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Four Sights of the Patient (Ophelia)

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Four Sights of the Patient (Ophelia)

by
Cecily Fergeson

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Abstract
I make work in a variety of media including photography, collage, drawing, painting, sculpture, and installation. My work incorporates the imagery and material of the human body. My current work attempts to reckon with the following subjects: a reclamation of the notion of the so-called *medical gaze* and its historical record in photography; the idea that receiving the *medical gaze* transforms patients’ bodies; the idea of illness as an *uncanny* and intimate experience; and, finally, the act of metaphorically retracing the body’s material journey through the medical institution as it exists today. I make this work in the context of a recent observation of surgery and my personal history with chronic illness and disability.

The history of Western medical photography haunts my work. In my practice, I find, make, and remake images of fragile bodies caught before the lens. When I do not photograph or construct these bodies myself, I appropriate and obtain images from various collections, public and private, of the expansive category of photography that I will from this point on refer to as the Western archive or archives of medical photography. I crop these images closely in the attempt to raise questions and contemplation about what kinds of bodies or situations exist beyond their clean borders. My work shades blue and violet what once existed in sepia and grayscale. It reprints and re-buries these flattened, vulnerable bodies in veils of graphite, pigment, and erasure in the attempt, through the gesture of drawing, to symbolically reinter the images. The goal of my work is to transform these scenes of disease, control, and physical holding between patients and caregivers – often so othered by age – from spaces to be looked *at*, to spaces the viewer must look *into*. My work attempts to explore and map the liminal space between the depths of the medical institution that these archives of photography reveal and the shallows of the outside world.
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One can feel obligated to look...One should feel obliged to think about what it means to look.\textsuperscript{2}  
– Susan Sontag, \emph{Regarding the Pain of Others}
Introduction
My work includes photography, drawing, painting, installation, collage, and other interdisciplinary methods of making. In my work, I explore and experiment with the issue and mechanics of the medical gaze, the body, and memory. My latest pieces grapple with the pictorial record of the Western medical institution: its archives of photographs, particularly images of patients, taken by doctors, professional photographers, and anonymous assistants. In this text, I explore my work and its relationship with the notion of the medical gaze – a term developed by Michel Foucault in 1963 – specifically through the lens of my own amateur observation of medical procedures as well as the notion of the archive as seen through the eyes of an artist. I will discuss the relationship in my work of the color blue-violet to ideas of falling, dimensionality, and the negotiation of agency between the viewer and the referent. I also focus on how my work addresses the idea that the patient’s body, in receiving the medical gaze, is transformed by it. I consider my practice in the context of the idea of illness as an uncanny state of being, alluding to the perceived presence of multiple wills – the splitting of selves into foreign and familiar, antagonistic and protagonistic – inside of one body that the experience of disease may cause. Finally, I discuss my work as it relates to the trace of the patient’s body. Throughout the text, I describe my practice and examples of my work. I end with paragraphs from my own observations of surgery and personal experiences of chronic illness.

The underlying inspiration for my work is my experience of growing up alongside a sister with neurological and physical disabilities. As a result of this developmental environment, I gained a sensitivity to the patterns of looking at difference embedded into the social structures surrounding my family and myself. Instead of simply looking at others with visible illnesses and disabilities when I encountered them – that dreaded stare that most people avoid, if not out of kindness or habit, at the very least learned propriety – I gained a general self-awareness that I
was looking. What does it mean to look? In the following text, I will discuss how my work attempts to explore this question.

In the first chapter, I describe my most recent work in drawing from and collaging with images, taken by doctors, photographers, and anonymous assistants, that my work appropriates from certain collections of the medical archive. I account for the sections of the archive that I have researched, appropriated, and restructured in my collage works. I have recently focused in particular on early photographs (mid-to-late-nineteenth century) that retain compositional elements of traditional portrait painting because these images, unlike contemporary medical photographs, typically contain not only the entire body of the patient, but also identifying features, including the face. In my practice, I attempt to break the hermetic seal of these historical images that allows their referents to be looked at so easily. I hope for my work to reclaim these images, and, in a symbolic sense, rebury not the patients themselves, but rather their memories. In the second chapter, I describe how the color blue-violet informs this segment of my practice.

In the third chapter, I discuss my work with uniform-making and how I intend for this work to explore the patient’s body as that which receives and is transformed, not only by the medical gaze, but also by the trappings of the contemporary medical institution. In this part of my work, I make altered versions of institutional garments such as hospital gowns and document the process of a model trying them on. I consider my documentation of these transformations in my studio with a model as a series of works in themselves: evidence that the transformation took place.

In the fourth chapter, I discuss my work with photographing soft, transparent body casts, which I make in the conceptual context of the uncanny body and the ill or disabled body as
uncanny. The process of making these casts is intimate, as it involves the direct touching of the bodies of others or my own for several hours. In their final form as photographs, the casts are also intimate, as they accurately reproduce the texture of the skin down to the last wrinkles and areas of scar tissue.

In the fifth and final chapter, I discuss my work as it pertains to the notion of retracing the journey of the patient’s body through the network and trappings of the contemporary medical institution. This body of work deals with fluid, staining, and imprinting: the retracing of a voyage forgotten, washed, and sanitized. Finally, as an addendum, I recount two metamorphoses: my own transformation from someone healthy into someone with a permanent diagnosis, and that of a patient whose surgery I was invited to watch.

As I have never known a reality apart from close relationships with those whom my society and its medical institution regard as being possessed of flawed or disabled bodies – the most important relationship being that which I have with my sister – I feel that I cannot escape the troubled idea of looking at illness: the way I look at it, the way I see others looking at it, and, finally, the way medical professionals look at it – the medical gaze. Among its other objectives, my work attempts to reckon with the recorded history of that looking. The following discussion of my work will delve into how and why, in manipulating imagery from archives of medical photography, my recent work tries to reclaim the subjectivity and memory of patients through a symbolic washing, shrouding, and re-interment in collage and drawing. It will also describe how my work tries to grapple with the transformation and trace of the patient’s body in the setting of the medical institution today. I hope for my practice to be one of reclamation and recovery: of healing these memories of flesh.
The *Medical Gaze*
(Amateur Observation and the Archive)
My current work attempts to deal with the concept of the *medical gaze* as it exists in images from the late nineteenth century in archives of Western medical photography and the representation of the patient as both subject and object. *Four Sights of the Patient (Ophelia)* is an installation of four large framed drawings; while each frame is four and a half feet tall and three feet wide, the drawings are different sizes (fig. 1). Three of the drawings are three and a half feet tall and two feet wide, fitting the proportions of their frames, and one is much smaller – nine by six and a half inches – floating in the upper portion of its frame. The images are four photographic collages printed on inkjet paper with mixed media drawings executed on their surfaces. The collages consist of medical photographs I appropriated from the archive of the Mütter Museum of the College of Physicians of Philadelphia and photographs I staged and shot to fit with the appropriated sources.\(^6\)

While I made different drawings on their surfaces, the grounds for the leftmost and rightmost drawings in *Four Sights of the Patient* are duplicates of the same digital collage (fig. 2-3). I composed this digital collage from three images: high-quality scans of two archival images from *Mütter Museum: Historic Medical Photographs* and one of my own digital photographs.\(^7\) In the photograph I scanned from page 124 (shot by Edward Pennock, optician, 1897), a nurse in a long dress, apron, and white hat stands in front of a waist-high counter, holding a patient steady for the camera. The patient is young – small enough to stand on the counter the nurse leans against. Their heads meet the same height. It is difficult to tell what sex the child is; though he or she is bare-chested and wears a loincloth, secondary sex characteristics are indiscernible. Each of the nurse’s hands perches on one small shoulder, left and right. The figures’ positioning made me think of a mother hoisting her child up to sit on the counter for a toenail clipping. Though I doubt that this familial relationship structure applies to them, I was attracted to the figures in this
image precisely because of that shadow-narrative of intimacy I perceived (or, rather, felt myself compelled to project upon them). In images like this, there are multiple layers of archetypal identities and narratives to sift through: the nurse is the caregiver, is the mother, is the woman. The patient is the child and the care-receiver.

The second archival source I used to make this collage base is on the page directly opposite of the image discussed above (125). This photograph, made in 1899 by an unidentified photographer, shows another long-dressed nurse, leaning against another waist-high counter, propping up a child patient. Again, I can see that this patient is a small child – perhaps four or five years old – because he or she stands on the surface against which the nurse leans her hips and, as in the previous image, their heads are the same height. The nurse wraps her arms around the patient’s lower body. Her face is inscrutable: the camera’s blurring makes it difficult to see whether she makes eye contact with the viewer or the floor beneath her feet.

I chose these images, with their leaning and patient-propping nurses, for the mix of reassuring and trapping figurative gestures I perceived the caregivers making toward the patient, the photographer, and themselves. I digitally combined these scanned archival images of nurses and patients with a photograph I took of a model – a young woman in a light blue modern hospital gown, which I found at a military surplus facility – in the hope of forming a structure of balanced bodies that conveys ambiguous holding and support. The two nurses, now on the left and right, flank a single, central figure in the collage. This central figure is now three figures in one: two children and a young woman in a hospital gown, shifting in and out of each other in the transparencies I digitally layered. This collage then became two different drawings.

To make the second image from the left in *Four Sights of the Patient* (fig. 4), I appropriated source material from page 195 of the Mütter Museum monograph: a photograph of
an *Unidentified Mental Illness*, shot ca. 1892-1900 by James F. Wood for the Philadelphia Psychiatric Society. A nurse in a floor-length white gown and lace-edged cap holds the patient still in the middle of the frame by gripping her elbows. The patient, a young woman in an ankle-length white dress, tilts her head all the way back in a strained position, exposing her whole throat and hiding her face. Into this image, as before, I digitally collaged a photograph I took of a young woman wearing a hospital gown. The back of her gown gapes open as she drifts through the composition in the foreground.

Once I digitally completed the collages, I printed them on matte inkjet paper, stretched and stapled them to the wall, and painted their surfaces with acrylic clear gloss medium. I then took graphite powder and applied it with a rag, darkening the whole of each image. Finally, I used erasers to excavate some areas of the images. I repeated this process, layering the drawing with barrier medium and graphite, darkening and lightening, until I saw that the spaces in the archival collages (now drawings) seemed deeper than that of their original source images. This process varied from composition to composition depending on the major shapes of the foreground and background. In the finished drawings of *Four Sights of the Patient (Ophelia)*, the graphite looks dark and dirty in some areas, and metallic and reflective in others. I planned for these effects to strengthen the intended visual impact of the work: a simultaneous sense of pushing and pulling. I also erased abstract shapes into the layers of graphite. Through the dull and reflective layers of medium and collage, these shapes attempt to penetrate the layers of the drawings, re-negotiating the distance between the viewers’ gazes and the images’ vulnerable referents. In manipulating the depth of these images, I hoped that my work might transform the appropriated photographs into objects that viewers must look into, rather than at.
Only one piece in *Four Sights of the Patient* does not include any appropriated imagery from the archive. The frame second from the right in the installation holds a small drawing, only nine inches tall by six and a half wide: a photograph of an uncertain feminine face, life-sized, painted with clear medium and smeared with violet pastel (fig. 5). When I made this work, as with its larger fellows that I covered in graphite, the purple pastel powder caught and became opaque in the matte areas I had missed covering in gloss with my brush and hands. Unlike the three larger drawings in *Four Sights of the Patient*, this image floats in a vast space. Of all the figures in these drawings, she alone stares directly back at the viewer. Her features slip and swim: she resists diagnosis, and, I hope, the imposition of solid narrative.

As Gretchen Worden notes, the earliest (early-to-mid nineteenth century) photographs of visible medical conditions, especially if taken of advanced cases of disease that severely warped the patient’s body, functioned as objects of private spectacle or “amazement” before they matured into primarily “records of progress in surgical technique.”[^9] I try to take this history of troubled looking into account in my practice; I want my work to struggle with the ethics of how to respectfully reckon with these photographs and their problematic history with patient agency and dignity. My recent work with drawing and collage, in a sense, tries to rehabilitate or reclaim these images.

This work with drawing, collage, and images from the Western medical archives finds its context in the notion of the modern *medical gaze* as defined by Michel Foucault, which Susan Ritchie sums up as “the process by which physicians construct patients by ‘seeing’ some previously represented medical pathology inscribed on their body.”[^10] In other words, the patient’s identity *becomes* the diagnosis, and vice versa. Foucault further points out that this gaze

[^9]: "The process by which physicians construct patients by ‘seeing’ some previously represented medical pathology inscribed on their body.

[^10]: "The process by which physicians construct patients by ‘seeing’ some previously represented medical pathology inscribed on their body."
coalesced into a network in the early nineteenth century, weaving ever more deeply into society at large as time progressed into the twentieth century:

Medicine can coincide with social space, or, rather, traverse it and wholly penetrate it. One began to conceive of a generalized presence of doctors whose intersecting gazes form a network and exercise at every point in space, and at every moment in time, a constant, mobile, differentiated supervision...since the question of the settling of doctors was not enough, the consciousness of each individual must be alerted; every citizen must be informed of what medical knowledge is necessary and possible.11

Stanley Burns, whose archive of medical photography has been published as the monograph *A Morning’s Work*, places the birth of “modern medicine” at a similar date to that which Foucault estimated, arguing that it began in tandem with the birth of photography in the mid-nineteenth century.12 Roy Porter further notes that modern medicine, or “scientific medicine,” is equivalent to the institutional practice that has developed particularly in the West over the past two and a half centuries.13 It is in this institution – in its conceptual framework, its hospitals and clinics, and its representational history in the photographic archive – that my practice attempts to find its bedrock. I am as fascinated by the holes and cross-fibers in Foucault’s “network” as by what it has captured: centuries of images of caregivers and patients passing through its warp and weft.

As my recent work attempts to reckon with sensitive archival material, I am interested in artistic practices that deal with historical archives. Bracha Ettinger works with imagery of catastrophic trauma and atrocity, particularly photographs taken by perpetrators during the Holocaust. As Griselda Pollock describes it, Ettinger’s practice engages in “a series of painterly transformations of fragments of archival photographs from the genocidal Europe of the 1930s and 1940s.”14 In her *Eurydice* series of paintings (1992 to present), Ettinger repeatedly works with an anonymous perpetrator photograph of a line of Jewish victims, stripped and awaiting
execution at the hands of the *Einsatzgruppen* in 1941 Ukraine.\textsuperscript{15} In *Eurydice, No. 17*, in which Ettinger has Xeroxed a pale and warped copy of this image onto paper and mounted it to canvas, shadowy figures huddle, barely defined, in high contrast against the paper and raw canvas backdrop (fig. 6). They seem to tremble or vibrate. The shades of violet, red, black, and blue pigment and paint veiling the fragile crowd seem to have been applied in horizontal swipes, so that the edges of each figure are pulled back and forth in striations. The paint appears thicker in some places than in others, effectively creating a protective “membrane,” as Pollock puts it, between the reproduced archival imagery and the viewer’s gaze.\textsuperscript{16}

I intend for my work to acknowledge ideas of identity, consent, and the visibility of the patient’s body by way of obfuscation. In this continuing part of my practice, I change the archival materials’ colors and shroud them in veils of graphite and pigment. I then attempt to deepen and fracture that space through erasure and drawing. My work hopes to engage in a symbolic washing and shrouding of these archival images so that it might reclaim the memories of these patient’s bodies. In a sense, my practice treats these images as bodies. I intend for my work to offer a sense of awareness that, in choosing to rebury these patients’ images – these vulnerable, flattened figures – one must first unearth them from their resting places in the archive.

Though my work appropriates images of vulnerable bodies from Western archives of medical photography, and I acknowledge their photographers and the sources where I found them, I do not reproduce the images here in this text. I follow the reasoning of Pollock’s essay, cited above; while Pollock verbally describes some of the more traumatic images with which Ettinger works, she declines to reproduce them in her critical essay on the *Eurydice* series:

To reproduce [those photographs] here would be to deny the whole purpose of this artist’s work on the relations held before us in the work of her painting in relation
to the very fact of the existence of a representation of a moment before a death that the photograph’s “shooting” disturbingly doubled in that inexplicable act of documenting wholesale murder.\(^{17}\)

I have decided not to show the archival footage my work appropriates, particularly if it features identifying images of patients, because I feel that this exposure would defeat the point of my attempts, in terms of ethics, to reclaim this archival material. The ethics of dealing with images that expose the bodies and vulnerabilities of people suffering from (or simply living with) medical conditions to the gaze of whoever comes across them, particularly in the context of museums and archives of curiosities, complicates my practice and work. Though the patients appearing in the images my work appropriates from the late nineteenth century are dead, this does not and should not absolve my work of being subject to this question: is it ethical to dredge up painful images and put them on display, even with the intent to rebury them with a greater sense of love and dignity? To do it without consent, even if those who could consent are dead? Should my work assume this privilege? If so, why?

In *The Art of Cruelty*, Maggie Nelson unpacks a critical conversation surrounding ethics in the photography of Diane Arbus, specifically noting Susan Sontag’s commentary:

Arbus supporters have tended to…[cast] her forays into various subcultures (nudist colonies, circus sideshows, the world of sex workers, homes for retarded adults, and so on) as those of a fearless and compassionate renegade. Meanwhile, her detractors have charged her with being an “exploitative narcissist,” slumming it in communities in which she did not belong in order to generate provocative portraits that are fundamentally unkind to their subjects…In this polar version of events, Arbus’s excursions to the “dark side” are either a record of adventuresome fellow-feeling or an extended exercise in callow, cynical coldness. Sontag famously thought the latter – in her 1977 book *On Photography* she roasts Arbus for “concentrating on victims, on the unfortunate – but without the compassionate purpose that such a project is expected to serve.”\(^{18}\)

Apart from exploitation, exposure, and nonbelonging, it seems that the gaze of the photographer is implicated as a problem here because the question of consent arises: did the
referents in the photographs agree to being photographed this way? Why would they? Could the people with disabilities consent? Nelson disagrees with this line of thinking, commenting that the imbalance of agency Sontag imagines in her criticism is skewed by her assumptions:

In retrospect, it seems clear that the problem lies more in Sontag’s standards than in Arbus’s cruelty. Changing times have not served Sontag’s assessment well, as the so-called victims and unfortunates captured by Arbus that Sontag presumes we should pity — those lives Sontag assumes are defined by horrific pain — include drag queens, dykes, sex workers, sideshow performers, interracial couples, and others for whom pity does not now seem, a priori, the order of the day.19

I feel that this conversation about the ethics of seeing, photographing, and reproducing images of the vulnerable, marginalized human form inspired me to think more critically about these issues as they might appear in my work. The photographs my work appropriates and recovers under layers of color and gesture are from the historical archives of Western medicine. Even if the dead could consent, there are no documents indicating whether many of the patients my work visually references consented to being photographed while they were alive. I do not want my work to function as, or to be about, the re-exposure of these bodies as curiosities, fodder for the othering gaze, or do the same to the identities of the bodies’ owners: I hope, rather, that my work will do the opposite — to reclaim and re-bury these images-as-bodies’ memories.
Blue-Violet as Dimensional Fulcrum
In *Four Sights of the Patient (Ophelia)*, the second drawing from the right floats in a large, white space: a young woman’s face, blurred in the inkjet photographic print and skidded over in violet pigment, stares out at the viewer (fig. 5). Her mouth opens slightly. Below her eyes, a second pair of eyes, half-lidded, sink into the soft pink of her cheekbones. The young woman’s head pushes at the boundaries of the photograph. Large purple splotches obscure parts of her forehead, nose, and much of her left cheek. When making this drawing, I intended for its soft color scheme to fall somewhere between indicating bruising of the flesh and bruising of the image itself. The layer of powder and clear medium applied to the work attempt to push and pull at the photographed reality here. The color spectrum surrounding purple – particularly blue-violet – has become increasingly important to my recent work’s grappling with the idea of the *medical gaze*, both aesthetically and as a vehicle for meaning.

I became inspired by blue-violet during my research of the Burns Archive monograph of historical medical photographs, *A Morning’s Work*. Located in New York, NY, the Burns Archive & Collection is one of the world’s largest collections of early medical photography.\(^{20}\) I was looking for photographs to appropriate, ideally of figures holding each other and themselves up, down, and together. I noticed that the monochromatic images in this collection of reproductions typically appeared in shades of brown, yellow, sepia, and variations of grayscale. However, some of the plates were different: neither sepia nor true grayscale, they appeared blue-purple, especially in comparison to one another (fig. 7). Their color caused the images to strike me differently. They seemed less like documents of a faded past and more otherworldly. I looked in the back of the book and found that these images resulted from a wide variety of photographic techniques used before the advent of color and digital photography. Those that appeared blue-violet in re-print were nearly all originally gelatin silver prints.\(^{21}\)
In my current work, blue-violet functions as a solvent for the exoticization effect that age tends to have on the visual impact of archival images. My works are partly inspired by how the grayscale and sepia colors of these objects, combined with historical dress and context, can trigger feelings of nostalgia and assumptions of archaic notions in the narrative of the images. These archival photographs, as objects (and, I would argue, especially as reproduced prints in books, evoking history textbooks), alienate history and its events from the contemporary eye. The past, they seem to say, is very much past: it is not gone in the sense of not existing, but it is othered as something overcome, left behind. It is my goal that, as the abovementioned archival material did for me, that blue or blue-violet, if used as a tool in my work, will help to prevent viewers somewhat from feeling that they are seeing a flat image of history. My work, with the help of blue, will hopefully puncture that space and make it deep, causing viewers to no longer feel themselves completely safe, opposite and apart from the documentation of a patient’s vulnerability. I hope to use blue in my work to implicate the viewer’s gaze, as blue implicated me and my looking as I searched through this archival material.

Yves Klein wrote about blue as a transcendent force that functioned beyond the capacity of any other color to suggest the metaphysical and the infinite:

Blue has no dimensions. ‘It is’ beyond dimensions, while the other colors have some. These are the psychological spaces…all colors bring forth associations of concrete, material, and tangible ideas, while blue evokes all the more the sea and the sky, which are what is most abstract in tangible and visible nature…blue, on the contrary, will create a suggestion of the elementary state of the brutal budding of matter.22

In Klein’s painting *Untitled Anthropometry with Male and Female Figures* (1960), the viewer encounters a large canvas (four feet, nine inches tall and ten feet, five inches wide) with five ultramarine-blue body-prints of human bodies (fig. 8). Each body print spans from kneecaps to shoulders. Klein himself made the outermost and center prints, while a female model made the
other two. Each print suggests a body held in a static, straightforward position. There are ghostly echoes of bodies’ silhouettes between each opaque form. When I see this juxtaposition of static, solid body prints evenly spaced across the printing surface and their vanishing echoes in between, I perceive a strange sense of motion in the painting. Klein’s blue, especially in the solid areas, is so vibrant that, to me, it almost seems like the bodies that made the prints did not stop when they pressed against the canvas, but fell right through to the other side. And they kept on falling.

Klein writes about blue and its evocation of sea, sky, and dimensionlessness. I am inspired to conclude that, if blue is indeed dimensionless, or boundless, then blue can symbolize or suggest potential free-fall: if not forever, then for a very long time. The sky and sea are not actually dimensionless, but blue is the color of these things – these natural phenomena – that are too huge for the mind to hold in entirety except for in abstract terms. Though humanity has left the Earth’s atmosphere since Klein made the abovementioned work, we have still not descended to the absolute bottom of the ocean. I believe that to see a powerful blue can be, in a sense, to see in abstraction the concept of falling. My work attempts to employ this idea.

In my work *Four Sights of the Patient (Ophelia)*, the violet-mottled photograph of a young woman’s face, floating in the large blank area in the second frame from the right, inspired me to create the last part of the work’s title in parentheses: *(Ophelia)*. I felt compelled to call this face, and subsequently the whole work, by that name because – looking at her under those brushstrokes and dashes of blue-violet – it seemed to me that I had nearly drowned her. I felt, too, that the veiling in the other drawings had begun to evoke a sort of lapping effect: layers of blue-grey transparency clustered around certain objects like islands in the ocean. And so, in part, I named this cluster of four drawings after *Ophelia*, the drowned Shakespearian maiden. Ophelia
refuses to sink quickly in either of the two contexts which came to my mind when I thought of her in relation to my recent work. First was the Shakespearian image of Ophelia in *Hamlet*, when the young woman drowns herself on hearing that her lover has murdered her father:

There, on the pendent boughs her coronet weeds
Clambering to hang, an envious sliver broke;
When down her weedy trophies and herself
Fell in the weeping brook. Her clothes spread wide,
And, mermaid-like, awhile they bore her up;
Which time she chanted snatches of old tunes,
As one incapable of her own distress,
Or like a creature native and indued
Unto that element; but long it could not be
Till that her garments, heavy with their drink,
Pull'd the poor wretch from her melodious lay
To muddy death. 24

The second image of Ophelia I imagined when naming this series was Sir John Everett Millais’s 1851 painting (fig. 9-10). In Millais’s *Ophelia*, a pale young woman with long reddish hair, wearing a jeweled gown, sinks halfway into the water of a deep blue-violet river. The banks, narrow around her figure, are dense with vibrant green foliage. Bright flowers in colors across the spectrum float around her head and upper body. Her face, chest, and hands emerge from the water; she arches back slightly, mouth open. The part of the title of my recent work that refers to this character attempts to communicate that, while these images of patients – and their referents, the patients themselves – sink ever farther into history, my work might allow them in a sense to continue speaking. Further, I hope that my work, while it symbolically re-shrouds these sinking bodies, should never bind the agency or voices of their imaged memories.

I was delighted to discover, in the course of refreshing my memory of Ophelia, that Bracha Ettinger uses the name “Ophelia” in her practice, along with “Eurydice” and others. I have already discussed how Ettinger’s work inspires me: I am attracted to her use and reclamation of traumatic archival images. However, I am also deeply inspired by the way
Ettinger deals in her practice with feminine archetypes, using them to re-orient conversations around contemporary womanhood, creativity, and vulnerability. Pollock comments on Ettinger’s use of the name Eurydice, citing the artist:

The Orphic look, looking back into the space of death rather than following the light to a future, is, therefore, deadly: it kills a second time. But this scenario of Orpheus and Eurydice opens up a space between two deaths. What, asks artist Bracha Ettinger, does Eurydice say, she who has seen the inhuman and suffers a second, mortal blow from a human gaze in whose homicidal return she is condemned to become a lost image, an image of the lost, loss itself as a feminine image? Thus this space between two deaths comes to be linked with the image, loss, death, and the feminine…Bracha Ettinger writes, “The figure of Eurydice seems to me to be emblematic of my generation, seems to offer a possibility for thinking about art. Eurydice awakens a space of re-diffusion for the traumas that are not reabsorbed. The gaze of Eurydice starting from the trauma and within the traumas, opens up, differently from the gaze of Orpheus, a place for art and it incarnates the figure of the artist in the feminine.”

Indeed, Eurydice is not just a name for a mythological person who died a second death. Eurydice is a woman. Tina Kinsella notes that Ettinger’s use of Ophelia’s name fits into Ettinger’s exploration of troubled feminine archetypes: the twice-lost (Eurydice), the reviled (Medusa), the cautionary (Ophelia), the stolen (Persephone). All are dead, damned, or lost. Some are mourned. None are forgotten. Kinsella describes the weight of these names in Ettinger’s more recent paintings (fig. 11-14):

A new series of oil paintings has emerged: Medusa—Demeter—Persephone. Ophelia, the “crazy” maiden now appears alongside the monstrous serpent-haired Medusa (Ophelia, Medusa, nos. 1 and 2, 2006-2013); the Graces, the three goddesses who bestowed charm, grace, creativity and fertility, escort Eurydice and Medusa (Eurydice, The Graces, Medusa 2006-2012), Persephone (Eurydice, the Graces, Persephone 2006-2012) and Demeter (Eurydice, the Graces, Demeter 2006-2012). In Ophelia, Medusa nos. 1 and 2 we see what appears to be a mouth, perhaps a silenced scream, that reappears in Medusa no. 1. Sometimes a face appears, almost doubled, as in Eurydice, the Graces, Demeter 2006-2012 and Eurydice, the Graces, Persephone 2006-2012. The Graces and Demeter keep company with Eurydice, there where Bracha keeps her and us at the threshold before the killing look of a second death, and we cannot quite see her. Then Persephone joins the Graces and Eurydice, she is Johannes Vermeer’s Girl with a Pearl Earring and she no longer inhabits the canvas alone. Finally in Demeter,
Persephone 2006-2013, the mother and daughter duet are reunited — or ensnared — in milky fronds. But look closer: here too is Medusa of the gaping mouth and she is doubling, multiple: she is legion. In this way, Bracha’s artworks cannot be considered in isolation, nor as repetitive serialisations. Rather...they are musical variations that weave webs and invoke shamanic initiations through the history of art, across and beyond time to forge conduits for the feminine: past, present and future. All these female figures which are held together as a defiance of the Now, in abeyance for the Eternal.\(^{27}\)

In *Four Sights of the Patient (Ophelia)*, the work attempts to consider Ophelia on terms more specific than someone who, driven mad by grief, falls into a river and drowns: Ophelia is a feminine presence and archetype. Her agency in the matter of her legendary death is questionable. Neither Shakespeare’s text nor Millais’s painting confirms her demise as suicide or an accident. Ophelia sinks into the dark, blue-violet water, weighed down by her heavy garment, as if it is an inevitability. This recent work, *Four Sights of the Patient*, which primarily depicts female patients and caregivers, reminded me of this ambiguous state of vulnerability and agency in the story of Ophelia, a character who chooses to surrender her choices to the water – to a blue-violet into which she falls. In Shakespearean terms, she is never to return, but in Millais’s painting, Ophelia always remains half-above the surface. I see patienthood as my work tries to represent it in both ways: some patients are able to sink only partially into the medical institution, but others are swallowed entirely.

In my work, I attempt to allow the color of blue or blue-violet the power to access a specific kind of malleability: when reproducing archival images, I sometimes digitally tint them in shades of blue so that the viewer has an opportunity, as I did, to not only avoid the alienating connotations of the antique but also have the opportunity to feel pulled into the work – into the suggestion of falling that blue can create. When I do not use blue digitally in my process, I apply the color directly to the print with pigment, as in the abovementioned segment of *Four Sights of the Patient*. My work attempts to achieve a kind of bending of space-time around blue-violet: if
this aspect of the work succeeds, the viewer has less of a chance to assume all the agency in the relationship between their gaze and the referent’s (patient’s) vulnerability as the object of the assumed *medical gaze*. In my work, I hope to make blue-violet function as a dimensional fulcrum: a way of reaching Ophelia and those who sink with her into the archives of medicine.
Reception of the *Medical Gaze* (Transforming the Patient’s Body)
In my series of photographs *Woman in a Long Hospital Gown*, the viewer encounters the artist and a model testing different ways of wearing an altered hospital gown, the *Long Hospital Gown* (fig. 15). When worn, this altered gown, in turn, visually alters the body of the patient – or at least, in carefully staged photographs, appears to hide an altered (or alternate) human form. This body of work exists in the context of the patient’s reception of the *medical gaze*. In this facet of my practice, I try to communicate how receiving the *medical gaze* transforms the patient’s concept of her body, and, as a result, the body itself.

I incorporate the making of clothes as a part of my practice, taking garments or the patterns for garments ordinarily found in hospitals and clinics and warping them until they are unrecognizable or useless for their original purpose. I made the *Long Gown* in the attempt to amplify the notion of the physical and emotional vulnerability of wearing a temporary garment in the space of the medical institution. The *Gown* consists of several hospital gowns that I found at a military surplus outlet. The gowns that formed my source material can be worn by any sex and most body types. They are made of CVC fabric (fifty percent cotton, fifty percent polyester) and printed with a regular navy blue pattern on white ground. The original gown is forty-five inches long from collar to hem: long enough to cover most adult patients from the neck to just below the knees. The *Long Hospital Gown* consists of material from six of these garments. It is one hundred and eighty inches long, or fifteen feet from collar to hem.

It was my first instinct to make the gown long at the bottom to keep it recognizable as a hospital gown and to implicate more of the body in its design. The most fraught aspect of the typical hospital gown is its open back, which I specifically manipulated in this work in the hope that the garment would functionally and symbolically increase the typical hospital gown’s proximity to nakedness. I hoped that to drastically grow the main body of the *Gown* would
increase its potential for revealing the body, heightening the anxiety that the open back produces.

I intended that the Gown would appear incapable (or at least less capable) of its intended function: to easily switch between securely covering and revealing the body. As I constructed the garment with my sewing machine, I added ties – which appear at the back of the neck and waist on either side in a typical hospital gown – at regular intervals, all the way down the back of the new garment. The ties are functionally purposeless after the first set of two.

As a photographic series, Woman in a Long Hospital Gown attempts to point to, and make symbolically present in a garment, the warping of self-perception that clinical or hospital uniforms and trappings can cause in patients. In these photographs, the viewer encounters the artist and the model testing out different ways of wearing the Long Gown. Its material is expansive enough to contain two, three, or even four bodies. Some poses, such as when the model stands on a ladder and allows the gown’s excessive material to hide her perch, suggest an uncanny body beneath the garment: the image suddenly implies that her legs are impossibly, inhumanly long. This iteration of the notion of the uncanny is specifically the anthropomorphic uncanny, as described by Ernst Jentsch: the discomfort that arises with the suspicion that an anthropomorphic object, such as a mannequin, is in fact a living human, or that a living human is in fact an inanimate object.29

Ana Mendieta’s work with the body is an important inspiration to my practice. In 1972, Mendieta worked with a fellow student and model in her studio at Iowa University, where she documented the process of preparing for a series of performance works entitled Feathers on Woman. Several of these documentations became finished works in the form of still photographs (fig. 16-17). In most of the studio shots, Mendieta is in the frame, gluing soft white chicken feathers, one by one, onto her model’s nude body (fig. 18-19). Feather by feather, the model
transforms from a naked young woman into an avian creature that, while a hybrid of human and animal, remains unmistakably female: her unshaven vulva remains exposed (unfeathered) in the finished photographs. Serious in some of these documentation shots, Mendieta and the model smile in others, apparently sharing the moments of transformation as variously pleasant, humorous, and powerful.

The hospital gown claims the neutral body and declares it not only subject to the medical gaze, but also a part of the medical institution: uniform, penetrable, sterile. The Long Gown attempts to exaggerate this transformation to the point at which this situation loses its ability to disappear into accepted normality. In this sense, the garment-making part of my practice is performative in two ways. I perform the part of the fabricator of uniforms and the tailor, analogous to the designers who make gowns and sell them to hospitals and clinics. My model, in this case, does actually ‘model’ my designs. However, the performativity of this work takes on another dimension: I attempt to recreate and exaggerate the felt fragility that these institutional garments inflict.

As the model and I worked through the ways that the Gown could be worn and displayed in my studio, we experienced a sense of absurdity – after all, among its other idiosyncrasies, the garment is so long that it is easily tripped over. For myself, however, during that process, I know that I also felt a kind of grim fascination with how easily the Long Gown transformed the model’s body into something not quite human. In the finished series of photographs, the parts of the model that emerge from the gown call into question the parts that remain hidden beneath it. It is this affect that I believe my work tries to evoke across several mediums and forms: the visible body calling the invisible body into question.
Illness and the *Uncanny* Body (Negotiating Intimate Forms)
In the series of photographs *Performative Skins*, I created highly detailed, close-up images of objects mimicking parts of the human body. The photographs are not of the actual body parts they suggest: rather, they are of backlit, transparent soft casts of living skin. In *Venus*, the referent is a soft, transparent cast of the skin of my own torso (fig. 20). Likewise, *Vulcan* depicts the soft cast of a male torso – a former lover of mine – printed at the same size as *Venus* (fig. 21).

Though the finished pieces are photographs, visceral materiality and intimate touch were essential to the process of making this work. The objects depicted in the *Performative Skins* series were soft casts of skin made from single, large pieces of glue and latex painted directly onto the nude body in thin layers and allowed to dry. Sometimes I painted the material on with my fingers; sometimes I painted it on with a brush. I feel that the idea of touching the body is present in this work in a way not unlike my rejections of archival medical photography, in that the results of the touching negotiate a conceptual space between exposure and hiding, revealing and covering, making vulnerable and protecting. It took intimacy and trust to allow a fellow artist to touch my body to produce the cast for *Venus*. Likewise, I produced the cast for *Vulcan* from a former lover’s body.

Likewise, this intimate body-painting process yielded highly (intimately) detailed casts. *Vulcan* shows body hair in male-pattern areas and a lack of breast tissue; *Venus* displays breasts and a female genital area with remnants of hair. The glue and latex reproduced every wrinkle in the skin’s texture when I – or a partner – peeled the finished cast away. While they retained these small impressions, the casts lost the larger shapes of the body, sagging and stretching. When I hung the casts and placed light behind them, however, they regained a warped semblance of their former structure.
I cropped the resulting photographs closely in the hopes of causing the viewer to assume and doubt whether the visible cast-forms extend past the frame of the image into full bodies. In pursuit of this uncertainty, I purposefully kept the photographs from reaching their full potential to suggest a real body. I allowed the cast of breast tissue visible in Venus to remain dented. The navel looks scarred shut in the image; the skin bulges and warps. Tiny holes betray a white glow behind the object. This work attempts to emphasize that, structurally, the body it shows doesn’t look right. The work also attempts to suggest this wrongness in the color of the photographed cast – yellow-brown, greenish, and metallic, which does not suggest health. It is difficult to tell in the cropped photographs whether the skin is inhabited or not, hopefully making the photographed cast-bodies uncanny.

After I cropped the photographed casts of full human torsos in Venus and Vulcan to suggest the continuation of the body outside the visible bounds of the image, I experimented with even closer views of the body in other works in the Performative Skins series. Vortex is a photograph of a cast pulled directly from a young woman’s lower abdominal area (fig. 22). However, the glue cast for Hang Navel– although it resembles a feminine navel and pelvic area – I pulled away from one of my forearms (fig. 23). In making these images, I found that the light used to reanimate the casts was as important to the reality that the photograph suggests as were the individual details of the casts themselves. While both Vortex and Hang Navel suggest navels and bellies, the implication of the former resulted from the direct casting of an actual belly. For the latter, on the other hand, I made an arbitrary hole in the cast of my arm and lit it so that a navel and pelvis were falsely suggested. With the help of light, this work encourages one body part to perform, or appear as, another. Thus, Performative Skins.
This part of my practice operates in the context of the notion of the ill body as the *uncanny* body: the sick or disabled person loses control of a part of themselves, thus undergoing a splitting of wills. A body part or system, in effect, becomes unrecognizable – or foreign from what it once was. As Anneleen Maschelein points out, the contemporary concept of the Freudian *uncanny* “can be summarized as a blend of psychological and aesthetic estrangement,” situational or anthropomorphic.\(^{30}\) If the foundation of the *uncanny* is the disturbing coexistence of the deeply familiar and strange in a single phenomenon, these *Performative Skins* suggest *uncanny* bodies.\(^{31}\) These photographs cannot definitely be said to depict live flesh, but they are not arguably of dead skin, either. They are not quite human, yet not quite inhuman. They are literally, at least on my part, recognizable both as self and not-self.

Lennard Davis, citing Jacques Lacan’s *mirror phase*,\(^{32}\) asserts that encountering someone with a visible illness or disability causes discomfort to those who consider themselves healthy, whole-bodied, and / or normal due to a fracturing of the illusory self-perception of wholeness:

> When the child points to an image in the mirror…the child recognizes (actually misrecognizes) that unified image as his or her self…In this sense, the disabled body is a direct *imago* of the repressed fragmented body. The disabled body causes a kind of hallucination of the mirror phase gone wrong…the *moi* is threatened with a breaking-up, literally, of its structure, is threatened with a reminder of its incompleteness.\(^{33}\)

This fracturing also takes place as part of experiencing illness firsthand, especially if one has previously been healthy. Drew Leder comments that the *uncanny* experience of illness is rooted in the remnants of Cartesian dualism: “Insofar as the body seizes our awareness particularly at times of disturbance, it can come to appear ‘Other’ and opposed to the self. Such experiences then play a part in buttressing Cartesian dualism.”\(^{34}\)

Helen Chadwick’s work grapples in part with these ideas of Cartesian dualism and the materiality of the body. Chadwick’s *Enfleshings I* and *II* consist of images printed as cibachrome
transparencies, mounted to glass, and hung on the wall (fig. 24-25). The images visible in this work, printed as transparencies, are photographs Chadwick took of two precise arrangements of red meat. They hang on the wall, a light fixture installed behind each glass plate. Glowing from the inside, the colors of the printed meat are deeply saturated. *Enfleshing II* suggests the musculature of a human torso. *Enfleshing I*, less pointedly representational with regard to the figure, seems to have a more symbolic tone: a glowing light bulb sits in the center of the composition. Mark Sladen writes that Chadwick intended to “defy the Cartesian opposition between mind and body” with these works.³⁵ Discussing this goal of troubling the mind-body binary in her writing, Chadwick states:

I have attempted to construct a series of works that might recompose the binary synthesis of experience and reveal the dialectical schism of language, not to advocate a singular essence, a wholeness or true self – a real me – but to weave loops, twists and turns around binary categories.³⁶

My *Performative Skins* are to a large degree inspired by my own diagnosis with a chronic illness: rheumatoid arthritis. My experience of illness has, indeed, been one of split wills: between my own conscious will, and that of my immune system. The latter’s decision to go into overdrive and attack the tissue of my joints makes me realize more acutely than most that I am not entirely in control of what my body does or feels. My diagnosis breaks the illusion of an “essence” of wholeness, as Chadwick put it, warping Lacan’s mirror. The *Performative Skins* series has allowed me to make a totem, of sorts, in *Venus* – an image representing my self, that is not myself: my body that is not under my control, my body that is (was) me.
Material Traces (What the Patient Left Behind)
My installation *Betadine Curtain* comprises five white cotton and plastic fiber sheets (each ninety-six by fifty-eight inches) suspended from the wall on a single line, as if they were laundry hanging to dry (fig. 26-28). The sheets are covered with traces of a thin golden-brown substance. Both the sheets and the fluid seen in the installation are frequently used in hospitals today. The sheets are a found object, purchased as disposable hospital sheets. The fluid incorporated in this installation is called Betadine. Also known as povidone-iodine, Betadine is an antiseptic fluid that medical practitioners use to disinfect the patient’s skin before surgery in the hospital.37 After closer inspection of the *Curtain*, one might notice that the sheets may have been appropriated from a hospital or clinic. In making this work, I poured Betadine, the heavily pigmented orange antiseptic described above, onto my body. Bearing fluid on my skin, I made prints on the sheets, in a sense making them dirty. The installation, therefore, bears traces of my body.

This portion of my recent work attempts to metaphorically create a record of memories of medical treatment and pain as both important and yet disposable. These works imagine back into being traces of patients and bodies that first world medical institutions and other areas of domesticity erase as a force of habit, hygiene, and legislation: used sheets, disposable material, stained dishes, and most of all traces of the body are found in this corner of my practice. I am interested in the act of symbolically recovering sites of bodily disassembly and healing in the contemporary medical setting.

I recall Ana Mendieta’s *Documentation of Untitled Work from the Silueta Series (Basílica of Cuilapán de Guerrero, Mexico)* (fig. 29). This document consists of a single 35mm slide taken by Mendieta in 1976 after she executed a *silueta* in the unfinished basilica of Cuilapán de Guerrero, just outside of Oaxaca, Mexico. The small image depicts a large, off-
white piece of fabric – perhaps a sheet – pinned up at the back of a stone alcove. The alcove recedes into the wall from an archway built and carved from pale, weathered stone blocks. A full-length imprint of a nude woman’s body – from face to toes – has been pressed onto the fabric using a deeply saturated red substance. Though this substance is not identified, its context points to the representation or use of blood: Mendieta consistently worked with blood and the idea of blood as a ritualistic material in her practice, sometimes mixing it with red tempera paint. I imagine Mendieta lying face-down, flat on the ground, on the sheet before installing it in the stone alcove. I can see her wiggling a little bit to get a darker, fuller imprint of her body. I notice that dark branches curl around the figure’s feet at the base of the alcove in the image as if in offering to a deity. The ritualistic aspect of this work of Mendieta’s deeply appeals to my desire to work with the body as something sacred, primitive, and contemporary at the same time: broken down, transfigured, and built back up by the modern medical institution.

I want my photography to suggest a documentation of a scene: I want it to document acts of marking and the leaving of traces by the body. In this sense, the photographs are traces of traces. In my series of photographs Blood on Porcelain (2016-present), the viewer sees puddles of blood and chunks of meat placed in porcelain dishes used for eating as well as other porcelain containers used as domestic decoration (fig. 30). To date, I have made nine small digital photographs of these objects and situations, each six and a half by six and a half inches. This body of works deals with my aversion to and fascination with blood as well as my desire to leave corporeal traces on both permeable and impermeable surfaces. I intend for the work to provide the viewer with a potential feeling of both disgust and visual pleasure. While this series refers to the medical world, at the same time I want to simply encourage the viewer to look at the body as
a mysterious field that contains or is made of blood, flesh, skin, the nervous system, living cells, and disease.

I made the Blood on Porcelain series partly in response to the first encounter I had as a child with the representation of the medical gaze in any art form: Roald Dahl’s short story “A Visit to the Doctor.” In this short section of his boyhood memoir, the author describes undergoing a tonsillectomy in 1924 at the age of eight. The setting is a town so small that the doctor operates out of his own house: the kitchen is right next to the surgery. These domestic and medical elements clash together when Dahl recounts the procedure:

‘It won’t take two seconds,’ the doctor said. He spoke gently, and I was seduced by his voice. Like an ass, I opened my mouth. The tiny blade flashed in the bright light and disappeared into my mouth...the next moment, out of my mouth into the white basin came tumbling a whole mass of flesh and blood...I sat there gasping. The roof of my mouth seemed to be on fire.”

I chose the porcelain dishware that I depict in Blood on Porcelain to announce a Western middle to upper-class sensibility; the clumps of meat scattered across it are purposefully anonymous. I intended for Blood on Porcelain to recreate that sensation that came so close to what I feel when I try to describe verbally what it feels like to others, usually without much success, what a memory of body horror, particularly in the case of spilling blood in a medical setting, feels like. I tried to create through this work a sense of instability around corporeality and domesticity – of vulnerability in a location of typical security. My most fundamental home is my body.

I discussed above how Ana Mendieta’s work with the body – particularly the female body – has inspired in me an enduring curiosity about the contemporary possibilities of ritualistic, physical marking with bodily fluids or fluids closely related to the body. I now recall a work of Yves Klein’s that was never documented. Circa 1960, as part of his series of
*Anthropometry* paintings, Yves Klein once experimented with making body prints, not in blue paint, but in cow’s blood. Klein acquired the blood and spent one late night making prints. However, that same night, Klein came to the conclusion that what he had done came “too close to the devil,” and the artist destroyed the bloody *Anthropometries* before they could be documented.40 The artist apparently pricked his thumb and “signed” the work in his own blood before burning it.41 I find this story fascinating: Klein’s last minute, fearful reaction to the affective power of a benign bodily substance suggests to me that blood, even in the increasingly modern world of the 1960s, was still spiritually threatening somehow. Maybe it still is. I find this notion exciting: perhaps what is ancient about the body may still remain powerful in artmaking, even in the twenty-first century.

I hope the use of blood in my work connotes purity, fragility, and filth: concepts that also indicate a feminine sensibility or body, which, as I will discuss below, is in opposition to the idea of the healthy body. The healthy body, as discussed earlier in the context of Leder and Davis, provides the illusion of wholeness and security until it falls ill. Then it becomes the patient’s body. The patient’s body is unstable, permeable: *abject*, in the terminology of Julia Kristeva. Kristeva writes of blood as it relates to her concept of *abjection*, the objectionable affect that often arises from the presence and flow of corporeal matter, or “polluting objects”:

While they always relate to corporeal orifices…polluting objects fall, schematically, into two types: excremental and menstrual. Neither tears nor sperm, for instance, although they belong to the borders of the body, have any polluting value. Excrement and its equivalents (decay, infection, disease, corpse, etc.) stand for the danger to identity that comes from without: the ego threatened by the non-ego, society threatened by its outside, life by death. Menstrual blood, on the contrary, stands for the danger issuing from within the identity (social or sexual); it threatens the relationship between the sexes within a social aggregate and, through internalization, the identity of each sex in the face of sexual difference.42
I hope that the status and experience of patienthood, as my work tries to tackle the subject, aligns with themes and concepts that often define the concept of femininity negatively: weakness, penetrability, exposure to a gaze with greater agency than one’s own, passiveness, leakiness, etc. The constant presence of blood and other fluids in the institutional medical setting – which tries to control, stop, and contain those fluids, and most often for perfectly good reasons – further aligns the clinic or hospital with a masculine presence, and, further, indicates an emasculating atmosphere to be in as a patient. Kristeva comments further with regard to the Western, Judeo-Christian view of blood, that blood is abject, even when it is not menstrual, because it relates to the menstrual and the feminine:

Blood, as a vital element, also refers to women, fertility, and the assurance of fecundation. It thus becomes a fascinating semantic crossroads, the propitious place for abjection where death and femininity, murder and procreation, cessation of life and vitality all come together.43

My current work – which primarily incorporates images of the female and feminine body – is partly rooted in and attempts to instigate ideas about the patient’s body as a fundamentally feminine body, whether the patient’s sex is male or female. Margrit Shildrick discusses the idea of the patient as feminine:

The relationship between practitioners and patients is constructed along putative gender lines. Clearly, not all doctors are men, nor all patients women, but the role of each is cast respectively as masculine and feminine. In so far as medical practice must deal with the breaching – even dissolution – of bodily boundaries, through infection, brokenness, death, and so on, it is brought face to face with the anxiety occasioned by body fluids…such threatening fluidity is characteristically assigned to female bodies. The sick, then, must be differentiated from the well; they become the (feminized) other.44

The spilling of blood, dirtying of sheets, splattering of decorative porcelain, elongation of an institutional garment that, for men, women, and children is called a gown – I intend for all
these gestures in my work to, in some capacity, evoke the feminine. I add to this list of intended feminine acts, the act of symbolically shrouding the archival medical photographs my work appropriates: washing and caring for the body. Though I believe that the act of digging up the images is brutal and penetrative, I hope that, symbolically and through my practice, the way that my work reburies them might be received as a caring or benevolent gesture.
Conclusion
I use a variety of interdisciplinary media and methods of making – sculpture, drawing, painting, photography, installation, and collage – in my practice. In this text, I have presented a variety of examples of this work and put them into context with recent and contemporary art theory, practice, and criticism. My most recent work attempts to grapple with the idea of the medical gaze from my vantage point: that of an artist, an amateur observer of medicine and its gaze, and a patient with a chronic disease. It also attempts to grapple with the idea of the feminine as it is embedded in the contemporary concept of patienthood.

In the first section, I discussed how this latest collage and drawing work appropriates images from various historical archives of medical photography in the attempt to reclaim and renegotiate not only the space between these records of the medical gaze and its recipients, but also the space between the contemporary viewer and those historical records. In *Four Sights of the Patient (Ophelia)*, I digitally collaged together some of the oldest of these images – from the late nineteenth and early twentieth century – tinted them blue and blue-violet, printed them, and went over them with graphite, pigment, and eraser until I felt that they were sufficiently shrouded. I chose this particular time period in the archive to emphasize the ease with which the patient’s body was and still can be viewed as a spectacle, particularly in the context of historical materials. I chose to collage the bodies together to emphasize their patterns of holding their own bodies and the bodies of others, as if to stay upright in front of the lens. To make semi-shrouds of the images of bodies, I chose layers of graphite and blue: graphite makes dark areas and reflective, shining patches of surface, while blue, as Yves Klein would put it, gives a sense of dimensionlessness to the works it touches. Time is the fourth dimension – and blue, or blue-violet, were the monochromatic tones that, for me, pierced the alienating veil of nostalgia that grayscale, yellow, and sepia usually lend to archival footage. I hope for this work to act as a
symbolic reclamation and reburial of these photographs: I try to treat the images like bodies in this continuing part of my practice, knowing that I must first dig them up before I have to reinter them under dust, fluid medium, and drawing.

In the second chapter, I explored how my work, particularly Woman in a Long Hospital Gown, grapples with the notion of the medical institution’s transformation of the patient’s body through the use of uniforms. This work functions around the idea of the impact of the medical gaze on the patient. The Gown was my attempt to create an object that could express this idea as a metaphor. In the third chapter, I discussed my series Performative Skins and its context in the notion of the uncanny body. In creating these images, I cultivated an intimate cast-making process: if I did not allow others to touch me, I had to persuade others to let me spread the casting material on their skins. These casts came away as strange, flaccid simulacra of their templates. In this facet of my practice, I explored the idea of the uncanny body as the ailing body. This intimate replication of my body’s form and texture allowed me to, in some sense, externally perform the strange intimacy I experience inside my own body: while I am consumed by my own disordered flesh – my immune system destroying my joints – I am still one and the same with it.

In the fourth chapter, I discussed my work as it relates to the trace of the vulnerable body or flesh in the context of the medical institution and my personal ideas of domesticity. In Betadine Curtain, I used the highly pigmented orange antiseptic fluid Betadine, typically used pre-surgery in hospitals, to make prints with my nude body on disposable white medical sheets. These sheets are used for emergency room beds, clinic beds, and ambulances. They are rapidly used and disposed of. I hung them up, five across, as a clothesline, as if someone had kept them to wash. In Blood on Porcelain, I scattered blood and chunks of meat across porcelain dishware,
which was common in my household growing up: porcelain is not disposable, but it is not precious either. These works attempt to point to the idea that materials that bodies or parts of bodies touch can be precious and disposable at the same time, and hopefully, perhaps, also call into question the dialectic of the preciousness and / or disposability of the visceral body itself. Finally, I argued that my work, building on these ideas, attempts to point to the idea of the patient’s body as abject and as feminine in the context of the medical institution.

My work tries to create the presence of absent bodies and the absence of present bodies. The bodies in these conversations that my work attempts to create about absence and presence, visibility and invisibility, are often ailing. Whether beneath layers of graphite and pigment dust, in Betadine body prints on disposable hospital sheets, in photographs of soft glue casts of skin, in images of chunks of flesh on porcelain, or as parts of a model hidden beneath an oversized hospital gown, my work deals with the trace of the body: most often the abject body of the patient in the modern or contemporary medical institution. In my studio practice, I make work that strives to reclaim these fragile, abject traces from the objectifying and often depersonalizing medical gaze as not only precious, but powerful.
Addendum: Metamorphoses

In this addendum, I explore two metamorphoses: first, my own transition from a so-called ‘healthy person’ into someone with a chronic illness, and second, the immediate corporeal transformation of an anonymous Patient whom I observed undergoing surgery.
I am twenty-two.

I wake up every morning with my hands and arms numb. This experience repeats until I begin to have night terrors for the first time since I was too young to remember them. A night terror is a panic attack that occurs during sleep. It is a feeling of overwhelming dread that grips my body and causes me to thrash and moan. Only vigorous shaking wakes me up.

Every day, my joints get stiffer. My ankles swell to the size of oranges. It becomes more and more impossible to get out of bed. Every socket in my body is a mortar filled with crushed glass; every rounded joint, a pestle grinding down on the shards. I gain thirty pounds of water weight with the swelling.

We don’t want it to be true, but my family and I know what the most likely diagnosis is. I go to an emergency room and get inconclusive results before I break and make an appointment with my father’s rheumatologist.

She diagnoses me with rheumatoid arthritis. An autoimmune disorder, inherited genetically. Once triggered, it is a life sentence. I cannot un-transform. Nonsensically, I feel that my body has betrayed me. This was not my vision of the future. My sister has enough of the family’s genetic detritus. I was supposed to be the ‘one that got away.’

I begin to take the standard medicine for my condition: methotrexate, a chemotherapy drug. When I visit the rheumatologist every few months, I notice that the list of my current medications and treatments says, “methotrexate poisoning.”

The methotrexate makes my hair fall out. I take a vitamin typically reserved for pregnant women, folic acid, to mitigate this side effect. I don’t stop losing hair. I just grow twice as much. I change my living arrangements to cope with my constant molting, placing a hair-catcher in every drain so the plumbing in my apartment doesn’t clog every week.

I poison myself to live a physically abled life, and I am grateful that the poisoning works.

...

A diagnosis is only one of a host of terms that refer to pathological somatic deviance – as in, “I have a diagnosis.” I have an illness. Disease. Disorder. Condition. Affliction. Ailment. Sickness. Syndrome. Disability.

There are small shifts between words among people like us. “I have” becomes “I am.” Sometimes it changes back. At least we have agency with this part of the transformation. I have [prefix]-itis. I am a [prefix]-aholic. Colloquialisms, euphemisms, diagnostic vocabulary. In Margaret Edson’s Wit, Vivian, a professor of
English poetry and cancer patient, discusses her relationship with words in the hospital setting:

Imagine the effect that the words of Jon Donne first had on me: ratiocination, concatenation, coruscation, tergiversation. Medical terms are less evocative. Still, I want to know what the doctors mean when they...anatomize me. And I will grant that in this particular field of endeavor they possess a more potent arsenal of terminology than I. My only defense is the acquisition of vocabulary.45

Arsenal, Vivian calls it: the doctors’ reserve of words to label her with. As I have known it, diagnosis is indeed a tool of war. Though Vivian would appear to describe her newfound knowledge of the medical lexicon as a shield, I have experienced it as a double-edged sword. In my life, diagnosis has functioned as stigma and stigmata: the former a negative label that Others me from healthy society and the latter a beneficent marker of difference – a wounding – that opens the gate for me to receive drugs otherwise reserved for chemotherapy patients.

While naming the mysterious and frightening force that is a particular disease drains the ailment of some power, it also means that one effectively gains an Othering label. I am never sure whether I am grateful for the fact that no one has ever tried to call me anything but a patient: “chronically ill person” or “rheumatic arthritic” are phrases much too long and tangled for most people to bother putting into casual conversation, unlike “disabled” or “autistic.” No one calls me “patient,” either. Even on its worst days, my autoimmune disease is invisible to all but those who know me.

I am twenty-six.

From the parking garage, I take two flights of escalators and cross a skyway to enter the Hospital. Through the skyway’s glass walls, I see headlights flickering down the nearby freeway in the pre-dawn dark. A Doctor meets me at the fountain in the hospital’s lobby. She has invited me to observe a bilateral laparoscopic hysterectomy today. I am wearing comfortable shoes. I had my flu shot the day before.

I change into scrubs. The receptionist that handed them to me keeps a record that I have borrowed them. The Doctor looks me over and approves of my costume. Then she says something grammatically bizarre: “Okay, we’re ready. Let’s go consent the Patient.”
I’m barely able to register the way the Doctor has wrenched the object-subject relations of this sentence before she turns and walks toward the door. Doesn’t she mean “get consent from the patient”? Or at least, “get the patient’s consent”? Is the imposition of consent grammatically or functionally possible?

We walk through a set of heavy, automatic double-doors into the prep-room. A warren of tiny hospital rooms surround and open into a larger central area. Each barely fits a single bed for one Patient and a chair for one family member. A curtain hangs from a rod across the front of each space to serve as a privacy barrier from the central area, which is packed with busy machines and bodies.

We stop at one of the alcoves. I can see a Patient inside; the curtain is open.

“She has fibroids in her ovaries. She doesn’t want any more children, and” – the Doctor pauses to glance at the chart on the clipboard on the wall – “it looks like she’s postmenopausal. So we’re going to take it all out. It will be about an hour and a half if everything goes well.”

The Doctor knocks on the wall next to the curtain and steps into the pocket-sized space. I follow her, clasping my notebook like a shield. I’m a voyeur. The thought skitters somewhere beneath the language center of my mind. I am neither a qualified mechanic nor a machine broken enough to merit presence here.

The Doctor asks the Patient, who is propped up to a sitting position in bed with the covers pulled up under her breasts, if she wants her ovaries completely removed. “Just confirming,” the Doctor says. “Yes,” the Patient says. Her husband is with her. He slumps sideways, asleep in his chair next to her bed. I notice the Patient’s eyelids repeatedly sliding shut. She’s barely conscious. I am not sure whether her sleepiness is from the early hour or from drugs.

“This is Cecily. Is it alright for her to observe today?”

The Patient’s eyes flicker open and focus on me for a second. She blinks. “Uh-huh.” I realize suddenly that there is a certain ceremonial emptiness in the Doctor’s question.

The true consent took place when I asked the Doctor if I could observe two weeks ago; it strikes me that She, not the Patient, is the real gatekeeper. It is because of the politics of the hospital as an institution that I am here. My scrubs, too, like a disguise, help me blend in and give me an air of legitimacy. I wonder if the Patient would have consented if I were wearing my street clothes.

All the staff wear blue or green scrubs and filmy blue shower-caps. My own scrubs are a shade of seafoam-green. As the Doctor leads me out of the prep-room, I silently wonder why ocean colors are the ones most commonly used in hospitals. After we “consent” the Patient, the Doctor and I enter a
small room whose dimensions roughly meet the size of the cubicle where we left Her. This room, however, has a long table in the center. My eyes lock with those of doctors and nurses sitting at the table, binders and stacks of paper piled up around them. Each binder belongs to a single Patient. I can see their names on the thick navy-blue spines. Inside each binder are seven sections in rainbow colors: notes (red), treatments (orange), diagnostics (yellow), radiology (green), laboratory (blue), monitoring (indigo), and orders (violet). I sit in a chair next to the Doctor as she spreads out and reviews the Patient’s binder.

When I look around the room a second time, I notice a small metal shelving system behind me that holds a few of the Patients’ binders. It is fitted with wheels; knowing from my last glance how thick the binders are with paper – like encyclopedia – it must be a relief to be able to push instead of carry them. I see large gaps in its rack. The missing binders lie open on the table, contents strewn and continually turning under the Doctors’ eyes and hands.

Surgical masks on, the Doctor and I step into the OR. I squint into the sterile florescent light flooding the room. It picks out every detail, from streaky black scuffs on the floor – left by athletic shoes or wheeled equipment? – to electrical sockets, the same white as the walls. Metal cabinets of all different shapes and sizes cover the walls, with the occasional computer screen or monitor nestled in between. I’m careful to step around or over cords coiling across the floor.

I stop next to a counter with a sink and soap dispenser and touch my face. I think I put my mask on incorrectly. The clear plastic splash guard extending from the bridge of my nose to my eyebrows, like an inverted welder’s shield, keeps fogging up. When I have adjusted my mask, the condensation fades to reveal the unconscious patient lying recumbent, bare from the breasts down, on a bed in the center-right of the room. My opportunities to look at her continue, but She cannot see me.

Within minutes of our arrival, the nurses have bent and spread the Patient’s legs and firmly strapped them into black pleather greaves, the shins all but swallowed. Between the restraints, I see the Patient’s exposed vulva and buttocks, the brown flesh abundant enough to make a single, deep crease from the bed’s surface to below her belly. I see no inner folds or labia – her body, though forcibly spread, protects its most vulnerable parts from my sight.

The nurses cover the Patient from head to foot with disposable sheets the color of their scrubs – faded blue – leaving a square of open flesh around the navel. Someone turns the overhead lights off. Only the large disc-lamps, extending down from the ceiling on multi-hinged arms and as wide as industrial trash-can
lids, remain fully engaged. The Doctor calls for one of the nurses to shift a lamp behind and over her shoulder as she sits on a stool between the Patient’s legs. The first step of the procedure is to make a one-inch incision in the Patient’s vaginal wall, the Doctor tells me, beckoning me closer.

I hang a few feet back, unsure of my correct place in the room. I notice the nurses’ eyes on me. The back of my neck itches when I turn away from their gaze. The Doctor’s own eyes, oblivious to my awkwardness, are focused between the Patient’s legs. I realize with some shame that, while I feel embarrassed by my feelings of being out-of-place, the Patient is far more exposed than I. And She is unaware of it. While I had observed the staff prep the room and equipment, someone had set up a complex piece of metal that holds the Patient’s vulva open. Where brown folds once protected their surface, pink and red labia now ripple exposed.

The Doctor’s head moves into my line of sight, and I can no longer see her actions. Someone hands her a green object shaped like a light bulb or like the end of a turkey baster. Having made the incision, she folds the soft object and inserts it into the vaginal canal.

“We use this silicone bulb to show where we made the incision in the vaginal wall. It’s where we’ll be removing the uterus when we’re done cutting and ligating the tubes.” The Doctor sits back, and the metal mechanism is left in place as she exchanges her bloody gloves for a new pair.

The four large television monitors interspersed between the lamps blink to life. They show nothing for a moment. Then, the laparoscope camera view suddenly fills each screen. The camera is still in the hollow steel shunt that will pierce the Patient’s abdomen. The screens show is of a dark tunnel with a blinding circular light at the end: a reflection of the camera’s light off the steel tray where it lies with the other tools.

“You can watch over here,” one nurse says to me firmly, pointing to a rolling stool in front of the largest monitor in the room, mounted against a far wall. I can’t see her mouth move behind her mask, but the muscle movements around her eyes suggest a hint of suspicion as to the purpose of my presence here. I would now have to turn my back on the operation to watch it.

I decide to sit on the stool and bide my time. Maybe, I think, if I show them I can stay out of the way, I’ll eventually leave the stool and get a bit closer. But I won’t turn my back.

From my corner, I hear the mechanized bed hum as it tilts the Patient’s body slowly, degree by degree, lifting her legs and lowering her upper body. In this dim light, she looks like a shrouded star-watcher on the wrong side of the hill: cocooned, feet up, head down.
“We put the Patient at an angle to encourage the bowels to move out of the way with gravity,” says the Doctor. “One of the more tedious parts of this surgery is that the bowels get in the way of the uterus and ovaries, and you have a higher chance of cutting the wrong thing.”

The blue paper sheets covering the Patient leave a square foot of dun-brown flesh exposed on the abdomen. I see the Patient’s navel, dimpled into the flesh, scarcely a finger’s width from the upper edge of the bare patch.

I watch the screens as a nurse moves the laparoscope from its position on the sterile tray and hovers it above the Patient’s abdomen. Colors swing rapidly across the four monitors as the blue-gowned nurse removes the laparoscope from the shunt and waits for another nurse to swab the square expanse of abdomen with betadine, a heavily pigmented orange antiseptic. The swabber punctures the abdomen with the shunt, and the laparoscope follows. Suddenly, the monitors glow in soft pinks, yellows, and orange. I am surprised at the softness of the internal organs as they slide, like raw egg yolks in a bowl, around one another. The Patient’s intestines shine in the way of new automobile paint: as if imbedded with millions of tiny reflective particles.

On the monitor, I watch Her abdominal wall bulge before a steel needle erupts through it from the outside world, squirting a clear jet of topical anesthetic. On the monitors, the tiny needle is in sharp focus and as long as a ruler. Another steel instrument comes into view and starts moving the intestines out of the way to reach the ovaries and uterus.

“These are bowel graspers,” the Doctor says, noticing that I have moved to stand a few feet from her shoulder. She tells me to observe the differences in the colors of the organs.

“Do you see the white areas of flesh? We’ve finally moved some of the bowels out of the way so we can get to work. Those white tubes are the ovaries. They’re that color because she’s post-menopausal and scarred from a long life of ovulation. Ugh.” The Doctor sighs. The laparoscope camera, like my mask did when I put it on incorrectly, has suddenly fogged up.

“The lens is colder than body temperature,” she explains, signaling to the others to pause for a moment.

When the mist clears, the Doctor points out the areas where she and the other surgeons will insert cauterizing pincers where the grasper was. The pincers will cut and burn, cauterizing the blood vessels and connective tissue holding the uterus, ovaries, and cervix to the abdominal wall and vaginal canal. “She’s got great anatomy,” says the Doctor. “Easy to see, few lesions.” The pincers close around one fleshy, white tube. They bear down and, suddenly, I hear a gentle buzzing noise. The tissue around the pincers’ grasp
bubbles and smokes. It is several long minutes before I begin to smell it: the raw, hollow smell of a freshly lit match, more phosphorus than flesh.

After half an hour, the animal odor I expected finally slinks into the air. When I first saw the cauterizing equipment, I had anticipated that it would come quickly and braced myself for disgust, nausea, and even fascination. By now, however, the meaty undertone hangs in the air like a disappointing afterthought.

I only realize how quickly I had formed such sensuous expectations when I feel that small touch of disappointment. Where does this shamefully eager anticipation come from? I recall Susan Sontag’s words on the odd sensation of discovering that iconic photographs of violence or despair are revealed to have been staged:

What is odd is not that so many of [them] have been staged. It is that we are surprised to learn they were staged, and always disappointed. The photographs we are particularly dismayed to find out have been posed are those that appear to record intimate climaxes, above all, of love and death.48

I continue watching the cauterization process on the screens. Is this an intimate climax of love or death? Or is it an intimate climax of healing? Of repair? I don’t know. The doctors may be posing the Patient and adjusting her coverings – not to mention her internal organs – but they do this at Her request. This is not the spectacle I was expecting. Am I grateful?

Slowly, hypnotically, carefully, the surgery progresses. Occasionally, I glance away from the monitors to watch the pink glow of their contents move across the surgeons’ blue gowns throwing soft violet shadows.

In an hour, the surgeons have successfully cut and cauterized all the tissue connections of the uterus, cervix, and ovaries to the woman’s abdominal cavity. A blue-swathed nurse or surgeon – they move so quickly in the half-dark now that I cannot identify bodies or hands other than those of the Doctor – steps in to attach a long, white conical plastic bag to hang from the bed’s edge below the Patient’s legs.

The laparoscope remains in the abdominal cavity: the team must now remove what they are calling the “specimen” – uterus, ovaries, and cervix – from the one-inch incision in the vaginal wall. The nurses manipulate the camera until I see the deep green of the silicone bulb through the tiny incision, an oceanic slash six inches long on all four screens above our heads. The Doctor waits between the Patient’s legs, looking into her vaginal canal, holding steel
graspers. She removes the bulb – the green stripe disappears from the screens – and carbon dioxide escapes the abdominal cavity through the Patient’s vagina with a flatulence that somewhat dispels the aura of ritual I feel in the room.

The Doctor hands the bloody bulb to an observing resident, who places it on a tray covered in white paper sheeting next to her. She and the others then manipulate the lump of organs that once served as the Patient’s reproductive system through the incision and down through the vaginal canal. I watch it come to rest in the Doctor’s gloved hands. I saw the organs’ modest curves of flesh as pink and white on the monitors, but they are dark scarlet in the outside world, under the harsh glow of the lamps. The Doctor spreads the specimen out on the disposable white cloth next to the green bulb.

“Here,” the Doctor says, looking at me and then back at the Specimen. “This large part is the uterus....”

I notice that the ‘large part’ is slightly smaller than my fist.

“...And these structures on either side are the ovaries and the fallopian tubes,” she continues, gloved fingers spreading the tubes and ovaries down and outward, the raw, springy flesh stretching just a little.

“And this is the cervix.” The Doctor prods the rubbery, cylindrical flesh extending from the bottom of the uterus gently.

“It’s much smaller than I thought it would be,” I say.

I watch the nurses place the Specimen into its white plastic container and take it away.

I look back toward the monitors, where they are using the steel pincers from both sides of the incision in the vaginal wall to pull a curved needle and barbed, clear thread through the flesh again and again until the hole is sealed shut. They do a neat job of it, I assume.

Two women count to twenty while holding a piece of equipment. I don’t know what it does. Light from the monitors moves over the Patient and doctors erratically as they remove the laparoscope from one abdominal area and insert it into another.

The laparoscope’s view of the inner body now resembles the bottom of the ocean floor. The distance is dark and what can be seen of the inner body surface is tinted blue. Pale specks and spongy bits of something float serenely past the lens. Hair-thin veins and capillaries web the gentle curves of the fleshy floor. The streaky yellow surface is pale and bulges mildly. A crater comes into view out of the dark, and the camera stops.

I carefully approach the Doctor from behind. She has rolled her stool back between the Patient’s legs, eyes fixed on the monitors.

“What’s going on now?” I ask her.

“We’ve inserted the laparoscope into the bladder,” she
explains. “We’ve tinted the fluid inside blue so we can see the ureter openings; when they go, we know we haven’t injured anything.”

We wait. The Patient’s body takes its time to process her liquid intake. Eventually, one little volcano contracts and releases a foggy spout of urine into the bladder. The room cheers when the second ureter opening finally functions.

The Doctor stands up from her chair, stretches, and beckons to me. “Let’s go consent the second Patient.”


Sigmund Freud’s definition of the “uncanny” affect or the *unheimlich*: “That species of the frightening that goes back to what was once well known and had long been familiar.” From Sigmund Freud, “The Uncanny,” in *The Uncanny*, translated by David McLintock (London: Penguin Books, 2003), 124.


Ibid, 124-125.

Ibid, 195.


Michel Foucault, *The Birth of the Clinic*, 31.


Griselda Pollock, “Rethinking the Artist in the Woman, the Woman in the Artist, and That Old Chestnut, the Gaze,” in *Women Artists at the Millenium*, edited by Carol Armstrong and Catherine de Zegher (Cambridge: MIT Press, 2006), 37.

Ibid, 40.

Ibid, 46.

Ibid, 38.


Ibid, 142.


I briefly thought that perhaps some of the blue-tinted archival images in *A Morning’s Work* or *Mütter Museum* were cyanotypes, which, by their nature, are monochromes of a deep blue with a green tint, but nearly none of the images in the aforementioned archives were made this way: only one out of the one hundred and twenty-seven plates in *A Morning’s Work*, for example, is a cyanotype. See “Notes on the Plates,” *A Morning’s Work*, plate 82 of 127.

23 Sidra Stich, *Yves Klein* (Stuttgart: Cantz Verlag, 1994), 177.
27 Ibid.
28 Hospital gowns are used in medical institutional environments for everything from a lengthy hospital stay to a brief clinic visit. They are made of cloth or paper and have only enough structure to cover the patient from neck to knees and shoulder to elbow. Their simplicity reinforces their power to embarrass and make the patient feel vulnerable. The gown is a garment constructed to allow ease of access to the body through gaze and touch in the case of examination or emergency.
40 Sidra Stich, Yves Klein, 185.
41 Ibid.
43 Ibid, 96.
44 Margrit Shildrick, Leaky Bodies and Boundaries: Feminism, Postmodernism, and (Bio)ethics (New York: Routledge, 1997), 100.
45 Margaret Edson, Wit: A Play by Margaret Edson (New York: Faber and Faber, 1999), 43-44.
46 According to the American College of Surgeons, blue scrubs were finally adopted in the mid-twentieth century because they helped surgeons to avoid eye-strain in the operating room. The pure white previously used for all clothing and sheets in hospitals had caused after-images and spots to appear in the vision because of the eye’s motion back and forth between the bloody colors of surgery and glaring white of everything else. Green and blue as colors both allow a gentle resting place for the eyes of surgeons, nurses, and other personnel when glancing away from the site of an operation. At the same time, they make the bloody colors of the operation site more vivid and easier to focus on. From Jessica L. Buicko, et al, “From Formalwear and Frocks to Scrubs and Gowns: A Brief History of the Evolution of Operating Room Attire,” Bulletin of the Surgical History Group (American College of Surgeons), 2016: 8, https://www.facs.org/~/media/files/archives/shg%20poster/2016/01_formalwear_and_frocks.ashx.
48 Sontag, Regarding the Pain of Others, 68.
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Cecily Fergeson

*Four Sights of the Patient (Ophelia)*

2018

Installation of four mixed media drawings on inkjet paper, framed in natural wood

53 x 34 ¾ x 1 ½ in. (frame size)
Figure 2-3

Cecily Ferguson

*Four Sights of the Patient (Ophelia) (detail)*

2018

Installation of four mixed media drawings on inkjet paper, framed in natural wood

53 x 34 ¾ x 1 ½ in. (frame size)
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Cecily Fergusson
*Four Sights of the Patient (Ophelia) (detail)*
2018

Installation of four mixed media drawings on inkjet paper, framed in natural wood
53 x 34 ¾ x 1 ½ in. (frame size)
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Cecily Fergeson

*Four Sights of the Patient (Ophelia)* (detail)

2018

Installation of four mixed media drawings on inkjet paper, framed in natural wood

53 x 34 ¼ x 1 ½ in. (frame size)
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Cecily Fergusson
*Betadine Curtain* (details)
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Betadine (iodine-povidone) on five medical disposable flat sheets (cotton and plastic fiber), string
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Figures 27-28:
Cecily Fergeson, *Betadine Curtain*, 2016 (detail). Betadine (iodine-povidone) on five medical disposable flat sheets (cotton and plastic fiber), string. 185 x 90 in.

Figure 29:

Figure 30:
Cecily Fergeson, *Blood on Porcelain* (1-9), 2016-present. Digital photographs (regular camera and endoscopic) of blood and meat on and in porcelain dishware and decorative domestic objects. 6 ½ x 6 ½ in. each.
Plates
Plate 1

Cecily Fergeson

*Four Sights of the Patient (Ophelia)*

2018

Installation of four mixed media drawings on inkjet paper, framed in natural wood

53 x 34 ¾ x 1 ½ in. (frame size)
Plate 2

Cecily Ferguson

Four Sights of the Patient (Ophelia) (detail)

2018

Installation of four mixed media drawings on inkjet paper, framed in natural wood

53 x 34 ¼ x 1 ½ in. (frame size)
Plate 3

Cecily Ferguson

Four Sights of the Patient (Ophelia) (detail)

2018

Installation of four mixed media drawings on inkjet paper, framed in natural wood

53 x 34 ¾ x 1 ½ in. (frame size)
Plate 4

Cecily Fergeson
*Four Sights of the Patient (Ophelia) (detail)*
2018
Installation of four mixed media drawings on inkjet paper, framed in natural wood
53 x 34 ¼ x 1 ½ in. (frame size)
Plate 5

Cecily Fergusson
*Four Sights of the Patient (Ophelia) (detail)*

2018

Installation of four mixed media drawings on inkjet paper, framed in natural wood

53 x 34 ¾ x 1 ½ in. (frame size)
Plate 6

Cecily Fergeson
Erasure I (Magdalene)
2017
Graphite on gesso on paper
48 x 36 in.
Plate 7

Cecily Fergeson
*Erasure I (Magdalene) (details)*
2017
Graphite on gesso on paper
48 x 36 in.
Plate 8

Cecily Fergeson
Erasure I (Masquerade)
2017
Graphite on gesso on paper
48 x 36 in.
Plate 9

Cecily Fergeson
Erasure I (Masquerade) (details)
2017
Graphite on gesso on paper
48 x 36 in.
Plate 10

Cecily Ferguson
Erasure I (Sleeper)
2017
Graphite on gesso on paper
48 x 36 in.
Plate 11

Cecily Ferguson
Shifter (Mother)
2017
Inkjet print mounted to board
48 x 36 in.
Plate 12

Cecily Fergusson  
*Woman in a Long Hospital Gown*  
2017  
Digital photographs  
Dimensions variable
Plate 13

Cecily Fergusson
*Vulcan*
2017
Digital photograph of backlit glue cast (inkjet print)
28 ½ x 16 in.
Plate 14

Cecily Ferguson

_Venus_

2017

Digital photograph of backlit glue cast (inkjet print)

28 ½ x 16 in.
Plate 15

Cecily Fergusson
*Vortex*
2017
Digital photograph of backlit glue cast (inkjet print)
12 x 15 in.
Plate 16

Cecily Ferguson

Convex

2017

Digital photograph of backlit glue cast (inkjet print)

12 x 6 in.
Plate 17

Cecily Fergeson
Pour
2017
Digital photograph of backlit glue cast (inkjet print)
12 x 15 in.
Plate 18

Cecily Fergusson
*Curtain*
2017
Digital photograph of backlit glue cast (inkjet print)
20 x 16 in.
Plate 19

Cecily Ferguson
Crevasse
2017
Digital photograph of backlit glue cast (inkjet print)
20 x 16 in.
Plate 20

Cecily Fergusson
Glowflap
2017
Digital photograph of backlit glue cast (inkjet print)
20 x 16 in.
Plate 21

Cecily Ferguson

*Quilt*

2017

Digital photograph of backlit glue cast (inkjet print)

20 x 16 in.
Plate 22

Cecily Fergeson

*Iris*

2016

Digital photograph of backlit glue cast (inkjet print)

20 x 10 in.
Plate 23

Cecily Ferguson
_Eveshed_
2016
Digital photograph of backlit glue cast (inkjet print)
19 ¼ x 12 in.
Plate 24

Cecily Fergusson

_Eveswell_

2016

Digital photograph of backlit glue cast (inkjet print)

19 ¾ x 12 in.
Plate 25

Cecily Fergusson
_Eve_
2016
Digital photograph of backlit glue cast (inkjet print)
19 ¾ x 12 in.
Plate 26

Cecily Fergusson

Eve series

2016

Digital photographs of backlit glue cast (inkjet print)

19 ¼ x 12 in. each
Plate 27

Cecily Fergeson
Hang Navel
2016
Digital photograph of backlit glue cast (inkjet print)
12 x 12 in.
Plate 28

Cecily Ferguson
Silver Knee
2016
Digital photograph of backlit glue cast (inkjet print)
12 x 16 in.
Plate 29

Cecily Ferguson
*Golden Knee*
2016
Digital photograph of backlit glue cast (inkjet print)
12 x 16 in.
Plate 30

Cecily Fergeson
*The Princess and the Pane*
2017
Installation
Dimensions variable
Plate 31

Cecily Fergeson
*The Princess and the Pane*
2017
Installation
Dimensions variable
Plate 32

Cecily Ferguson
The Princess and the Pane (detail)
2017
Installation
Dimensions variable
Plate 33

Cecily Ferguson
The Princess and the Pane (detail)
2017
Installation
Dimensions variable
Plate 34

Cecily Ferguson
Betadine Curtain
2016
Installation (documented in Re-Pose, exhibition with Jenn Brown, 2016)
185 x 90 in.
Plate 35

Cecily Fergusson
Betadine Curtain (detail)
2016
Installation (documented in Re-Pose, exhibition with Jenn Brown, 2016)
185 x 90 in.
Plate 36

Cecily Fergeson
Betadine Curtain (detail)
2016
Installation (documented in Re-Pose, exhibition with Jenn Brown, 2016)
185 x 90 in.
Plate 37

Cecily Fergeson
Betadine Curtain (detail)
2016
Installation (documented in Re-Pose, exhibition with Jenn Brown, 2016)
185 x 90 in.
Plate 38

Cecily Fergeson
Blood on Porcelain, No. 1
2016
Digital photograph
6 ½ x 6 ½ in.
Plate 39

Cecily Fergusson
Blood on Porcelain, No. 2
2016
Digital photograph
6 ½ x 6 ½ in.
Plate 40

Cecily Fergeson
Blood on Porcelain, No. 3
2016
Digital photograph
6 ½ x 6 ½ in.
Plate 41

Cecily Fergeson
*Blood on Porcelain (Innards), No. 4*
2017
Endoscopic photograph (digital)
6 ½ x 6 ½ in.
Plate 42

Cecily Fergusson  
*Blood on Porcelain (Innards), No. 5*  
2017  
Endoscopic photograph (digital)  
6 ½ x 6 ½ in.
Plate 43

Cecily Fergusson

Blood on Porcelain (Innards), No. 6

2017

Endoscopic photograph (digital)

6 ½ x 6 ½ in.
Plate 44

Cecily Fergusson
Blood on Porcelain (Innards), No. 7
2017
Endoscopic photograph (digital)
6 ½ x 6 ½ in.
Plate 45

Cecily Fergusson
Blood on Porcelain (Innards), No. 8
2017
Endoscopic photograph (digital)
6 ½ x 6 ½ in.
Plate 46

Cecily Fergeson

*Blood on Porcelain (Innards), No. 9*

2017

Endoscopic photograph (digital)

$6 \frac{1}{2} \times 6 \frac{1}{2}$ in.
Plate 47

Cecily Fergusson
*Performative Skins* (Process Shots)
2017
Digital photographs
Dimensions variable
Plate 48

Cecily Fergusson
*Performative Skins (Process Shot)*
2017
Digital photograph
Dimensions variable
Plate 49

Cecily Fergusen
Document of a *Performative Skins* experiment (Studio Shot)
2016-17
Digital photograph
Dimensions variable
Plate 50

Cecily Fergusson  
Document of a *Performative Skins* experiment (Studio Shot)  
Glue mixed with charcoal powder, pulled from prickly pear cactus  
2017  
Digital photograph  
Dimensions variable
Plate 51

Cecily Fergusson
Document of *Marshmallow Head* (Studio Shot)
Wire mesh, glue, marshmallows, blowtorch
2017
Digital photograph
Dimensions variable
Plate 52

Cecily Ferguson
Document of *Marshmallow Torso* (Studio Shot)
Wire mesh, glue, white and pink marshmallows, blowtorch
2017
Digital photograph
Dimensions variable
Plate 53

Cecily Fergeson

_Diver Fly_

2015

Brocade, raw canvas, cotton thread, and gesso on canvas

16 x 12 in.
Plate 54

Cecily Fergeson

*Hive*

2015

Brocade, raw canvas, cotton thread, and gesso on canvas

16 x 12 in.
Plate 55

Cecily Fergusson

Washerwomen

2015

Cotton fabric, cotton thread, and xerox transfer on handmade paper

9 ½ x 13 ¾ in.

Edition of 8
Plate 56

Cecily Fergusson
Shattered Skull
2014
Fabric, cotton thread, and whipping twine on canvas
48 x 36 in.
Elizabeth Huth Coates Library Collection
Plate 57

Cecily Ferguson
Fractured Femur
2014
Fabric, cotton thread, and whipping twine on canvas
48 x 36 in.
Elizabeth Huth Coates Library Collection
List of Plates

Plates 1-5. Cecily Fergeson, *Four Sights of the Patient (Ophelia)*, 2018. Installation of four mixed media drawings on inkjet paper. Each framed in natural wood at 53 x 34 ¾ x 1 ½ in.


Plate 38-46. Cecily Fergeson, *Blood on Porcelain* series, 2016-present. Inkjet photographs. 6 ½ x 6 ½ in. each.


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