

- the presentation and processing of symbolic pain
A work of art can also handle pain in its entirety without pictures of pain or without the artist suffering pain in front of the audience. **Berlinde de Bruyckere's** *Untitled* is composed of three different-sized beds covered with layers of blankets with holes cut through them. The work easily gives rise to thoughts of suffocation, family violence and atrocities swept under the carpet, which happens in homes. Yet there is not a single picture of pain.

Tony Oursler's *Choking doll* is really a cloth doll onto which are projected the facial contortions of the actor. It looks like it really hurts and not just physically. **Tiina Ketara** made a doll in her own image (*You and I*) which lies on the ground. It looks like something is wrong even though there are no bruises or blood. If the viewer tries to help the doll up, it begins to chat about its life and finally bursts into song. The current work of **Rafael Wardi**, an artist who has also done valuable work as a pioneer in Finnish art therapy, revolves strongly around the feelings caused by his wife's serious illness.

If one considers why an artist handles painful subjects, it is easy to think that 'maybe things are quite difficult for him, because he is an artist and has certainly experienced all kinds of things'. Not all art, however, is necessarily autobiographical or expressionist, nor is every self-agonising artist a sadomasochist. Instead of thinking 'That is really sick!' when seeing pain in art, I have begun to ask who is it that is sick? Maybe the artist shows the type of sickness and its symptoms. Even though I can not bear to look at all the pain, I sometimes really have to see and experience it, even if it is just at the dentist's. And when will art reach its limits? How far can it go? It is perhaps more necessary to ask how far I am ready to carry my convictions, how far I would be ready to go.

MINNA TURTAJAINEN

The writer is a Helsinki art historian and Klasma guide.



Tasapainoisia säästö- ja sijoitusratkaisuja.

Tapiolan uudet vakuutussäästö- ja sijoituspalvelut sopivat sinulle, joka haluat taloudellista tasapainoa koko elämäsi. Tarjoamme mahdollisuuden hyvään tuottoon edullisilla kuluilla. Turvakesi saat yli 140 vuoden kokemuksemme sijoittamisesta maailmantalouden hyviltä ja huonoilta vuosilta. Tapiola-rahastojamme hallinnoi Tapiola Rahastoyhtiö Oy. Lisätietoja saat netistä ja asiantuntevaa apua toimitamme ja asiakaspalvelustamme 0203-45370



As part of the Photography Centre's
second Month of Photography,

Sue & Glynis Hillyard

invite you to view an exhibition of photographs & poetry
documenting their conversation with cancer & the cosmos

The exhibition will be opened by

Rika Pienaar

Oncologist

Dr. Maria Christodoulou

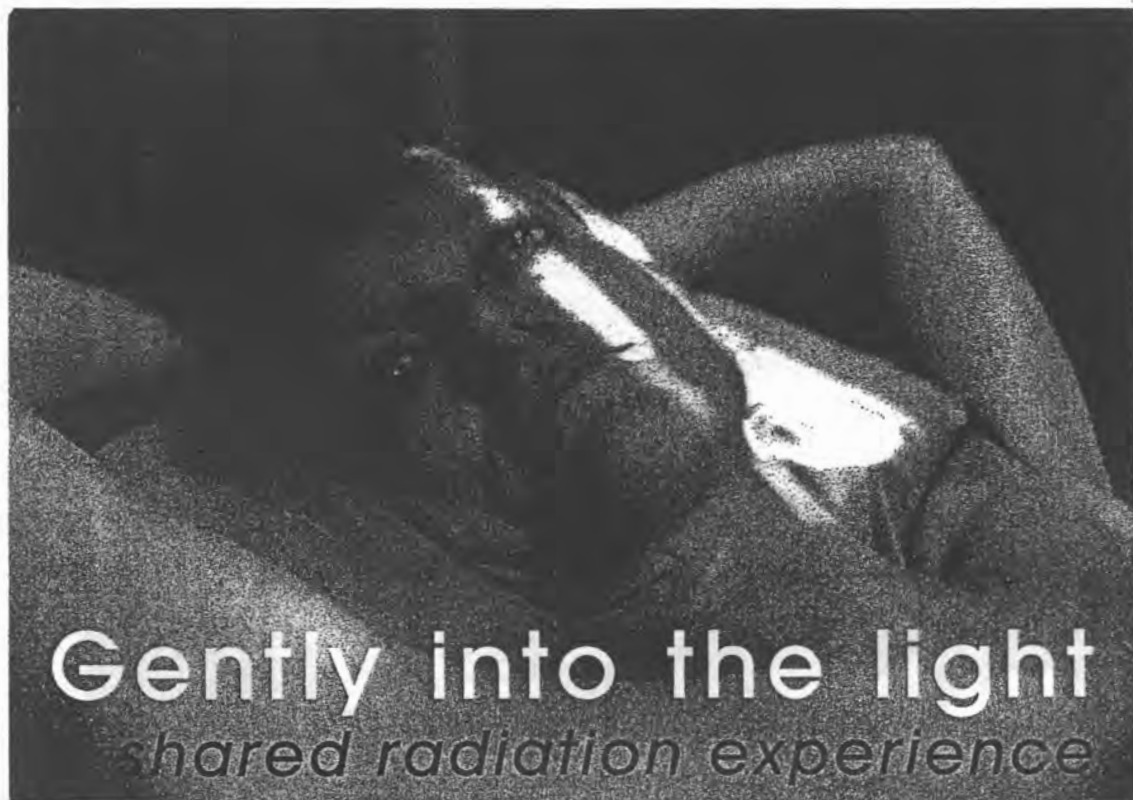
GP & Energy Healer

Wednesday **27 March** 2002

at **18h00**

Healing Centre, 161 Main Rd, Greenpoint, Cape Town tel. 021.439 6975

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MAY 23, 2001

TIME

**THERE IS NEW AMMUNITION
IN THE WAR AGAINST**

CANCER.

THESE ARE THE BULLETS.

Revolutionary new pills like GLIVEC combat cancer by targeting only the diseased cells. Is this the breakthrough we've been waiting for?



13 FEBRUARY 5, 2001

TIME

**BUSH AND EUROPE
PARIS HAUTE COUTURE**



HOW TO GET HEALTHIER

(Even if you've had too much fun)
New research shows it's easier than you think to undo the damage that causes HEART DISEASE, CANCER AND DIABETES



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ARE WE WORKING OURSELVES TO DEATH?

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EXCLUSIVE PRINCESS STEPHANIE'S CIRCUS ROMANCE

'The true heroism of ordinary people'
Anneliese Burgess on her work with Special Assignment

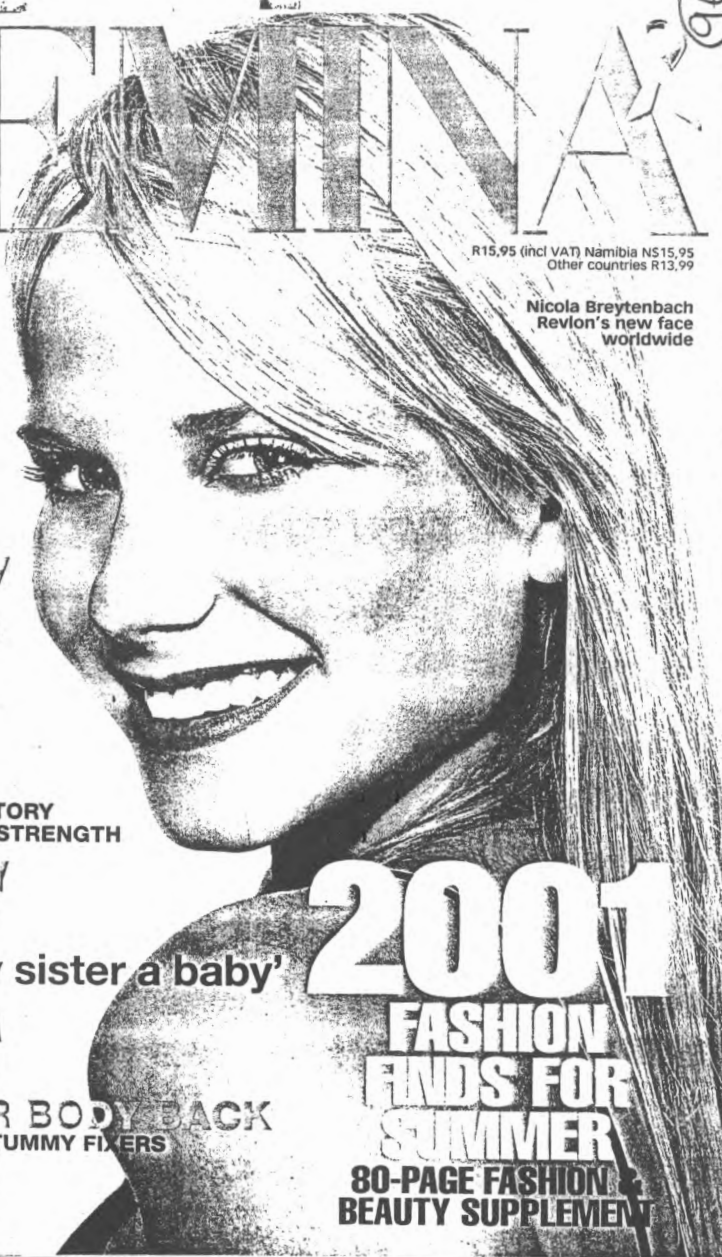
THE GIFT CANCER GAVE ME
ONE WOMAN'S STORY OF FINDING HER STRENGTH

IS INFIDELITY INEVITABLE?

'I gave my sister a baby'

HOW TO FIX A BROKEN MAN

GET YOUR BODY BACK
CELLULITE AND TUMMY FIXERS



Nicola Breytenbach
Revlon's new face worldwide

2001 FASHION FINDS FOR SUMMER
80-PAGE FASHION & BEAUTY SUPPLEMENT

Mandela dismisses fears his prostate cancer is more serious than initially thought

JEREMY MICHAELS
Parliamentary Bureau

JOHANNESBURG: Former President Nelson Mandela has dismissed reports that his prostate cancer is more serious than was thought initially, and says he is inspired by other people who have won the battle against cancer.

"I do feel that you can fight cancer and win," Mandela said

in an exclusive interview with Independent Newspapers at his office in Houghton.

It seemed like business as usual at the Nelson Mandela Foundation offices yesterday morning.

Mandela looked relaxed in one of his famous casual shirts as he sat back in a chair behind his desk, but took questions about his health seriously.

"I have these microscopic

cancer cells in my prostate, but they (the doctors) are confident they'll be able to clean it out".

Last week Mandela joked about his cancer when he was asked at a news conference about his health.

But yesterday the 83-year-old statesman was adamant his three doctors would not mislead the public.

"Doctors don't say your health is excellent if in fact it is

not, because that would destroy their credibility".

On reports that his cancer was more serious than was being disclosed, Mandela said: "I don't know what they mean."

Twelve days into his radiotherapy, Mandela said he was not feeling any side-effects.

"They now have computers, and they can direct the beam to the spot, and very accurately.

Up to now there have been no

side-effects.

Although he hasn't been feeling tired, Mandela has been ordered to rest.

"I have cut down my programme, because I'm having treatment for seven weeks, five days a week, so I have to be very careful.

"There's a recommendation that in the afternoon I must rest, I must sleep.

"That may be the reason

why I do not have side-effects".

As for progress on writing his memoirs as president, Mandela acknowledges that "there has been a little disruption as a result of the treatment".

Madiba draws his courage from other people who have fought cancer and won.

"One of the advantages of prison is that you can read," he says, reflecting on his years in prison. Graça Machel, his wife

of three years, has been at his

side since the cancer was discovered two weeks ago.

"We have won some other fights and battles and we will win this one too," she said confidently as Mandela greeted disabled children in the background.

For now, Mandela is taking it one day at a time and takes comfort in knowing that his normally busy wife is nearby.

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France mourns Paparemborde

SAPA-AFP

THOUSANDS paid tribute to Robert Paparemborde, one of France's greatest prop forwards, who died this week aged 52 from pancreatic cancer.

His funeral took place in his native town of Pau in the Basque region of south western France yesterday.

Several thousand locals and sporting personalities packed the town's Saint Martin's church for the funeral service for Paparemborde, who was capped 55 times between 1975 and 1983.

He was later buried in the village of Feas in the heart of the Pyrenees. The coffin was draped in shades of blue of the Barbarians and was carried by Paparemborde's former French international teammates: Jacques Fouroux, Jean-Francois Imbernon, Jean-Luc Averous, Roland Bertranne, Alain Paco and Gerard Cholley.

The French government was represented by Agriculture Minister Jean Glavany. The mayor of Pau, Andre Labarrere, attended, with representa-

tives of French rugby including national federation president Bernard Lapasset and technical director Pierre Villepreux.

All current team members of his former club Pau were present, along with members of Racing CF, which Paparemborde led to the French title as coach in 1990.

Paparemborde was three times a member of French teams that won the Five Nations, in 1977, 1981 and 1983, the first two being Grand Slams.

After his playing career was over he went into rugby administration and was manager of the French team until 1992. He was an unsuccessful candidate for the presidency of the French Rugby Union Federation in 1991.

Paparemborde formed a formidable French front row alongside Cholley and Philippe Dintrans in one of the greatest French packs, which also numbered Jean-Pierre Rives, Jean-Claude Skrela and Jean-Pierre Bastiat.

He won his first cap against South Africa in 1975 and his last against Wales in 1983.

NEWS

Ex-Bok lock Basson dies of cancer

FORMER Springbok lock Wium Basson died at his Pretoria home yesterday. He was 25.

Basson, who played for the Blue Bulls, was diagnosed with terminal cancer late last month.

Doctors could not do anything to help him and gave him a few weeks to live.

Basson flew to Lagos, Nigeria, to consult a faith healer, T B Joshua, who was reputed to have healed a range of illnesses.

Joshua had helped rehabilitate

former Springbok flyhalf Jaco van der Westhuizen, who had torn knee ligaments.

Basson undertook the pilgrimage to The Synagogue with 130 other South Africans who had various illnesses.

He returned disappointed on Friday. Although he had queued for hours, the faith healer did not see him.

Basson had played 48 games for the Bulls.

He toured with the Boks to

Argentina, France and England in 1998.

His career was ended abruptly by a serious neck injury last season.

Basson was the third Blue Bulls player to have been hit by a life-threatening illness in the past six months.

Bok lock Krynauw Otto's career was ended in August by bleeding on the brain. Reuben Kruger is being treated for a brain tumour. - Own Correspondent

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The world leader speaks on life, death and heaven / 16

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Cancer a blessing — Tutu



FOCUSED: Desmond Tutu says cancer focuses the mind and brings a new intensity to life.

LONDON: Archbishop Desmond Tutu, 69, says being struck by cancer is a gift that has focused his mind and brought new intensity to his life.

The Nobel prize winner, speaking in a BBC World Service interview due for broadcast on December 23 and 24, said his battle with prostate cancer had taught him not to take things for granted.

"It's actually wonderful. You're bowled over initially and then you say: This is a wonderful message, because this messenger says: You know something? You've been taking a lot of things for granted."

On the Truth and Reconciliation Com-

mission, Tutu said it held important lessons on forgiveness for those who have suffered in decades-old conflicts in Northern Ireland and the Middle East.

The instinctive thing is to try to get your own back. But once you go down that route, your action provokes a counter-action. And you are then down this road which they have been walking in Northern Ireland and the Middle East.

"What you then say is: I'm trying to understand you. I want to be in your boots. And I will be ready to forgive you. You, on your part, must be ready to ask for forgiveness." — Reuters

Gulf war cancer scare ignores facts

by Steve Connor

It is almost impossible for science to prove a negative: to show that cellphones are not the cause of brain tumours, to demonstrate that the measles, mumps and rubella combined vaccine does not cause autism, or to prove that depleted uranium is not the cause of the illnesses suffered by veterans of the Gulf war and Balkans conflict.

In the case of depleted uranium, however, scientists have the benefit of several studies, some going back 50 years, of the health risks of working with uranium.

Melissa McDiarmid, professor of medicine at the University of Maryland school of medicine in Baltimore, is more familiar with this scientific literature than most. She has also studied and cared for some of the 60 American soldiers who became accidental victims of depleted uranium "friendly fire" incidents during the Gulf war.

There are essentially two reasons why the military has chosen to make armour-penetrating bullets out of depleted uranium: it is cheap and highly effective. As a by-product of the nuclear industry, depleted uranium is abundant. It is about twice the density of lead and packs an enormous punch as a "kinetic energy" penetrator, using its considerable momentum to crack open the toughest armour. Depleted uranium penetrators also self-sharpen during impact and are pyrophoric, meaning they ignite when slicing through thick toughened material.

Depleted uranium is chemically identical to uranium, a natural element. The nuclear industry extracts as much of uranium-235 and 234 as it

can from uranium ore in order to make the enriched raw material for nuclear fuel. What is left behind is "depleted" and possesses only 60 percent of the radioactivity of natural uranium, which is itself not very radioactive.

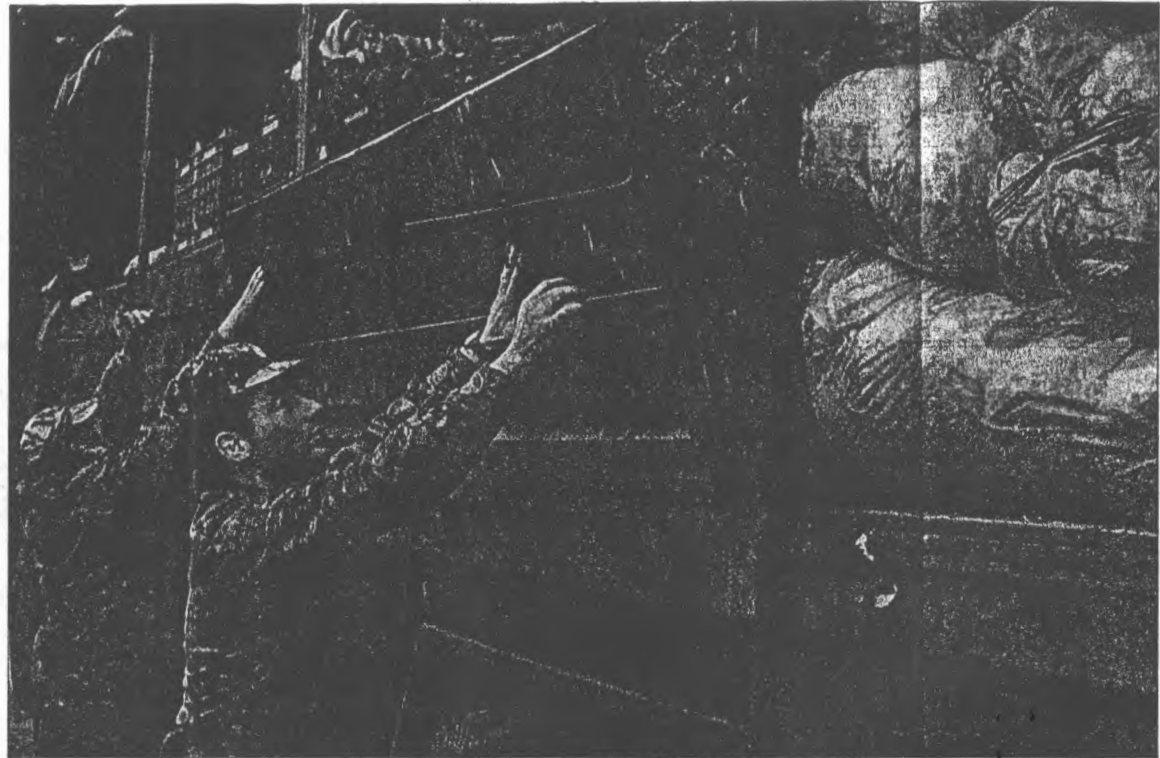
"Unlike many agents that seem to prompt health concerns suddenly, we know quite a lot about the health effects of depleted uranium," McDiarmid says. There have been 11 extensive studies of uranium miners who have been monitored for a range of cancers and other illnesses.

When the United States Centre for Disease Control and the Agency for Toxic Substances and Disease Registry reviewed the evidence, they concluded that "no significant differences in cancer [of the lungs] was found between workers who are occupationally exposed to uranium and control populations".

A committee of the US National Academy of Sciences and Institutes of Medicine has also reviewed the scientific literature and concluded that there is no evidence to prove that uranium exposure in these workers has resulted in cancer, but neither have the studies been able to rule it out unequivocally.

The difficulty of "disproving" a health risk with depleted uranium was also highlighted in a study by Steve Fetter, from the University of Maryland, and Frank von Hippel, a nuclear scientist at Princeton University in New Jersey. Their review of the scientific literature was one of the most extensive undertaken, and they looked at both exposure to soldiers and civilians living in the area where depleted uranium was used.

"Due to the low radioactivity of DU [depleted uranium], radiological



Active service: Greek soldiers load provisions for their peacekeeping forces in Kosovo last week. Greece is among several nations screening its troops because of a health scare over depleted uranium used in munitions during the Gulf and Balkans conflicts

PHOTOGRAPH: AP

hazards to individuals would become significant in comparison to background radiation doses only in cases of prolonged contact, for example, when shards of a DU penetrator remain embedded in a soldier's body," they wrote in the journal *Science and Global Security*.

"Although the radiation doses to virtually all civilians would be very low, the cumulative population dose resulting from the dispersal of hundreds of tons of DU, as occurred dur-

ing the Gulf war, could result in up to 10 cancer deaths.

"Our tentative conclusion is that concerns about the public health and environmental effects of DU are overblown... DU contamination is unlikely to have any measurable effect on public health in Iraq or Yugoslavia," they say.

The continuing study of the American servicemen has also failed to identify a cancer risk, or indeed any other illness not directly

associated with being injured by a munition. Yet these people, about a quarter of whom still have DU shards in their bodies, have been exposed to the highest doses imaginable. This will not impress the low-level radiation campaigners who believe that particles of insoluble oxides created when DU burns become lodged in the lung, where they can emit dangerous alpha radiation.

They claim that this could account for the half dozen cases of

leukaemia in Italian soldiers, even though cancer specialists doubt that blood cancers could have arisen so soon after the apparent time of DU exposure in Bosnia.

McDiarmid is aware of the problems she and other scientific sceptics face. "You come off sounding as if you're dismissing what has happened to these young people. I am not... but equally we cannot ignore what we already know," she says. -

Foreign Service

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Alternative therapies are not 'demonic arts'

I WRITE with reference to Judith Soal's article of March 7, entitled, "Demonic' Ceres health practice closed."

I agree with David Nye (chairperson of the SA Complementary Medical Association) that physiotherapist Brunhilde Winter needs education, and take exception in the strongest possible terms to her claim that complementary therapies such as aromatherapy, reflexology and reiki are "demonic" or have any roots in the occult.

For her information, aromatherapy originated in France, reflexology was practised by the ancient Egyptians, and reiki was developed by the dean of a Christian university in Kyoto.

Practitioners of complementary therapies do not "invoke spirits". These therapies are not allied to religion at all.

If Winter or Christians anywhere have any questions they would like answered about aromatherapy they are welcome to contact the Association of Aromatherapists Southern Africa on (021) 531-7314.

Both the owner of the gym and the concerned farmer admit that they know little. What a pity that fear of the unknown should deprive Ceres of two caring therapists.

HELEN RANGER

AROMATHERAPIST, RONDEBOSCH



**MEXICO:
THE DAY OF
THE DEAD**



Holbein



Jo Spence/Terry Dennett, *The Final Project*, 1991-2