Embodied

by

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We are obsessed with bodies. Spring and summer we watch human hurlers throw sewn leather spheres across twenty meters of space at speeds approaching 160 km per hour. The target is small and catcher-framed, where a club-equipped adversary awaits, a kilo of turned ash held at the ready, success signaled by a sharp crack of hard leather on harder wood. Rising silently, arcing gracefully, tracing a path, a hundred, or hundred and fifty meters distant before returning to earth. Perfection. Fall and winter we watch as hundred twenty kilo, padded and helmeted, humans block, tackle, punt, pass, kick, and, if they are the Bengals, fumble a dirigible shaped more or less inflated bladder made of leather and lace. And those are just the male bodies. Obsession with the female leads us down darker corridors of sex and shame, portraiture and pornography, paradise lost and paradise regained. But the surest sign of our obsession is the dollar sign of an economy that devotes nearly twenty percent of all its efforts to what the ancients called the *cura corporis* — medical care.

What is the history of this grand obsession — its origins and the particular and peculiar form its has taken in Western Civilization? In tonight's paper, I will follow two distinct historical paths from antiquity to the present, one strange one familiar, in search of an answer, before proving once again the truth of Bob Hilton's dictum that no matter the title, the subject is always the author.

Tracing the origins of the medicalized body is the familiar story, claimed even by today's practitioners, who swear an oath named after its semi-legendary founder — Hippocrates. He and his followers created a profession and a philosophy of body that was among the most influential achievements of the ancient world. Greek physicians understood the body through analogy with the natural world: as there are four elements in matter (earth, wind, fire, water) there are four in the body — blood, phlegm, yellow and black bile. All the sublunar world is in constant motion and flux, but health was thought to be a balance, a homeostasis, where elements are in "correct" proportion to each other. Disease was thus a disruption of that balance caused by a myriad of things: action of one of the four seasons (winter was phlegm season), errors in diet, even the influence of the extra-lunar world of the planets could play a role. A physician's job was to diagnose the imbalance and prescribe a remedy, usually via extraction or infusion — e.g. bleeding, enemas, emetics, or change of diet, or perhaps something from a vast *apothecarium* of plant and animal extracts. Diagnosis, prognosis, cure, all were the province of the physician whose role continued as the Roman Empire rose and fell, followed by Byzantines, Westerners, and the greatest physicians of the medieval world, the Islamic physicians of Baghdad.

Traditions from the ancients continue in the modern practice of medicine — from the Greek names of the specialities, to the wonderful traces left in language. Are there more beautiful adjectives than phlegmatic, sanguine or bilious? Who would give up saturnine, mercurial, or lunatic? More recently, Dr. Victoria Sweet has revived the view of body as analogous to the animal and vegetable world, and that healing is really more about removing obstacles than intervening forcefully in the natural restorative force of the body. In works like *God's Hotel* and *Slow Medicine* she calls into question many certainties of modern medicine by recalling older traditions and philosophies of curing and healing the body.

The stranger story of origins of our obsession is the theology of body, specifically the dogged insistence of Western Christianity from the fourth century that God was embodied. By church tradition it was the emperor Constantine the Great who insisted that the nature of the incarnation be defined once and for all by the council of bishops he called together at Nicaea. Controversy had been raging for some time with followers of Arius of Alexandria who insisted on a distinction between a born and unborn God, with the former as subordinate to the latter. It must be said that Arius's position was the more elegant and truer to Greek philosophical traditions, which rejected intermingling divine and mundane as they rejected confounding mind and body — it was as Juvenal put it a *mens sana in corpore sano* — in that order. Imperial authority in the long term drove a wedge between Orthodox and Roman Catholic Christology that resulted in a complete break in the eleventh century, one that endures to the present day. But it allowed the West to ponder and develop the implications of a divine humanity — that the body was not just a thing of defecation and decay, but could be a vehicle of holiness and resurrection.

For this we must observe what Jesus did with his body. He was born of a woman: granted, a woman who was a virgin and as medieval theologians argued, one free of the sin of Adam. Yet, he was a normal child and only as a mature man in his late twenties did he fully embrace what he called his "father's business." From the record of the Gospels, he was one of many prophet/teachers who traveled throughout a profoundly unsettled Judaea, an occupied territory of the Roman Empire. Caught up in a crack down on sedition by the Romans and subversion of Jewish orthodoxy, according to his Jewish denouncers, he was executed according to the fashion of the time, by being fastened to and hoisted up on a wooden cross, to die of asphyxiation or exposure, whichever came first. Thereafter, as proclaimed in the Nicene creed, he was entombed and after three days rose from the dead — bodily, not as some kind of ghost, and appeared numerous times to his followers before being assumed bodily into heaven.

The sheer corporality of this narrative is unique among world religions and set medieval people to draw new conclusions about the theology of bodies. That bodies could be a locus of holiness became a fixed belief and led to the veneration of objects and body parts associated with Christ and his saints. Luther came to joke that if all the fragments of the true cross were collected, they could rebuild Noah's ark. But more significant were the bodies of saints, either martyrs to Roman persecution in the early days, or others whom the community or much later the papacy acknowledged as holy, whose sanctity lived on in their dead bodies to miraculously cure their successors. Every Western church had its collection of holy relics as does our own St. Peter in Chains, so this cult of relics continues in the twenty-first century. As important as relics to medieval Christians was the insistence on the resurrection of the body at the end of time. And this was understood to be an experience of *every* body, that like Jesus Christ would enter eternity with the very body they possessed at the age of thirty. Theologians of the University of Paris and elsewhere wrote with great ingenuity about how this would come about even to those who never reached that age, or who had fallen victim to shipwreck, cannibalism, devouring by wild beasts, or any of the other nightmares of decay and fragmentation that could befall a human corpse.

The *ne plus ultra* of this line of theology was the doctrine of transubstantiation, the church dogma that in the Mass the bread and wine of the eucharist invisibly transmogrify into the body and blood of Christ. Thus the consecrated host became the ultimate relic and came to be displayed in monstrances, like other holy relics, carried around in church processions or exhibited on holy days. In the later Middle Ages, the feast of *Corpus Christi* became a major church festival of riotous observance and conviviality. It was one of the first things to be suppressed by Protestant reformers. But nothing could entirely efface the Western insistence

that the self was inextricably bound up with the physical body and that it would -- it must -- be restored in resurrection if there were any truth to Christianity at all.

For physicians and theologians bodies are abstract things, but for us in this room, our bodies are all too real as we sit, doze, snooze, or look longingly at the buffet table. But few of us think much about our own body until it is broken. That moment came for me late in the morning of August 22, 2015 while I was descending a hill near Bellemont farm in Western Massachusetts. I was participating for the fourth time in a 160 kilometer long bicycle ride through remote backroads organized as the Deerfield Dirt Road Randonnée, or D2R2 for short. It has a cult following in the Northeast, attracting nearly a thousand riders to a day-long trek through backroads where dirt is the predominant road material and the object is to climb and descend whenever possible. I was riding the bike I had used the year before, the second-string gravel bike belonging to my brother-in-law, Joe Cravero. He was slightly ahead of me as we crested a hill and began to descend at about the sixty kilometer point in the ride.

The descent was typical, perhaps a half mile with a sharp right turn at the bottom. But as I gathered speed and reached for the brake levers to squeeze them and thereby draw the calipers against the wheel rims, there was no resistance. The levers clattered against the handlebars. Years of corrosion from Boston winters had caused both cables to fail. I had no brakes. I often wonder at the human reaction when normally trustworthy machines fail. Do pilots have to be trained to give up and get out quickly when engines fail? In my case, I was already traveling fast enough that I didn't think to just lay the bike down, which in hindsight was the right course. Instead, I stayed on the bike, yelled at the other cyclists around me that I had no brakes and saw that I was about to plow into a group of fellow randonneurs who were slowing at the bottom of the hill. I veered right into a parallel drainage ditch, traveling now at a considerable rate of speed. That's the last thing I remember. Apparently, after a short distance I crashed into a drain that had a masonry superstructure projecting a half meter or so above ground level. In retrospect this was probably the second best possible outcome since it stopped the bike and catapulted me into what must have been a soft pile of leaves and brush. The collision was violent as everyone on the hill, including Joe at its bottom, heard me hit. This worst-best outcome was marred only by my right hand and leg striking the masonry as I rocketed past. The hand was broken; the leg shattered at mid-tibia.

Of course I wouldn't know this for some time. I was knocked unconscious on impact -- the state of my riding glasses suggest a head first entry into my resting place. By the time Joe made it back to me I was semi-conscious and responded to his questions. A concussed brain plays funny tricks on you; I had the feeling of being at the bottom of a dark well with voices echoing down to me from above. I have no visual memory of that first hour; I was like a protagonist in a Haruki Murakami novel where the well is both your past and future. I remember being annoyed at Joe's insistence that I move my legs, learning later that he was afraid I'd sustained a spinal chord injury; but there was little pain as the best part of an hour passed before any help arrived.

A randonnée is by definition unsupported so there was no trailing vehicle, or sag wagon as they're commonly called. There was also no cellular service of any kind, so someone had to be dispatched to find the nearest signal so that an ambulance could be summoned. I should explain that Joe is a pediatric anesthesiologist at Boston Children's hospital, so he took care of me for those long minutes before the ambulance arrived. I remember being strapped on the backboard and hoisted into the ambulance. Joe told me later that he grew impatient with the fumbling efforts of the EMT to insert the IV in my arm, so he did it himself. The ambulance crew had the last laugh, however, for as they turned back onto the road Joe watched as they pumped morphine into me, remarking at some point that in their zeal they may be overdosing me. As if on cue, I stopped breathing, and Joe did too, but the crew just straightened my broken leg and the pain snapped me right back among the living.

In the meantime, Joe had made a series of decisions on my behalf. I needed a level one trauma center right away and there were two within a hundred fifty kilometers. Joe chose his former hospital, Dartmouth-Hitchcock in Hanover, New Hampshire, which dispatched a helicopter to pick me up. Thus that ambulance ride covered only four miles, reaching the baseball field of a nearby school where a helicopter could safely land. I was packed aboard, unconscious again, for a MASH-like ride to the waiting medical staff. And that's how I entered the American medical industrial complex.

I should state that my employment at a public university in Michigan provides me a PPO plan that would prove to be very good insurance indeed. I barely saw a bill; only the haplessness of the ambulance company, which failed to get my insurance information, sent me a bill for $1500, or $375 per mile. I was quickly assessed at Dartmouth and taken to surgery. My physician sister, Carolyn, Joe's wife, told me later she cried for an hour after seeing the x-ray of my leg; she wondered if I'd ever walk again.

As a medieval historian, I'm inclined to take the long view of things and even though my surgery was performed in anything but medieval conditions, the choice of tools remains pretty much the same. From antiquity, barber/surgeons in cases like mine could choose saw or splint. Until the mid-nineteenth century, amputation would have been the likeliest treatment of such a severe fracture: who can forget the battlefield pictures of the Civil War with the piles of severed limbs around the medical tents? Had my injury occurred in the first half of the last century, the treatment would probably have been external fixation in a splint/cast. This would have pinned the shattered bones in proximity to each other, where they would knit together if all went well in eight to ten weeks. The drawback for the patient here was the necessity of complete bedrest and inactivity for that period. In the last fifty years, surgeons have taken the splint inside the limb threading a stainless steel or titanium rod through the shattered bones and affixing it with screws to solid bone above and below the fractures. This was the choice of my surgeon, what is called intramedullar nailing.

My first post-surgical memory was an exquisite moment of pain relief. I had been given a plunger that when depressed released a measure of morphine into my vein. I did it once or twice just to experience the sensation of pain falling back as if struck by an irresistible force. By the next day, Sunday, I was aware of what had happened to me and had taken stock of life with a broken hand and leg in which locomotion was only possible with a walker. I could put no weight on my rebuilt leg. My surgeon assured me however that I was on the road to recovery, as the cliché states, and within two or three months I would be able to resume my hyperactive life. In the meantime I would be released to the care of my sister, who had attending privileges at the hospital, but would take me to her house in Hanover until the surgeon released me for the longer journey to Cincinnati.

Here there was the first problem in what my sister called the continuity of care. I had been released from the hospital without provision for the home duty nursing I needed in the first days after surgery, that is the care of my wound and above all the administering of the anti-coagulant I required. One of the most common complications after surgery is blood clots and I was prescribed a drug to be administered subcutaneously in the abdomen to prevent them. This I could not do myself, and without my physician sister in residence, I might well have fallen victim to a potentially fatal after-effect of surgery. I was later told that confusion about my health insurance had interfered with that part of my care.

I next encountered the practical difficulties of living in a multistoried house in which all the full bathrooms are in the upper story and thus reachable only by stairs. Carolyn had requisitioned the living room downstairs for my hospital bed and I had access to a half bath off the kitchen after traversing three rooms. Bathing could only occur in the kitchen sink and I stopped

shaving altogether, developing both whiskers and a stronger than customary odor as the days passed. After ten days I was discharged by my surgeon to the care of my partner, Tracy, who had come from Cincinnati to accompany me home. Carolyn figured out the logistics of hiring a private car service to take me from Hanover to the Boston airport, a journey of two hours or so. That passed with remarkably little trouble, much to my surprise, and Tracy had another hospital bed waiting for me in our repurposed dining room. Again, I faced life with an upstairs bathroom, a downstairs toilet and the kitchen sink. I didn't know it then, but I would not have a shower for the next six months.

Soon I was thrust into solitude as Tracy left me alone to teach her classes and attend to her duties as director of graduate studies in UC's department of History. It was barely two months since I had stepped down from my job directing a center at Western Michigan University with seven employees and two dozen graduate students under me. Now my life in a broken body had fallen still. How did I fill my day in the small space between bed, bathroom, and sofa? I wish I could say that I taught myself Greek, reread Plato and Aristotle, or finally made it through Joyce's *Ulysses*. I did none of those things. I did a good deal of thinking about my life and my prospects. I had chosen to return to Cincinnati and to move in with Tracy, who had been my companion for more than a decade but always at a distance. She would also prove to be an invaluable ally in my struggle to heal my shattered leg.

Shortly after my return I scheduled an appointment with an orthopedist at UC Medical Center who had come highly recommended. My son, Jimmy, took me to the first appointment as driving was out of the question for me as it would be for the next seven months. I distinctly remember the x-ray and the visit of the resident who looked at it and prepared for the arrival of his supervisor. He arrived and I recall that he looked only at the x-ray, saying that he disagreed with the judgment of my first surgeon and that my fracture would require bone grafting. This was a distinct departure from what my medieval barber/surgeons could imagine, requiring bone from my hip to be placed in and among the fractured bits of my tibia. With that, he left with future procedures still to be planned.

What he failed to notice became increasingly clear in the next week or so: the wound caused by my shattering bones was infected. Tracy was the first to notice it, having been charged with "wound care" and when she asked what that meant she was told, "just keep it clean." Neither of us knew then that a fairly common secondary problem in cases such as mine is infection, either through the Trojan horse of the titanium nail and screws, or from the simple fact that I had been spread-eagled in a drainage ditch with an open fracture for an hour. There is also in the medical literature findings of an unexplained correlation between serious leg fractures and incidence of osteomyelitis, or bone infection, as if it was the job of bacteria to test the viability of my rebuilt leg. At her insistence, Tracy took me to my primary-care physician and he was sufficiently alarmed to send me to another orthopedic surgeon who was "good with wounds."

And that is how I entered another health-care network based largely in the northern suburbs of Cincinnati. Even though I had been a patient of my primary care physician for nearly thirty years, I had not realized he was affiliated with a network that would influence, if not determine, who and where I would receive my care. The orthopedist's office was in Blue Ash and unlike his UC colleague he spent a good bit of time with me explaining what the next steps would be. To combat the infection, he recommended a surgical procedure to clean out the area and a course of intravenous antibiotics, which he thought would vanquish the infection. He did not tell me the worst case outcome -- amputating the leg. So in October I underwent a second surgery in a second hospital not far from the office of my orthopedist.

It was interesting comparing that experience with Dartmouth Hitchcock, a large academic hospital. Clearly, this hospital took much greater care with its decoration and what can only be

called customer service. The place looked like a hotel with bright colors, cheerful people and a private room, unlike the double I had in New Hampshire. But I was a bit nonplussed to learn that most of the nursing care was provided by nurse's assistants who were supervised by registered nurses. I thought ruefully of my own institution, the public university, where large swaths of classes are taught by adjuncts or graduate students. It seems that the drive to reduce costs and retain customer loyalty has resulted in cuts in the quality of personnel who provide services. I find this a disquieting development.

One other measure to reduce costs is to discharge patients as soon as possible and to deliver care at home whenever possible. A whole industry has arisen to provide intravenous medicines to people like me, who receive a PICC line (peripherally inserted central catheter) before leaving the hospital. This is essentially a device that keeps a vein open and available for IV medications for long periods, hopefully without infection or other complications. It requires the weekly attention of a visiting nurse to change the dressing, draw blood to measure effect, and to insure function as well as a compounding pharmacy to fill and dispatch the prescription usually by same-day messenger. It can also place the burden of administering the dose on your partner, who receives only the barest instructions from the nurse about the procedure. In hindsight this led to some comical scenes of Tracy having to mix the antibiotic powder with sterile water by breaking two capsules and agitating the recalcitrant powder so it would dissolve. We eventually learned to insist on already compounded medicine that we could store in the refrigerator.

In weekly visits to an infectious disease specialist, I learned the effects of the expensive agents flowing into my veins. Despite repeated attempts, they were never able to successfully culture the bacterial cause of my infection, which forced a shotgun approach of rotating antibiotics hoping for one that would be effective. I never knew the total cost of all this, but once my doctor let slip that an antibiotic I was using cost $300 per day; this continued for six weeks. At the end, I faced another decision. Indications were that my infection had receded, but only time would tell if it had been eradicated altogether. A necessary step was then removal of the surgical metal in my leg, followed by a period to observe and then another surgery to install new metal and begin all over again. I thus learned that once infection touches any surgically installed metal, it must be removed to prevent the infection's recurrence.

But who should do those surgeries? On the one hand was my suburban orthopedist who took much time with me and who was no doubt competent, but whose practice really centered around replacing worn-out joints for the elderly, not addressing complex fractures. On the other hand there was the UC specialist, who by all accounts was a skilled surgeon, and who informed me on a return visit that he did twelve to fifteen cases like mine a year. But he had also committed an error in missing my infection and he gave me little time -- I called him my ninety second orthopedist. The decision? Back to UC. First, though I had repetition. My UC surgeon wanted to make doubly sure about my infection, so he put me on another six-week regimen of antibiotics after removing the tainted metal from my leg, replacing it with a plaster cast. These were some of my most uncomfortable weeks, for the cast caused me more pain than before and it was more difficult to get around. At last, in late February, 2016 I entered UC hospital to have my internal splint reinstalled.

It was after that surgery that I had another experience of the imperfections of our medical system. Nothing went amiss with the surgery, but the day after, late Saturday into Sunday, the critical shortage of registered nurses and the resulting difficulty of staffing weekends affected me. At midnight a nurse came on duty complaining to me about having six patients for her coming shift. To be fair, keeping hospitalizations short has resulted in a concentration of seriously ill patients and a heavier workload for nurses and other staff. I told her that I would be little trouble, I just need my pain medications on time, and one was due at 2 a.m. That hour came and went; I put my call button on and made my request. She only showed up a half hour

later with the pills, and then discovered that my IV fluids needed replacing. She disappeared for an hour before reappearing with the fluid, hanging it, and then telling me she'd be back to draw blood. I told her then that no, she would not be taking my blood, and ordered her from the room after informing the supervising nurse to keep that nurse away from me. A few minutes later, a resident entered to inform me that I must accept the care of this nurse and I told her that no, I did not. Fortunately, the supervising nurse intervened and took over my care for the rest of that shift; but I stubbornly continued to believe in a patient's absolute right to accept or refuse treatment.

Physical therapy was for me the Promised Land of Progress, denied me for six long months. UC's department was housed in the former Holmes hospital building where my son was born decades ago, which I took for a good omen as I began my real recovery in March, 2016. The therapy room was well equipped and run by "big" Erin an eclectic therapist adept in the arts of massage and acupuncture who quickly sized me up as someone who just needed direction and an occasional restraining hand. As a life-long athlete I understood the need for persistence and patience as progress was often measured in fractions obtained through considerable pain. Six months of inactivity had cost me half the muscle mass and the ability to even straighten my right knee. To walk again properly I had to recover both mass and flexibility while not interfering with the bone growth now freed of infection's grasp. My tools were weight machines, excruciating massage, and a marvelous invention, an anti-gravity treadmill that harnessed compressed air to mitigate my body weight as I pounded the moving pavement with both feet. Soon after beginning the three to four weekly visits to Holmes, I began to take Uber to the Recreation Center at UC on other days. Later my son made fun of me as the only person he knew who went to the gym on crutches.

My progress was measured by what I cast off. I went from two crutches to one; then to a cane, and by mid-summer I was walking on my own some nine months after the crash. A year after my last surgery, my x-ray showed a perfectly healed tibia with no visible sign of injury. I was acutely aware of my good fortune through all of this, having paid leave from my university, the medical facilities and therapies covered by my health insurance, the love and support of Tracy, my family and friends, especially fellow Literarian, Richard Gass, who quietly collected articles about successful amputee athletes for me, before just as quietly discarding them. It could have been different. I followed the cases of two other athletes who suffered injuries similar to mine and whose outcomes display the range of the possible. Taylor Phinney was a very promising young American road cyclist when in 2014, during the National Road Race Championships, an errant motorcycle on the course forced him into a guardrail during a high-speed descent of Lookout Mountain outside Chattanooga, Tennessee. He shattered his left tibia, injured his knee, and was more or less told that his racing days were over. But after two years of rehabilitation, he began racing again, and last month he finished eighth in the famously difficult Paris-Roubaix road race. Dave Mackey was a world champion ultra distance runner -- races of fifty to a hundred miles -- who on a training run above Boulder, Colorado in May, 2015, caused a section of the trail to collapse, tumbling him downhill and resulting in a crushed lower left leg. Surgery, bone grafts and infections followed the injury; grafts failed, the rod was unstable, surgery followed surgery leaving him in chronic pain. At last in November, 2016, he had the leg amputated trusting that a prosthetic would give him more chance of running again. As of early this year, he is able to hike his mountains, but not yet run them.

What is it to heal from traumatic injury? Phinney and Mackey give two answers to the question; but as for me I knew I had to return to the D2R2 and ride those unridden kilometers. When I told Richard, a man not known for faintheartedness, he was incredulous, telling me that after thirty years of friendship, he no longer doubted my insanity. I think most others agreed with him. But my sister and brother-in-law understood and promised to help me in my quest. We entered for the 100 kilometer distance and prepared the best we could. When I packed up a bike and gear for the drive east, I felt nervous but ready for the challenge. In Hanover, we

rode together and I was apprised of their plan for my return to the 2017 D2R2. First, I would ride Joe's new acquisition, a state-of-the-art mountain bike with big wheels, wide tires, and most important, hydraulic disk brakes. It was the bike equivalent of a Humvee. Next, we would ride together, with a friend of Carolyn's, who was fit but not fanatic and charmingly named Carmen. Our foursome would concentrate on enjoying the day, riding conservatively, lingering over lunch, and getting me to the finish line. It worked like a charm: they waited for me at the top of climbs, waited for me after challenging descents, laughed and talked and marveled as we passed through centuries old farms, each demarcated by stone walls and barking dogs. And they celebrated with me when I crossed the finish line. Later, over a plate of food and a craft beer, surrounded by other happy finishers, I analyzed my feelings of somehow being re-embodied. Not in the same body of two years before; but finally in a body I could recognize and accept as my own. That was a good day; that was a very good day.