ANGLO SAXONICA

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University of Lisbon Centre for English Studies
Centro de Estudos Anglísticos da Universidade de Lisboa

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Special issue on MEDICAL HUMANITIES

Guest Editor BRIAN HURWITZ

Número especial sobre HUMANIDADES MÉDICAS

Editor convidado BRIAN HURWITZ

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Medical Humanities: Origins, Orientations and Contributions

Brian Hurwitz
Centre for the Humanities and Health, King's College London

Medical Humanities: Origins, Orientations and Contributions

> To speak of clinical medicine as human medicine is no mere gloss: it calls… for a kind of discernment characteristic of the knowledge that human beings have of other human beings—rooted in long experience, cultivated in years of practice.
>
> Stephen Toulmin 79[1]

> Medicine is the most humane of the sciences, the most empiric of the arts, and the most scientific of the humanities.
>
> Edmund Pellegrino, *Humanism and the Physician* 17

This issue of *Anglo Saxonica* features papers illustrating scholarly work undertaken in the Medical Humanities. The field now spans a variety of discourse communities that share an overarching interest in bringing the intellectual approaches of the arts and humanities to bear on problems raised by health, disease and responses to illness. The papers collected in this issue engage with a range of materials and media—memoirs, letters, short stories, myths, ethnographies, case histories, films and TV series—and employ a diversity of methods: techniques of literary and oral history, the history of ideas, close reading and analysis of film, to generate insights into how health and disease are expressed in human artefacts and cultural memory.

[1] Cited in Cole *et al.* 213.

The physician and philosopher Edmund Pellegrino held that the humanities "teach us to deal with the unmeasurable phenomena of human existence" (Pellegrino, *Humanism and the Physician* 4), and to engage with the sort of human accomplishments the literary scholar Ronald Crane characterised as "not amenable to adequate explanation in terms of general laws or natural processes, physical or biological" (Crane 15). Each of the papers brought together here offers its own demonstration of how relatively little immeasurability matters in relation to health and illness in understanding the meaning and significance of individual, social and imagined human existence.

Conjoining medicine and humanities within a single term was the inventive move of the historian of science George Sarton, the founder-editor of the journal *ISIS*, who coined the term in 1948 (Sarton, "Seventy-first critical bibliography of the history and philosophy of science and of the history of civilization (to October I 947)"). Medical Humanities is now a scholarly configuration and meeting ground for new conversations between disciplines, practices and professions interested in what is also sometimes known as the Health Humanities (Crawford *et al*.; Therese Jones *et al.*). Sarton had earlier called for a "new humanism," one capable of critically situating science as a wellspring of knowledge and progress, and of responding to its growing number of specialisms which he believed conferred great explanatory power, but at the cost of fragmenting knowledge without providing a complementary framework for understanding the human and cultural significance of scientific discoveries and inventions (Sarton, "The new humanism" 9-42). Sarton argued for a synoptic and encyclopaedic vision of the sciences which would explicitly bring together:

> (…) scientists, historians, philosophers, [and] sociologists to coordinate and harmonize their points of view; to broaden their horizon without lessening the accuracy of their thought; to make the accomplishment of their higher task easier in spite of the increasing wealth of knowledge. (Sarton, "The new humanism" 32)

The "higher task" he aimed for was "the humanization of science" which would flow from the multidisciplinary positioning of its methods and assumptions in historical, philosophical and cultural contexts. Sarton's programme was premised on the deep assumption that although all

"[k]nowledge is one" it has two primordial sources: nature and history. Only the latter—understood from the disciplinary perspectives of the humanities—could supply the interpretative framework required fully to understand the former. However much insight scientists might gain into the workings of the universe this understanding would inevitably lack an appreciation of their own cultural and conceptual lineage—the long, transnational, intellectual chain of observations, thoughts, inventions and experiments, undertaken in different epochs, which has contributed to present-day scientific understanding. The "humanization of science" for Sarton was "a compromise between the claims of the future and those of the past (…) a combination of the scientific and humanistic spirit" that recognised and countered the effects of disciplinary fragmentation in the sciences (Sarton, "The new humanism" 32-33).

Five years before Sarton proposed his "new humanism," William Osler, the Regius Professor of Medicine at Oxford (1905-19), in his Presidential Address to the Classical Association, referred to the humanities as "the hormones" of innovatory thinking that activate new ways of thinking (Osler, "The Old Humanities" 1-7). Whilst science could provide the knowledge required to diagnose and treat diseases, it offered no tuition (or intuition) on matters of vital interest to medical students, concerning how they were to understand doctor patient relationships and how they should manage interactions within and between the profession and the public. By reading medical biographies and becoming familiar with medical history—pondering the characteristics, thoughts and experiences of earlier physicians within their historically determined institutional and conceptual worlds—young doctors could tap the experience, orientations and insights of previous medical generations.[2] This rationale was the impetus for Osler's interest in the history of medicine, and for amassing a vast library of books and manuscripts devoted to medical culture of all sorts spanning several civilisations (Osler, *The Collecting of a Library* xv-xxvi).[3]

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[2] See, for example, his collection of autobiographical studies in *An Alabama Medical Student*.

[3] John Harley Warner, the historian of medicine, says of Osler's humanism that "[it]was a very bookish kind of elite, homosocial professionalism. Medical history provided the

Osler's interest in the humanities and medicine did not arise in a discursive void. As an undergraduate student of religious studies he had considered a career in the footsteps of his father as a minister in the Church of England (Bliss). But when he turned to medicine he absorbed the concerns of other physicians and scientists of the second half of the nineteenth-century, who argued for a broadly-based education in the face of increasing scientific specialisation, a training that would ground the education of future physicians not only in the fledgling sciences of biology, physiology and pharmacology, and the growing number of clinical specialities, but also in study of the humanities: history, classics, philosophy and literature. In the middle of the nineteenth-century the professor of botany at Oxford was typical of those giving voice to such concerns in calling for a more rational system of medical education:

> Most persons (…) will agree with me in thinking that a really good medical education embraces something more than the regulation standard of professional attainments; that it implies a general development of the faculties of the mind by early discipline, some amount of general information on subjects unconnected with the profession, the habits and feelings of gentlemen, and a moral and religious training. (Daubeny 78)

Beyond promoting the manners and etiquette of the well-educated English gentleman as the role model of modern bedside doctoring, Sir Clifford Allbutt, Fellow of the Royal Society and inventor of the clinical thermometer, advised medical students at St. George's Hospital in London to read outside of science and medicine. In an address to the opening session of 1889 he shared with them his own student reading habits:

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platform for a humanism closely tied to medical historical libraries, bibliography and book collecting. Clubbish and exclusively male, the gentlemanly gatherings that cultivated this bibliophilic, literary humanism forged links between the physician's identity and liberal education, civility and moral wisdom. Old books in particular were tangible links tying present to past and, for American physicians with cosmopolitan aspirations, connecting the New World with the old Old World. Osler was but one such medical humanist, yet both at the time and much more so in later memory, he was made to stand for the whole" (93).

> I read three books to enlarge my medical mind, namely, Grote's *History of Greece*, Gibbon's *Decline and Fall* [*of the Roman Empire*], and Mill's *Logic*. Rather by accident than by design, I fell upon these three, but if to these can be added some great work of imagination (every man who has been at school can keep up his Homer with but a little trouble, and in any case has Shakespeare at his side), I think no finer culture could be had. (Allbutt, "Introductory address" 757)[4]

At the turn of the century, the neurologist and psychiatrist Sir James Crichton-Browne, also a Fellow of the Royal Society, argued in the pages of *The Lancet* that:

> The poet is the interpreter of nature and in our poets we have guides more or less trustworthy in our wanderings in her demesne, for if they are true poets they transcend scientific analysis and not merely put forth beautiful visions but anticipate and create. The great masters of poetic literature should not, therefore, be unknown to the medical student who aims at the Ideal, of which also art and music and the drama may be powerful auxiliaries. (935)

[4] In *Aequanimitas* Osler wrote that: "A liberal education may be had at a very slight cost of time and money. Well filled though the day be with appointed tasks, to make the best possible use of your one or of your ten talents, rest not satisfied with this professional training, but try to get the education, if not of a scholar, at least of a gentleman. Before going to sleep read for half an hour, and in the morning have a book open on your dressing table. You will be surprised to find how much can be accomplished in the course of a year. I have put down a list of ten books which you may make close friends. There are many others; studied carefully in your student days these will help in the inner education of which I speak.

Old and New Testament.
Shakespeare.
Montaigne.
Plutarch's *Lives*.
Marcus Aurelius.
Epictetus.
Religio Medici.
Don Quixote.
Emerson.
Oliver Wendell Holmes—Breakfast-Table Series" (388).

He also promoted "[e]xcursions into the pages of history" to enable medical students to develop "an inner understanding of the world and disclose to him in ages, nations, and social groups the operation of qualities and will (…)" (935).

Similar concerns were expressed in the USA; Silas Weir Mitchell in his book *Doctor and Patient* (1909) recommended that physicians develop literary and artistic interests as a means of enlarging their clinical experience (Mitchell 59). Osler developed these arguments and aspirations into a rationale for incorporating humanities' components into medical training. One response to his calls was the creation in 1929 of the first chair in the history of medicine in the USA at Johns Hopkins University which, through the learning and teaching it would engender, could help counter fragmentation in medicine. At the dedication ceremony for the new chair, the neurosurgeon Harvey Cushing regretted the extent to which medicine had become "scattered and subdivided (…) there is crying need", he argued, "for someone to lead it from the wilderness and bind it together (…)" (38).

After the Second World War, when reviewing *A History of Scientific English* in the pages of *ISIS*, George Sarton praised its author, the American surgeon Edmund Andrews, and in doing so configured medicine and the humanities in a single redolent phrase:

> I have read this book with deep interest. It is clear that the author, trained as a physician, had a strong historical and philological instinct. His death at the early age of 48 is a sad blow to the medical humanities, for very much could have been expected from him. The book is of special value, because it combines medical experience with philological insight. ("Seventy-first critical bibliography" 127)

This assessment appeared in a bibliography that spanned two and a half millennia—the seventh-century BC to the mid-twentieth century—and featured a huge diversity of texts typifying the synoptic approach Sarton advocated, together with notes and comments, and short exegeses touching on religion, history, culture, and pre— and modern science and medicine. In one note Sarton quoted Ashley Montagu concerning the need to bring the humanities and sciences into closer relation:

> The humanities and science are still too far divorced from one another in our present compartmentalized state of development. The department of English or literature in our educational institutions can do most to bring what no one should ever have allowed to have been put asunder together again. This should be done in the light of the belief that a liberal education is one in which science and the humanities are combined, in which science becomes one of the humanities, in which the emphasis is upon culture and not upon technics, upon education not instruction (…). ("Seventy-first critical bibliography" 115)

Medical Humanities was coined at a time when questions about the role of the humanities, humanism, and a liberal, multidisciplinary education were actively being debated not only in terms of their role in medical education, but in terms of the sort of scholarship it was believed doctors in training should become familiar with, which included the history and culture of scientific knowledge, debates that continue to inform the Medical Humanities today. However, beyond sporadic appearances in book reviews in the pages of *ISIS* it would be several years before the term gained much of a foot hold. Though students of the natural sciences at Cambridge in the 1940s requested courses on literature and poetry—which for many years were taught by members of the English Faculty (Henn)—the Medical Humanities remained an ill-defined possibility.[5]

In the 1950s, the UK physician, Hugh Barber, argued for the value of immersing medical students in literature so that they could become familiar with "fallible human nature of which they themselves are part" (Barber 78). In the 1970s the Australian surgeon Anthony Moore read

[5] We recognise that the Medical Humanities was the domain in which the Spanish physician and historian of medicine and culture, Pedro Laín Entralgo, worked in the 1940s, '50s and '60s, although as far as I am aware he did not himself use the term. Entralgo (1908-2001) remains an influential figure in the history of medicine, but unfortunately only a few of his many works have been translated into English: *Doctor and Patient*, Trans. Frances Partridge (1969); *The therapy of the word in classical antiquity*. Trans. & Ed. L. J. Rather & J. M. Sharp (1970). Arguably his most influential work was *Medicina e historia* (1941).

literary texts with medical students under the rubric of the medical humanities, as a way of raising their moral awareness;[6] the American physician, Robert Coles began promoting the value of literary reading amongst clinicians, to help them examine their own characters in relation to their practice (Coles); and the moral philosopher Robin Downie in Glasgow espoused poetry to enable clinicians to develop "whole person understanding", through imaginatively entering into the lives of fictional others (Downie 98). These initiatives attest to the means by which science and humanities disciplines productively interacted over the need to synthesise human and clinical aspects of medical practice despite the claims of CP Snow in *The Two Cultures* (1959) that there was an unbridgeable chasm between the intellectual worlds of the humanities and of the sciences.

In the postwar era additional influences also came to shape this nascent field, particularly the growing importance of medical ethical issues in research and provision of healthcare. Moral questions turning on conflicts of principle, value and the workings out of virtue in professional contexts had long been represented in forms closely allied to the arts and humanities—novels, dramas, films, memoirs and biographies—in a literature which broadened and deepened the moral perspective presented by bioethical case reports, and provided ethicists with a repository of situations and contexts finely graded by moral ambiguity worthy of reflection, comment and calibration.[7] Two of the leading journals in Medical Humanities started life entwined with medical ethics journals: the American *Journal of Medical Humanities* first appeared as the *Journal of Medical Humanities and Bioethics* (1980), and the UK journal *Medical Humanities* (2000) was initially launched as an offshoot of the *Journal of Medical Ethics*. The emergence of narrative as a versatile and fluid notion capable of configuring multidimensional meanings in healthcare provided some of the intellectual ballast for these developments,[8] reflected in the

[6] "The Art of Medicine: A Missing Subject" (1975); "Medical humanities: an aid to ethical discussions" (1977)*; The missing medical text (*1978).

[7] See for example, Chambers *et al.*; Rosenstand; Singer and Singer.

[8] See Emily Jones *et al.*; Hurwitz and Bates.

founding of scholarly publications which represented facets of the Medical Humanities as a domain, such as *The Journal of Medical Ethics* (1975), *The Journal of Medicine and Philosophy* (1976) and *Literature and Medicine* (1982).[9]

This brief lineage indicates how Medical Humanities as a field emerged from criss-crossing interactions which sought to illuminate medicine across a wider terrain of enquiry than established bimodal disciplines such as medical ethics or medical history, literature and medicine or the history and philosophy of science, by employing a fuller range of methods, analyses and perspectives than those disciplines routinely deployed.[10]

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[9] Many departments of Medical Humanities retain this link to Medical Ethics in their titles and teaching programmes. See, for example, the John P McGovern Center for Humanities and Ethics at the University of Texas at Houston: https://med.uth.edu/mcgovern/about-us/mission-and-goals/ (accessed 1/09/15) and the Medical Humanities and Bioethics Programme at the Feinberg School of Medicine, Northwestern University, Illinois: http://bioethics.northwestern.edu/ (accessed 1/09/15). For a Spanish account of the value of the Medical Humanities see Lazaro.

[10] Recent scholarly work illustrating the power to be harnessed by a Medical Humanities approach is provided by Catherine Belling's study, *A Condition of Doubt*, which undertakes a serious deconstruction of labelling people 'unreliable narrators' and confronts the central concern of many of these patients, that there is something threatening that is lurking inside their bodies. Belling posits hypochondriacs as more attuned than others to the "inescapable experiences of embodiment", and less able to sustain the fantasy and fiction of invulnerability that "normal" live by. For Belling, hypochondria is not simply a condition within a person, nor is it a form of somatization or an emotional or psychological state manifesting as a physical response or a symptom. Hypochondria is a condition of embodiment amenable to a postmodernist approach to the reading of stories marked by streams of beginnings which rarely ever develop, the result being a person stuck in multiple arrested unsatisfactory stories. Joanna Bourke's book *The Story of Pain: From Prayer to Painkillers* offers another example of scholarly work in this field, which explores the nature of pain in Anglo-American culture from 1760 to the present, through a reading of letters, memoirs, poems, prayers, songs, stories, images, medical textbooks, philosophical and scientific investigations, and music. It considers a profusion of testimonies expressive of pain and discomfort, and develops a historical account deeply informed by the language and conceptual resources in which pain has been articulated, endured and comprehended over the centuries.

The first Institute devoted to the study and furtherance of the Medical Humanities was founded in in 1973 at the University of Texas Medical Branch at Galveston. For over fifty years it has fostered a broadly-based vision of the field, encompassing philosophical, historical, visual, literary, and religious dimensions of healthcare, offering tuition at clinical, masters and doctoral levels. The first UK academic unit devoted to the area was established at the Centre for Philosophy and Health Care at the University of Swansea, which launched a masters programme in Medical Humanities in 1997 focusing on philosophical inquiry that harnessed perspectives from history, medical anthropology, sociology, literature, the visual arts, politics, social policy and theology. More recently, the Centre for Medical Humanities at the University of Durham has championed the field as a sustained attempt to understand

> medicine as a human practice and, by implication, human health and illness (…) "medical humanities" denotes humanities looking at medicine, looking at patients, and—crucially—*looking at medicine looking at patients.* The way medicine conceives and represents patients shows up in the way that it treats patients. Therefore "medical humanities" isn't the name of a further humanities discipline, but is simply the name of a field of enquiry (…). The disciplines actually involved in it are familiar humanities and social sciences disciplines, having in common both an interest in individual experience (…) and a recognition that *subjective experience* can be a legitimate source of knowledge.[11]

These accounts indicate how polymorphous a field Medical Humanities has become, including within its purview multidisciplinary and inter-disciplinary research,[12] facets emphasised in a recent textbook on the

---

[11] Centre for Medical Humanities, University of Durham https://www.dur.ac.uk/cmh/medicalhumanities/ (accessed 30/08/2015). A number of other Centres for the Medical Humanities have been developed in UK universities including at Leeds, Glasgow, Keele, Kent, Birkbeck. The Centre for the Humanities and Health at King's undertakes research and teaching at masters, PhD, MD and postdoctoral levels http://www.kcl.ac.uk/innovation/groups/chh/index.aspx.

[12] Carson *et al.*; Hurwitz "Medical humanities: lineage, excursionary sketch and rationale"; Hurwitz, "Medical humanities and medical alterity in fiction and in life."

subject,[13] by Thomas Cole, Nathan Carlin and Ronald Carson. These authors stress a quite different conception of "humanizing" to that Sarton had in mind in the 1940s. They quote John Gregory, the eighteenth-century Edinburgh physician and moralist, who extolled sensibility as the chief quality required for the practice of medicine. In *Lectures on the Duties and Qualifications of Physicians* of 1772 Gregory insisted that: "The chief quality [of the physician] is humanity, the sensibility of heart that makes us feel for the distress of our fellow-creatures, and which, in consequence, incites us (…) to relieve them" (McCullough 170). This notion, developed by eighteenth-century writers, novelists and philosophers, positioned sensibility as a moral and psychological faculty:

> How selfish soever man may be supposed, there are evidently some principles in his nature, which interest him in the fortunes of others (…) Of this kind is pity or compassion (…). the most exquisite sensibility. The greatest ruffian, the most hardened violator of the laws of society, is not without it. (Smith 47)

On this account the physician's sensibility is not qualitatively different from others' but an intensified capacity which all human beings share. Cole and others valorise its modern incarnation—as sympathy or empathy—in helping health practitioners to move beyond spectatorship to responses in their relationships with patients. This responsivity and recognition, it is argued, needs to be engendered and nourished in medical students today, a moral mission that features in how departments of Medical Humanities particularly in US medical schools see their role, which frequently revolves around the sociology of the profession and professionalism. But such missions are not shared by all Medical Humanities scholars, many of whom conceptualise the field first and foremost as a terrain of enquiry and research, not one configured primarily as an antidote to the depersonalising effects of biomedicine. However, this is partly a matter of emphasis: the very nature of the field that has been outlined—which seeks to combine

[13] Cole *et al*. define the field as "an inter— and multidisciplinary field that explores contexts, experiences, and critical and conceptual issues in medicine and healthcare, while supporting professional identity formation" (ix).

knowledge, feeling, moral concern and action and focus on the damaged humanity which illness often brings (which can have many sources) —means that studies in the Medical Humanities frequently result in reflections and comment on current-day practices that carry health policy implications.

The epigraphs to this introduction hint strongly at the hybrid and experiential nature of many healthcare practices, and a prominent theme across the papers in this collection is the continuing relationship and dialogue between the pre-modern and modern in medicine today. Dante Gallian and Maria De Benedetto's paper on *Memories of the Heart* examines the views and feelings of São Paulo patients who have undergone heart transplantation, focusing on attitudes towards the gift as organ and cultural symbol. They find mythic and scientific ideas coexist not only in the thoughts and feelings of the recipients but also in the responses of healthcare staff. Lesley Gray and Patricia Novillo-Corvalán locate artistic and developmental forces at play in the life and work of the nineteenth—and twentieth-century Spanish neuroanatomist Ramón y Cajal. In *Beyond the Neuro* they examine Cajal's work on hypnosis and its grounding in his enduring interests in the arts, his conviction that imagination is an essential and active ingredient of modern scientific thinking, with the best scientists never really quite growing up; they retain, he believed, childlike capacities for vigorous imagination. Mary Carpenter discusses the third draft of Margaret Mathewson's account of rough handling and painful dressing of her shoulder, following surgery in the Edinburgh Royal Infirmary performed by the antisepsis surgeon, Joseph Lister. *Making the Case for Herself: A Patient Writes* brings out the care with which in 1879 Mattewson put her experiences and thoughts to paper for the third time, revealing how a poor patient worked out her feelings about the gratuitous manner in which this painful experience was inflicted on her, and how also to complain about it at the hands of medical students and doctors. Mattewson had both a personal and direct relationship with her surgeon, an extremely distinguished practitioner at the time—then in his third professorial chair—a dimension of healthcare relationships not easily accounted for within the hegemonic discourse of Foucault's medical gaze. Michael Clark examines the persistence of the wounded healer motif in modern films and TV series and the profile varieties of woundedness retains

in modern healthcare, which continues to mediate the work of healing and the way it is understood today. He delineates how the classical myth is threaded and rethreaded through many cultural forms of modern medicine. Maria Vaccarella examines the sympathy which the nineteenth-century Irish physician William Wilde had for Irish culture, and how immersed in it he was professionally and as a scholar: "the cultural world of the Wildes was also shaped by Irish nationalism" she writes, "by colonial political and economic structures, and by the complications and paradoxes that marked the 'Anglo-Irish' in general." For Wilde, the boundary between folklore and modern institutionalized medicine, between the pre-modern and the modern, was a porous and highly productive one. The final paper in the series is by Isabel Fernandes, the Scientific Coordinator of the Project Narrative & Medicine at the University of Lisbon. Entitled "'A short story that wouldn't work after the opening lines': Frustrated Maternity in First-Person Narratives," Fernandes examines two memoirs for the poetical activity they reveal in everyday life. Often unrecorded, this sort of dialogue between experience and inner life Fernandes finds "tied up with day-dreaming, planning ahead and surrogate living." The continuing presence and agency of the un-narrated and poetical haunt these two particular works which concern childlessness. Both authors seek to break out of the frameworks in which their lives hitherto have been contained, and which determine their sense of social and self-worth: the results are much fuller accounts of the lives they have lived and the healthcare problems they have been through.

One of the early proponents of the role of literature in medical education, Joanne Troutman, in 1982 wrote:

> No matter how well trained as observers (…) we normally do not see the full range of details in any situation. What's more, as we go about our daily tasks, we do not have the time or the facility to arrange those details in some kind of memorably insightful patterns. Often we do not truly perceive even the familiar; and thus our knowledge of reality grows blunted and hazy. We move through unseen worlds. (24)

The sharpening of perceptions, reflections and thoughts which Troutman refers to is one of the benefits of interpenetrating contacts between the medical and the humanities. They enliven each other as Edmund Pellegrino

noted: "[l]iterature gives meaning to what physicians see, and it makes them see feelingly' (Pellegrino, "To look feelingly" 20). The papers in this issue of *Anglo Saxonica* report original studies in the field of Medical Humanities, scholarship that is reinvigorating interactions between thought, feeling and perception in relation to healthcare practices.

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Abstract

This issue of *Anglo Saxonica* features papers illustrating scholarly work undertaken in the Medical Humanities, a field that encompasses many discourse communities sharing an interest in bringing the intellectual approaches of the arts and humanities to bear on problems raised by human health and disease. The papers collected here engage with a range of materials and media—memoirs, letters, short stories, myths, ethnographies, case histories, films and TV series—and employ methods characteristic of the Medical Humanities: techniques of literary and oral history, the history of ideas, and the close reading and analysis of film and texts, which generate new insights into how health and disease are expressed in human artefacts and cultural memory. Together they provide an introduction to a field whose origins lie in concerns clearly articulated in the second half of the nineteenth-century, about the educational philosophy and basis of medical training in a world increasingly shaped by scientific specialisation and loss of contact with the history of the discipline and its own practices. This introduction briefly sketches these origins and indicates how concerns which CP Snow later discussed in *The Two Cultures* (1959) were not only anticipated decades earlier but actively debated by physicians in educational fora. The Medical Humanities took the form of multidisciplinary inquiries into the history and ethics of medical practice as shaped by its rootedness in human relationships and the debt it owes both to science and the broader culture. Today it is an evolving research-based configuration whose authors publish in medical, humanities and Medical Humanities journals. It is well represented by the papers in this volume.

Keywords

Humanism; history of medicine; history of science; medical ethics; doctor patient relationships

Resumo

Este número da *Anglo Saxonica* apresenta artigos que ilustram o tipo de trabalho académico levado a cabo no campo das Humanidades Médicas, o qual engloba diversas comunidades discursivas que comungam do interesse em convocar abordagens intelectuais das artes e das humanidades para tratar os problemas suscitados pela saúde e pela doença humanas. Os artigos aqui reunidos envolvem uma série de matérias e media—memórias, cartas, contos, mitos, relatos etnográficos, estudos de caso, filmes e séries televisivas—e empregam métodos característicos das Humanidades Médicas: técnicas da história literária e oral, da história das ideias, a leitura cerrada (*close reading*) e a análise fílmica e textual, os quais suscitam novos modos de encarar a expressão da saúde e da doença em artefactos humanos e na memória cultural. Além disso, constituem uma introdução a uma área cujas origens se ligam a preocupações, claramente expressas na segunda metade do séc. XIX, com a filosofia educacional e as bases da formação médica, num mundo crescentemente dominado pela especialização científica e pela perda de contacto com a história da disciplina e respectivas práticas. Esta introdução esboça sumariamente essas origens e mostra como os problemas que C. P. Snow mais tarde discutiria em *The Two Cultures* (1959) foram não só antecipados algumas décadas antes mas até intensamente debatidos pelos médicos em âmbito educacional. As Humanidades Médicas configuraram-se como inquirições multidisciplinares à história e à ética da prática médica dado o enraizamento desta última nas relações humanas e a sua dívida tanto para com a ciência como para com a cultura em geral. Trata-se hoje dum campo de pesquisa em devir, cujos autores publicam quer em revistas da área médica quer da área das humanidades e das Humanidades Médicas. Os artigos neste volume são bem ilustrativos dessa amplitude.

Palavras-chave

Humanismo; história da medicina; história da ciência; ética médica; relações médico-paciente

Memories of the Heart: Initial Interpretations Based on Narratives of Heart Transplantation Experiences in Brazil

Dante Marcello Claramonte Gallian
Centro de História e Filosofia das Ciências da Saúde, Escola Paulista de Medicina (EPM), Universidade Federal de São Paulo (UNIFESP)

Maria Auxiliadora Craice De Benedetto
Centro de História e Filosofia das Ciências da Saúde, Escola Paulista de Medicina (EPM), Universidade Federal de São Paulo (UNIFESP)

Memories of the Heart: Initial Interpretations Based on Narratives of Heart Transplantation Experiences in Brazil

1. The human heart: from the soul's seat to a biomechanical pump

In the incommensurable world of images that has been accompanying humankind since its origins, similarly to what happens in the world of physical phenomena, a certain "gravitational" order seems to exist, in which some elements play a role that is more central than others. Thus, for example, in the constellation of images connected with the physical or "inert" world, this polarizing role, as Gaston Bachelard has demonstrated, has always been associated with the four elements: fire, earth, water and air. On the other hand, when we focus on the constellation of images referring to man himself, this preponderant role has almost always been played by the heart.

Mircea Eliade, in the sixth volume of the *Encyclopedia of Religions* (234-237), argues that both in Asia and in Europe, the identification of the heart as the central organ of life is explicit in cave paintings that represent animals killed in hunting scenes, and also in burials of diverse cultures, since the Upper Paleolithic period.

The ancient Egyptians believed the heart was the sole organ of material life and the center of spiritual life. Two hieroglyphs designated it, representing, sometimes, its physical dimension, sometimes, its moral and spiritual dimension—dimensions that do not oppose one another; rather, they complement each other. The great importance attributed to the heart by ancient people is illustrated by the conceptions and costumes that were in force at the time. In inhumation and mummification rituals, for example, the heart was the only preserved organ and it was subsequently replaced in the thorax, as, according to the *Book of the Dead*, "it is in man's heart that his life takes refuge in death and it is in the heart that it germinates again to eternal life." Therefore, the Egyptians considered the

heart not only the organ of feelings, but also of will, memory, personality, wisdom and thought, which was not separated from feelings. The heart, the seat of prayer and divine love, has been given a religious and mystic dimension since very early times (Doresse 82-87).

The ancient Semites share a very similar perspective, particularly the Hebrews. According to Antoine Guillaumont (42), they believed that "the heart is not only the organ that is indispensable to body's life; it is also the center of psychological and moral life, of inner life." The biblical text contains numerous parts in which the heart is portrayed not only as the principle of corporal life, but also as the center of spiritual life. In the Bible, the heart is also the seat of wisdom, memory, of the soul's moods (both good and bad), of passions and feelings, of desire, and of conscience. This idea expands in the messianic message that is fulfilled in the Pentecost in the New Testament, when God shows that He wants to dwell in human hearts.

Among the ancient Greeks, in texts written by Hesiod, Homer and Aeschylus, the term *kardia* takes us to a universe of meanings and actions that identify the person in his/her integrality. It appears in epic and lyric poems, and in tragedies, as the seat of feelings and passions, and also of intelligence, thoughts and, last but not least, as the place of divine inspiration, the place where gods meet. However, from the 6th century BC onwards, the moment in which philosophical thought emerges in Greece, the term *kardia* is gradually replaced with others, such as *nous* and *psyqué*, which will result in the Latin terms *mens* and *anima* (Guillaumont).

In this context, Plato seems to have been the first to deprive the human heart of its central hegemony, which can be seen in his famous tripartite theory of soul, described in the *Timaeus*. In it, the philosopher locates the human soul, in its intellectual and immortal dimension, in the head, or, more specifically, in the brain. The head, as the part that is farthest from the telluric and mortal dimension, is the extremity that is closest to the celestial world, a world that is identified with the kingdom of ideas, of perfect and universal divine archetypes. It is in the head, that is, in the brain, that the action of thinking is experienced in a sensitive way—a superior activity that defines the human essence. With the heart and, more generically, with the chest, Plato associates "the sensitive soul" or the "emotional soul," which represents the principle of feelings and passions,

such as wrath and courage. Spatially situated on the center, between "heaven" and "earth," between the head and the "lower parts," inhabited by the vegetative, instinctive soul, the human heart and, generally speaking, its surroundings, plays a fundamental role, although subsidiary to the immortal soul: it is "the mediating organ that maintains the distance between two extremes: reason and desire" (Neschke-Hentschke 43).

This perception meant a divide in the history of conceptions about the human heart, but not necessarily a break with older traditions. In the fields of philosophy and medicine—which also began its development as a branch of the philosophy of nature, the philosophy of the human *physis*—, the ideas and conceptions about the place and role of the heart as a physical and psychological organ tend to vary, sometimes adopting a platonic view, sometimes an ancient, pre-platonic perspective. Thus, for example, in texts associated with one single tradition, like *Corpus Hippocraticum*, we can find treatises that explicitly state that the brain is the seat of intelligence and of the soul, such as *On the Sacred Disease*. On the other hand, in the treatise that has the name of the organ itself, *On the Heart* (*Peri Kardia*), there is the statement that "man's intelligence is inherent in the left ventricle [of the heart] and commands the entire soul" (Hippocrates, translated by Littré).

In the beginning of the Hellenistic period, Aristotle revisits the issue of the heart in a new perspective. When he considers that the psyche is the fundamental principle of organic life, he concludes that the intellective soul, responsible for the faculty of thought, is not associated with any corporal organ and develops a theory that denies what Plato had postulated about the brain's functions. Thus, to Aristotle, the heart is the main organ of the human body, as it is from the heart that all the other organs develop. In addition, as the heart produces, receives and distributes blood, Aristotle considered it the body's source of food. Furthermore, as the organs of perception, like ears, eyes and skin, connect with the heart through blood vessels, diverse sensations converge on the organ, which, therefore, becomes responsible for coordinating the impressions of the external world. In opposition to Plato, who situated the coordination of the senses in the brain, Aristotle defines the heart as the place responsible for perception and, at the same time, as the center of emotions (Neschke-Hentschke).

It is important to remember that, with Aristotle, the quarrel between

"brain supporters" and "heart supporters" is placed within the philosophical and scientific domain—it was no longer a discussion that opposed philosophy to the ancient and religious traditions. Since ancient times, through the Middle Ages and reaching the Renaissance, the field of philosophical debate in relation to this quarrel was configured by the opposition between Platonists/Neo-Platonists and Aristotelians/Stoics. The former did not strengthen the role of the brain as the central organ of human thought, but tended towards an intense spiritualization or disembodiment of the soul, while the latter insisted in the central and essential role of the heart in the human being's organic, psychological and spiritual life (Neschke-Hentschke).

Considering the strictly medical field, Galen evokes the Hippocratic and Platonic tradition and advocates not only the distinction of the soul's faculties, but also the location of thought in the brain. At the beginning, the importance of Galen seemed to tip the scales in favor of those who considered the brain as the center of the human being. However, in practice, at least in the aspect concerning the emotional and psychological understanding of man, the Aristotelian tendency carried some weight, and determined the rule of cardiocentrism during the Middle Ages until the beginning of Modernity (Guillaumont).

The idea of the heart as the fundamental organ that identifies the human person predominated during a long period of the history of Western thought, and the reasons for this are multiple and complex. In fact, one of the factors that most contributed to this was the influence of Christianity, both through the Holy Scriptures and through theology or spiritual experience. The New Testament, introduced as the continuity and, at the same time, the fulfilment of the messianic promises that were present in the ancient Hebrew law, reinforces the importance of the heart as an organ that is connected with the psychological and spiritual dimensions of the human being. The heart is the source of life, of good and bad thoughts, of faith and hope. In the scope of Saint Augustine's philosophical and theological reflection, the heart is metaphorically understood as the image of the soul and of the spirit. However, in the more existential and mystic sphere of his work, particularly in his *Confessions*, the term heart emerges with an insistent frequency, meaning the person's deepest intimacy, the word that "defines the individuality of our being." In the *Confessions*,

the essentially Platonic philosophical language loses ground and is replaced with poetic and biblical language. This determines the development of two languages that are projected throughout the history of Christianity: the language of the Platonic mystique and the language of the heart mystique, as Saint Thomas Aquinas will subsequently call it. Even though the heart mystique has found, in Eastern Christianity, a fertile soil, its presence has also been felt in the West, in a fainter and more diffuse way (Guillaumont).

In Europe, in the 16th century, it is the heart and not the brain that, in the images of philosophers and doctors, is characterized as the center, not only of physical and emotional life, but also of intellectual and moral life. It is interesting to notice that, many times, from the theoretical point of view, these philosophers and doctors stated that they were faithful to Galen. From the practical point of view, therefore, the medieval period, as well as the Renaissance, was essentially characterized by cardiocentrism, which was deeply marked by political metaphors and analogies comparing the heart to the king. Thus, in the medieval period, the heart was considered the sovereign of the human body and, in the Renaissance, it occupied the position of sovereign of the social body.

With the advent of the Scientific Revolution, the wind began to blow in another direction and the brain received the status of the organ of personality, as the function of definer of the self was granted to personality. The dichotomy seems to have persisted, as some philosophers, shamans and religious people have maintained the perspective in which the heart is the center, while other philosophers and scientists insist to attribute this role to the brain (Gallian).

On the other hand, the scientific discoveries of Harvey and of other physicians of the early days of Modernity, such as Miguel Servet, intensified the “desecration” of the heart and, at the same time, impelled its characterization as a biomechanical pump. In addition, they opened the way to the possibility of surgical intervention in the organ (Gallian). Thus, Harvey has contributed, in a fundamental way, to the phenomenon of the so-called “mechanization of the heart,” to use the term coined by Thomas Fuchs. His revolutionary *Exercitatio de motu cordis et sanguinis in animalibus*, whose first edition was published in Frankfurt in the year of 1628, is a mark in the configuration of the scientific method founded on empirical observation and experience. At the same time, it also emblematizes the

apotheosis of the Aristotelian cardiocentrism. In other words, as Lain-Entralgo summarizes it quite well, "the discoverer of blood circulation was able to be modern without ceasing to be Aristotelian" (Lain-Entralgo 240).

2. The interchangeable heart

It is important to remember, however, that the path that was followed until heart surgery became possible was much harder and full of obstacles when compared to that of other surgical specialties. Up to the 1940s, the majority of the doctors believed that the heart would be an unapproachable organ in surgical terms. There was no technical support for it, and perhaps heart surgeries were doomed to be unsuccessful in the short run. The words said by Dr. George Geckekeler, head of the Hahnemann Medical College in Philadelphia, addressing Dr. Charles Bailey, after his second unsuccessful attempt to correct mitral valve stenosis, illustrate this idea: "It is my duty as a Christian not to allow these killing surgeries to be performed anymore." But Bailey did not give up. He was able to perform, in June 1946, after four failures, the first successful mitral commissurotomy. Thanks to his determination, the era of intracardiac surgery began and other surgeons repeated his achievement at other centers. It is important to notice that, at the time, extracorporeal circulation machines had not been created yet. Until then, a long way had already been traveled. From this period onwards, a great transformation began and a history characterized by a succession of failures started to include great successes (Murtra).

In less than fifty years, many advances in the field of heart surgery were achieved and, with the development of extracorporeal circulation machines, new techniques emerged, or the former ones were enhanced. This allowed the correction of valve defects and congenital anomalies, myocardial revascularization and the performance of heart transplantations. In Brazil, these advances have been closely monitored and there are heart surgery teams at many hospital centers that are able to perform high complexity surgeries, including heart transplantations. Today, they are no longer novelties in the majority of the large hospitals in the Brazilian capital cities, including Hospital São Paulo (HSP) of Escola Paulista de Medicina (EPM) — Universidade Federal de São Paulo (UNIFESP), which was one of the pioneering institutions to perform the procedure in Brazil (Costa).

Thus, there seems to be no doubt anymore: an organ that can be replaced by means of a surgical act cannot be considered anything else but a simple biomechanical pump. This is the predominant discourse in the teaching and practice of the Health Sciences, and this discourse has been more and more accessible to nonprofessionals and to users of healthcare systems, who apparently have fully accepted it.

The question is: to what extent have nonprofessionals, and even healthcare professionals, really incorporated the premises of scientific discourse? Literature, poetry and popular music provide us with clues that the view of the heart as an organ with which deep images, feelings and contents are associated is still strong and co-exists, in a contrasting way, with scientific postulates. With the advent of heart transplantation, the theme referring to the relationship between the heart and the psyche, especially regarding feelings and behaviors, has been revived, and it has been a source of inspiration for scripts of film productions and even of a Brazilian soap opera that was a great success in the prime time. As an example, we can cite the movie *Blood Work*, launched in 2002, directed by Clint Eastwood, and produced and distributed by Warner Home Video. The story is about Terry McCaleb (Clint Eastwood), a retired FBI agent who has undergone a heart transplantation. He is hired by Graciella Rivers (Wanda de Jesus) to investigate the death of her sister, who was the donor of his new heart. The investigator discovers that the murderer is, in fact, a serial killer that McCaleb himself had chased during many years, when he still worked for the FBI. A soap opera broadcast by a big Brazilian TV station also approached the theme. *De Corpo e Alma* (With Body and Soul), written by Glória Perez, was broadcast from August 03, 1992 to March 06, 1993. The central theme was the love affair between a judge and a woman who had been submitted to a heart transplantation. The donor had been an old love from the judge's past.

3. The project MEMORY OF THE HEART

To further investigate these issues, the Centro de História e Filosofia das Ciências da Saúde (CeHFi), of Escola Paulista de Medicina (EPM), which is part of UNIFESP, located in São Paulo, Brazil, has developed a research project entitled *Memória do Coração—Visões acerca do Coração Humano*

a Partir da Experiência do Transplante (Memory of the Heart—Views of the Human Heart based on the Transplantation Experience).

It is interesting to mention that the project emerged in an original and unexpected way. To celebrate the 75th anniversary of EPM, CeHFi developed an Oral History project (Bom Meihy and Holanda, 2007) that was called *75X75: 75 histórias de vida para contar os 75 anos da EPM-UNIFESP* (75X75: 75 life histories to tell the 75 years of EPM-UNIFESP). The project resulted in two books and one film[1], and the aim was to present the institution's collective memory through accounts of people who had lived or still live an important part of their lives in an intense relationship with the School. In the search for a "target community," in which multiple experiences and worldviews intertwine, professors, managers and eminent people in the university context were interviewed. In addition, we interviewed individuals who, being less eminent and even unknown, also participate in the configuration of the basis of the university culture, as they unconsciously reproduce and transmit values and images of collective memory. Therefore, the list of 75 interviewees included employees, students, people in the geographical surroundings, and, as it is an institution that largely provides healthcare services, patients. Among these, it was the life history of a patient who had been submitted to a heart transplantation that called our attention and promoted the investigation of previous questionings, which collaborated to the formulation of the project Memory of the Heart.

First, the patient narrated, in detail, the health problems that had led him to the heart transplantation waiting list of Hospital São Paulo (the hospital-school of EPM/UNIFESP). Then, he reported a curious incident: when everything was ready, the doctor in charge decided to consult with him in order to cancel the surgery, and explained that the compatible heart that was available "had a problem": the donor had been a psychopath! As the patient himself told us, the surgeon said to him: "This situation is just six of one, half a dozen of the other. I won't put this heart into you; we

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[1] The books were: 1. Gallian Dante Marcello C. *75X75 EPM/UNIFESP, Uma História, 75 Vidas*. São Paulo, EdUNIFESP, 2008, 352 p. and 2. Gallian, Dante Marcello C. (Org.) *et al*. *Recortes da Memória. Lembranças, Compromissos e Explicações sobre a EPM/UNIFESP na Perspectiva da História Oral*. São Paulo, Ed. UNIFESP, 2009. The film, in DVD format, has the same title of the first book.

don't know what it contains!"[2] The patient also refused to receive the heart and, fortunately, in the following week, there was another compatible donor, the procedure was performed, and the patient recovered well. He has become part of the history of EPM as one of the first heart-transplanted patients in Hospital São Paulo.

The main objective of the Project *Memory of the Heart* was to investigate, based on Oral History accounts, the views, conceptions, senses and meanings concerning the human heart based on the experience of heart transplantation, in a perspective that is not only functional, but also symbolic-cultural, psychological and existential.

The specific objective of this Project was to structure a database of life histories of individuals involved in some way with the experience of heart transplantation. In addition to serving as data source to the present study, the database will also be available in the *Banco de Memórias e Histórias de Vida da EPM/UNIFESP* (BMHV–Memory and Life History Database of EPM/UNIFESP), so that other researchers, patients and healthcare professionals can consult it.

Due to the nature of the questions to be studied, we decided to employ qualitative methods focusing on Hermeneutic Phenomenology to ground the research project (Miller and Crabtree).

4. Collecting narratives of transplantation experiences

Within this context of a hermeneutic-phenomenological nature, adequate to answer the guiding questions and, at the same time, to allow the generation of new questions and interpretations, Oral History was the richest and most opportune approach. Thus, the data were collected by means of interviews conducted in accordance with the Oral History approach (Bom Meihy and Holanda). They were non-directive open interviews, in which the participants had the opportunity to report their lives freely—the

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[2] The full account is available at the website of the *Banco de Memórias e Histórias de Vida* (BMHV—Memory and Life History Database) of EPM/UNIFESP, another product that resulted from the 75X75 Project. Available at http://www.unifesp.br/centros/cehfi/bmhv/index.php/entrevistas/entrevistas-do-projeto-75x75/20-achiles-ortozani-filho

researcher's questions did not guide the flow and the construction of the narrative. This means that the dynamics of the interviewee's memory in relation to everything involved in the transplantation experience was what really mattered. Thus, a much richer document from the phenomenological standpoint was produced. Whenever necessary, the researcher asked questions, either to further investigate a theme of interest, or to ask the cut-off questions. The latter, as it usually occurs in the Oral History approach, were left to the end of the interview in case the questions concerning the focus of the research had not been spontaneously approached. The cut-off questions were the following: "what does the heart mean to you?"; "what does it mean to live with someone else's heart?"

The participants were selected, according to the Oral History approach, because they were part of the target community—individuals to whom, in some way, the transplantation experience played an important role in their lives. In fact, these individuals were asked to reflect on the heart much more than the rest of the population. René Leriche stated that "health is life in the silence of the organs" (Canguilhem 35), a fact that can be easily observed. When we are well, we do not even think about our organs, which work continuously in order to maintain a healthy and harmonic life. These members of the target community were contacted in a colony, that is, all of them were part of the community of Hospital São Paulo (HSP) and/or of the Heart Transplantation Outpatient Clinic of the HSP. They were divided into three networks: thirty patients who were in the late postoperative heart transplantation period and are followed up in the corresponding outpatient clinic of HSP; ten relatives who accompanied the patients in their life trajectories; and ten members of the healthcare team (doctors, nurses, psychologist, social worker), responsible for the care provided for the patient.

The interviews were recorded and, after being carefully heard, they were transcribed, that is, they underwent a "literal" transposition in which the texts still presented "mistakes," discontinuities and incoherences, which are typical of the oral discourse. The transcribed texts underwent a textualization process in which speech was transformed into a first-person account. The written code was given priority due to the type of document that we wanted to construct. Finally, the transcreation of the text was performed, in which the interview was transformed into a literary report

that was faithful, at the same time, to the narrator's speech and to the fundamental canons of the written code. Through the transcreation process, it is possible to incorporate, into the text, subliminal language and the emotions expressed by the interviewee. At this last stage, the interviewee's presence is fundamental, as transcreation can only be considered concluded after it has been revised and approved by the interviewee. This procedure reinforces the collaborative and ethical dimension of the Oral History approach. During the entire process, the importance attributed to the interviewed volunteers can be clearly noticed; therefore, in Oral History, they are called collaborators (Gallian).

5. Interpreting the narratives

The texts generated according to the description above were interpreted by means of an organization style that is called immersion / crystallization (Borkan), which is adequate to the interpretation of texts and is inspired by Hermeneutic Phenomenology. Thus, the following themes emerged: gratitude, spirituality, renaissance, non-allusion to an imminent death threat, and polarity in relation to the meaning of the heart.

This paper presents a collective narrative (Margolin; Brown) based on the individual accounts provided by the participants in the project *Memory of the Heart*. The focus here was on the theme "polarity in relation to the meaning of the heart," which emerged, sometimes explicitly, sometimes subtly, in the accounts of patients, relatives and healthcare professionals. Although each human being's life narrative is special and each one's experiences are unique, this strategy was chosen because it allowed the identification of collective narrative agents—patients/relatives and professionals—in the narratives that were obtained as it was explained above. So that the collective narrative agent is characterized in a narrative, it is necessary that three conditions are met: "(a) the argument position in numerous narrative propositions is occupied by an expression designating a group of some kind; (b) the predicate position in these propositions is occupied by predicates that designate the group's holistic attributes or collective actions; (c) the group as such fulfills a range of thematic roles in the narrated sequence" (Margolin 591).

The patients' narrative was constructed in first person singular, and

beliefs, feelings and insights, that is, the themes shared by all patients, were emphasized. However, in this collective discourse, we also tried to encompass pluralism, relativism and subjectivity (Lieblich; Tuval-Mashiach and Zilber) by incorporating other ideas that the collective agent reported as if they belonged to another individual who was also a member of the group of interviewed patients. Regarding the healthcare professionals' narrative, greater objectivity and homogeneity were observed. This was evident in their collective narrative and, due to this, it was constructed in first person plural.

6. Narratives

A) Patients and relatives

I have Chagas Disease[3]. I was feeling very bad. I could not walk anymore and I was terribly thirsty day and night. If I drank a little bit more water or if I ate a small piece of a watery fruit, my body swelled and my shortness of breath became unbearable. This happened a long time ago, when heart transplantations were just beginning to be performed in our country. I had already seen some cases on television. Thus, I decided to ask my cardiologist, who was from a city in the interior of the State, whether heart transplantation would be indicated to me. He discouraged me by saying that I should forget the matter, as changing the heart is not the same as changing a shirt.

I ended up being referred to this hospital and I attended a consultation with a doctor from the Heart Surgery team. He asked for some examinations and, after seeing the results, he told me that I would really have to change the "carburetor." I think that the heart is one of the main parts of our body. If it does not work well, we cannot do anything. At the beginning, I had some doubts. If I changed my heart, would my feelings change? But the doctors explained to me that the two things were unrelated. The feelings are in the brain. The heart is only a biomechanical pump.

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[3] You can get information about Chagas Disease at the webpage of the World Health Organization (WHO), available at: http://www.who.int/topics/chagas_disease/en/.

In fact, in the state I was in, almost immobilized by the heart failure, it was easy to understand that the heart is a biomechanical pump, as the doctors had explained. But deep inside me, there was always a tiny doubt. While I was in the transplantation waiting list, I used to talk to the patients who had already been operated on. And, trying to solve that tiny doubt, I asked them if anything had changed in relation to their feelings after the surgery. The answer was unanimous. "I'm the same person." "I still love my wife in the same way." "The feelings are in the brain."

There are many inexplicable things in this world. Sometimes, the doubts confounded me again and I wondered how it would be to live with someone else's heart. But the doctors gave me a little book that explained everything. The heart pumps the blood to the other organs. And, without blood, there is no life. To me, the heart is a pump, but it is also life. If I had to summarize in one word what the heart represents to me, the word would be life. Take the kidneys, for example: there are two and if one does not function, the other does all the work by itself. But we have only one heart. The heart is a very important organ because it maintains the body alive. Without it, we cannot live. The heart is life. Living with another person's heart means hope, the hope of a new life. If it were not for this heart, my life would have ended long ago.

I know that Chagas Disease can attack the heart, the intestines or the esophagus. The doctor explained that, in my case, unfortunately, the affected organ was the heart. I do not know why the "bug" had this preference. Some patients told me that they had to undergo a transplant because of a heart attack that practically destroyed their heart. One of them said that his life had always been full of tribulations and reasons for nervousness. He used to be very agitated and wanted to control everything. He believed that his heart got sick because of all this. The nervous system was shaken and this affected the heart.

During all this time, I have been in contact with many patients who have already undergone the surgery or who are waiting for the transplantation. In the clinic's waiting room, we hear many of their stories and their companions' stories. Stories that are even funny.

One patient told me that, some time after the transplantation, she visited her relatives in a small town in the interior of the Northeast region, whose inhabitants were simple people with a low level of education. The

majority of the people she met did not want to believe that she carried in her chest the heart of a person who had already died. Some asked her whether she was alive or dead. Others were afraid to get near her and treated her as a walking dead zombie. After some time, seeing that she was the same person, they got used to it.

Another patient told me that she was very impressed when she learned that, to live, she would have to receive the heart of a person who had already died. She said that she was afraid of the dead. Of spirits. She was even afraid when her mother died — afraid that her spirit would appear to her.

Another interesting, but sad, account was given by one patient's sister, who went to the clinic to thank the professionals who had provided care for her. The patient had died. The surgery had been successful, but since the beginning, the patient said that she was seeing the spirit of a person, perhaps the donor, floating in her room and looking at her in a terrifying way. This happened frequently and the patient could not bear it anymore. She became depressed, stopped taking the drugs that prevent the organ's rejection and died.

Before I got sick, I did not even remember that a heart was beating inside my chest. As my condition gradually worsened, I became more and more interested in some issues related to the heart. I enjoyed talking to people who had already been operated on and they provided many clarifications referring to their experience with the transplantation. I have always believed in the doctors' orientations, but nothing compares to sharing experiences with people who have experienced situations that are similar to ours. When I was in the transplantation waiting list, I did not find any patient who said that their feelings had changed after the surgery. This became a frequent question asked by my friends and relatives, both before and after the surgery. Some made jokes: "What if you receive a woman's heart? Do you think you'll change?" Mainly after the surgery, many of them asked me questions of this type. "Do you still love your wife?" "Are you supporting another soccer team now?" "Are you supporting the soccer team that the donor used to support?" However, when I woke up after the surgery, I realized I was the same person. Nothing had changed in mind. My feelings were the same. But I could not resist making a joke. When my wife came to see me, I asked her: "Who are you?" "What are you doing here?"

In short, I am the same person. My feelings have not changed. Only one thing has changed. Faith. What has changed is my faith. These experiences have increased my faith in miracles. Faith in life.

In fact, the heart is a great mystery. I cannot decipher the heart. I think it is everything. I am even scared of it. Sometimes, we feel something weird and we immediately start caressing the heart so that nothing bad happens. But it is complicated. I think that two organs command us—the heart and the brain. These are the two things that suffer the most in us, because the heart means love, and the brain stores many things. And these things go to the heart, and sometimes it gets tight. The heart is affected by our thoughts. If we are not thinking about anything serious and our mind is quiet, the heart is also calm. But if we have problems, the heart feels it. This is what I think.

B) Healthcare professionals

In our work as healthcare professionals at a Heart Transplantation Unit, we have a very close contact with colleagues, transplanted patients, patients in the waiting list and patients' relatives. It is in the workplace that we spend the largest part of our time. Sometimes, we spend months beside a patient in the pre— or postoperative period, and this enables the creation of a close bond. Thus, when a compatible donor becomes available to a patient who has been watching his death get closer day by day, it is a great joy. A party, both to the patient and to us, professionals.

We get in contact with much pain, suffering and risk of imminent death on a daily basis, and this makes us hold on to technical issues to the detriment of philosophic and practical issues. Even so, we are affected by the usual questions asked by relatives and patients who are in the waiting list. A very frequent question is, "Will my feelings change after the transplantation? Will I still love my wife?" Our answer is invariably the same.

The heart is a pump, a very complex biomechanical pump, but still a pump. Fortunately, with today's technology, we can replace it, and this makes the individual leave an unsustainable situation and move on to an immeasurably better one. However, we must recognize the emotional appeal aroused by these new technologies. There was a soap opera on television whose plot portrayed the story of a man who fell in love with

the woman that had received the heart from his deceased wife. Films and books have portrayed things of this kind. All this, which from the scientific point of view is an absurd, has a positive side, as it motivates people and increases the percentage of organ donors.

The idea that the heart is associated with behaviors and feelings is more common than we tend to believe, even among individuals with high level of schooling. We monitored a patient in the postoperative period of heart transplantation whose lawyer came to us because he wanted to defend him in a different way. This patient had killed an individual who had crashed a party. There was a discussion and the patient shot the party crasher, who ended up dying. The lawyer wanted to propose the following defense: "He received the heart from a criminal; therefore, the murder is not his fault."

Men and women usually have different perceptions regarding heart transplantation. Women never want to know if the received organ belonged to a man or a woman. To men, this is a frequent concern.

We do not usually think of the heart in a symbolic way. Above all, the heart represents life. Life and independence. Independence to walk, to drink water, and to do the basic things of life. The so-called "things of the heart" do not exist. Everything is in the brain. Even so, there are some things that the brain explains, others it does not. The things that reason cannot explain we attribute to the heart.

In fact, the heart is a great mystery. Maybe because it responds to our feelings, thoughts and moods. It beats calmly when we are calm or it responds with tachycardia in moments of stress. As we have been working with heart transplantation for so many years, it is difficult to ignore the symbology attributed to the heart. We have to know people's beliefs in order to be able to calm them down in relation to the postoperative period. It is important to guarantee, to the patients in the waiting list, that they will have a normal life, and to explain, in the best possible way, everything regarding the technical aspects, so that they can understand them. Thus, they will accept the procedure and will adhere to the postoperative treatment.

Even after working in Cardiology for so many years, it is not easy to see a sick organ being removed from the receptor's thorax and being thrown away. The heart has automaticity and even when it is totally separated from the body, it keeps beating and moving. It is as if the life that inhabits the

heart insists in not abandoning it. We usually consider donors as dead people. Obviously, only when cerebral death is verified will they be considered for organ donation. However, in fact, they are not dead. They are the ones that most carry life. They are worth five, six, even ten lives, depending on what they will donate, and people who consider that an organ donor is a dead person are wrong. We have to consider them as Life, always!

Deep inside us, the idea of the existence of soul and spirit is not an absurd. It is expected that we, who are constantly witnessing a life fading away to make room for another, glimpse the existence of something superior, perhaps an energy, of which we are part and to which we will return one day. The energy is not lost; it gradually enhances and organizes itself. The Hindus think that we are part of divinity, of God. During the surgery, the patient gets very cold and nothing functions. Afterwards, little by little, life goes back into the patient. We cannot explain the sensation of experiencing all this. It is very interesting!

7. Final remarks

The polarity in relation to the heart, in which sometimes the organ was considered a biomechanical pump, and sometimes it was associated with feelings, behaviors and emotions, could be clearly seen in the discourse of transplanted individuals and their relatives. Many patients strived to demonstrate that they had intellectually incorporated the scientific discourse and emphasized that the heart is only a biomechanical pump. Nevertheless, when they reported the discourse and doubts of relatives and friends regarding the transplantation, they let slip ideas and beliefs about the heart that were similar to those expressed by our ancestors.

Some of them vehemently denied having ever attributed a broader and subtler meaning to the heart, while others expressed this idea, but compared it with the scientific discourse.

The opinion that the heart surpasses the material dimension that is commonly attributed to it and acquires a central role in which it is associated with feelings, emotions and deep contents, although vehemently denied by most of the healthcare professionals, also emerges, in a veiled form, between the lines of their discourse, as the collective narrative presented here clearly shows.

Having concluded the stage of collection, transcreation and approval of the narratives, the Project *Memory of the Heart* is, today, in the stage of immersion and crystallization of these narratives, stimulating a rich dialog between the emerging themes and the multiple theoretical approaches that history, philosophy and the humanities in general can provide.

Although we are still in an initial stage of interpretive exploration, the collected narratives point to a promising reflection streak, which, from the experience of the heart transplantation, enables us to rethink the reach and limits of scientific discourse in the scope of society in general and of scientific culture in particular. Furthermore, it enables us to reflect on the permanence of some anthropological ideas and conceptions in a perspective of *longue durée* (long term) (Braudel) within a context of quick transformations, which originate questionings that are not only technical-scientific, but also ethical and existential.

In short, the narratives derived from the heart transplantation experience point, undoubtedly, to Blaise Pascal's famous phrase, which continues to be relevant to this day: "The heart has its reasons of which reason knows nothing" (Pascal).

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Abstract

This paper discusses conceptions about the human heart in a historical perspective based on pictorial representations dating back to prehistory until the present day. Associated with the very idea of personhood, the heart, in diverse cultures and traditions, has played a central anthropological role, not only from a biological point of view, but also from psychological and spiritual standpoints. With the advent of the Scientific Revolution and Enlightenment rationalism, the heart was "dethroned" from its socio-cultural hegemonic position. This is the context in which this paper presents the preliminary results of a research project that investigated the views, conceptions, senses and meanings attributed to the human heart today, based on the experience of heart transplantation. The work is grounded in interviews, a perspective that is not only functional, but also symbolic-cultural, psychological and existential. The heart considered as a biomechanical pump and sometimes an organ associated with feelings, behaviours and emotions, is a polarity that emerges in the narratives of heart-transplanted patients and their relatives and, in a subtle or veiled form, in the narratives of healthcare professionals too.

Keywords

Medical narratives; history of the human heart; life oral history; heart transplant; heart's meaning

Resumo

Neste artigo são enfocadas, em uma perspectiva histórica, as diferentes concepções acerca do coração humano vislumbradas desde as representações pictóricas que remontam à pré-história até os dias atuais. Associado com a própria ideia de pessoa, o coração, em diversas culturas e tradições, tem desempenhado um papel antropológico central, não apenas do ponto de vista biológico como também do psicológico e espiritual. Com o advento da Revolução Científica e o Racionalismo que caracterizou o Iluminismo, o coração foi destronado de sua posição socio-cultural hegemônica. Dentro desse contexto, este artigo apresenta os resultados

preliminares de um projeto de pesquisa que investigou as visões, concepções, sentidos e significados atribuídos ao coração humano na atualidade, com base na experiência do transplante cardíaco. O trabalho baseia-se em narrativas produzidas através da metodologia da História Oral de Vida, o que permitiu um aprofundamento em relação tanto aos aspectos funcionais quanto aos simbólico-culturais, psicológicos e existenciais. O coração foi considerado ora uma bomba biomecânica, ora um órgão associado a sentimentos, comportamentos e emoções. Essa polaridade emergiu das narrativas de pacientes e seus familiares e, de forma sutil ou velada, nas narrativas dos profissionais de saúde.

Palavras-Chave

Narrativas médicas; história do coração; história oral de vida; transplante cardíaco; significado do coração

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Beyond the Neuron: Ramón y Cajal and the Uses and Abuses of Hypnosis

Lesley Gray
University of Kent

Patricia Novillo-Corvalán
University of Kent

Beyond the Neuron: Ramón y Cajal and the Uses and Abuses of Hypnosis

Santiago Ramón y Cajal (1852-1934) is widely known as the "father of neuroscience" for his ground-breaking scientific research in the fields of histology and neurobiology. His systematic study of the micro-anatomy of the brain led to the discovery of the neuron as an independent unit of brain structure, which laid the foundations of modern neuroscience and earned Cajal the Nobel Prize for Medicine in 1906. This public image of Cajal, however, only shows us the supreme scientist at work, the assiduous microscopist who revolutionised our understanding of the way that the human brain works. Cajal, in fact, was a far more complex and multifaceted figure, since he was also a gifted artist, a prolific writer (he wrote essays, aphorisms, short stories, and a biography), and an indefatigable researcher whose scientific investigations include areas of study outside the field of neuroscience. As part of his diverse range of interests, Cajal became fascinated by the phenomenon of hypnotism, which ran broadly in parallel to his neuro-histological career.

Cajal's most noteworthy contribution to the field of hypnotism is a pioneering case study that proposes the use of hypnosis for the alleviation of pain during childbirth. Entitled, "Dolores del parto considerablemente atenuados por la sugestión hipnótica" (1889; "Labour pain considerably diminished by hypnotic suggestion"), the article was published in the *Gaceta Médica Catalana*, a prestigious, Barcelona-based medical journal. The subject of hypnotism also features in Cajal's fictional story, "El fabricante de honradez" ("The Fabricator of Honour"), which was included in the short story collection, *Cuentos de vacaciones* (*Vacation Stories*; written between 1885 and 1886, published in 1905), and appeared under the humorous pseudonym "Dr Bacteria." In "The Fabricator of Honour," the main protagonist of the story is a charismatic physician whose dubious

experiments involving hypnosis raise crucial medical and ethical questions regarding patient susceptibility and medical treatments. It is our argument that Cajal's medical case study and his fictional story reveal not only a profound interest in the practice of hypnotism (Cajal was contemporaneous with two of its major practitioners: Jean-Martin Charcot and Hyppolite Bernheim), but also foregrounds both the benefits and dangers of hypnotic methods. While the medical case study dispels the stigma of hypnotism as the domain of charlatans and quacks by considering its analgesic potential, the fictional story, on the other hand, is a cautionary tale on the perils of human manipulation and the potential outcomes on society and the individual.

Cajal's Hypnotic "Amusements"

In his autobiography, *Recuerdos de mi vida* (1917; *Recollections of My Life*), Cajal states that he felt the calling of art at the tender age of eight, an aesthetic vocation he would cultivate throughout his childhood and adolescence. Cajal's diligent and pragmatic father, himself a physician by profession, strongly discouraged his son's artistic sensibility which inevitably led Cajal into "an obstinate war between duty and desire" (see Novillo-Corvalán). In an effort to curb the unruly behaviour of his young son, whose propensity was to be outdoors with his sketchbook making drawings of the natural world rather than studying in the classroom, Cajal's father took his son from school and apprenticed him to a barber, thus ensuring he had a trade. In his autobiography Cajal writes, "[the apprenticeship] placed me in contact with the soul of the people, (…) it developed in me that feeling of humility and modesty, which is associated with inborn poverty" (*Recollections* 107). Still, the portrait of the young Cajal reveals that the rebellious son never entirely restrained his artistic pursuits, despite the fact that he eventually fulfilled his filial duty and became a Doctor of Medicine in 1873 at the University of Zaragoza. Certainly, a medical career allowed Cajal to integrate his newly acquired scientific profession with his promising artistic talent, and eventually enabled him to produce exquisite drawings and visual images of the brain that revealed minuscule details of its nerve cells. The interplay between art, poetry, and medicine enabled Cajal to perceive brain cells through both a rationalist and a poetic lens, an

interdisciplinary fluidity he himself termed "lirismo científico" ("scientific lyricism") (*Recuerdos* 173).[1] The American critic Laura Otis, who translated Cajal's *Vacation Stories* into modern English, notes that Cajal was, above all, "a visual thinker, [who] learned best through observation; (…) once science and medicine became a visual experience, Cajal found himself fascinated by the human body" (*Introduction* ix). For Cajal, then, observation was a crucial quality, a skill that would be essential to his pathbreaking discovery of the cell as an independent unit of the brain. In his study *Reglas y consejos para la investigación científica* (1897; *Advice for a Young Investigator*), Cajal quotes Ramón Pérez de Ayala's dictum that "[we ought to] look at things as if for the very first time," adding that, "we must free our minds of prejudice and fading images" at all costs (*Advice* 111-12).

Cajal was appointed to the Chair of Anatomy at the University of Valencia in 1884, where he would remain for a period of three industrious years that was crucial to his scientific and literary development. To begin with, this permanent academic position allowed Cajal to set up his microscopy laboratory and to purchase the necessary equipment to undertake his nascent neuro-histological research. Secondly, this period coincided with the outbreak of the 1885 cholera epidemic that spread rapidly across the Iberian Peninsula and decimated the population (see Sánchez-Granjel). Cajal temporarily interrupted his histological investigations of the nervous system in order to devote himself to the assiduous study of the infectious bacteria, *Vibrio cholerae*, that the German bacteriologist Robert Koch described as the cause of Asiatic cholera (Porter 434-6). The medical microbiology pioneered by Koch in Germany and Louis Pasteur in France, not only offered Cajal the opportunity to participate in an important public-health research programme, but also provided him with scientific information that would later reappear in his fictional stories. For example, in "The Fabricator of Honour" the creation of a moral vaccine or "anti-passion serum" (*Vacation* 44), Cajal betrays the current medical anxiety about the development of vaccines against all sorts of diseases, while at the same time ridiculing the image of the "mad" or "hubristic" scientist. Thirdly, Cajal wrote the collection of science-fiction tales *Vacation Stories*, which

[1] All translations from the Spanish are ours, unless otherwise stated.

would be published in 1905, almost twenty years after they were written, and one year before he received the Nobel Prize. Last, but not least, the Valencia period is intricately connected with Cajal's growing interest in hypnosis. In his autobiography, he mentions that during his time in Valencia he "developed two kinds of amusement; picture-taking excursions and the experimental study of hypnosis, a budding science which at that time was attracting the curiosity of and inspiring a passionate interest in the minds of the public" (*Recollections* 311). It is perhaps hardly surprising that Cajal would focus on these "amusements" as both would involve the concept of seeing, which became a recurrent theme throughout his life, whether it was through a camera lens, a microscope, or by observing the behaviour of people.

It is important to foreground that Cajal the "scientist" carefully distinguished between his work in microscopy and the multiple "hobbies" he developed alongside his scientific career. Indeed, despite Cajal's conscious attempt to demarcate the boundaries between his research, literary pursuits, and investigations into less conventional areas such as hypnosis, it is evident that the artificial gap that he created is not as unbridgeable as it seems. This is attested by the publication of his medical article on hypnotic analgesia in *Gaceta Médica Catalana*, which shows that the study of hypnosis was much more than a casual "amusement." Some critics (Stefaniduo *et al.* 357) have dismissed the *Catalan Medical Gazette* as a "regional" and, therefore, relatively low-impact publication, an assumption that is challenged by the fact that the journal was one of the most important medical periodicals in Spain during the latter part of the nineteenth century (Barona Vilar 58-9) and, most significantly, it was the journal in which Cajal had chosen to publish his pathbreaking investigations on "neuronal theory."[2] The coexistence of Cajal's publications on neuro-histology and suggestion in the same journal questions his flippant labelling of his hypnotism research as a mere "amusement." If Cajal's aim was to disseminate his findings on hypnotism within the Spanish and European medical community, he succeeded in at least achieving a mention, albeit an

[2] See, for example, Cajal's "Estructura del cerebelo," which appeared in *Gaceta Médica Catalana* in 1888 and "El renacimiento de la doctrina neuronal" that was published in 1907.

anonymous one, in the *British Medical Journal* in November 1889, in which his hypnotic method is hailed as a "new addition to obstetric therapeutics" (Anon, *BMJ* 1053).

Cajal and the Benefits of Hypnosis

José Sala *et al*. summarise the early work on hypnosis in Spain, suggesting that it was only in the second half of the nineteenth century, particularly with the work of James Braid in Britain, William James in the US, and Jean-Martin Charcot (at the Salpêtrière, Paris) and Hippolyte Bernheim (at the Nancy School) in France that interest developed in Spain. Initially, many of the ideas that would later become the key principles of hypnotherapy, such as the trance-like state and the susceptibility to suggestion, were closely aligned with mesmerism, the practice that followed the controversial theories and treatments of eighteenth-century Austrian physician, Franz Mesmer. After Mesmer's death in 1815, mesmerism maintained its popularity but was frequently branded a pseudo-science by the scientific establishment and was often associated with the work of charlatans or strange occult practices. With time, however, the question of the relationship between mind and body developed into a matter that was considered deserving of serious study. Much of this shift in opinion has been attributed to the work of James Braid (1795-1860), a Scottish doctor widely believed to have been one of the first to adopt the term "hypnosis" (Crabtree 158). Braid's investigations into the subject began after witnessing the trance-like states induced in audience members during the 1841 Manchester stage performances of Swiss mesmerist Charles Lafontaine. Curious to discover how individuals in a state of apparent somnambulism appeared oblivious to the often painful stimuli applied to them during these dramatic demonstrations, Braid carried out his own research into the cause and effects of what he had seen. Braid was particularly anxious to distinguish his work from the mysterious magnetic fluids and supernatural forces of mesmerism, therefore his experiments considered the more pragmatic physical and psychological results of suggestion and focused attention. Although, as noted by Pintar and Lynn, "much of Braid's fame may be retrospective" (Pintar and Lynn 46), nevertheless the results of his work led to hypnosis developing into a respected clinical technique, and

by the end of the nineteenth century it was considered in some respects to be at the forefront of medical research.

Despite the work of Braid and those who followed him, such as Eugène Azam, Joseph-Pierre Durand, and Ambroise-Auguste Liébeault, hypnosis remained a contentious subject in Spain. In 1887, for example, Abdón Sánchez Herrero, Professor of Therapeutics at the University of Valladolid, and a man described by Ryan A. Davis as "Spain's foremost exponent of hypnotism" (Davis 2), prefaced his famous book on hypnosis and suggestion, with a plea to the official Spanish health authority for protection against "the slander against me that has been and is still being carried out" (Sala *et al*. 362). Despite this initial hostile climate, Cajal decided to set up a "Committee for Psychological Investigation" during his stay in Valencia, the venue for these gatherings being none other than his own family home. The patients treated by him included lawyers and physicians, although in his autobiography he only mentions those who were "healthy and apparently free from any neurotic taint" (Cajal, *Recollections* 313). He was less willing to deal with the "[c]rowds of unbalanced people, and even those completely mad who flocked to consult [him]" once the success of his clinic became known and "having satisfied [his] curiosity, [he] dismissed [his] patients" (*Recollections* 314). Cajal himself comments that the results of his experiments concerning hypnosis caused him: "Mingled sentiments of surprise and disillusionment: surprise at recognizing the reality of phenomena of cerebral automatism deemed thitherto tricks and deceptions of circus magicians; and sad disillusionment by the consideration that the human brain (…) suffers from the enormous defect of suggestibility" (*Recollections* 315).

Cajal's unsettling realisation of the effectiveness of "suggestibility" prompted his more serious investigations into hypnoanalgesia that culminated in the publication of his study in *Gaceta Médica Catalana*. The year that Cajal published his study of hypnosis and childbirth, 1889, is significant as it was also the year that Charcot hosted the First International Congress for Experimental and Therapeutic Hypnotism in Paris and so perhaps he had less cause for concern about its reception than did Herrero two years earlier.

The subject of Cajal's medical case study was his own wife, Silveria Fañanás García, who had a history of difficult and painful childbirth. She

welcomed the use of hypnosis for the delivery of her sixth child, after she was reassured that the method would not jeopardise her health or that of the baby. Cajal mentions that she had previously been the subject of numerous hypnotic experiments and that "she underwent vigil suggestion [i.e. while awake] with great ease" ("Pains of Labour" 355). He then reports that "ten days prior to the birth, Silveria underwent hypnosis and it was suggested to her that labour was evolving rapidly, the contractions of the uterus were strong and frequent and in contrast to what ordinarily happens the pain was minimal and tolerable" ("Pains of Labour" 355). By pre-testing his method, Cajal ensured that during childbirth his wife achieved a similar state of anaesthesia and suggestibility, without losing consciousness, which alleviated the pain of the contractions and the dilation of the cervix (Lanfranco *et al*. 2). Cajal then adds that "upon the termination of the labour, the patient shifted on the bed, unable to mask her happiness for being freed, at such little cost, from a long-feared painful moment" ("Pains of Labour" 355). It is not difficult to see that for Cajal the experiment was a success. And yet the successful outcome of the hypnotic case study is radically undermined by Cajal's tentative conclusion, where he admits that "we have been unable to reach a definite conclusion to this day" and that "it will take more concomitant evidence to establish an aetiological relationship between these two phenomena" ("Pains of Labour" 356). This hesitant tone is a far cry from the unequivocal microscopic evidence of his neurological investigations, showing a more cautious Cajal whose reservations contrast with the firmly established scientific rigour of his histological studies. For the "empiricist" Cajal, moreover, the hypnotic method required further experimentation and quantifiable evidence which he was unable to provide. In this sense, Cajal's medical restraint shows that he did not want to tarnish his scientific name as a histologist by forging himself a reputation as a hypnotic dilettante or, at its worst, an impostor in a field widely associated with charlatanry.

On the other hand, and despite Cajal's call for caution in interpreting his research into hypnosis, it is important to foreground the success of the experiment and the fact that mother and child were unharmed. This is not an insignificant consideration, particularly during a period that witnessed the rise of anaesthesia during surgical operations. Ether anaesthesia as a form of localised pain relief was first used by Boston dentist William

Thomas Green Morton in 1846, having persuaded surgeon John Collins Warren to allow him to anaesthetise a patient prior to the removal of a neck tumour using his ether vapour inhaler, which rendered the patient insensitive to pain (Porter 367). Interestingly, John Snow, the first physician-anaesthetist, successfully administered chloroform to Queen Victoria in 1853 for the birth of her sixth child, Prince Leopold, using a portable inhaler (King 536). She later recorded the effectiveness of the procedure in her diary, writing that "the effect was soothing, quieting & delightful beyond measure" (Porter 367). The discovery of ether anaesthesia became one of the biggest blows to hypnotic anaesthesia, prompting the eminent Scottish surgeon Robert Liston, who undertook the first general surgical procedure under ether at University College Hospital in London, gleefully to remark that chloroform "beat mesmerism hollow" (Guthrie 701).

However, the revolutionary use of chloroform was far from risk-free and devoid of complications or side-effects. For example, in a research paper presented to the American Gynecological Society (and subsequently included in the November 1878 of the *British Medical Journal*), Dr William T. Lusk warned of the dangers of using chloroform in labour, stating, among other things, that large doses of chloroform "may endanger the life of the woman" (Anon, *BMJ* 699). Stefanidou *et al*. write that in Spain and Latin America "the dangers of anaesthesia and chloroform and a sense of religious orthodoxy (…) played against its use" (357). This is the context in which Cajal clearly viewed hypnotic suggestion as a safe and effective method that avoided the potentially risky use of anaesthetics.

Interestingly, the technique of epidural anaesthesia was pioneered in 1921 by another Spaniard, the surgeon Fidel Pagés Miravé. The technique revolutionised the field of obstetrics and spread rapidly throughout Europe in the 1930s and 1940s (De Lange *et al*. 429-31). However, Deborah Lupton reports that in the mid-twentieth century onwards, there has been a shift towards "natural" childbirth that involves as little drug intervention as possible, a reaction against the routine biomedical use of epidural anaesthesia, artificial induction of births, and caesarean sections (Lupton 148). The recent trend to "demedicalize childbirth" has been linked to hypnosis anaesthesia. The last decade, for example, has witnessed a rising interest in the use of hypnotic methods and alternative medicine to alleviate pain during labour (Cyna *et al*.; Huntley *et al*.). This evidence shows that

despite the medical reticence of Cajal's early experiment, his findings offered a valid approach to pain relief whose potential value and efficacy would still be contested more than a century later.

Cajal and the Dangers of Hypnosis

Cajal published *Vacation Stories* in 1905, one year before he was awarded the Nobel Prize for Medicine, a coincidence of dates that is far from accidental. In his foreword to the collection, he explains that the stories were in fact written in 1885-6, at a time when his emerging medical career was not yet firmly established, thus partly justifying his decision to postpone their publication. A flippant Cajal, however, dismissively labelled the tales as "pseudo-scientific narratives" (the full title of the book is, in fact, *Cuentos de vacaciones: Narraciones seudocientíficas*), and believed that the amateurish stories might have put at risk his nascent scientific reputation, thus relegating the collection to two decades of virtual oblivion (see Novillo-Corvalán). D.J. O'Connor explains that the belated publication of *Vacation Stories* was due to Cajal's concern that these "anti-religious, anti-establishment" tales might threaten his scientific funding, thus explaining his decision not to publish them until his scientific career was properly established (O'Connor 100; see also Otis vii-viii). Indeed, Cajal feared that the five tales included in *Vacation Stories* could compromise his scientific reputation, not least because they were a collection of seemingly "subversive" science fiction tales that openly undermined the deeply-rooted religious beliefs and local superstitions of Spanish society, through their empiricism, secularism, and application of scientific methods. Moreover, in delaying the publication of the "Dr Bacteria" stories, Cajal the "scientist" is displaying the same type of reticence he had shown towards his hypnotic activities. What Cajal previously labelled as just mere "amusements" (i.e. photography and hypnotism) can be easily extended to his aesthetic drive, which he self-effacingly called a "literary mania" (Marañón 134). But, as shown earlier, this labelling is deceptive and contradictory; since the demarcation between Cajal's different pursuits was not as rigid as he claimed. The stories, in effect, are closely linked to Cajal's microscopic and hypnotic investigations, illustrating the interplay between literature, art, and science through his endeavour to test the ethical implications of his

scientific discoveries within the relatively "safer" confines of fiction. For Cajal, then, the science fiction tales allowed him the possibility to test *risqué* scientific ideas and to apply them to literary characters, with all their frailties and passions.

The titles of the fictional stories illustrate an attempt to speculate with a variety of moral conundrums that would have preoccupied Cajal throughout his career as a scientist. For example, at first glance the title, "The Fabricator of Honour" sounds rather stilted, old fashioned, and moralistic. Yet this title is not intended to be serious, but rather a playful engagement with one of the most significant themes of Spanish Golden Age theatre: the code of honour. Thus, "The Fabricator of Honour" is a humorous reworking of well-known titles such as *El medico de su honra* (1631; *The Surgeon of his Honour*), a tragedy by Pedro Calderón de la Barca. However, the similarities end here, as Cajal is preoccupied in dramatising the conflict between science, morality, and hypnosis, as opposed to the tension between family, honour, and revenge that is established in Calderón's play.[3] Thus, the concept of "honour" is perceived through the lens of the scientific and moralistic dilemmas it raises. Dale Pratt, in this respect, considers that in Cajal's stories "[the] characters resolve their problems according to their own gods (the ideals of progressive science)" (82).

Cajal's story concerns a distinguished physician named Dr Alejandro Mirahonda, "a favourite disciple of those learned doctors of hypnotism" (*Vacation* 38), who decides to test the effects of his moral vaccine in the small town of Villabronca, a city where "[f]rom day to day, the disorder and lewdness spread, especially now that [it] had become primarily industrial" (*Vacation* 42).[4] It is worth paying attention to the negative connotations of the compound word "Villabronca," a playful coinage that brings together

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[3] It should be noted, however, that Cajal's story "For a Secret Offense, Secret Revenge" uses the plotline of Calderón's tragedy. See Otis xvi.

[4] All English translations of Cajal's *Vacation Stories* belong to Laura Otis. In her introduction to *Vacation Stories*, Otis talks about the problems of translating Cajal's stories. They are written in "long convoluted sentences." which Otis has tried to shorten to appeal more to modern readers (xix). Cajal's "humor, high tone, and inspirational insights" remain though, and his rich and romantic style is as evident in his stories as it is when he is describing what he sees under the microscope.

the word "villa" (town) with the adjective "bronco," meaning in Peninsular Spanish "row," "trouble," and "disruption." Cajal is equally tongue-in-cheek in naming the hypnotist Mirahonda, "mira" (look) and "honda" (deep), which is an allusion to, or even a parody of, the trademark physical feature of the mesmerist: magnetic and enthralling eyes. Laura Otis aptly translates it as "either Deep Look or Looks Deep" (*Vacation* 75), while the critic O'Connor remarks that Cajal is, indeed, very fond of using "preposterous names" (118). Cajal is evidently satirising the clichéd perceptions of the hypnotist as a figure of both admiration and ridicule, a mark that is extended to the entire physical description of this charismatic personage that instantly conjures up the portrait of the mesmeric magnetiser:

> He had the tempestuous beard of an angry apostle, and his enormous, deep, black eyes with an irresistible, searching gaze had pupils that seemed to emit clouds of magnetic effluvia. His eyebrows were long, thick, mobile, and serpentine, apparently endowed with a life of their own. (…) Besides this, he had a very substantial voice famous for its roars, but he knew just how to manage it, transforming it, according to the situation, into the gentlest, sweetest, and most caressing music. (*Vacation* 39)

It is noteworthy that Franz Mesmer (1734-1815), the founder of the theory of "animal magnetism" was renowned for his enthralling eyes and suggestive voice (see Wyckoff 124). Cajal is also critiquing the pseudoscience of physiognomy (i.e. the assessment of someone's character by the way that they look) that was revived by the Swiss writer and theologian Johann Lavater in the late eighteenth century. Cajal underscores the inadequacies of the age-old physiognomic formula by showing that Mirahonda, who appears to possess the correct countenance for his position, ultimately deceives the citizens of Villabronca with his fake moral vaccine (*Vacation* 45). We will say more about this later on. Therefore, Cajal is warning his readers that people, particularly eminent scientists, should not be taken at face value. Thus, the story deals not only with one man's ability to exert power over an individual, "[f]or him, to impose ideas or to suppress existing ones in docile minds was child's play" (*Vacation* 40), but also to extend control across the masses in his desire to "realize an ethical purification of the human race" (*Vacation* 44). Here Cajal is foreshadowing the sinister

potential of hypnosis, remarking in the story that these effects were produced "not just in hysterical people but even in sane, alert individuals" (*Vacation* 40), which brings to mind his own experiment with his wife. The target of Cajal's sharp satire, however, is directed more at the hubristic scientist than at the stereotyped figure of the charlatan. For Dr Mirahonda "all of the wonderful miracles attributed to saints and magnetizers were (…) a mere game. To enact them, all he needed was one impetuous look or a simple verbal command" (*Vacation* 40). At the same time, Mirahonda's performance inoculation of the citizens of Villabronca is accompanied by all the ritual trappings, pomp, and ceremony characteristic of Mesmer's flamboyant salons in eighteenth-century Vienna and Paris. For example, the brass band playing grave and solemn music in Cajal's story is a parodic reference to the celestial glass harmonica played in Mesmer's hypnotic sessions (see Pyntar and Lynn 20).

Mirahonda demonstrates the efficacy of his experiment by parading the reformed drinker, smoker, gambler, and brawler, and providing supporting testimonies from their factory foreman, since Mirahonda knows that "strong minds are not persuaded by more or less truthful tales but only by irrefutable proof *de visu*, which cannot fail to be accepted" (*Vacation* 44). Again, Cajal returns to the powerful effect of the visual, the proof being in the seeing, although, of course, appearances can be deceptive. The narrative *coup* of Cajal's plot is that the "moral vaccine" that forces the citizens to lead a life free of "vice" is none other than plain water, a fake "elixir" that achieves the desired effect through the power of suggestion. But while the town is morally reformed and vice and criminality are fully eliminated, other crucial ethical questions arise, concerning free will, personal identity, and the violation of civil liberties. On a more prosaic level, the town was suffering commercially from the effects of this "exemplary" behaviour, since consumerism decreased and morality, ironically, had a negative effect on the town's financial growth. Therefore, Mirahonda is asked to provide an antidote to restore the *status quo* in Villabronca, a new serum that, once again, turns out to be just plain water (*Vacation* 63). At the end of the story, the only winner is the unscrupulous Mirahonda who announces the publication of a ground-breaking research paper in which he irrevocably demonstrates that "the possibility of reeducating people by means of suggestion is a firmly established fact" (*Vacation* 65).

Apart from issuing an admonition about the dangers of hypnosis (whether the susceptibility of the hypnotic patient, particularly women, or the possible criminal abuses of the hypnotist),[5] Cajal also seeks to debunk other influential contemporary nineteenth-century debates, namely, Lombrosian criminology. The degeneration and criminal theories of Cesare Lombroso as presented in *Criminal Man* (1876) developed an aetiological explanation of crime that defines criminal behaviour as an atavistic regression to prehistoric man that can be identified in the anatomical and physiological signs of born criminals (see Gilfoil). Therefore, Cajal negates the Lombrosian deterministic theory that criminal behaviour had a biological basis, proving through the power of hypnosis that "criminality is a social, not biological, artifact" (Pratt 93).

Conclusion: The Uses and Abuses of Hypnosis

The hyperbolic and hubristic tone of Mirahonda's dubious practice sets a stark contrast to the excessive caution and medical restraint shown by Cajal in his hypnotic case study. These antithetical attitudes demonstrate that the fictional story allowed Cajal to speculate freely with the possible dangers of hypnotic suggestion. This makes evident, once again, the inter-dependence between Cajal "the storyteller" and Cajal "the scientist" to show that the case study and the fictional story are the two sides of the same coin. In the latter, Cajal brings an imaginative, yet realistic, view to the controversial subject of hypnosis, a practice that could potentially alleviate suffering but could also lead to the exploitation of vulnerable people, or at least those individuals more open to suggestion. At a didactic

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[5] It is also worth mentioning that around the same time that Cajal published his *Vacation Stories*, the Spanish writer and artist Blanca de los Ríos published two stories on the dangers of hypnosis (see Davis 1-16). Davis states that these stories serve as a warning of the vulnerability of women to the power of suggestion, particularly by men, and their need to be educated in order to avoid the dangers of "donjuanism." In "The Fabricator of Honour," not only are many of the women portrayed as debauched hussies in danger of tempting the scientist to stray from his "principle that the fascinator must never himself be fascinated" (*Vacation* 41) but those who are more acquiescent, such as Mirahonda's beautiful and rich German wife, are "subjugated forever with a single look" (40).

level, then, the science fiction story is constructed as a type of dystopia or cautionary tale.

In the scientific case study, on the other hand, Cajal examines the medical applications of hypnosis by mapping the concepts of consciousness and suggestibility to the physiological workings of the brain in an attempt to offer scientific explanations to the workings of hypnosis. His medical finding that the more a patient was exposed to the process of hypnosis the faster and more effective were the results, may be linked to his neurobiological research and to his belief in the neuroplasticity of the human brain. Benjamin Ehrlich has recently published excerpts from his translation of Cajal's book of aphorisms entitled *Charlas de café* (1921; *Café Chats*). One of these aphorisms particularly seems to embrace Cajal's idea of neuroplasticity:

> Nature has endowed us with a limited number of brain cells. This, then, is the capital, great or small, that no one can increase, because the neuron is incapable of multiplying itself. Fortunately, however, as compensation we have been granted the limitless privilege of being able to shape, stretch, and entangle their extensions, like cognitive telegraph lines, forming nearly infinite connections between reflective associations and intellectual creations. (…) And there is nothing more worthless and even dangerous than a rigid mind, incapable of learning and correcting itself. (*Café Chats* 181)

The aphorism also suggests the idea that the real "danger" lies on narrow-minded views of the world, particularly "rigid minds" incapable of accepting new ideas. This assertion may be interpreted as a veiled allusion to Cajal's arch-enemy, the Italian physician and anatomist Camillo Golgi, who introduced the staining method of silver chromate that Cajal used to develop his pathbreaking "neuronal theory" and who, ironically, shared with Cajal the Nobel Prize for Medicine in 1906 (see Finger 204). Golgi belonged to the opposing "reticular camp" and myopically continued his defence of his outdated theory at the Nobel award ceremony in Stockholm, to the dismay of Cajal and those present (see Jones 170-8).[6]

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[6] More recently, however, Paolo Mazzarello has leapt to Golgi's defence, noting that Cajal has almost singlehandedly contributed to the creation of a caricaturised portrait

Cajal comments in his autobiography that it is in the nature of adolescents to see "the world through a magnifying glass, everything appears to him enlarged and with a rainbow halo; in contrast to old age, which seems to see things through a concave lens that reduces and debases everything" (*Recollections* 104). However, Cajal retains his youthful view of things, as Pratt comments, "[Cajal] shows that the best scientists never grow up—it requires a certain childlike capacity for an adult to continue a vigorous life of the imagination" (236). Cajal brought an imaginative, yet realistic, view to the controversial subject of hypnosis, a practice that could potentially alleviate suffering but could also lead to the exploitation of vulnerable people. By looking at the medical applications of hypnosis and by trying to map the concepts of consciousness to the physiological workings of the brain, Cajal tried to offer scientific explanations to the mysterious elements of the phenomena displayed. His belief that the more a patient was exposed to the experience of hypnosis the faster and more effective were the results, is related to his ideas of neuroplasticity and learned behaviour. However, Cajal was neither blind to the abuses of the hypnotic technique nor to the ruthless streak that scientists in positions of power might display in order to further enhance their reputations, exploring through his fiction what happens when the boundaries blur. This shows, once again, that the subject of hypnotism was not just a mere "amusement" in Cajal's industrious career, but rather an ongoing interest that informed his scientific and literary writings and that allowed him to expose the benefits and the dangers of hypnotic suggestion.

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of Golgi as a "scientific dinosaur, whose errors had been so large and numerous as to defy understanding, a dead-end of scientific progress" (vi). For Mazzarello, therefore, scholarship on the history of neuroscience ought to shake off this type of stereotyped construction of Golgi in order to reappraise his immense contribution to the field.

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Abstract

Santiago Ramón y Cajal is widely known as the "father of neuroscience" for his ground-breaking scientific research in the fields of histology and neurobiology. His work in this area laid the foundations of modern neuroscience and earned him the Nobel Prize in Medicine in 1906. This public image of Cajal, however, only shows us the supreme scientist at work, the assiduous microscopist who revolutionised our understanding of the way that the human brain works. Cajal, in fact, is a more complex and multifaceted figure, since he was also a gifted artist, a prolific author of medical and literary works, and an indefatigable researcher whose scientific investigations include areas of study outside the field of neuroscience. As part of his diverse range of interests, Cajal became fascinated by the phenomenon of hypnotism, which ran broadly in parallel to his neuro-histological career.

Cajal's most noteworthy contribution to the field of hypnotism is a pioneering case study published in 1889 that proposes the use of hypnosis for the alleviation of pain during childbirth. The subject of hypnotism also features in Cajal's fictional story, "The Fabricator of Honour," which was included in the short story collection, *Vacation Stories* (written between 1885 and 1886; published in 1905). It is our argument that Cajal's medical case study and his fictional story reveal not only a profound interest in the practice of hypnotism but also foreground both the benefits and the dangers of hypnotic methods. While the medical case study dispels the stigma of hypnotism as the domain of charlatans and quacks by considering its analgesic potential, the fictional story, on the other hand, is a cautionary tale on the perils of human manipulation and the potential outcomes on society and the individual.

Keywords

Hypnotism; Ramón y Cajal; science fiction; suggestion; pain relief

Resumo

Santiago Ramón y Cajal es conocido como el "padre de la neurociencia" por su revolución científica en el campo de la histología y la neurobiología. Su trabajo en estas áreas sentó las bases de la neurociencia moderna y le ganó el Premio Nobel de Medicina en 1906. Esta imagen pública de Cajal, sin embargo, sólo nos muestra el gran maestro en su laboratorio, el asiduo microscopista que revolucionó nuestra comprensión de la forma en la que funciona el cerebro humano. Cajal, por cierto, es una figura más compleja y multifacética, siendo que también fue un talentoso artista, un prolífico autor de obras médicas y literarias, y un investigador infatigable cuyos trabajos científicos incluyen áreas de estudio fuera del campo de la neurociencia. Como parte de su amplia gama de actividades, Cajal quedó fascinado por el fenómeno de la hipnosis, que desarrolló en paralelo a su carrera neuro-histológica.

La contribución más notable de Cajal en el campo del hipnotismo es un estudio médico publicado en 1889 que propone el uso de la hipnosis para aliviar el dolor de parto. Entre 1885-86, mientras tanto, Cajal escribe un cuento de ciencia ficción titulado "El fabricante de honradez" que luego incluye en su colección, *Cuentos de Vacaciones* (1905), y cuyo tema es el hipnotismo. El objetivo de este artículo es demonstrar que tanto el caso médico como el cuento de ciencia ficción revelan, por un lado, el profundo interés de Cajal en la práctica de la hipnosis y sus posibles fines terapéuticos y, por otro lado, su preocupación por los riesgos de la sugestibilidad y la posible manipulación del hipnotizador. Si bien el estudio médico disipa el estigma de la hipnosis como la especialidad del charlatán y el embustero, "El fabricante de honradez", por el contrario, es una advertencia sobre los peligros de la manipulación humana y sus posibles consecuencias en la sociedad y el individuo.

Palabras Clave

Hipnotismo; Ramón y Cajal; ciencia ficción; anestesia; sugestibilidad

Making the Case for Herself: A Patient Writes

Mary Wilson Carpenter
Queen's University, Kingston, Ontario

Making the Case for Herself: A Patient Writes

> The first dressing Mr ___ made I really thought he had overturned all the ligaments etc. which had then begun to go together. The pain was dreadful and the draw sheet & pillows &c had to be changed for the blood from the wound then the bandages was tight. Miss Logan came in and I was leaning on the table & crying from the pain & soreness. Dear-o-me have you got bad news. No Miss Logan, not in the way you mean, but I have got a cruel dresser!![1]

This passage is taken from Margaret Mathewson's unpublished manuscript, "A Sketch of Eight Months a Patient in the Royal Infirmary of Edinburgh, 1877." The manuscript, of which three different versions are now known to have been written, is here dated August 8th, 1879 by the author. Mathewson, a twenty-nine-year-old Shetland woman, had traveled to Edinburgh to seek treatment for her tuberculous shoulder. She had been admitted by Joseph Lister, Professor of Surgery, on February 23rd, 1877, and he had performed the operation known as "excision of the shoulder joint" on March 23rd.. This was major surgery, involving the removal of all infected tissue, including parts of the bone, but it was hoped that enough muscle, ligament, and other connecting tissues could be retained to allow the patient to regain some use of the

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[1] Margaret C. Mathewson, "A Sketch of Eight Months a Patient in the Royal Infirmary of Edinburgh,1877," dated by the author August 8th, 1879, 107-8. Unpublished manuscript. Hereafter parenthetically: "Sketch" Aug 8, 1879.

arm.[2] Lister dared to attempt such a complex operation because of his pioneering practice of antiseptic technique, which he hoped would prevent "putrefaction" of the wound and subsequent death of the patient. For Mathewson, the risks of such an operation and the prospect of a lengthy, tortuous recovery were far preferable to the more usual treatment for her condition—amputation of the arm. Although the pain of having dressings changed and the arm put through a full range of motion had been excruciating when Lister first did it—no analgesics were administered for such dressing changes—it had gradually become more tolerable as the wound began to heal and the house doctors who took over the dressing changes developed their skill in moving the arm more gently but still sufficiently to prevent the joint from becoming "stiff."

That is, until the dressings were turned over to a medical student as part of his six-month rotation in the surgical wards. The student to whom Mathewson was assigned, never named in this version of the "Sketch," was her first experience of a "cruel dresser." In her graphic description, he manipulated the arm so forcefully that blood poured from

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[2] William Watson Cheyne, in his 1911 *Tuberculous Diseases of Bones and Joints*, describes the operation as beginning with "a long anterior incision, except in so far that after the ends of the bones have been removed, the whole of the synovial membrane should be carefully dissected away. The incision commences just external to the tip of the coracoid process and extends downwards and outwards parallel to the anterior border of the deltoid, dividing skin and fascia only, the arm being slightly abducted and rotated outwards the shoulder resting on a sand-bag. The biceps tendon is freed from its sheath, and the deltoid is raised. If the deltoid bursa is affected it must be dissected out, and the front part of the capsule is also taken away. The arm is now carried backwards and the head of the bone protruded, the muscles attached to the tuberosities being partially or entirely divided. In most cases enough bone can be removed without complete division of the rotators. The glenoid cavity is now removed, and the remains of the capsule clipped away" (Cheyne 326-27). By the time of this second edition of his book, Cheyne considered the danger of the operation relatively slight if performed early in the course of the disease, and before abscesses had broken through the skin. However, at the time of Mathewson's operation, she had had "chest disease" for four years and had had suppurating abscesses in the shoulder joint for more than two years. On admission, Cheyne told her she had an abscess in the joint and another glandular abscess on the collar bone ("Sketch" Aug 8, 1879 4).

the wound and he then bandaged it with such tightness that she—usually so stoic that Lister had openly praised her for her courage—had cried from the "pain and soreness." In this 183-page holograph narrative, the longest and last written of the three known versions of her "Sketch," she spares no detail about the cruelty of this dresser and then, even more astonishingly, writes of how she confronted him, telling him that she was determined to "inform" on him as she had that privilege, and that this could result in his dismissal.

Why should this account of a patient confronting a medical student be termed "astonishing"? In part, it is because Michel Foucault's thesis that the "birth of the clinic," or hospital medicine, in the nineteenth century had effected a dramatic change in the status of the patient has become standard in what one historian has termed "historiographical orthodoxies" (Hogarth 97). Foucault proposed that the sick man, "previously the focus of attention, was now simply 'the accident of his disease, the transitory object upon which it happens to have seized'" (59). Many other scholars have contributed to this view of the hospital patient. In a much-cited essay, for example, the British sociologist, Nicolas D. Jewson stated even more emphatically that the "sick-man" is "unequivocally subordinated to the medical investigator" and "designated a passive and uncritical role in the consultative relationship, his main function being to endure and to wait" (234-35). Stuart Hogarth succinctly explained these orthodoxies as assuming that prior to the nineteenth century, "the patient was powerful and doctors were weak, but this dynamic was reversed in the nineteenth century when medical theory and practice became forms of social control, part of a wider disciplinary system for the control of docile and passive bodies" (97). Mathewson's account of a ward or non-paying patient confronting a medical student upends this post-Foucauldian orthodoxy, representing herself as a bold challenger to the medical hierarchy of the hospital, even claiming power to have a dresser dismissed. It is an astonishing claim.

But Mathewson's "Sketch" is astonishing also simply because of its existence. Narratives written by nineteenth-century hospital patients are believed to be rare. Hogarth prefaces his essay on Joseph Townend's brief autobiographical account of his experience as a surgical patient in the Manchester Infirmary in 1827 as "possibly the most detailed description

of hospital life by a working-class patient in the nineteenth century now available to us" (97). Medical historian Michael Brown has commented that the collection in which Hogarth's essay appears, *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c. 1550-1950*, was doomed to fail in its central concern with following in the social historical tradition of "history from below" and therefore of "recognizing the agency of sick poor people and of reconstructing patients' experiences of illness and of medicine," with the single exception of Hogarth's essay (940). This is because, as recognized by the editors of the collection, Anne Borsay and Peter Shapely, the nature of the available source materials for their project "continues to be largely from the perspective of institutions, donors, administrator and professionals." How, then, could the essayists access the actual "voices and experiences of the recipients of charity?" (Brown 940). In fact, they could not, with the exception of Hogarth's essay. The collection therefore winds up doing exactly the opposite of what it was intended to do: it "fits neatly into an established body of post-Foucauldian scholarship examining the dynamics of institutional discipline and 'social control'"—the other end of the spectrum from doing "history from below" (Brown 940).

Mathewson's "Sketch" is far more detailed than the ten-page account in Townend's autobiography (Hogarth 97). Yet the work appears to be surprisingly little known today, despite having received considerable scholarly attention in the late twentieth century. The physician-historians W. B. Howie and S. A. B. Black first mentioned the "Sketch" in a brief article, "Hospital life a century ago" in 1976, and then discussed it in a longer article, "Sidelights on Lister: a patient's account of Lister's care." Martin Goldman, a BBC Radio Scotland science producer, later published excerpts from the "Sketch" and some of Mathewson's letters in *Lister Ward* (1987), a collection of memoirs by Lister's medical contemporaries that also includes a selection of poems and letters by William Ernest Henley, a private or paying patient of Lister's at the Royal Infirmary of Edinburgh from 1873-75.[3] Guenter B. Risse described the "Sketch" and quotes from

[3] A selection of excerpts was also published in four installments in the *New Shetlander* in 1987-88 by the editor John Graham, who had supplied the

it extensively in his history of hospitals based on case histories, *Mending Bodies, Saving Souls: A History of Hospitals* (361-98).[4]

All of these scholars, however, based their work on the assumption that there was only a single version of the "Sketch."[5] But in March, 2013, the Chief Archivist of the Shetland Archives, Brian Smith, sent me a brief e-mail beginning "Hold on to your hat!" A box in an attic had been found in Lerwick. In it were a number of miscellaneous papers related to Margaret Mathewson, and among them were two earlier written versions of the "Sketch." These manuscripts dramatically revised my understanding of the magnitude of what Margaret Mathewson had achieved in writing what she chose to call a "sketch."

Making Meaning vs. The Patient's View

Until that discovery in 2013 of two earlier versions of Mathewson's "Sketch," the greatest significance of this unusual document had seemed to be its upending of the "historiographical orthodoxies" cited by Hogarth:

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manuscript from which Goldman took his excerpts. Graham had earlier supplied Drs. Howie and Black with the manuscript on which they based their articles. All of these earlier articles and selections of excerpts were from the July 26th, 1879 version of the "Sketch," titled "A Help to Memory, or a Sketch of Eight Months a Patient in the Royal Infirmary of Edinburgh, 1877."

[4] As Risse documents his source for Mathewson's "Sketch" as a copy available at the Medical Archive Centre, Edinburgh University Library (later the Lothian Health Archives), and this copy is a photocopy of the photocopy held in the Shetland Archives, his references are to the August 8th, 1879 version of the manuscript. Risse had begun his exemplary practice of citing a patient's account in his history of the Royal Infirmary of Edinburgh, *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary of Edinburgh*, where he notes that Joseph Wilde's *The Hospital: A Poem in Three Books* (1810), which he quotes extensively, "represents the impressions and reactions of a hospitalized patient around 1800" (*Hospital Life*, 389, n51).

[5] This was also the case for my discussion of the case in *Health, Medicine, and Society in Victorian England* 28-31, and for the few twenty-first century scholarly articles on Margaret Mathewson's "Sketch": see Brunton, ed. *Health, Disease and Society in Europe 1800-1930* 32-36, Carpenter (2012), Marland (2004).

here was a nineteenth-century hospital patient who not only told her story from her own point of view, but demonstrated vividly in that story how little she had been silenced or passively subjected to the "clinical gaze" made so omniscient in Foucauldian theory. Mathewson's "Sketch" obviously made a strong case for "the patient's view," as called for by Roy Porter in his classic essay, "The Patient's View: Doing History from below." But the discovery of those two earlier versions, now also complemented by hundreds of letters written by the Mathewson family, previously held uncataloged in the Shetland Archives but now cataloged and in the process of transcription, has given Mathewson's "Sketch" a wholly unprecedented significance.[6] Here we can study "the patient's view" in process, as it evolved in letters written in the moment of experience through three successive writings of her "Sketch" (and beginning of a fourth) "from memory," not from "jottings" or notes, as she insisted in every Preface.

Mary E. Fissell distinguishes the newer cultural history of medicine from the older social history by proposing that "the core of cultural history is its attention to the making of meaning—to how people in the past made sense of their lives, of the natural world, of social relations, of their bodies" (365). The two earlier written manuscripts recently found in that box in the attic, together with my preceding observation that the one manuscript of the "Sketch" held in the Shetland Archives and the photocopy of another manuscript still in private ownership were differently dated by the author and in fact were not identical versions of Margaret Mathewson's story, provide an unparalleled insight into a ward patient's process of making meaning out of her life-changing hospital experience. Here we may read, not the patient's view, but this particular patient's views as she wrote and re-wrote her story. Each time her writing produced new meaning, made new sense out of her life, her body and its "natural world," and above all, of the relationships formed in the social world of the Infirmary. It was in and through these relationships that Mathewson imagined and reimagined her own identity not just as a "case history" authored by a doctor, but as a "successful," even a "favorite" case, written by herself. Each "Sketch" was

[6] The letters, now numbering more than 1800, have been transcribed under the editorial supervision of Kenneth E. Carpenter.

a new sketch of herself, a Margaret Mathewson newly imagined and freshly drawn.

Fissell concludes her essay with her regrets about what she finds lacking in the cultural history of medicine. Cultural history, she notes, does not inspire "a kind of indignation or desire for justice" such as that in the most exemplary works written in the tradition of the social history of medicine. Citing Ruth Richardson's *Death, Dissection, and the Destitute* (1987), she comments that this work "leads the reader to identify with the poor who were at risk of dissection both before and after the Anatomy Act" (383). In my reading of the different versions of Mathewson's "Sketch" as marking new steps in her understanding of her transformative hospital experience, I hope to retain its place in the tradition of social history, as well as locating it in the new cultural history, for its different histories of this patient encourage the reader to identify sympathetically with those who were among the sick poor in Victorian Scotland, but not among the poor in spirit.

The New Cultural History of the "Sketch"

Before comparing Mathewson's evolving accounts of her relationship with the "cruel dresser," it will be helpful to recount the history of those histories, as I have come to know it over the past two years. Mathewson wrote her first account of her experience in December, 1878, a little more than a year after she had returned home from the Infirmary. As she later wrote in a letter to William Watson Cheyne, a resident of Fetlar (neighboring island to Yell, where Mathewson lived) who had been Lister's House Surgeon at the time of her admission:

> Perhaps Sir you have heard ere now that I have written "A Sketch of my Eight Months in The Royal Infirmary" as a cousin of mine got a loan of it and went off to Fetlar & read it to too many there thus you probably have heard of it. It was written in December '78, only not at all in "The Infirmary," as I had nothing noted down there of the many strange things I saw & heard (only "The Convalescent" Meals) all the rest of it is entirely from memory & to be as a help to memory in after years D.V. but of late I have been prevailed on to enquire

> about having it printed. But I have not heard the printers terms as yet only I believe it will be too high for me.[7]

The version of the "Sketch" to which she refers as having been "written in December '78" is almost certainly one of the two found in the box in the attic: a defective copy lacking title page, preface and date, also lacking the first five and last one or two pages of the manuscript. This copy includes a few "duplicate" pages—pages with the same page numbers but in which the narrative is the same but not told in the identical words. (Such non-identical but identically numbered duplicate pages indicate that the manuscript was compiled by taking pages from more than one copy.) This short version was apparently about 78 pages long and is hand-sewn into a little cover made from ordinary brown wrapping paper, and labeled "Margaret Catherine Mathewson's Journal in the Royal Infirmary." Like all subsequent versions, it was written on standard letter-size paper, folded in the center. Booklets were formed by hand-stitching through this center.

Along with this version were found two pages, still attached together by a small piece at the top, evidently the first and last pages of a separate manuscript copy. One side of the first page bears the title "A Sketch of Eight Months a patient In 'The Royal Infirmary' of Edinburgh Viz from Feb 23rd to October 23rd 1877," and one side of the other is a page numbered "78" and concludes with the place and date, "School House East Yell Dec. 15th, 1878."[8] There is also a Preface with the same date which states

> This Sketch was wrote as a help to memory and wrote from memory not from jottings & was designed for none but myself but in complying with the urgent request of my friends

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[7] Letter addressed to "Dr. Cheyne" and dated Aug. 4th, '79. As the letter was found among the then uncataloged materials relating to the Mathewson family and held in the Shetland Archives, it is probably a copy or a first draft of the letter sent to Dr. Cheyne, not the actual letter sent. Words underlined in letters and versions of the "Sketch" in my text are so underlined in the original document.

[8] The Mathewson family lived in the Schoolhouse, which had been built in 1822 to house not only the classroom but living quarters for the schoolmaster (Margaret's father, Andrew Dishington Mathewson) and his family.

> to print it I acceded to try it, & wrote it over commented on some points passing over others & thus enlarged it to 150 pages or more & am now enquiring the printers terms (…).

This Preface, which obviously must have been written later than the date given on the same page, documents one motive for her second writing of the "Sketch": reader demand. Though she claimed to have written the "Sketch" only for herself, she gave it to friends to read, and they "urgently" requested that she have it printed. The "Sketch" was from its earliest beginnings a socially constructed text, part of what might be called an epistolary dialogue between Mathewson and her family and friends. Every version of the Preface (of which there are four) is signed, "Believe me, Your affectionate friend, Margaret C. Mathewson," as she would have signed a letter. In this age of the Penny Post and its frequent letter-writing (the mail was delivered three times a day including Sundays at the Infirmary), Mathewson clearly imagined her "Sketch" as a kind of lengthy letter to her friends.

This earliest version of the Preface also states, as do all of the subsequent Prefaces, that she hopes the "Sketch" will "help to strengthen the weak faith of some Christian & lead some sinner to Jesus (…)." Mathewson was an ardent Wesleyan Methodist, converted at the age of fourteen in the Mid-Yell Chapel, and her hospital experience was inherently a profoundly religious experience for her.[9] Each new version of the "Sketch" enlarges on the religious material included in it, and this in turn enlarges our view of her social world in the Infirmary, as every religious experience described is either part of a conversation with another patient, a sermon given by a chaplain or perhaps a medical student and heard in the hospital chapel or in the midst of the ward, or a dream or vision seen only by the patient but later told to someone else, perhaps a nurse.

The other manuscript copy found in the box is undoubtedly the one she describes in this preface as enlarged to 150 pages or more, as it consists of another little hand-sewn booklet (no cover for this one) that is actually

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[9] Mathewson writes about her conversion in August, 1862 in her "Autobiography," a fragment of which was found among uncataloged materials in the Shetland Archives in June, 2012.

164 pages long. It bears a title in very elegant handwriting, "A Help to Memory, Or A Sketch of Eight Months a patient in The Royal Infirmary of Edinburgh.1877."[10] The Preface for this manuscript, dated July 26th, 1879, states:

> The following Sketch was originally written for my own private use as "a Help to Memory," and was written entirely from memory, eighteen months, after I came home from the Infirmary. And in complying with the urgent request of my friends to publish it, I have written several copies and given to some of my most intimate friends and also on loan to many more and in thus publishing it (as I do not mean to print it at present) (…).

There was only one printing press in the Shetland Islands at this time, the Shetland Times Press that printed the islands' first newspaper.[11] It was located in the town of Lerwick on the main island of Shetland, as it is today. Mathewson must have found, as she wrote to Cheyne, that the "terms" or cost of printing was too high for her. This copy of the "Sketch" is evidently compiled from several other copies of the manuscript, as many pages are re-numbered, with the earlier numbers blotted out and written over.

The Preface for this version of the "Sketch," which I assume to be the second written, refers obliquely to another motive for writing: although all "Managers, Officals, [sic] Attendants" in the Infirmary deserved her "highest approbation," Mathewson wrote that she "could not conscientiously omit refereance [sic] to that person & say 'All' but I believe it was not Mr _____ natural or habitual disposition to be cruel but that it was 'an experiment' with a view to benefit the public" ("Sketch" Jul 26, 1879, npn). She suggests, in effect, that her desire to write about her treatment by "Mr _____," who is sometimes in this version called

[10] This is the only version of the title which has the phrase, "A Help to Memory," included in it. Hereafter parenthetically: "Sketch" Jul 26, 1879.

[11] The first issue of the *Shetland Times* was printed in 1872. It continues to be printed today, but is now also available online.

"Mr H____," had become a leading motive for rewriting the "Sketch." She needed to re-tell that part of her story, to re-construct that particular relationship. And this Preface includes another motive for writing, that of "Hoping 'The Sketch' may encourage some suffering person to go there if need be without hesitation." This addition to the Preface suggests her growing sense of identification with the Infirmary, especially with those members of the staff whose mission is to help those who suffer.

The third copy of the "Sketch," dated August 8th, 1879, remains in private possession.[12] It is this version of which the Shetland Archives holds a photocopy.[13] This version of the "Sketch" is the longest—183 pages long—and the manuscript appears to be a single, complete copy, with no re-numbered pages. In the Preface to this version, Mathewson states more matter-of-factly that she is "complying with the request of my friends," in thus making the "Sketch" public. And she notes much more briefly that all at the Infirmary deserved her highest approbation—"with one exception." Yet it is in this version that she goes into the greatest detail as to how the unnamed "cruel dresser" treated her and how she confronted him, telling him that she was "determined to inform" on him.

The Shetland Archives holds yet a fourth version, a holograph manuscript dated September 27th, 1879. However, only the Preface and first six pages are in Mathewson's bold, clear hand. The rest is a copy known to have been made by a friend of hers, Laurence Williamson (1855-1936). Mathewson does note in the Preface that she has "written several copies, having left out some insignificant items and put in others more interesting." And in this Preface she writes more emphatically that she has no

> desire to expose or censure any of the Infirmary Managers, Drs or Nurses, or anything in connection with "The Institution," as all deserves my highest approbation, and I will ever consider myself under a debt of gratitude, for the

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[12] This manuscript is in the possession of John Clark, a great-grand-nephew of Margaret Mathewson. He has generously allowed me to examine and photograph this manuscript, as well as many family photographs.

[13] The Lothian Health Archives in Edinburgh also has a photocopy of this version of the "Sketch."

> great kindness, attention, and benefit I received, and hoping the Sketch may help to encourage other people not to hesitate in going to "the Infirmary" if they require it (…) ("Sketch" Sep 27th, 1879 npn)

And she closes with her usual hope that the "Sketch" may help strengthen the weak faith of some Christian reader. On page six of this manuscript, the narrative is picked up by another hand, Williamson's, and continues to the end of the story. Because Williamson's hand is much smaller, this copy is only 93 pages long.

Her account of the "cruel dresser" in this version is much less graphic in its description of the dresser's treatment of her wound, and there is no mention of confronting him, nor of threatening him with the prospect of his dismissal if she chooses to inform on him. It was only after the discovery of the two earlier versions of the "Sketch" that I could identify Williamson's copy as a copy of the July 26th, 1879 version, despite the date given on this manuscript of September 27th, 1879. Although Mathewson apparently intended to write yet a fourth version of the ""Sketch," the August 8th, 1879 version is in fact the last written version, at least as now known.[14] It is in this version that Mathewson emerges as a patient most fully empowered by her new medical knowledge, a patient of whom other patients and visitors frequently inquire, "Are you a nurse?" It is in this version that she writes how she boldly confronted the "cruel dresser." Her writing and re-writing of her story produced new meanings both for her encounter with the "cruel dresser" and for the person she had become in her "sketches" of herself produced in the two years following her richly complex hospital experience. Although there are many fascinating differences between this version and the earlier two, in the interests of conserving space

[14] In an essay written before I had had opportunity to examine the two manuscripts found in the box in the attic in 2013, I described how much more confrontational the account of the "cruel dresser" was in what I assumed to be the earlier version, dated August 8th, 1879, and questioned why Mathewson might have taken a more cautious attitude in what I assumed to be the later version, dated September 27th, 1879. Only after I had examined the two earlier dated manuscripts did I find that Williamson had made his copy from the version of the "Sketch" dated July 26th, 1879 (Carpenter 2013).

I will here focus on her encounters with the "cruel dresser" as constructed in the re-writings of the "Sketch."

The Patient's First Sketch

In the earliest-written of the two manuscripts only discovered in 2013, we find the most shocking revelation about "Mr. Hart"—the cruel dresser is here named as he is in Mathewson's letters written in 1877—and his intentions in his violent, cruel movements of Margaret's arm. In this shortest version of the "Sketch," Margaret writes:

> There was one Mr Hart who got all the No 2 patients to dress and he was awfully cruel until I told him I would inform the Dr if he did not treat me more gentle as I believed his manner of dressing was keeping back the progress of my arm, Many nights not sleeping at all for the renewed pain after the twisting & squeezing while dressing. He said he knew it was retarding its progress a little but he wanted to keep me a while longer here, as he was learning a lot off my case as it is such a glorious case to us. ("Sketch" Dec 15, 1878 38, author's underlining).

In this earliest writing of the "Sketch"—written from memory, as she insists in the Preface—Mr. Hart acknowledges openly that yes, he is twisting the arm around enough to retard the healing process as he wanted to keep her there a while longer—he was learning such a lot off her case because it was such a "glorious case to us"![15] To put it bluntly, he was twisting and squeezing the arm enough to deliberately tear the muscles and ligaments apart, causing the blood to flow afresh. And he had no qualms about telling her that he intended to slow the healing of her arm as it was such a

[15] Mathewson also used the phrase "glorious case" earlier in this first version of the "Sketch," though it doesn't appear in either of the later versions. But in the December, 1878 "Sketch," she describes the "doctors running to & fro shouting here was a glorious case" after someone "run over at the railway station" had been brought in (7). Evidently "doctors"—most probably students—used the phrase to describe a serious or unusual case on which they would have a chance to see unusual treatments. This accident case is described in both of the succeeding versions of the "Sketch," but without reference to the students' delight in such

"glorious case"—one from which he could perhaps profit by demonstrating his superior skill as a dresser to the Professor. And in this first version, Margaret writes that "I felt quite angry at him but I said nothing. But oh Mr Hart you are cruel," to which she writes that he replies, "Well I will try & be more gentle & you wont tell the Dr. will you. I will indeed if you are not more gentle," she asserts, and then says "he was a little more gentle" ("Sketch" Dec 15, 1878 38).

A letter written to her father, dated June 11th, 1877, documents the brutality with which Mr. Hart manipulated her arm:

> I mean to ask (…) if they will let me go to the convalescent now, as then I would (I hope) get free of the fearful Squeezing Mr Hart gives me arm It couldn't be worse any way I think if it should'nt be much better. On Saturday he dressed me sitting on a chair (as I was up before he came, just to see if it would be any better being out of the bed) & it was worse than ever but I tried not to cry out much, he put his knee on my side below my arm and pulled up my arm with both hands and the blood ran down over my clothes (thro the place where the tubes was in) it was very sore and painful all Saturday afternoon & night & I hardly sleep't any & it was still sore Yesterday morning but got a little better after that so as I sleept very well last night.

Accordingly, when Lister returns from London (where he was negotiating an appointment at King's College Hospital), and as she reports, asks her how she was getting on, she replies, "Thank you Sir but ordinary." Apparently surprised, he replies, "You ought to be getting well on by this time." Margaret writes that when he dressed her arm, she was sure he would know what had been done to the arm since he had dressed it last. And indeed, when he undid the bandages, he said "dear O me what's being doing here. Dr. who is the dresser of this case. Certainly not you Sir No sir. But it's Mr Hart here (his face fired up)." Lister continues, "Well Mr

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exciting surgical prospects. The accident victim, however, gave them no satisfaction, as he was in such poor condition Lister could do nothing for him, and he soon died.

Hart you have not failed to move it but this has been rather much and must have caused severe pain to the poor patient did she never complain on you to Dr. Rh. Dr. Rh said no sir never to me. Prof then ast me did you generally feel pain after the dressing? & did you always sleep well." Margaret writes that she told him "I always felt severe squeezing pain after the dressing so much so as the first 2 nights I sleep't little or none Sir." And Lister then asks her, "did you think Mr. Hart did it intentionally to cause you pain." And Margaret replies "No Sir I think he did it for my future benefit." Lister says to Mr Hart, "you see she will not talk against you after all. But you must be more gentle in future." Margaret here writes in parentheses, "(I had to be cautious what I said at that time as it would have been worse for me afterwards if I had spoken unfavorably of him to the Prof)" ("Sketch" Dec 15, 1878, 39-40).

In fact, her brother Arthur had written to her at the time that he thought she ought to complain directly to the Prof. In a letter dated July 6th, 1877, he wrote:

> Were I you I would not submit to Mr. Harts roughness quietly, he is a public servant—as they all are—and a complaint from a patient must have some weight with his superiors and at the very least there would be an inquiry which might bring other cases against him, I should say that the professor would be the person to complain to of excessive roughness in most cases when you are dressed, by Mr. Hart, if not convenient personally, a short note through the post might have due effect with professor, I hope however that by this time your shoulder will have healed up completely and then there will be no call for the foregoing.

Arthur was at home in Yell at this time, though he had been in Edinburgh at the time of her operation and stayed in lodgings nearby for several weeks so he could visit her. Arthur had been diagnosed with "pulmonary consumption" in January, 1875, and advised by doctors in Edinburgh that he should leave his job as a shipping clerk and either return to Shetland or take a trip somewhere south. His suggestion that she should complain directly to the Professor, as a complaint from a patient must have some weight with a medical student's superiors is surprising to readers formed by Foucauldian and other late-twentieth century theory assuming that the

clinic patient could only submit silently to treatment, however "rough."[16] However, Arthur was probably the best-read and most informed member of his family, and his statement that not only Mr. Hart but everyone at the Infirmary were public servants reflects Enlightenment philosophy that the mission of voluntary hospitals was to care for the sick poor and thus benefit the health of the population in general. Edinburgh, as Mark Jackson comments, had by this time become "one of the leading centres of Enlightenment medicine," so perhaps it is not so surprising that patients who had been educated in a culture shaped by the Scottish Enlightenment might have more of a sense of entitlement than patients in other countries, or even patients in other parts of Britain (129).

Margaret nevertheless was clearly afraid to complain about Mr. Hart's treatment, even to the House Surgeon, as Lister evidently expected her to, and even more so if she had answered Lister more honestly in the presence of not only Mr. Hart but his fellow students and the other doctors present, including visiting physicians from other countries who had come to study Lister's antiseptic methods. "I had to be cautious," she comments, as "it would have been worse for me afterwards if I had spoken unfavorably of him to the Prof." So here she takes the more prudent course and lies to the Prof, responding negatively to his question as to whether she thinks Mr. Hart had intentionally caused her pain. Lister nevertheless has spoken to the student in such a way that, as Margaret says, "his face fired up." M. Anne Crowther and Marguerite Dupree note that Lister's reputation for rebuking students severely if he thought they had mistreated a patient is well known. "His pained and public reproaches if dressers appeared at all careless or treated patients without proper consideration affected his supporters for the rest of their careers," they comment (102).

[16] W. B. Howie writes that "from the beginning of the hospital movement it was appreciated that there was a need for a system through which complaints could be made and wrongs redressed" (345). Some infirmaries actually listed the patient's rights. However, Howie concludes that complaints by patients against members of the medical staff were few in number because they carried considerable risks to the patient who, if the accusation was found to be without foundation, might be expelled from the infirmary and never allowed to re-enter (357).

Whether Margaret's caution in her response to Lister's question resulted in better treatment from Mr. Hart is not told in this version, where we hear no more about him till close to the end of the narrative, as she is leaving the Infirmary. Mr. Hart had just returned from his holidays at Vienna, she reports, and when he asks "how is the arm now, he took hold of it & moved it so quick & Squeezed it, I was about dropping down with the pain he gave me." Even at this time, she can only say, "You are a cruel creature," to which Mr. Hart replies "Yes but when I come to Shetland you will be able to pull me about through the voes in a boat, then you will only see I was not cruel but did it for your good & you will have cause to thank me all the days of your life." But Margaret goes on to describe this final meeting in terms that suggest that, while she still may have feared him, he still liked the idea of having her take him for a ride, shall we say, and was attempting to soften her up. "Well," Margaret continues, "it may be so but at present I can't say but Mr. Hart was a cruel dresser," to which he replies coyly, "Oh Margt you are a cruel lassie to say so If I come to Shetland I'll come & see you at any rate—whether you thank me or no." To which Margaret replies, perhaps grudgingly, "Well if you do come so far north I will be glad to see you there," but Mr. Hart offers in turn, "Well but wont you come back here and be a nurse. I'm sure you would suit fine for that." Margaret replies that she doesn't think she'll ever be back again in Edinburgh, and with that, "I left him," she says ("Sketch" Dec 15, 1878 69-70).

This version of the "Sketch" then tells of her going to visit Dr. John Chiene (not named here but identified in subsequent versions) at his home in Edinburgh. He's very pleased with the state of her arm, and tells her that "Prof Lister has made a good job of you, you must have been a favorite case to him" ("Sketch" Dec 15, 1878 73). He gives her a prescription for ointment for the arm and urges her to write him when she gets home. He will not accept Mathewson's offer of payment for the consultation, and repeats that she should write him if she needs anything else. This version of the "Sketch" then appears to conclude with an account of the journey home through extremely rough seas (not unusual at this time of year), but as the final page or two are missing, we cannot know exactly how she ended this narrative.

The Patient's Second Sketch

The next-dated version of the "Sketch," also not known until it was found in the box in the attic, is expanded to 164 pages. Throughout this longer version of the "Sketch" she does not name Mr. Hart, either using only a line for his name or in a few cases speaking of him as Mr. H. And in this version she continues to use cautious language in what she recounts about what she actually said to the student, also about Lister's rebuke to him and her response. Her description of the dresser's cruel behavior is much less vivid than in the earlier version:

> (…) until then I had not known what "a cruel dresser" meant as my suffering only began then. The first dressing I believed he had again drawn my arm out of the cup and reopened all the wounds etc. the two following nights I sleept none at all and this was invariably the case after dressing me, while he was on duty, I felt sure I could not progress under this treatment and consequently would have to stay a long time still in "the Infirmary. ("Sketch" Jul 26, 1879 105)

Note the absence of detail about the blood running down, also that she does not include any statement here of her making a complaint to the student, nor of his reply that he did want to keep her in the Infirmary a while longer because hers was such a glorious case! And Margaret's account of what is said when the Prof returns from London and dresses her arm is similarly cautious:

> One morning Prof. came in and asked me How are you getting on now: Thank you Sir, but ordinary. How is that? You ought to be getting on well by this time however I will see as I am coming to dress you in a little. Thank you Sir. I did not answer Prof's question as I did not wish to inform on Mr ___, as there was a great amount of events might come out of it. I was not aware of at the time. And evidently it could only add to my suffering instead of abating it. Thus I avoided the information for a time hoping Mr. H. would improve. ("Sketch" Jul 26, 1879 105-06)

And here also she is cautious about what she says to the Prof in front of Mr. ____ :

> I was really glad to see Prof back as I hoped he would again dress me. He came and when he had undone the bandages he stoped, and said Dr, what's been doing here? Who is now the dresser of this case Mr H____ Sir (Mr H was present and took a red face) Prof. said well Mr H. you have not failed to move the joint but this is too much, and has reopened what was now set together and thus retarded the healing process, then the pain it must have given the patient. Did she never report you to Dr. Roxburgh? Dr. Roxburgh said never to me Sir. Prof. then asked me Did you always feel pain after the dressing? Yes Sir and did you always sleep well the following night, No Sir. For the two following nights I seldom sleep't any. Do you think Mr. H did it intentionally to cause pain? No Sir. I think Mr H did it chiefly so as to secure good movement of the joint so as I should not have a stiff joint (Prof. then patted me on the back and said you are a considerate and patient young woman.) Now Mr H you see she has not said a word against you: therefore you will surely treat her more kindly. Yes Sir. I had to be cautious how I answered prof. here again as I believed a great deal would depend on what I said regarding the dressing as "many a word in anger spoken find its passage back again," says the poet. ("Sketch" Jul 26, 1879 106-07)

In this second remembering, she inserts the proverb, implying obliquely that had she voiced her anger at her treatment by the dresser to the Professor, she would have suffered still more at the hands of the then humiliated and probably vindictive dresser.

And with that, we hear no more about Mr H or Mr. _____ in this version of the "Sketch." In this version first intended if possible to be printed, and if not that, then sent around to as many people as possible in handwritten copies, Margaret did not even write that she had complained to the dresser. But in a letter to her brother Arthur written while she was in the Infirmary, dated June 28th, 1877—one that only came to light recently— she had written that she told Mr. Hart, "if it continues to be as sore I will have to speak to the Dr. about it," and when Mr. Hart replied, but you know it must be more," and that he also took what she said rather "sharp," so

> I didn't care for I meant to do so but thought if I told the Dr. without again telling him he might think it harder of me. Yesterday when he came to dress me he told me it should be well moved today & how bad it was of me to think of telling the Dr. but thinks I well he can't be much worse than he's been & I'll just exert my self not to shout out if possible & bear it as well as I can but he will know that if he does anything to hurt it so as the Dr. etc. has to be called that they will know it was'nt myself could do it. Thus I encouraged myself for any battle, and to my surprise he has never been so gentle since he came here & ast me to shew him what part of the joint I felt sorest when moved, well I'll try to be more gentle with it as it must be sore (and you are so patient with it all) & then the Dr. came in & he told him that I was thinking my arm too much moved Oh but she knows it must be moved or she' ll have a stiff joint all her life.

In other words, in this letter written to her brother at the time of her encounters with the "cruel dresser," she recounts her fears both about speaking to the dresser, and about reporting him to the Dr., but states in the letter that she did nevertheless speak to Mr. Hart. She reports Mr. Hart's response here as telling her not only that the joint must be moved but that it was "bad" of her to think of telling the Dr. But in fact, though she was prepared for the worst next time, to her surprise he was gentler than he had ever been. And Mr. Hart had told the Dr. that Margaret was thinking her arm "too much moved," to which the Dr. had replied without sympathy that it must be moved or she'd have a stiff joint all her life.

This second version of the "Sketch" concludes with a visit to Dr. Cheyne at his residence on Fetlar in the summer of 1878. She explains to Dr. Cheyne how she had written to Dr. Chiene in Edinburgh when her arm "gathered" (swelled) after her return to Shetland, and how he had sent her a drainage tube in the mail. Cheyne asks, in her account:

> And who put it in for you? Myself, Sir, before a glass. Dear-O-me!! That was good of you. But why did not your Father or brother do it? They could not bear the idea of any thing so thick going into an open sore as they thought that would cause unsufferable pain to me Sir. ("Sketch" Jul 26, 1979 160)

Cheyne is properly amazed at this, and after questioning her about how she dresses the wound, during which she recites the precise proportions of boric acid crystals and water to be used, exclaims to her: "Dear-O-me but how well you understand it!! That is quite right. Margt & you should come and be a nurse in the Infirmary as you would soon get on" ("Sketch" Jul 26, 1879 162). This laudatory recommendation from the man who had by then become Lister's House Surgeon at King's College in London (he was home for his holidays at the time Mathewson visited him) obviously meant a great deal more than Mr. Hart's dismissive "I'm sure you would suit fine for that."

Mathewson concludes this "Sketch" with a new vision of herself as getting healthier and stronger all the time. Her arm "healed quite up in end of August and since has progressed in strength gradually, (and it required 17 months to heal) and I can now do any sort of indoor work" ("Sketch" Jul 26, 1979 163, author's underlining).

The Patient's Third Sketch, or the Patient Gets The Last Laugh

But in the third version of the "Sketch," dated August 8th, 1879, which I now believe to be the version she completed last, as well as the longest, she writes as a much more confident and confrontational patient than in either of the two earlier versions. It is from this version that I have taken the quotation I used at the beginning of this essay, in which she describes how Miss Logan found her crying with the pain after her first dressing by the "cruel dresser," and how so much blood had poured out from the wound that the draw sheet and pillows had to be changed. Although she qualifies her complaints about this dresser by saying that "I believe Mr ____ was trying experiments in my case and not really from a cruel design," she goes on to really let him have it:

> (…) one day he asked me if I was not wearying to get away? I am indeed. But your style of dressing is preventing my progress and prolonging my stay here. Well you know yours is a rare case and that's my chance for lessons," Well Sir Indeed, if you presume to dress me any longer so cruel; I am determined to inform on you, as I have that privilege if I choose, thus I am reminding you of that, so as to prepare you

> for your dismissal Sir. Do you really mean it Margt? I really mean what I say Sir, as I have suffered too long for your pleasure (…) ("Sketch" Aug 8, 1879 109)

Following this, there are lines that have been crossed out, as if perhaps Mathewson had doubts about including them:

> rather than to cause any gentleman lose so important a situation as you are preparing to fill. Well I am very much obliged to you for this notice as I know you have it in your power to cause my dismissal, & I beg your pardon, & I shall not be so hard again if you don't inform this time yet. ("Sketch" Aug 8, 1879 110)

This patient not only complains to her "cruel dresser," but tells him she can have him dismissed as she has that privilege, and she really means it because she has suffered too long for his pleasure! And the medical student, in Margaret's description of the episode this time, says he is much obliged to her for giving him this notice because he knows she has it in her power to cause his dismissal, and he humbly begs her pardon, and promises to do better.

Did Mathewson—a Victorian ward patient, after all—actually ever go as far as this? We do not have a letter that confirms that she actually told the medical student that she could have him dismissed. But we do have the two letters in which she confides to Arthur that she did complain to the dresser, and that the Dr. (presumably Roxburgh or the House Surgeon) was told about it, but by the dresser, also the letter in which Arthur tells her that she should complain about Mr. Hart's rough treatment to his superior, as a case might be brought against him if there are other complaints, and that he and all the medical staff are "public servants."

How does Margaret describe what Lister says to the dresser, and what she replies, in this version? Here the Prof stops after he has undone the bandages, and asks,

> Whats been doing here? Who is the dresser? Mr ____ Sir, said Dr. R. Well Mr ____ you have not failed [the word "ceased" is crossed out here and "failed" inserted instead] to move the joint here (Mr ____'s face got red) and have reopened what was set together Sir. Which I am sorry for as I expected to see

> its great progression at this date. Then the pain it must have given the patient! Dr. did she never report Mr ____ to you? "Never to me Sir" then said to me. Did you always feel pain after the dressing? Yes Sir and did you always sleep well the following nights? No Sir I seldom sleep't any the following two or three nights Sir. Just so. Well do you think Mr ___ did it from cruelty, or to cause you pain? ("Sketch" Aug 8, 1879 110-11)

This is surely the frankest language yet: did the patient think the dresser caused her pain from sheer "cruelty"? If Lister did actually use such language, it would indicate that he was fully aware that some dressers might be sadistic in their treatment of ward patients. But we will surely never know whether he did or not. What Margaret's writing and re-writing of the incident does show is that she was capable of turning what she had recorded earlier about the medical student's own language against him, and getting the last laugh herself. She replies:

> No Sir, I think Mr ___ did it so as I should not have a stiff joint afterwards, Sir. How do you think so? I think so Sir, as Mr ___ told me I would be able to pull him around the bay near our place in Shetland, when he came there to spend his Holiday yet some day perhaps Sir (a laugh). Very good proof gentlemen, the patient understands "a stiff joint." Now Mr ___ you see this young woman has not said a word against you to any person & surely you will treat her more gentle. (but no it was the same next dressing day). ("Sketch" Aug 8, 1879 111)

In this version of the narrative, she relocates what the dresser said from the rather degrading exchange placed at the end of the narrative in her first version, and heard only by herself, to her exchange with Lister before the assembled company of other medical students and doctors who always accompanied him on his rounds. She makes the "cruel dresser" into her own "glorious case," making him the butt of *her* joke, and she takes up a collegial and most satisfying position with the medical staff herself. And the Professor responds approvingly, as he might have to a promising student, about her understanding of the term "stiff joint."

Though we have no record of what Margaret or Mr. Hart or even Prof. Lister actually said, the combined record of her repeated versions of the "Sketch" and her letters written from the Infirmary certainly document that Margaret Mathewson of Shetland was no docile, objectified or silenced patient. And I will add here that Mr. Hart was no fictional construct or product of her imagination. He was almost certainly one David Berry Hart who is included in a photograph of Lister's clerks and dressers in 1875 that is reproduced in Crowther and Dupree's *Medical Lives in an Age of Surgical Revolution* (4). He graduated from the Edinburgh medical school in 1877, is listed as a resident at the Edinburgh Royal Infirmary from November 1878 to May 1879, and went on to become a much respected obstetrician and gynaecologist.[17]

There are other aspects of this longest and latest-dated complete version of the "Sketch" that testify to Margaret's increased sense of medical knowledge, and that strongly suggest she was envisioning herself as that new figure of female power, the Nightingale-style nurse. According to the second and third versions of the "Sketch," it was not only the cruel dresser who made the flippant suggestion that she might come back and become a nurse. She records Dr. Cheyne as encouraging her to think about this possibility, and in the last version of the "Sketch," she includes a long dialogue with a nurse in which the nurse not only urges her to return and enter training as a nurse, but says she'll be happy to recommend her to the Matron. Margaret Mathewson's writings and re-writings of her "Sketch" transform her from the position of "glorious case!" at the mercy of a callous medical student to someone who had been told she was a "successful" case of Prof. Lister's, even a "favorite" case—someone who should consider becoming a nurse herself.

Of course, sadly, she didn't live to make this dream a reality. In the year 1880, three of the Mathewson adult children died of tuberculosis: Arthur, aged 40, in February; Margaret, aged 32, in September; and Walter,

[17] I thank Archivist Laura Gould at Lothian Health Services Archive in Edinburgh, as well as Anne Crowther and Marguerite Dupree, for directing my attention to this information.

a lighthouse keeper in Devaar, Scotland, aged 38, in October.[18] But Margaret's writing and re-writing of her story and of herself make, I believe, a most interesting case for history. In a recent article, "Making the Case for History in Medical Education," David Jones *et al.* write that history "re-humanizes medicine in the face of scientific reductionism and demonstrates that medicine is fundamentally social, an encounter between (at least) two humans, each embedded in social, economic, and political contexts" (11 of 30). Margaret Mathewson's "Sketch" demonstrates the fundamentally social nature of medicine in that world of the nineteenth century hospital where it has been thought that patients were de-humanized, objectified and silenced. Medical students may have considered them just "cases," glorious or otherwise, doctors and professors may have seen them as sick bodies available for experiment, but the story as told by this particular patient makes the case definitively that medical practice is always social, always inevitably the lived relations between living human-beings trying to make sense out of this complex, universal experience we call illness.

Acknowledgment

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[18] Walter's death certificate states that he died of "encephalitis," but it is likely that it was tuberculosis that had spread to the brain.

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Abstract

Margaret Mathewson, a twenty-eight-year-old Shetland woman, was admitted to the Royal Infirmary of Edinburgh on February 23, 1877 as a ward patient of Joseph Lister's. He subsequently operated on her tuberculous shoulder and she remained in the Infirmary or its associated convalescent home for eight months. After her return to Shetland, she wrote a narrative account of her experience which she circulated in handwritten copies among her friends. Such accounts by nineteenth-century ward patients are believed to be rare, so Mathewson's narrative is valuable for that reason alone. But a close reading of her narrative not only provides an unprecedented picture of the social world of this well-known medical institution, but upends the "historiographical orthodoxies" that patients became docile, passive bodies on whom physicians experimented as they wished, the patient's consent not being required. Mathewson's account documents her agency in responding to the various levels of the medical hierarchy and also in her interaction with other patients, thus establishing her "Sketch" as a unique contribution to the social history of medicine "from below." Recent discoveries of earlier versions of her narrative and also of a large cache of previously unknown letters to and from her family allow us further to read the document as cultural history, showing how a working-class Victorian patient made meaning from her complex hospital experience as she wrote and re-wrote her narrative.

Keywords

Margaret Mathewson; Joseph Lister; hospitals; patients; tuberculosis

Resumo[19]

Marget Mathewson, uma mulher das ilhas de Shetland, de vinte e oito anos, foi admitida na Enfermaria Real de Edimburgo no dia 23 de Fevereiro de 1877 como paciente de Joseph Lister. Lister operou o seu ombro tuberculoso e ela permaneceu

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[19] I thank Gustavo Furtado for supplying this translation.

na enfermaria ou na sua casa em convalescença durante oito meses. Depois do regresso às Shetland, escreveu a história da sua experiência que circulou em cópias manuscritas entre os seus amigos. Acredita-se que histórias desse tipo, narradas pelos próprios pacientes durante o século XIX, sejam raras, e a narrativa de Mathewson é, portanto, valiosa. Além disso, uma leitura cuidadosa da sua narrativa oferece não só uma visão sem precedentes do mundo social dessa instituição médica, mas também contradiz as "ortodoxias historiográficas" em que tais pacientes eram corpos dóceis, passivos, nos quais os médicos experimentavam livremente, sem que o consentimento do paciente fosse necessário. A história de Mathewson documenta a sua resposta a vários níveis da hierarquia médica e também a sua interacção com outros pacientes, fazendo do seu "Sketch" um contributo singular para a história social da medicina "vista a partir de baixo". Descobertas recentes de versões anteriores da sua narrativa, assim como de um conjunto de cartas destinadas a e recebidas pela sua família, permitem-nos aprofundar ainda mais a leitura desse documento como história cultural, revelando como uma paciente vitoriana de classe trabalhadora tornou significativa a sua complexa experiência no hospital através da escrita e da re-escrita da sua história.

Palavras-Chave

Margaret Mathewson; Joseph Lister; hospitais; pacientes; tuberculose

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Wounded Healers and Sick Societies: Two Recurrent Themes in the Representation of Doctors and Medical Care in Film and Television Dramas

Michael J. Clark
Centre for the Humanities and Health, King's College London

Wounded Healers and Sick Societies: Two Recurrent Themes in the Representation of Doctors and Medical Care in Film and Television Dramas

Introduction

In literature and story-telling of all kinds, including stories narrated through film and television, one of the oldest and most persistent themes associated with the art and science of medicine has been the idea of the doctor as wounded healer, symbolised in Greek mythology by the wounded centaur Chiron (or Cheiron), the *protégé* of Apollo and tutor of Asklepios, the god of medicine and healing. In this oft-recurring storyline, doctors are represented as gifted and characteristically driven individuals who suffer from some (often hidden) physical or psychological "wound" or defect which compels them to pursue the knowledge of healing as a means to cure their own illness while treating those of others. In many modern versions of this quasi-mythological narrative, both in literature and in fiction films, the doctor's own self-healing is represented either as a necessary condition for the attainment of his or her full potential as a healer, or as part of a broader process of "healing" of the modern health care system, or even of the ills of contemporary society—sometimes, as all three together. This idea of the wounded healer is important for understanding medical fiction films and other screen-based dramas from the early 1930s to the present, but I think it is also particularly significant for teachers and scholars in the Medical Humanities, because I believe that this idea also plays a key role, albeit a largely implicit one, in contemporary debates over the role of the humanities in medical education and professional development. In this paper, I shall seek firstly, to understand the ubiquity and importance of narratives of self-healing and medical and social renewal in fiction films and television dramas about doctors and medicine, by examining some of the key constitutive elements of the myth of the wounded healer, both in its ancient and modern versions; and secondly, to explore further the

relationship between the doctor's own quest for self-healing and the "healing" of medical and social ills, as portrayed in a wide range of medical fiction films from both English and non-English-language cinemas. In the process, I also hope to shed some light on the implicit role of the idea of the wounded healer in contemporary debates about the purpose of the medical humanities in medical education and professional development, and to show how "woundedness" has become not just a problem for individual doctors but a major concern for modern medicine as a whole.[1]

The Greek Myths of Chiron and Asklepios

As already indicated, the origins of the idea of the wounded healer are to be found in the classical Greek myth of Chiron, the wounded centaur, son of the Titan Cronos and Philyra, daughter of Oceanos. Chiron (or Cheiron), who lived in a cave on the slopes of Mount Pelion in Thessaly, was known as "the wisest of the centaurs," for unlike his rough, ignorant and riotous fellow creatures, he was dignified in bearing and serious in manner, gentle and kind, immensely learned, and dedicated to improving the lot of mankind through the teaching and practice of medicine, as well as music and poetry. Chiron was friend to Heracles and was entrusted by Apollo with the education and upbringing of many Greek heroes, including Actaeon, Jason and Achilles, and of Apollo's own son Asklepios (or Asclepius), to whom Chiron taught the art of medicine. However, while attempting to pacify his fellow centaurs in a quarrel with Herakles, Chiron was accidentally wounded in the thigh by a poisoned arrow fired by his friend, and as a result suffered agonising pains from which, however, as the child of an immortal, he could not be released by death. Thereafter, Chiron devoted himself to the teaching and practice of medicine in the vain hope of finding a cure for his agonising wound, before being allowed to take the place of the Titan Prometheus in Hades and eventually being

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[1] Earlier versions of this paper were given in seminar presentations to the Centre for the Humanities and Health, King's College London, in March 2013 and as part of the Associates of King's College (AKC) lecture series on the Medical Humanities in November 2014. I am grateful to Brian Glasser, Professor Brian Hurwitz and all others who offered constructive criticisms and feedback on these occasions.

set in the stars by Zeus as the constellation Centaurus.

Chiron was honoured as a friend to mankind and as patron of the art and science of medicine, which he duly transmitted to his pupil Asklepios, the Greek and Roman god of medicine and healing, who was himself "wounded" by virtue of being snatched from his dead mother Coronis's womb as she lay on her funeral pyre, and by having been raised a second time from the dead after being struck down by a thunderbolt from Zeus in punishment for his temerity in raising certain of his patients from the dead. The idea of wounding and "woundedness" was thus intimately bound up with the practice of medicine and healing in Antiquity, and the figure of Chiron, the semi-divine healer who seeks to discover an effective treatment for his own wound while bringing the benefits of medicine to all, became an essential part of the founding myth of Western medicine.[2] In classical times and again following the Renaissance, Chiron's life and work as teacher and healer became a favourite subject for artists and writers, and it should come as no surprise that, shorn of its mythological trappings, the myth of the wounded healer also figures very prominently in modern fiction film and television dramas about doctors, medicine and healing.

The Wounded Healer Motif in the Judaeo-Christian and Non-European Cultural Traditions

Although Chiron is probably the best-known and most immediately recognisable example of the "wounded healer" figure in Western culture, a similar idea is also to be found in the Judaeo-Christian tradition. Christ

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[2] For the Greek myth of Chiron, and its relations to the myths surrounding the figure of Asklepios, see especially Robert Graves, *The Greek Myths* (London; Penguin Books, 1960), Vol. 1, Ch. 21, para. n, on p. 79; Ch. 50, "Asclepius," on pp. 173-178; Ch. 101, k, on p. 358; Vol. 2, Ch. 126, para. g, on p. 114; Ch. 133, l, on p. 149; Ch. 148, b, on p. 215; Ch. 151, g, on p. 234; John A. Sanford, *Healing and Wholeness* (New York & Toronto; Paulist Press, 1977), pp. 42-49; Edward F. Erdinger, *The Eternal Drama: The Inner Meaning of Greek Mythology* (Boston & London; Shambhala, 1994), p. 135 ("Cheiron…stands for the wounded healer"); Arthur Cotterell & Rachel Storm, *The Ultimate Encyclopedia of Mythology* (London; Hermes House, 1999), "Chiron," on p. 31; and Jenny Pearson, Mary Smail & Pat Watts, *Dramatherapy with Myth and Fairytale* (London; Jessica Kingsley, 2013), "Chiron the Wounded Healer," pp. 102-103.

himself has been described as "the wounded healer par excellence,"[3] while in the pastoral theology of the charismatic Dutch Catholic priest Henri Nouwen (1932-1996), the wounded healer is re-imagined as a model for the Roman Catholic priesthood.[4] Similar figures may also be found in some non-European cultural traditions and mythologies, as for example the Chinese Daoist "Immortal" Iron-Crutch Li (*Li Tieguai*), a disciple of Lao-Tsu, patron of medicine and pharmacy and healer of the sick poor, who has a permanent limp, walks with the aid of an iron crutch, and is noted for his ugliness, rudeness and unkempt appearance, as well as his skill and dedication in medicine and healing.[5] Moreover, as many studies in cultural anthropology have attested, shamanism of various kinds is still very widespread in many parts of the world, notably Siberia and East Asia, the Americas and many parts of Africa, and in almost all traditional societies where shamans play an important role, their "calling" as seers and therapists is closely associated with life-changing episodes of serious illness and apparent descents into altered states of consciousness or even comas, before emerging as permanently changed persons with special healing and prophetic powers. Shamanism is a very important model for New Age healers, while Jungian analysts in particular have also drawn many parallels between shamanic healing and psychotherapy.[6] However, in this context I shall confine myself largely, though not entirely, to examples drawn from

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[3] By the American Jungian psychotherapist David Sedgwick, in his *Introduction to Jungian Psychotherapy: The Therapeutic Relationship* (Hove, E. Sussex; Brunner-Routledge, 2001), p. 74. In the *Gospel According to St. Luke*, Ch. 4, v. 23, Christ is said to have quoted the Greek and Latin proverb "Physician, heal thyself," apparently with ironic reference to himself.

[4] For the wounded healer idea in modern Christian pastoral theology, see especially Henri J.M. Nouwen, *The Wounded Healer: Ministry in Contemporary Society* (New York; Doubleday, 1979).

[5] See the article on "Iron-Crutch Li" in Wikipedia [see "Internet Sources," below]. I owe this reference to Drs. Vivienne Lo and Michael Stanley-Baker (University College London).

[6] For the analogy between shamanic healing and psychotherapy from a Jungian perspective, see especially Stanford, *Healing and Wholeness* (1977): 63-85, 93, and David Sedgwick, *Introduction to Jungian Psychotherapy* (2001): 71-73.

"Western" (European and North American) cinemas and television, and to representatives of "regular" medicine rather than folk-healing or complementary medicine.

Other Wounded Health Care Professionals, Artists and "Creatives"

Although the wounded healer myth is most commonly associated with medical doctors, they are not the only health care professionals whose efficacy is seen as in some way bound up with their own personal experience of "woundedness." There are many wounded nurses in both cinema and television—think, for example, of the French-Canadian Nurse Hanna, played by Juliette Binoche, in Anthony Minghella's film of Michael Ondaatje's novel *The English Patient* (1996), who has lost both her fiancé and her best girl-friend in the Second World War; of the French Nurse Anaïs, played by Sabine Azéma, in François Dupeyron's film *La Chambre des officiers* (*The Officer's Ward*) (2001), who has lost her only son missing, presumed dead, in action in the First World War, or indeed of Nurse Briony Tallis in Joe Wright's film of Ian McEwan's novel *Atonement* (2007), forever trying to atone for her catastrophic childhood misunderstanding of adult behaviour through service to others and eventually through public confession on live TV. There are also wounded paramedics, such as the burnt-out Manhattan paramedic Frank Pierce, played by Nicholas Cage, in Martin Scorsese's film of Joe Connelly's novel *Bringing Out the Dead* (1999), and wounded psychotherapists and counsellors, like the character of Sean Maguire, played by the late Robin Williams, in Gus Van Sant's *Good Will Hunting* (1997); wounded priests, poets, playwrights, singer-songwriters, artists and actors, like the Peking opera star Cheng Dieyi, in Chen Kaige's *Farewell My Concubine* (1993); wounded film-makers (like Chen Kaige himself), wounded journalists and news photographers, wounded judges, like Judge Joseph Kern (played by Jean-Louis Trintignant) in Krzysztof Kieslowski's *Three Colours Red* (1994), and, not least, wounded detectives, like the popular British television characters Inspectors Morse, Lewis, and Frost and, from a former American television era, Chicago Police Superintendent Robert T. Ironside. The motif of the wounded healer also figures in some documentary films about doctors,

medicine and surgery, such as Geoffrey Smith's BBC-Television documentary *The English Surgeon* (2007), in which the English neurosurgeon Henry Marsh and his Ukrainian colleague Igor Kurelits journey to a remote village in Western Ukraine to meet the family of Tanya, a young peasant girl who died aged only fifteen after a series of unsuccessful neurosurgical operations for a brain tumour carried out in London, and who for the two neurosurgeons has come to symbolise the limits of their power to heal and save. In the 1995 Swiss film documentary *Kräuter und Kräfte* (literally, *Herbs and Healing Powers*, more usually rendered as *The Power of Healing*), the narrator-director Jürg Neuenschwander returns to his home in the Emmental district of Switzerland after travelling around the world in order to explore his own personal and psychological problems while simultaneously investigating various "alternative" healing practices in the city and canton of Bern. In art, literature and cinema, as in illness and healing, "woundedness" is apparently a key to unlocking many of the most important aspects of the creative and therapeutic processes. But while this recurring theme of doctors, writers, artists and film-makers exploring and seeking to come to terms with their own "woundedness" and simultaneously exploring alternative paths to healing and "wholeness" is clearly very important and highly suggestive, I shall not pursue it any further in this context.

The "Wounded Healer" Figure in Jungian Analytical Psychology

The idea of the wounded healer does not, then, belong exclusively to any one cultural tradition or medical specialty, but in the modern period it has become particularly closely associated with the Swiss psychiatrist and psychotherapist Carl Gustav Jung (1875-1961) and with Jungian analytical psychology, to such an extent that some writers have referred to the wounded healer almost as if Jung had actually invented, or at least rediscovered, the idea.[7] With his deep-seated problems with paternal and

[7] See, for example, the Wikipedia article "Wounded Healer," the first sentence of which states that "Wounded Healer is a term created by psychologist Carl Jung": http://en.wikipedia.org/wiki/Wounded_healer.

intellectual authority figures, his tendency to have affairs with former patients and/or students, such as Sabina Spielrein and Toni Wolff, and his acknowledged descent into psychosis in 1913-15, Jung himself has often been regarded as an exemplar of the wounded healer, most obviously perhaps in Claire Dunne's illustrated biography, entitled *Carl Jung: Wounded Healer of the Soul* (2000).[8] Jung certainly took a keen interest in the figure of the wounded healer, and in the development of his ideas about the crucial importance of the counter-transference for the success of the psycho-therapeutic relationship, Jung interpreted the Greek myth of the "wounded physician" as a metaphor for the process whereby the "wounds" present in the unconscious of both therapist and patient are exposed to and interact with each other and are thereby "re-wounded" in the course of analysis, but with potentially healing and even personally transformative results. In his essay "Fundamental Questions of Psychotherapy" (*Grundfragen der Psychotherapie*, 1951), Jung wrote that:

> Any complicated treatment is an individual, *dialectical* process, in which the doctor, as a person, participates just as much as the patient… Difficult cases… are a veritable ordeal for both patient and doctor… A good half of every [psychotherapeutic] treatment that probes at all deeply consists in the doctor examining himself (*sic*), for only what he can put right in himself can he hope to put right in the patient. It is no loss, either, if he feels that the patient is hitting him, or even scoring off him; it is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician.[9]

In his *Introduction to Jungian Psychotherapy* (2001), the American Jungian analyst David Sedgwick has described the Greek myth of the wounded

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[8] Claire Dunne, *Carl Jung: Wounded Healer of the Soul – An Illustrated Portrait* (New York; Parabola Books, 2000).

[9] Carl Gustav Jung, trans. R.F.C. Hull, "Fundamental Questions of Psychotherapy" (*Grundfrage der Psychotherapie*), in Jung, *The Practice of Psychotherapy* (Vol. 16 of *Collected Works of C.G. Jung*) (2nd. edn.) (London: Routledge, 1966): 111-125, Para. 239 on p. 116. Italics in original.

healer as "…the central myth or story of the Jungian psychotherapeutic relationship," and has indeed claimed that "The wounded healer is not just a story… but a hypothesised archetype that underlies and gives shape to Jungian psychotherapy."[10] Elsewhere, Sedgwick explains in more detail that:

> In a psychological sense the [therapist] has an open wound. He[/she] is already wounded in life, or by life, and… he[/she] frequently gets in some way rewounded by the patient… a therapeutic relationship involves [the therapist] living through and picking apart the patient's transferred illness. By understanding him[/her-]self, by working on "his own hurt" that is generated by the patient,… healing is effected in the patient. Whether it be his [or her] initial wounds or simply the patient's rewounding of him[/her], the therapist's hurt and the patient's are fused, so to speak, in the unconscious or in a therapeutic space created between them where the[ir] emotional problems crystallize.[11]

It might seem unlikely that such a process could convincingly be represented on screen, but long before the release of David Cronenberg's film *A Dangerous Method* in 2011, we find a very clear instance of this idea in action in a scene from *Good Will Hunting* (1997), in which the eponymous Will Hunting, played by Matt Damon, a brilliant self-taught mathematician and juvenile delinquent who has been forced to attend counselling sessions as a condition of parole after being convicted for assault, very cleverly figures out and promptly "hits on" the hidden psychological "wound" of his therapist Sean Maguire, played by Robin Williams, during their first session, with dramatic results as Maguire only just refrains from throttling his client.

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[10] Sedgwick, *Introduction to Jungian Psychotherapy* (2001), p. 73. See also Sedgwick, *The Wounded Healer: Counter-Transference from a Jungian Perspective* (Hove, E. Sussex & New York; Routledge, 1994). On the "wounded healer" as an archetypal figure, see C.J. Groesbeck, "The Archetypal Image of the Wounded Healer," *Jl. Analytical Psychology* 20 (1975): 122-145.

[11] Sedgwick, *Introduction to Jungian Psychotherapy* (2001): 81-82.

The precise status of the wounded healer idea in Jungian analytical psychology is not entirely clear. As we have already seen, Sedgwick regards the wounded healer myth as "…not just a story… but a hypothesised archetype that underlies and gives shape to Jungian psycho-therapy." There can be little doubt that the idea of the wounded healer does play a central role in Jungian ideas about the therapeutic relationship, but I cannot find any clear statement in Jung's published works to the effect that he actually regarded the wounded healer as an *archetype* of the collective unconscious —at any rate, I can find no mention of the wounded healer as such in either the Contents or the Index to "The Archetypes and the Collective Unconscious" in Vol. 9, Pt. 1 of Jung's *Collected Works*. My own preference is for the more nuanced view taken by Andrew Samuels and his co-authors of the *Critical Dictionary of Jungian Analysis* (1986), namely, that "The wounded healer motif is a symbolic IMAGE of something archetypal,"[12] a position which clearly affords considerable scope for analysing screen-based dramas with prominent medical themes and content, although not so far one which has been applied to any significant extent in the rather select body of published Jungian and post-Jungian studies of film and television.[13] The Jungian concept of the analyst as wounded healer is not an easy one to grasp, but I have dwelt on Jungian interpretations at some length here because I believe that they do have special interest and value for the Medical Humanities generally, and for the analysis of fiction films and television dramas with strongly developed medical storylines, content and characters in particular. I shall return to this theme later.

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[12] Andrew Samuels, Bani Shorter, & Fred Plaut, *A Critical Dictionary of Jungian Analysis* (London; Routledge & Kegan Paul, 1986): 65. Capitals in original.

[13] For some recent Jungian and post-Jungian perspectives on film and television dramas, see Christopher Hauke & Ian Alister, eds., *Jung and Film: Post-Jungian Takes on the Moving Image* (Hove, E. Sussex: Brunner-Routledge/Philadelphia, PA: Taylor & Francis, 2001); Luke Hockley, ed., *Cinematic Projections: The Analytical Psychology of C.G. Jung and Film Theory* (Luton: University of Luton Press, 2001); and Christopher Hauke & Luke Hockley, eds., *Jung and Film II: The Return: Further Post-Jungian Takes on the Moving Image* (Hove, E. Sussex & New York: Routledge, 2011).

Varieties of Woundedness in Medical Fiction Films from the 1930s to the Present

As will be apparent by now, the figure of the wounded healer is ubiquitous in fiction films and television dramas with strongly defined medical themes, settings and characters from the early 1930s down to the present. However, it is actually quite difficult to identify many clear, brief examples from fiction film and television dramas of what might be termed "primary" instances of doctors or other health care professionals being "wounded." Usually, this is an ongoing and cumulative process, which only becomes apparent by watching an entire film, or else takes place off-screen and in the past, and is only indirectly referred to rather than directly represented, as in the case of the estrangement betweend New York psychiatrist Dr. Mark Powell, played by Jeff Bridges, and his adult son Michael, in Iain Softley's film *K-Pax* (2001). However, there are many passages which show doctors and other health care professionals living with their wounds on a day-to-day basis, or show how, in the course of medical or psychotherapeutic treatment, a doctor, or therapist, and a patient, or client, may uncover each other's wounds and "re-wound" each other, usually figuratively but sometimes literally. Thus Martin Scorsese's film *Bringing Out the Dead* (1999) contains several haunting scenes in which Nicholas Cage's burnt-out paramedic Frank Pierce encounters the "ghosts" of patients whom he failed to save as he makes his nocturnal rounds through New York's mean streets. In a very different context of practice, in Nanni Moretti's film *The Son's Room* (2001), psychotherapist Giovanni Sermonti, played by Moretti himself, is forced to terminate his clients' therapies following his teenage son Andrea's death in a scuba diving accident, either because his clients inadvertently play on his own feelings of guilt for not having been present at the time of his son's fatal accident, or else because in the depths of his grief he cannot cope with their callous self-complacency. These examples of "re-wounding" are drawn mainly from psychotherapeutic contexts, but in Akira Kurosawa's *Drunken Angel* (1948), this confrontation literally takes the form of a desperate struggle between doctor and patient over a physical rather than a psychological illness, in the scene where the hot-tempered and alcoholic Dr. Sanada, played by Takashi Shimura, and the arrogant young gangster Matsunaga, played by Toshiro Mifune, fight

in the doctor's surgery over Matsunaga's refusal either to accept Sanada's diagnosis of tuberculosis or to undergo treatment for his illness.

In "Western" medical movies and literary fictions from an earlier era which are basically wounded healer narratives, such as *Arrowsmith* (1931) and *The Citadel* (1938), doctors are shown as "wounded" psychologically in their practice by the cumulative effects of bad health conditions, their patients' general ignorance or neglect of basic hygiene and health protection measures, medical malpractice, and the selfishness and complacency of their medical colleagues in the face of overwhelming levels of preventable sickness and death, and this is also partly the case in Kurosawa's *Drunken Angel* (1948). Such narratives naturally tend to assume a more or less tragic character, but in other, less highly charged contexts, the results of a doctor's wounding may be more comic than serious. Thus in the recent Thai movie *Syndromes and a Century* (2006), a young woman doctor completely loses control of a medical consultation with an elderly Buddhist monk complaining of joint pains because she allows herself to become distracted by some unfinished financial business involving a third party, and ends up being prescribed to by the monk for what he imagines to be her own physical and psychological problems. In the Indian medical gangster comedy *Munna Bhai M.B.B.S.* (2003), the very neurotic Dr. J.C. Asthana, Dean of the Grant Medical College in Mumbhai, is constantly being driven to the verge of a nervous breakdown by Munna, an amiable gangster-turned-medical-student, whom he simultaneously envies for his easy, natural manner and instinctive emotional intelligence and despises for his vulgarity, ignorance and criminal life-style. In some classic wounded healer narratives such as *Arrowsmith* and *The Citadel* which resemble the *bildungsroman* of German Romantic literature,[14] a doctor's "wounding" and "woundedness" only take on their full significance in a life-historical perspective which is itself usually set in the context of a more or less complex portrayal of contemporary social as well as medical ills. But where woundedness is reduced to an idiosyncrasy or mere quirk of personality

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[14] *Bildungsroman*, a German literary term which came into use in the early twentieth century, is defined as "a novel about the moral and psychological growth of the main character" (Merriam-Webster's Dictionary).

and bears no very complex relation either to the formation of a doctor's character or to the social and professional circumstances which have shaped his or her development as a physician and healer, it can be simply a comic diversion rather than a key to understanding the relationship between historical medical and social conditions and individual character and destiny.

Stating the Obvious? Some Apparent Weaknesses of the "Wounded Healer" Idea

Despite the frequency with which wounded healer figures and narratives appear in modern film and television dramas and even documentaries, there is a sense in which all this may seem rather trite, even trivial. There can be very few people, including doctors and other healers, who have led such sheltered lives, or been so fortunate, as never to have suffered some more or less significant accident or psychological trauma. Even in the most affluent and highly "developed" societies, "wounding" of some sort, whether physical, psychological, or both, is an almost inescapable aspect of the human condition, and it would be more surprising if doctors and other health professionals had *not* experienced some significant adverse event in their lives which might qualify as a predisposing "wound" than if they had. Indeed, there is some empirical research which suggests that even in the U.K., between two-thirds and three-quarters of practising psychotherapists have experienced some kind of significant adverse or traumatic life-event which they report as having influenced them in their choice of profession.[15] Moreover, there are many entire societies—Russia,

[15] By the Scottish counsellor and psychotherapist Alison Barr. See her paper "An investigation into the extent to which psychological wounds inspire counsellors and psychotherapists to become wounded healers, the significance of these wounds on their career choice, the causes of these wounds and the overall significance of demographic factors," in COSCA [Counselling and Psychotherapy in Scotland], 3rd. Annual Counselling Research Dialogue (Stirling, 9th. Nov. 2006), Portfolio of Abstracts, p. 3, which gives a fairly detailed summary of her findings. There is a full text version of this research, which was carried out for her M.Sc.in Counselling Studies at the University of Strathclyde (2006), at http://www.issuu.com/imran_manzoor/docs/wounded-healer_research_alison_barr_part_1_of_2 and part_2_of_2.

Germany, China, Argentina, Israel, Palestine, Syria, Iraq, Afghanistan, Vietnam and Cambodia, South Africa, Rwanda and nearly all the former Yugoslav republics come readily to mind—which could be regarded as more or less seriously "wounded" by their recent histories, while many others, such as the U.S., India or Sri Lanka, contain significant minority groups which might similarly be regarded as having been collectively "wounded" by their historical experiences. The condition or state of being "wounded" is ubiquitous in post-modern, as indeed in modern and pre-modern societies, and, like all very widely distributed attributes, can be, and often is, made to explain almost anything.

The notion of "woundedness" itself is very vague and ill-defined. Although there is quite an extensive literature on the psychodynamics of *wounding*, especially in the context of Jungian analytical psychology,[16] there has been very little attempt to define what counts as a "wound" for this purpose or to classify different types of "wounds," whether physical or psychological, individual or collective, involuntary or self-inflicted, etc., and to differentiate between them in terms of their severity, extent, lasting impact, etc. Almost any kind of experience can be, and usually has been, counted as a "wound" somewhere in the literature, from childhood sexual abuse to professional self-doubt, and no doubt others are being added to the list even at this moment. Again, many of those familiarly described as "wounded" healers—Carl Jung, for example—might equally well be described as *flawed* healers, a term which carries a very different connotation and implies a much lower level of esteem. But it may be argued that all this is beside the point. The question, surely, is not so much whether people have been "wounded" or not, or even in what way, but rather, *how* they reacted to the experience, and what influence it had in shaping the subsequent direction of their lives. We are not so much concerned here with *actual experiences* or statistical relationships, as with *images*, *perceptions* and *persistently recurring narratives* which cinema and television audiences and, indeed, whole societies have apparently found helpful and meaningful in trying to make sense of their individual and collective experiences of illness, healing and the doctor-patient relationship, and which cannot

[16] See especially the works of Jung and Sedgwick cited above.

therefore simply be dismissed as trite or trivial. The fact that the idea and image of the wounded healer have been with us for so long and are so widely disseminated is itself testimony to their enduring fascination and appeal for both doctors and lay people, while their continued popularity with story-tellers and image-makers in contemporary society makes them an obvious subject for analysis and cultural commentary.

House, M.D. – The Wounded Healer on Television?

And so at length we come to *House, M.D.*, one of the best-known and most successful of all TV medical or hospital drama series. First broadcast in the U.S. by Rupert Murdoch's Fox TV network in November 2004 and continuing through seven more seasons and 177 episodes before finally ending in May 2012, *House* has inspired a whole raft of academic commentary on its philosophical, medical-ethical and cultural ramifications, and almost single-handedly revived academic discussion of the wounded healer figure as a hot topic in film and cultural studies as well as the medical humanities.[17] As the title of one such edited collection, *House: The Wounded Healer on Television* (2011) clearly implies, the main character, Dr. Gregory House, Head of "Diagnostic Medicine" at the (fictional) Princeton-Plainsboro Teaching Hospital in New Jersey, played by the British actor Hugh Laurie, has more apparent attributes of a wounded healer figure than you can shake a stick at.[18] He walks with a pronounced limp, with the aid of a cane or walking stick, and is addicted to Vicodin, a powerful painkiller, following a botched operation for an infarct in the blood vessels of his right quadriceps thigh muscle—surely a knowing reference to the centaur Chiron's wound. He has a history of childhood

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[17] See Andrew Holtz, *The Medical Science of House, M.D.* (Berkley, CA; Berkley Boulevard Press, 2006); Henry Jacoby, *House and Philosophy: Everybody Lies* (Chichester, W. Sussex & New York; John Wiley & Sons, 2008); and Luke Hockley & Leslie Gardner, eds. *House: The Wounded Healer on Television: Jungian and Post-Jungian Reflections* (London & New York; Routledge, 2011).

[18] For House's apparent attributes of a wounded healer, see especially the essays by Luke Hockley, Angela Cotter and Leslie Gardner in Hockley and Gardner, eds., *House – The Wounded Healer on Television* (2011), Chs.1, 6, 9.

physical and mental cruelty and possibly sexual abuse, and what might charitably be termed a borderline personality. Although he heads up a team of brilliant diagnosticians, physicians and surgeons, he is very much a maverick outsider, who consistently disregards not only hospital regulations and procedures and the explicit instructions of his clinical boss, Dr. Lisa Cuddy, but also the ethical rules of his profession, social and cultural norms of political correctness and common politeness, medical collegiality and etiquette, simple good manners and even, at times, the formal prohibitions of the criminal law. At least until Season 6 of the series, in which Drs. House and Cuddy most improbably try to form a couple, House lives alone, has really only one (male) friend, his colleague Dr. Wilson, no visible family or long-term relationship, seldom changes his clothes, shaves or combs his hair, diets on junk foods, caffeine and alcohol, and has few interests outside medicine other than rock music, reality TV, motor cycles and video games. He subjects both his colleagues and his patients to various forms of verbal and emotional aggression, even humiliation, and prefers as far as possible to avoid any direct contact with patients. He is also a brilliant doctor, who can solve obscure medical problems which no-one else has been able to unravel, and is a medical, or rather disease, detective *par excellence*—not for nothing is his room number 221B.

However, the many apparent tick-box correspondences between House and the image of the "wounded healer" are rather deceptive. There are many respects in which House diverges from, and even contradicts, the classic wounded healer profile, and several Jungian commentators on the series have preferred to see him as a trickster or a narcissistic *puer* (an arrested adolescent) rather than as a wounded healer.[19] Firstly, his interest is in *diseases,* rather than patients, and although he is not devoid of humanity, especially towards babies, young children and (other) obviously damaged adults, he prefers not to have to see or engage with patients any more than is absolutely necessary. Secondly, House certainly does not believe in the therapeutic value of empathy—he believes in hard science

[19] See, for example, the essays by John Izod and Sally Porterfield in Hockley & Gardner, eds., *House – The Wounded Healer on Television* (2011), Chs. 2 & 7 [See Note 8, above, and bibliography for full reference].

and the power of his own intellect and intuition to solve the mysteries of disease, not in a touchy-feely, person-centred approach to bedside medicine. He *is* interested in what might be termed "narrative medicine," but only as a means to elicit clues to help him solve the mysteries of disease presentation, not as a path towards greater understanding of the patient's reaction to illness. Thirdly, although his own multiple physical and psychological wounds and defects do give him certain insights into the complex workings of disease, he does not seek to find a cure for his own wounds in the course of healing those of others. On the contrary, he believes that his woundedness is inseparably connected with his unusual intellectual abilities and diagnostic powers, and that if he were to find a "cure" for his own physical disability and chronic pain, he would in all probability lose his intellectual cutting edge—hence his repeated insistence, when challenged about his apparent addiction to painkillers, that he has a "pain problem" and not a "pain management" problem. For House, woundedness is the price he has to pay for success in his profession, and he steadfastly resists all attempts by his colleagues to persuade him that his pain is largely psychogenic rather than physical in origin or to wean him off his self-destructive habits and refusal to contemplate positive change or personal growth.

All this apparent perversity and bloody-mindedness on House's part certainly make for entertaining television, and do effectively challenge received liberal opinions about what qualities a good doctor should have. But despite frequent reference to the negative impact of HMOs (Health Maintenance Organisations) on both patients and doctors, there is no really serious critique in *House* of either the medical profession or the U.S. health care system, and certainly no question of "wounded healing" potentially contributing towards "healing" the wider ills of society. Rather, House's "healing" takes place *in spite of* its apparent failure to connect with, much less resolve, any of the ills of medicine or of the wider society which are occasionally referred to in passing. Indeed, we might say that "wounded healing" really only takes on significant social implications in cinematic contexts where medicine is seen either as a key strategic battle-ground for social progress, as it was in the 1930s and '40s in films like *Arrowsmith* and *The Citadel*, or where the doctor-patient relationship is seen as a model for, or moral lesson in, humanistic social intervention, as in the "medical

movies" of the great Japanese director Akira Kurosawa, notably *Drunken Angel* (1948) and *Red Beard* (1965). Where this is not the case, or has long ceased to be so, then even self-healing does not necessarily have any wider social implications, as (for example) in *Good Will Hunting* or *Bringing Out the Dead*.

Some Implications of Wounded Healer Narratives in Film and Television Drama

What, then, are we to make of all this? First of all, "Wounds do not a healer make"—that is, "woundedness" is neither a necessary nor, obviously, a sufficient condition for effective healing. Wounds may simply incapacitate the doctor or therapist, as in Nani Moretti's *The Son's Room* (2001), or in the case of Dr. Allison Cameron's conspicuous inability to break bad news to the parents of sick children, in *House*, *M.D.*, Season 1, Episode 3. Alternatively, the content and context of the doctor-patient relationship may make full healing impossible, as in the Scottish director Gillies MacKinnon's film of Pat Barker's novel *Regeneration* (1997), which focusses on the battle of wills played out between Dr. W.H.R. Rivers, played by Jonathan Pryce, and his disillusioned and embittered officer-patients at Craiglockhart military psychiatric hospital in 1917-18, or, from a much earlier cinematic era, Joseph L. Mankiewicz's *No Way Out* (1950), in which Sidney Poitier plays a young black hospital doctor in the American deep South who has to treat two injured white racist criminals who then accuse him of malpractice. Moreover, as David Cronenberg's account of the relationship between Carl Jung and Sabina Spielrein in *A Dangerous Method* (2011) would suggest, wounded story-telling *à deux* can have as much potential for mutually assured destruction as for constructive healing and personal growth.[20] Clearly, some "wounds" are more helpful than others in this regard, and context and timing count for at least as much,

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[20] This interpretation would seem inherently plausible, at least in the general case. However, for a very different and rather less sensational view of the Carl Jung-Sabina Spielrein relationship, see John Launer, *Sex versus Survival: The Life and Ideas of Sabina Spielrien* (London & New York; Duckworth, 2014). I owe this reference to Prof. Brian Hurwitz (King's College London).

if not more, than "woundedness" *per se*. More importantly, perhaps, "wounded" doctors who do not or cannot acknowledge their own "woundedness" may not be capable of entering into a fully therapeutic relationship with at least some of their patients—see, for example, the case of surgeon Dr. Jack McGee, played by William Hurt, in Randa Haines' film *The Doctor* (1991), or the obstetrician Dr. Han, in the South Korean movie *Push! Push!* (1997). Conversely, an apparent absence of significant "woundedness" need not necessarily detract from a doctor's diagnostic and therapeutic competence, although obviously this is less likely to receive attention from film-makers since it has much less dramatic potential and interest for the lay audience.

One especially interesting type of "woundedness," which has particularly attracted the attention of screenwriters, directors and producers, is that which a doctor sustains in the exercise of his or her profession, rather than through some previous accident, injury or psychological trauma unrelated to his or her medical work. Thus, for example, the whole scenario of Akira Kurosawa's film *The Quiet Duel* (1949) stems from a young Japanese doctor's accidental self-infection with venereal disease while treating a soldier for syphilis during World War II. Typically, in many contemporary film and television dramas, "woundedness" is represented as a reaction to personal or professional problems arising in the course and context of everyday medical practice, such as the illness or death of a close friend or colleague, the failure of a major operation, or some serious error of medical or surgical judgment resulting in a disastrous outcome. However, as we have seen, in older medical dramas such as *Arrowsmith* and *The Citadel*, "woundedness" and self-healing often have a much more public, even political, dimension, and are frequently associated with (for example) doctors confronting major ethical dilemmas, trying to resolve conflicts between the demands of scientific method and humanitarian need, or attempting to expose some glaring defect in the organisation of health care or the self-interested complacency of the medical establishment.

In modern wounded healer narratives, this wider ethical and political dimension has very largely been lost, although it does occasionally surface in an attenuated form in the shape of attempts to reform medical institutional environments and practices, as in Penny Marshall's film of Oliver Sacks' memoir *Awakenings* (1990) or Iain Softley's *K-Pax* (2001), although

in the latter case it is actually the deeply traumatised mental patient and would-be extra-terrestrial Prot, played by Kevin Spacey, rather than his psychiatrist Dr. Mark Powell, played by Jeff Bridges, who brings about radical improvements in the quality of his fellow mental hospital patients' lives. However, amid the post-modernist collapse of the progressive ideologies which once enabled audiences to make sense of film narratives which associated the awakening of a doctor's social conscience with improvements in health care, progress in medical science and the renewal of his or her sense of vocation, the idea that the wounded healer's quest for self-healing can also help to "cure" the defects of the health care system and the ills of society, so strongly present in older medical classics like *The Citadel*, has all but disappeared.

Conclusion—Some Aspects of the Relation of the "Wounded Healer" Narrative to the Medical Humanities

How precisely does all this relate to the medical humanities? Firstly, as the Jungian writer Andrew Samuels and others have pointed out, the idea of the wounded healer is implicitly opposed to the all-too-common idea of the doctor, especially the psychiatrist, as all-knowing and all-powerful, and the patient as a mere passive recipient, rather than as an active participant and partner in therapy, especially psychotherapy.[21] In this view, which is closely tied in with the Jungian interpretation of the countertransference phenomenon in analysis, there is no clear-cut distinction between doctor, or therapist, and patient: both are wounded and both are potential healers, an idea which further resonates with the American medical sociologist and narratologist Arthur Frank's concept of the "wounded storyteller." Frank regards the wounded healer figure and what he calls the "wounded storyteller" (who may be a patient or a doctor) as two sides of the same coin or "different aspects of the same figure," an idea which is crucial for narrative medicine.[22] According to Frank,

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[21] See Andrew Samuels, Bani Shorter, & Fred Plaut, *A Critical Dictionary of Jungian Analysis* (London; Routledge & Kegan Paul, 1986), entry "Healing," pp. 64-65.

[22] Arthur W. Frank, *The Wounded Storyteller: Body, Illness and Ethics* (Chicago & London; University of Chicago Press, 1995), pp. xi-xii, 183. For narrative medicine

> As wounded, people may be cared for, but as story-tellers, they care for [each] other. The ill, and all those who suffer, can also be healers… Through their stories, the ill create empathic bonds between themselves and their listeners. Those who listen then tell others, and the circle of shared experience widens. Because stories can heal, the wounded healer and wounded storyteller are not separate, but are different aspects of the same figure.[23]

This process of healing through wounded story-telling might seem much better suited to literary than to cinematic treatment, but Iain Softley's film *K-Pax* (2001) does succeed rather well in conveying this idea through the medium of fiction film, albeit with a generous admixture of melodrama and psychic detective story. In the contemporary world, the most powerful and most readily accessible stories about health care and medicine for mass audiences are no longer those narrated through literary works and print-based media, but those told through the media of film, television and interactive media; and if we wish to understand the significance of stories of wounded healers and healing in today's world, we have to do so through the analysis and interpretation of medical movies and TV dramas as well as literary works. As Samuels *et al*. remind us, "the wounded healer motif is a symbolic IMAGE of something archetypal,"[24] and as such, we need to attend closely to images, both still and moving, as well as to narratives in words, in order fully to appreciate the role of the wounded healer in shaping (for example) patient expectations of medical care and the dynamics of the doctor-patient relationship, in cases of physical illness as well as psychological distress.

However, there is something more than this. The "wounded healer motif" is not only a very ancient symbol of something archetypal in the collective unconscious, to borrow Jungian language for a moment, but also

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generally, see especially the works by Charon, Frank and Kleinman cited in the Bibliography.

[23] Frank, *The Wounded Storyteller* (1995), p. xii [see Note 22, above, and Bibliography for full reference].

[24] Samuels et al, *Critical Dictionary* (1986), p. 65 [see Note 12, above, and Bibliography for full reference].

for some a persuasive metaphor for the ills of medicine today.[25] Whereas in movies like *Arrowsmith*, *The Citadel* and *Drunken Angel* from the 1930s and '40s, a doctor's "woundedness" and (unmet) need for self-healing was seen as a potential limitation or check on the capacity of "scientific" medicine to improve the physical condition of humankind, by the end of the twentieth century the domination of medical practice and health care by science and technology could be seen as almost as great a threat to the soul of medicine as greed, big pharma, health care bureaucracies or professional self-interest. Although the idea that the doctor's self-healing might be a step towards a broader process of "healing" of the modern health care system and even of the ills of society had all but disappeared, the "woundedness" which had formerly been seen as primarily affecting individual doctors was now seen as a chronic condition of Western medicine as a whole. Before the rise of biomedical science and technology had made the doctor-patient relationship so much more complex, distant and highly mediated, physicians' "wounds" had a specific, individual character and history. Whether physical or psychological in origin, for the most part they reflected the physician's own direct experience of medical practice, with all its dangers and hazards, and its permanent condition of anxiety, pain, often tragic outcomes and frequent professional disappointment. However,

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[25] What follows in the next two paragraphs is very largely my own interpretation, and cannot straightforwardly be attributed to any particular critic of modern medicine. However, some elements of this implied critique may be found in Dr. Richard Smith's television programme "Fashion Victims" (Part 3 of the series *The Dreaded Lurgi*, BBC-TV, first broadcast in October 1991) and James Le Fanu, *The Rise and Fall of Modern Medicine* (London; Abacus, 2000), although neither Smith nor Le Fanu explicitly refer either to the wounded healer myth or to the medical humanities as such. See also Angela Cotter's essay "Limping the way to wholeness: Wounded feeling and feeling wounded" in Hockley and Gardner, eds., *House: The Wounded Healer on Television* (2011), Ch. 6 (See Note 8, above, for full reference). Many elements of this interpretation are also to be found in the articles and blogs on the Web site of the south London G.P. and psychotherapist Dr. David Zigmond, http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.htm, although Zigmond prefers to speak of "Life Medicine" rather than "Medical Humanities." See, for example, David Zigmond, "Physician Heal Thyself: The Paradox of the Wounded Healer" (1984), http://www.marco-learningsystems.com/pages/david-zigmond/n30.7.14__physician-heal-thyself.pdf.

with the advent of "scientific" medicine, the substitution of a barrage of tests for classical diagnosis and the substantial delegation of therapeutics to nurses and medical auxiliaries, there is much greater scope for sensitive doctors to feel distant from their patients and alienated from the healing process, and thus to develop psychological "wounds" around their sense of vocation and their understanding of medicine as a form of organised benevolence.

For some observers, the study and practice of "Western" scientific medicine has itself come to be seen as a form of collective self-inflicted "wounding," one which needs to be "healed" by the more empathic, "holistic" and reflexive forms of practice associated with the medical humanities. In this view, the adoption of more humanistic approaches to understanding patients and their illnesses, and recognition of the limitations of scientific medicine in treating (for example) chronic disease, can improve the whole condition of medicine—or so it is hoped. But just as "woundedness" is, of itself, neither a necessary nor a sufficient condition for true healing to take place, so meeting the apparent "deficit" on the humanities side in medical education and professional development is, of itself, no guarantee of greater empathy or more effective communication skills with patients. As the centaur Chiron found through long years of intense suffering, there is no magic (self-) healing formula, whether for the doctor or therapist's own woundedness or for the defects of medicine as a whole. A better understanding of patients and their illnesses, and of the limits of scientific medicine and hi-tech diagnostic and therapeutic interventions, can only really be achieved by prolonged, hard experience and intense, sustained critical reflection on patient histories and practice and on the formation and professional development of the physician. While the "Medical Humanities" can have an important part to play in this process, they cannot provide a cure-all for the ills of modern medicine.

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Abstract

Ever since Classical times, the idea of the doctor as "wounded healer" has been a persistent theme in literature and story-telling of all kinds. Since the 1920s and '30s, this idea has also figured prominently in many fiction films and television dramas with medical themes, characters and story-lines. Following the pattern first traced in the Greek myth of Chiron the wounded centaur, healing has often been closely associated with some kind of "woundedness", whether physical or psychological, which compels the physician to pursue the knowledge of healing as a means to cure his or her own illness while treating those of others. This paper seeks to understand the ubiquity and importance of narratives of wounded self-healing and medical and social renewal by examining the working out of the "wounded healer" storyline in a wide range of film and television dramas with prominent medical themes, ranging from *Arrowsmith* (1931) and *The Citadel* (1938) to *Red Beard* (1965) and *House, M.D.* (2004-2012). It also seeks to highlight the implicit role of the idea of the wounded healer in some contemporary critiques of modern medicine and in debates surrounding the role of the humanities in medical education and professional development.

Keywords

Wounded healer; Chiron; Film & television; Medical humanities; *House, M.D.*

Resumo

Desde a época clássica que a ideia do médico como "curador ferido" se tornou num tema recorrente na literatura e em narrativas de toda a espécie. Desde os anos 20 e 30 do século XX que esta ideia também adquiriu relevo em muita ficção fílmica e em dramas televisivos que abordam temas, personagens ou enredos médicos. Seguindo o padrão primeiramente traçado pelo mito grego de Quiron, o centauro ferido, a cura tem sido frequentemente associada a algum tipo de ferimento, quer de natureza física quer psíquica, que obriga o médico a aprofundar a ciência da cura como meio de curar a sua própria doença ao mesmo tempo que

trata as dos outros. Este artigo procura entender a ubiquidade e a importância de narrativas de auto-cura por parte de seres feridos, bem como de renovação médica e social, examinando o modo como se desenrola o enredo de histórias de "curadores feridos" numa vasta gama de dramas televisivos e fílmicos com temas médicos, desde *Arrowsmith* (1931) e *The Citadel* (1938) até *Red Beard* (1965) e *House, M.D.* (2004-2012). Também procura enfatizar o papel implícito da ideia do "curador ferido" em algumas críticas contemporâneas à medicina moderna e em debates em torno do papel das humanidades na educação médica e no desenvolvimento profissional.

Palavras-chave

Curador ferido; Quiron; filme & televisão; Humanidades médicas; *House, M.D.*

Sir William Wilde, Ophthalmologist and Ethnographer

Maria Vaccarella
University of Bristol

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Sir William Wilde, Ophthalmologist and Ethnographer

In 1874, the satirical magazine *Ireland's Eye* published a caricature, entitled "A Wilde (K)night in Ireland's Eye," which was meant to parody Sir William Wilde's opening address "On the Ancient Races of Ireland" to the Anthropological Section of the British Association in Belfast earlier that year. The unmistakably Celtic setting of the caricature mirrors the topic of his lecture; nonetheless, neither the anachronistic juxtaposition of landscape and subject nor Sir William's ethnographic interests are the targets of the parody. The cartoon alludes to the scandal this prominent doctor was involved with ten years earlier, when his patient Mary Travers accused him of sexual assault (Powell and Peter 13-14). Hence, in the caricature, his surname becomes indicative of a predatory sexual nature, his knighthood provides the clue to wild nights of excesses and his medical specialization, far from being ophthalmology or otology, is the more prosaic "pat-ology." In this context, the underlying motto "To see is to believe" seems to cast doubts on the scholar's reputation once again and to invite readers to look closer into his dubious character.

Until very recently, this was the crystallized image of Sir William Wilde: an eminent doctor and Irish studies scholar, whose achievements in both fields were obfuscated by a sex scandal, which links back to his three illegitimate children and anticipates his youngest son Oscar's future scandalous life. T.G. Wilson's biography of Sir William starts with the emphatic declaration: "This is the story of a man who, like his son, had many faults. Like his son also his achievement was great—in fact, I am not sure that when the final judgement is made, he will not be pronounced the greater man of the two" (I). Rather than having his career overshadowed by his son's fame, this looks like a rare case of the supposed sins of the son visited upon the father. Further unbiased research needs to be done on Sir William Wilde the polymath and this article is a first speculative attempt

at reflecting, within a medical humanistic framework, on his extraordinary position as a leading eye and ear doctor with a genuine interest in Irish popular cures, and as the father of an iconic Anglo-Irish writer.

Born in County Roscommon in 1815, William Wilde, as a child, accompanied his father Thomas in his medical calls around the county and developed an interest in medicine and folklore. Later, as a medical student in the late 1830s, he travelled around the Mediterranean as personal doctor to a wealthy Scottish merchant, Mr Robert Meiklan: it appears that Wilde decided to specialize in ophthalmology, because he was struck by the number of Egyptians affected by trachoma, a potentially blinding infection of the eyelids which spreads to the cornea, usually found in conditions of poverty and scarce hygiene (*Ibid.* 47-50). Wilde also excelled in otology and gave his name to a type of incision, used for mastoiditis drainage. To list but a few of his many achievements, he founded the first eye and ear hospital in Dublin in 1844 and the following year became editor of the *Dublin Journal of Medical Science*. In 1854, he was appointed Census Commissioner to Ireland, a work rewarded with a knighthood ten years later. Nonetheless, in Richard Ellman's words, William Wilde also "trained his own eye on Irish archaeological remains, and his ear on folklore" (10). Throughout his life, he was a keen intellectual, who collected books and, together with his wife, the nationalist poet Speranza, turned their house into one of Dublin's leading cultural centres (Coakley 37-38).

Wilde's main interest was Irish pre-history: his researches spanned archaeology, topography and ethnography. There is great terminological confusion with regard to Wilde's work on the study of Ireland's earliest inhabitants and of the nineteenth-century Irish-speaking population: anthropology, ethnology and archaeology are indistinctly used and, of course, cannot be easily equated to the academic disciplines bearing the same names nowadays. To this group of activities we could add what Sean Ryder calls "romantic pseudo-science" (10) namely phrenology, as we know that in 1843 Wilde addressed the King's and Queen's Colleges of Physicians—the forerunner of the Royal College of Physicians of Ireland—in Sir Patrick Dun's Hospital with a lecture on various kinds of skulls he had found in prehistoric burial sites (Wilson 138). Wilde himself seemed to prefer ethnology, but his studies lack the distinctive comparative focus

of contemporary ethnology, which is why I prefer to describe his collection of enquiries as a single cultural formation, ethnography. Describing Wilde as an ethnographer also gives a better sense of his struggle to realign his perspective vis-à-vis his informants, rather than setting a critical distance between his privileged social position and the group he was investigating.

Decades before the Irish Literary Revival and the foundation of the Folklore of Ireland Society (An Cumann le Béaloideas Éireann) in 1927, Sir William was practising their credo, laying the foundations of future Irish folklore with its distinctive focus on the preservation of Irish oral narratives and language, in which he was fluent. As Anne Markey maintains, Wilde inaugurated "a new approach to Irish folklore emerged in the wake of the Great Famine during the late 1840s" (21-43). Up to that moment, the collection of Irish tales in English had been a mere attempt at replicating the success of the Brothers Grimm, epitomized by the publication of Thomas Crofton Croker's *Fairy Legends and Traditions of the South of Ireland* in 1825. In Markey's words, "the traditional tales in the first series of *Fairy Legends* are filtered through the literary lens of a group of educated Irishmen whose privileged social background set them apart from the group among whom these stories traditionally circulated in oral form" (26). Rather than celebrating Irish culture, Croker's work commodified its most palatable aspects in order to capitalize on a then current transnational literary trend, the all too common exploitation of protoanthropological studies in the context of colonisation: *Fairy Legends* showcased once again the supposed backwardness of the Irish peasantry and provided further discursive reinforcement of England's "civilizing mission."

Wilde's *Irish Popular Superstitions*, published in 1852, starts from very different premises. Its preface highlights, first of all, the role of Shakespeare in perpetuating English popular superstitions (for example, in *A Midsummer's Night Dream*) and then moves on to the Irish setting in a sympathetic and unbiased tone:

> A wild and daring spirit of adventure—a love of legendary romance—a deep-rooted belief in the supernatural—an unconquerable reverence for ancient customs, and an extensive superstitious creed has, from the earliest times, belonged to the Celtic race. We cannot, therefore, wonder that among

> the but partially civilized, because neglected and uneducated, yet withal chivalrous inhabitants of a large portion of Ireland, a belief in the marvellous should linger even to the present day. (V)

This compassionate account of the "partially civilized, because neglected and uneducated" Irish peasants is then complemented by a personal, heartfelt narrative of his own engagement with the Irish-speaking population:

> When I now enquire after the old farmer who conducted me, in former years, to the ruined Castle or Abbey, and told me the story of its early history and inhabitants, I hear that he died during the famine. On asking for the peasant who used to sit with me in the ancient Rath, and recite the Fairy legends of the locality, the answer is: "He is gone to America;" and the old woman who took me to the Blessed Well, and gave me an account of its wondrous cures and charms—"Where is she?"—"Living in the Workhouse." (VI)

Wilde illustrates how the harsh living conditions of the peasantry (famine, mass emigration, workhouses) will have a detrimental impact on the preservation of Irish language, history, legends and cures—a form of precious national heritage, rather than a bunch of regional false notions. As sketched in the preface and reinforced throughout the text, he presents the origin and persistence of folklore as a matter of historical circumstances rather than inveterate ignorance: science develops in a similar way, through continuous refutations of previous knowledge as nothing more than superstition and through the coexistence of institutionalized and counterfeit practices. Medicine, the field in which superstitions linger longest, he wrote, is no different:

> The only difference between the water-doctor living in his schloss, the mesmeriser practising in the lordly hall, or the cancer and consumption cure of the count or duchess, spending five thousand a-year in advertisements, paid into the queen's exchequer, who drives his carriage and lives in Soho-square, and the "medicine man" of the Indian, or the "knowledgeable woman" of the half-savage islander, residing in a hut cut out of the side of a bog-hole, or formed in the cleft of a granite rock, is that the former are almost invariably

> wilful impostors, and the latter frequently believe firmly in the efficacy of their art, and often refuse payment for its exercise. (30)

This constant blurring of the social categories along the axis of gullibility and progress disjoints the binary thinking at the core of the colonial enterprise that subtended Croker's first forays into Irish folklore. Wilde self-fashioned himself much more as a mediator between the different social strata of colonial Ireland, as well as between different systems of knowledge in the nineteenth century. In Ryder's words:

> William Wilde is also keen to bridge the worlds of the modern and pre-modern in terms of scientific knowledge. He tries to prove the value of legendary, mythic and folk material by showing how it can be mapped against the historical and archaeological record, attempting to give value and dignity to the 'primitive' oral culture of the peasants at the very moment when science threatens to discard all such knowledge. (10)

We can only hypothesize that his unfinished volume on Irish popular cures would have contained an expanded version of this subtle form of socio-political criticism, originating from a historical survey of medical practices. After his death in 1876, much of the material he had collected and edited was incorporated into Lady Wilde's *Ancient Legends, Mystic Charms, and Superstitions of Ireland*, first published in 1887. From these pages we can get a glimpse of an overall sensible approach to healing in disadvantaged contexts:

> The corner of a sheet that has wrapped a corpse is a cure for headache if tied round the head.
> The ends of candles used at wakes are of great efficacy in curing burns.
> A piece of linen wrap taken from a corpse will cure the swelling of a limb if tied round the part affected. (82)

Although within a general mystical atmosphere that attributes special healing powers to objects connected to death, funeral wakes and burials, these practices ultimately point to compression of temporal or occipital arteries for pain relief in headache, the application of tallow from candles to burnt skin to prevent blisters, and vasoconstriction to reduce swelling.

These practical pieces of advice highlight the porous boundary between folklore and institutionalized medicine: the pragmatic basis of these popular cures might have convinced a qualified doctor such as William Wilde of their intrinsic beneficial effect, a sort of grassroots medicine for the "partially civilized, because neglected and uneducated" Irish peasants.

Wilde advocated on different occasions the profitable widening of accessibility to culture for the lower classes in Ireland. For example, when he was awarded the Cunningham Gold Medal from the Royal Irish Academy in 1873, he declared:

> It is highly gratifying to me that my labours in the cause of our national antiquities—a subject so dear to my heart—should receive this distinguished mark of your approbation (…). Permit me (…) to entreat to you to open your museum freely to the public at all times, and especially (…) to the working and artisan classes who not only desire to be acquainted with the past history of their country but who have an hereditary claim to artistic excellence (…) of admiring something better than a pewter pint or an illegal noggin. (Anon. 1875 in Froggatt 274-275)

It is tempting to link these open-minded views to some form of radical nationalistic politics, but all the evidence points towards William Wilde's constant Unionism throughout his life, in sharp contrast to his wife's involvement with the Young Ireland movement that overtly promoted nationalistic uprising. Nonetheless, William Wilde was perceived as a patriotic intellectual: in the introduction to his very last lecture "Ireland: Past and Present, the Land and the People," delivered on 27th April 1864 for the YMCA in Dublin, Dean Graves invited the audience "to listen to the subject Sir William Wilde had chosen for his lecture without being ashamed of the national feelings it was calculated to stir up within them" (De Vere White 184). Despite the final praise of the potentially fruitful union of Saxons and Celts, Sir William did make some strong claims on that occasion, by stressing, for example, how the subjugation of Ireland was accomplished through the Famine, rather than at the time of Henry II (*Ibid.* 227-228). Once again, Wilde stated that the disastrous management of the Famine on the part of the imperial government stemmed from neglect, inscribed within a colonialist framework.

Such considerations are bound to have an impact on Oscar Wilde scholarship, which recently has been concerned with retrieving the role of his Anglo-Irish upbringing in the development of his future aesthetics. Ryder claims that:

> (…) to see Oscar in the lights of his parents' lives and careers is to firmly locate him as an Irish writer, or, more specifically, as the product of an emergent and vibrant nineteenth-century Dublin-based middle class. The culture of this class had much in common with the bourgeois cultural of Victorian Britain generally. (…) Yet the cultural world of the Wildes was also shaped by Irish nationalism, by colonial political and economic structures, and by the complications and paradoxes that marked the "Anglo-Irish" in general. In many ways Wilde's parents reflected the full range of these complexities. (Ryder 7-8)

If, for example, as Richard Pine suggests, Irish folklore influenced the creation of his own fairy tales (165), then this cross-pollination was probably not only mediated by the work of his poet mother, as commonly believed, but also by the careful investigations into Irish popular culture conducted by his father. It would be crucial to reconstruct in a more accurate way what sort of intellectual exchanges were going on among the Wildes at 1 Merrion Square or during their holidays in the West of Ireland.

It is indeed significant that, in his 1882 lecture tour in America as the apostle of Aestheticism, Oscar Wilde passionately promoted Irish art. More specifically, in his talk in San Francisco, he went as far as recommending that the city should host a museum of Irish art, to display, among other works, his father's copy of a restoration of the grand shrine of St Manchan of Lemanaghan (7th century).[1] This artefact, reproducing an "icon of Irishness," according to Maggie M. Williams, had first been shown at Dublin's Temple of Industry in 1853, a most interesting cultural initiative

[1] See Oscar Wilde, *Irish Poets and Poetry of the Nineteenth Century: A Lecture Delivered in Platt's Hall, San Francisco on Wednesday, April Fifth, 1882*, ed. Robert D. Pepper (San Francisco: The Book Club of California, 1972).

aimed to showcase post-Union Ireland as part of the United Kingdom. Williams explains how, on this occasion: "the picture that [the exhibition organisers] rendered of Irishness as something distinctive without being drastically Other was partially established through the aestheticization of the Celtic" (69). Both William and Oscar Wilde contributed to this cultural operation, closely intertwined with broader political issues of the times.

Consequently, a better assessment of the different levels of nationalistic commitments within the Ascendancy will shed light on the fervid political and cultural atmosphere that led to the Irish Revival. As far as the nineteenth century is concerned, James MacGeachie explains how Dublin was generally perceived to have missed out on Victorian progress: it was "a dissolute urban backwater that lived on in a Georgian stage-set vacated when real political power moved to the imperial centre of London after 1800" (86). This image contrasts with the title of William Wilde's most famous biography, *Victorian Doctor*, arguably an attempt to reassert his share in his coeval medical culture from the periphery. Wilde is thus contrasted to his fellow Irishman Robert Bentley Todd, who has been portrayed as the Irish physician "who colonized the imperial centre, editing what became a canonical collection for Victorian practitioners, the six-volume *The Cyclopaedia of Anatomy and Physiology* (1835-39), and founding King's College Hospital, London" (*Ibid.* 88). A closer look at Wilde's multi-disciplinary work gives a better sense of the development of vibrant Dublin intellectual circles, along non-generally-Victorian, but quite nineteenth-century Anglo-Irish lines.

In conclusion, the role of medicine in the development of Sir William's non-medical interests cannot be overemphasised. Because of his profession, and his father's practice before his, Wilde came into close contact with Irish lower classes and could appreciate their shared love for landscape and tradition. As James MacGeachie stated, "Wilde was also a pioneering author of the history of Irish medicine by virtue of that creative tension between, on the one hand, a professionalizing drive towards scientific medicine and, on the other, the enchantments of Celticism and the West of Ireland. This creative tension was emblematic of his career. Wilde gave Irish medicine a particular story about what being an Irish doctor meant" (*Ibid.* 92). Sir William Wilde's legacy is a very complex reflection on the professional identity of doctors in cross-cultural contexts,

of their engagement with issues of social justice and political allegiances, all filtered through the rediscovery of folklore, in what looks like a very medical humanistic endeavour.

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Abstract

This article is a first speculative attempt at reflecting, within a medical humanistic framework, on Sir William Wilde's extraordinary position as a leading eye and ear doctor with a genuine interest in Irish popular cures, and as the father of an iconic Anglo-Irish writer. Mainly interested in Irish pre-history, Wilde was very active in preserving Irish oral culture, including folk medicine. The pragmatic nature and easy availability of these lay cures fascinated the prominent ophthalmologist, and set the example for an unbiased appreciation of Irish culture at a time of historical turmoil. I also briefly assess how a better understanding of Sir William's work on Irish traditions will shed new light on Oscar Wilde's Anglo-Irish upbringing, as well as on the political and cultural atmosphere that led to the Irish Revival.

Keywords

William Wilde; Oscar Wilde; Irish culture; Anglo-Irish ascendancy; folk medicine; history of medicine

Résumé

L'objet de cet article est une réflexion, dans le cadre des humanités médicales, sur la position inédite de William Wilde en sa qualité de ténor de la médecine passionné des soins populaires irlandais et de père d'un écrivain anglo-irlandais emblématique. Profondément intéressé à la préhistoire, Wilde a participé activement à la préservation de la culture orale irlandaise, dont la médecine populaire. Le pragmatisme et la facilité d'accès de ces soins profanes fascinaient le grand ophtalmologue, et servent d'exemple en tant qu'appréciation objective de la culture irlandaise au cours d'une époque tumultueuse. Nous nous occuperons aussi brièvement de comment une meilleure compréhension du travail de Sir William sur les traditions irlandaises puisse mettre en lumière de nouvelles perspectives sur l'éducation anglo-irlandaise de Oscar Wilde ainsi que sur l'atmosphère politique et culturelle menant à la Renaissance irlandaise.

Mots-Clés

William Wilde; Oscar Wilde; culture irlandaise; éducation anglo-irlandaise; médecine populaire; histoire de la médecine

“A short story that wouldn’t work after the opening lines”: Frustrated Maternity in First-Person Narratives

Isabel Fernandes
School of Arts and Humanities, University of Lisbon
University of Lisbon Centre for English Studies

"A short story that wouldn't work after the opening lines": Frustrated Maternity in First-Person Narratives[1]

> Les écritures intimes proprement dites appartiennent aux premiers cercles de la vie privée, á la respiration de l'organisme intellectuel et spirituel, aux pulsations de l'existence en recherche d'équilibre.
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> Gusdorf, George (1991) *Les Écritures du Moi*. Paris: Éditions Odile Jacob, 1992, 287.

This article will address two different narratives by contemporary British women authors: the short story, "Jackson's Pollock's Curtains," by art critic and writer Sue Hubbard[2] and Hilary Mantel's memoir, *Giving up the Ghost: A Memoir*.[3] Even though belonging to different literary genres, they share a common theme—frustrated maternity—and illustrate the same type of narrative situation, being both first-person narratives, and will allow me to exemplify two of the

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[1] This article is an output of research developed under the Project *Medicine & Narrative–(Con)texts and practices across disciplines* [Ref. PTDC/CPC-ELT/3719/2012], held in CEAUL/ULICES-University of Lisbon Centre for English Studies, and funded by FCT (*Fundação para a Ciência e a Tecnologia*). It is an expanded and revised version of a paper delivered at the International Conference, *A Narrative Future for Healthcare*, held at King's College, London, 19-21 June 2013.

[2] In her anthology of 2008, *Rothko's Red and Other Stories*, henceforward referred to as RR.

[3] Hilary Mantel's *Giving up the Ghost: A Memoir* (2003), henceforward referred to as GG.

three different types of illness narratives proposed by Arthur W. Frank in his book *The Wounded Storyteller*, namely: chaos narratives and quest narratives, while at the same type allowing me to complexify things somewhat more.[4]

1. Sue Hubbard's "Jackson Pollock's Curtains"

The twelve-page-long short story by Sue Hubbard concerns the case of a mature married woman who, obsessed with the idea of losing the opportunity of experiencing maternity, before it was too late,[5] got pregnant, even though her self-centred, contented husband was not very keen on the idea, and ended up by losing her 49-hour-old newborn she-baby, while still in hospital.

The narrative is told in the first person by the woman herself, sometime after the traumatic event has occurred, and it takes place while she is shopping at the supermarket, on a Friday, before the weekend when her husband will be away from home for the first time since the fatal happening. In spite of her husband entreaties that she stays at home, oppressed by solitude and by the ghosts of her past traumatic experience (especially by the colour pink in the empty baby's room), she decides to go shopping and prepare for hosting her husband's employer and wife, in anticipation of a possible job promotion for him.

We gradually understand in a circuitous and intermittent way that she has been having a slow and difficult recovery from that psychologically damaging event and it soon becomes apparent by the circular and obsessive nature of her reasoning that she is not yet well and has not really been able to cope with it. The reader realizes this little by little, since the narrative is rendered in the form of an interior monologue, echoing the modernist stream of consciousness technique, by means of a chaotic and at first sight disconnected flow of ideas, words, idioms, and quotations from songs and

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[4] The third type in Frank's classification is "restitution narratives," which will not be addressed here.

[5] The sentence "it'll-soon-be-too-late" (occurring on pages 49 and 56, for instance), emphatically suggests the urgency the woman felt.

other audio-visual sources, casual words that evoke other more psychologically charged ones.[6] The reader is confirmed in his/her own worst suspicions as, at the conclusion of the story, s/he is surprised by the protagonist's kidnapping of a baby that lies in a pram momentarily left unattended at the till. This decision, having been determined by a sudden impulse rooted however in one of the many lines of mental associations that had just run through her consciousness, is seen as replicating a childhood loss, that of a rabbit, named Bouncer, which succeeded in escaping, and echoes her grand-father's soothing words to ease her tears: "If he doesn't come back, we'll get another one; *we'll go to the shop and you can choose another Bouncer*" (RR 55 - emphasis added).

One of the striking things about the style in this narrative piece is the way in which the reader is invited to draw a parallel between the chaotic mesh of interweaving lines of thought the narrative builds itself upon and the type of painting its title alludes to, namely, Jackson Pollock's well-known effect of interwoven "squiggly black lines and spilt paint" (RR 53), dense webs of apparently random patterns resulting from his method of drip painting that the woman sees reproduced in the pattern of the curtains in her hospital room. As in the case of Pollock's method, this woman's way of dealing with her predicament is as much dictated by impulse (bodily impulse)[7] as by a sort of implausible logic or order that accounts both for the randomness of what we read and, paradoxically, a sense of overdetermination or necessity that nevertheless pervades the piece inevitably leading to its unorthodox conclusion.

When confronted by one of his critics' complaints that there was no method in his paintings, but only chaos, the painter maintained that it was

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[6] Dorrit Cohn, in *Transparent Minds,* uses the expression "interior monologue" to name this narrative device that aims at registering the stream of consciousness occurring in first person narratives (Cf. 186 ff). Significantly she adds: "[o]nly fictional characters can be heard as they put thoughts into words without speaking them aloud or writing them down; or rather, they can be 'overheard,' for they address their discourse to no one, least of all to a reader" (189). And see also note 11 of present article.

[7] Echoed ironically in her remark: "I should have made a list, and then you only buy what you need, and don't shop on impulse" (RR 52).

"[n]o chaos, damn it."[8] One is tempted to add here: not chaos but the complex (dis)order of nature. Indeed Pollock believed "his free yet controlled application of paint had a connection to his inner being—his unconscious—which in turn connected to larger forces outside the self."[9] The same could be said in the case of this fictional character's behaviour: that behind its apparent randomness lies the compulsion of natural laws. This is nowhere more apparent than in the reference to the spilling of maternal milk that occurs overnight after delivery but becomes totally useless, since the child dies. As in Pollock's case, the spilling of paint from the painter's arms and hands, while executing a sort of dance over the outstretched canvas on the floor, is seen as something coming essentially from the body, so in this story we have this physiological unstoppable mechanism asserting itself blindly in spite of the dramatic circumstances of the newborn's death and making these circumstances even more unbearable. No wonder then that milk becomes a leitmotiv resurfacing throughout the story—as a sign of inexorable natural laws asserting themselves, beyond the individual's will.

> Concentrate or you will forget something. You should have written a list. Coffee. Yes, we'll need coffee after the meal. We've run out. Continental medium roast or Kenyan? I'll need milk for the coffee. The milk leaked. Can't cry over spilt milk. Little yellow patches of cholesterol leaked onto the pale blue flowers of my nightie. Smelt of sick when it dried. It wouldn't stop. Just went on and on. Seemed such a waste. They had to give me pills to dry it up. It seems the body just keeps going no matter what. Like clock work. Tick-tock. (…) (RR 51)

The unnamed protagonist is thus caught unawares by the compulsion of her bodily mechanisms as well as by the more superficial demands of her

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[8] See http://www.moma.org/collection/object.php?object_id=78386 (accessed 4-4-2013).

[9] *Ibidem*. Moreover, as we read on: "[w]hen asked to describe the relationship between his work and nature, Pollock stated emphatically, 'I am nature.'"

daily life (leaving her job, her housewifely duties) and interweaves both in a seemingly chaotic flow of words and sentences where the banal as well as the traumatic are so levelled as to become hardly distinguishable. It is for the reader to disentangle them, diagnose her case and assess her condition, thus reconstructing her clinical case report.

To accomplish this task successfully, the reader, positioned in a role similar to that of a psychotherapist, has to pay attention not only to the linguistic devices shaping her particular utterance but also to interruptions in the flow of words, to sudden breaks in sentences that correspond to silences. The repeated use of reticence marks signals the unsaid or unacknowledged event at the heart of this female character's predicament,[10] whose presence is hinted at by indirect scattered allusions. The three dots, mere reminders of an absence, correspond to that which is never fully uttered and therefore not accepted, as is the case, for instance, in the following example: "I wonder if the Humphries eat fish. It's the first time I've done any real entertaining, the first time since (…)" (RR 48). According to Arthur W. Frank, this is: "the hole in the story that cannot be filled in (…). The story traces the edges of a wound that can only be told around" (Frank 98). And, still according to Frank, this is one of the defining features of what he calls "chaos narratives."

The key issue here is this woman's inability to cope with her traumatic experience which is reflected in her inability to speak out, to verbalize it (Freud's famous talking cure).[11] In other words, she is caught in a vicious circle where words or, better still, mental reasoning (instead of having a cathartic or liberating effect) are a means of justifying to herself an unacceptable deed (the kidnapping of someone else's baby) that nevertheless appears as the only possible outcome for satisfying

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[10] In fact, repetition plays a central role underlying the free-associative technique that throws light on her mentally deranged state of mind (repetition of words and phrases, repeated use of leitmotivs, such as milk, curtains, and rabbits, etc.).

[11] Here again, Frank explains: "the chaotic story cannot be told" (*Ibidem*). In the case under scrutiny, it is the fact that this is a fictional rendering of the chaotic stream of consciousness of a deranged character that makes the narrative emerge as possible. In true life, the narrator of this story would never be able to tell it.

her yet unappeased maternal impulse, for her "body is imprisoned in the frustrated needs of the moment" (Frank 98).

The above quotation, on the other hand, signals the temporal dimension inherent in this case. In fact the frustration of pressing physical needs makes it impossible for trauma to be overcome and this in its turn hinders any possibility of change, as the past impinges continually upon the present. In the case of this text it is the past (and/or plans made in the past) that is given room. Even though the action takes place while the protagonist is in the supermarket and attending to her immediate shopping list, her thoughts continually travel to the more or less immediate past. And when she evokes past plans these do not translate into moves for change but rather emphasize the unbearable sense of loss curtailing any future beyond the ever-present fulfillment of frustrated wishes.

As Cathy Caruth argued, taking up some of Freud's ideas and his own writing experience, trauma manifests itself in the belated repetition of an overpowering experience that dominates the person who lived it, like ghosts from the past haunting their victims.[12]

2. Hilary Mantel's *Giving up the Ghost*

As in the painting by Gustav Klimt, entitled *Hope II*, the theme of pregnancy in Hubbard's story is shockingly linked to death or unaccomplished (physical) hope[13] and this too is the theme of Hilary Mantel's memoir, *Giving up the Ghost*, where, however, the situation is totally different, even though frustrated maternity is also very much at the centre of it, as the last lines of the poem by Judy Jordan chosen as an epigraph to the book show: "My children who won't hear. / The night full of cries they will never make."

Mantel's life story is here revealed also in a devious way since ghosts of her past are pervasive presences throughout the narrative and chronology becomes irrelevant rather submitting to the whimsical irruptions of previous

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[12] Cf. Caruth 19-24.

[13] Notice also the unexpected inclusion of a skull in the womb of the standing pregnant woman in Klimt's painting.

deeply felt experiences or expectations. But at the heart of her life story is also the inexorable reality of the body, of physiological ailments with their attendant psychological sequels. As a critic rightly summed up: "she chronicles a long history of misdiagnosis and neglect, in which her symptoms of unidentifiable pain were thought to be depression caused by unrealistic ambition. Courses of tranquillisers followed, with disastrous side effects. She was 27 when endometriosis was diagnosed and a hysterectomy performed. The babies who would never be born to her are plaintive, poignant ghosts in this unrelenting story of losses and defeats" (Niall).

Based on her own life experiences as a child and as a young woman on her path to maturity, Mantel's book insists moreover on the idea that it is not so much the actualities experienced in life, but rather the imaginary anticipation of things yet to come that shapes and nurtures our lives and therefore, when dreams are cut short and expectations aborted, can shatter them. This, undoubtedly, is at the heart of the thought by Portuguese poet Sebastião da Gama: "Dreams are what pushes us forward",[14] but when dreams fail to materialize the remnants are ghosts of aborted stories, narratives half told or, in Mantel's words: "A short story that wouldn't work after the opening lines."

At this stage it makes sense to quote the entire paragraph form which this sentence was taken, in order to introduce Mantel's world view as it is presented to the reader:

> You come to this place, mid-life. You don't know how you got there, but suddenly you're staring fifty in the face. When you turn and look back down the years you glimpse *the ghosts of other lives you might have led*. All your houses are haunted by *the person you might have been*. The wraiths and phantoms creep under your carpets and between the warp and the weft of your curtains, they lurk in wardrobes and lie flat under drawer liners. *You think of the children you might have had but didn't*. When the midwife says 'It's a boy,' where does the girl go? *When you think you're pregnant, what happens*

[14] Sebastião da Gama [1924-1952] used this sentence as the title of one of his books of poetry.

> *to the child that has already formed in your mind*? *You keep it filed in a drawer of your consciousness, like a short story that wouldn't work after the opening lines.* (GG 20-21, emphases added)

This quote makes us ponder on what it means to write an autobiographical report. To include just that which actually happened and simply give up the ghosts of what might have been, will be inadequate, since in our lives so much depends upon this dimension of possibilities to be fulfilled, a dimension tied up with daydreaming, planning ahead and surrogate living, which I will call poetical, drawing from Aristotle's description of the difference between history and poetry:

> [I]t is not the poet's function to describe what has actually happened, but the kinds of thing that might happen, that is, that could happen because they are, in the circumstances, either probable or necessary. (…) The difference [between the historian and the poet] is that the one tells of what has happened, the other of the kinds of things that might happen. For this reason poetry is something more philosophical and more worthy of serious attention than history; for while poetry is concerned with universal truths, history treats of particular facts. (Aristotle 43-44)

In this sense, one could argue that the way we live our lives has in it a lot of poetical activity, taking place in the uncontrolled flow of our daily consciousness, where plans and dreams yet to be fulfilled act as catalysts to the painful need of pushing on our day to day routines, and thus adding to our living an extra temporal dimension beyond the chronology, very often a fantasy of a compensatory nature. According to Adam Philips, it is as though we would learn to live in-between two realms: the life we actually live and the one we would like to experience (Cf. Phillips xi).[15] This I will call, for lack of a better word, the "surreal" dimension, where dreams are acted out and juxtaposed to the narrow contingency of lived

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[15] Still according to Phillips: "one realizes how much of our so-called mental life is about the lives we are not living, the lives we are missing out on, the lives we could be leading but for some reason are not" (*Ibid.*).

experience.[16] The admission of this poetical activity in our daily lives is, I think, what is behind Mantel's use of the writing metaphor that closes the paragraph I have just quoted and which poses the questions of the nexus between daydreaming and (creative) writing, namely narrative.[17] That both generate a sort of breathing space that counteracts the drawbacks and difficulties we all experience in life seems obvious. Imagination, according to Phillips and Morley, "is one of humankind's major adaptative tools" (112). A lot of testimonial statements from writers in justifying their craft could here also be invoked, but the epigraph taken from George Gusdorf suggests precisely this dimension of physical compensatory wellbeing that corresponds to the act of autobiographical writing, just as in our daily living daydreaming is as natural and as necessary as breathing to keep us moving on.

However, it is Mantel who also signals in her memoir the difficulty of writing about the events of her past life, much more so than devoting herself to imaginative writing. Here is what she says:

> I have hesitated for such a long time before beginning this. For a long time I felt as if someone else was writing my life. I seemed able to create or interpret characters in fiction, but not able to create or interpret myself. About the time I reached mid-life, I began to understand why this was. The book of me was indeed being written by other people: by my parents, by the child I once was, and by my own unborn children, stretching out their ghost fingers to grab the pen. I began this writing in an attempt to seize the copyright in myself. (GG 70-71)

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[16] In narratological terms this dimension could be called "psychological time," "subjective time," or "time in the mind," or even, according to Henri Bergson, "durée," as opposed to the chronological time of narrated events. Cf. Bergson, *Œuvres* (Paris: P.U.F., 1963), 88-89.

[17] The existence of a relationship between the frequency and intensity of day-dreaming in children and adolescents and the possibility of their becoming artists was evidenced by a series of studies carried out in the NY City area by Charles Schafer. Cf. Jerome L. Singer, *Daydreaming and Fantasy* (London: George Allen & Unwin, 1976), 67.

To her, it was fiction that came first, not life writing! Fiction was easier for it kept the ghosts alive, gave them space to creep back and reclaim her past as theirs—fiction somehow kept her ties to her past untouched, alleviated her life pains, but did not kill them. Writing her memoir was her attempt at getting rid of those ghosts and reclaiming her rights over her past life. This, in turn, made it possible for her to move on into new territories.

In the novel *Goldberg's Variations* by the British writer, Gabriel Josipovici, one finds an illuminating passage that clarifies this issue. One of his characters confesses:

> [W]riting things down, bending over the white page, dipping the pen in the ink, pausing, looking up, staring again—all that brings release and appeasement, such as merely closing the eyes and imagining never does. Mama is gone today, I remember writing down, she will not return for at least a week. Papa died yesterday in his sleep, I wrote later. I held his hand before but I am not sure he knew it was me.
>
> Why do we feel the need to write down this sort of thing? It explains nothing. It does not alter the facts. It tells nothing we did not already know. And yet it brings relief. Of that there can be no doubt. The feeling is palpable. As one writes the pain round the heart eases, the knots inside one are loosed, the state of shock into which one had been thrown gives way to something else, one picks up ones normal rhythm of breathing again, of moving. (Josipovici 103)

If imagining and daydreaming create a play strategy (akin to the child's play[18]) making us able to cope daily with dire routine, difficulties, aborted aspirations, disillusion and/or trauma, life writing about such critical events, about dreams that were cut short by contingency and/or illness, loss or disaster replicates and gives space to the development (at another level, or at a remove) of this "surreal" dimension of our lives and thus contributes also to a redressing of our human balance as we go by. But in Mantel's case, as we have seen, it is not simply a question of making life

[18] Cf. Winnicott.

breathable but emancipating from her past by writing, thus creating a life where future developments are possible.

And just as the figure of the wandering artist, invoked in Josipovici's narrative quoted before and inspired by Paul Klee's *Wandering artist (a poster)* [*Wander-Artist (Ein Plakat)* /] (1940), Mantel closes her memoir with a similar hardly sketched author figure, moving in the distance and packed with the burden of yet untold stories, pregnant with narratives for which she will have to find a voice, in an incessant quest:

> Sometimes, at dawn or at dusk I pick out from the gloom—I think I do—a certain figure, (…). It is a figure shrouded in a cloak, bearing certain bulky objects wrapped in oilcloth, irregular in shape: not heavy but awkward to carry. This figure is me; these shapes, hidden in their wrappings, are books that, God willing, I am going to write. (GG 251-52)

It will be apt to conclude with a quotation form Arthur W. Frank to highlight the difference between Mantel's predicament as the finally empowered teller of her own story/ies and the entrapped impotent protagonist of Hubbard's text: "The quest narrative affords the ill person a voice as teller of her own story, because only in quest stories does the *teller* have a story to tell." (Arthur 115) And one could add: in quest narratives, beyond a story to tell, the teller has the expectation of a future to live, even if that future turns out to be unenvisioned and unwanted. Such is the power of narratives.

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Abstract

I propose to offer an analysis of two first-person narratives, one fictional—"Jackson Pollock's Curtains" by Sue Hubbard (in her 2008 volume, *Rothko's Red*)—and the other, a memoir by Hilary Mantel, *Giving Up the Ghost* (2003), in order to explore two contrasting ways of dealing with situations of frustrated maternity. The differences will be illustrated by looking at the formal characteristics of the two texts, by references to painting, especially in the case of Hubbard's short story, and by relating them to two of the types of narratives of illness as proposed by Arthur W. Frank in his *The Wounded Storyteller* (1995), namely: "chaos narrative" and "quest narrative."

Keywords

"Chaos narrative"; "quest narrative"; frustrated maternity; Hilary Mantel; Sue Hubbard

Resumo

Analisarei duas narrativas literárias de duas escritoras britânicas contemporâneas: um conto de Sue Hubbard, da antologia *Rothko's Red*, publicada em 2008 e o livro de memórias de Hilary Mantel, *Giving up the Ghost: A Memoir*, de 2003. Apesar de diversas, ambas são narrativas de primeira pessoa, com uma temática comum—maternidades frustradas, e servirão para ilustrar dois tipos diferentes de narrativas de doença, segundo as categorias propostas por Arthur W. Frank na sua obra de 1995, *The Wounded Storyteller*: a narrativa caótica ("chaos narrative") e a narrativa de demanda ("quest narrative"). Far-se-á igualmente alusão a pinturas para as quais os textos remetem ou com os quais podem relacionar-se (em particular o conto de Hubbard).

Palavras-Chave

"Narrativa caótica"; "narrativa de demanda"; maternidade frustrada; Hilary Mantel; Sue Hubbard

NOTES ON CONTRIBUTORS

NOTAS SOBRE OS COLABORADORES

Mary Wilson Carpenter is Professor of English, Emerita, Queen's University, Kingston, ON. She has published *Health, Medicine, and Society in Victorian England* (2010), *Imperial Bibles, Domestic Bodies: Women, Sexuality and Religion in the Victorian Market* (2003), and *George Eliot and the Landscape of Time: Narrative Form and Protestant Apocalyptic History* (1986), as well as numerous articles and essays on Victorian literature and feminist theory. Her most recent field of research is Victorian literature and medicine.

Michael J. Clark is an Associate Member of the Centre for the Humanities and Health, King's College London, and of the U.C.L. China Centre for Health and Humanity, University College London, and was formerly Head of Medical Film and Audio at the Wellcome Library for the History and Understanding of Medicine, London. His main interests lie in the study of the representation and treatment of aspects of health care and health-related issues, biology and the history of medicine in contemporary and archival film and television. As well as publishing a number of articles on the representation in film and television of various aspects of medicine and biology, especially pain, cloning and genetics, Dr. Clark has published several articles on aspects of the history of psychiatry, and together with Dr. Catherine Crawford (University of Essex) co-edited the collection *Legal Medicine in History* (Cambridge University Press, 1994).

Maria Auxiliadora Craice de Benedetto is a generalist practitioner, researcher at the Centre for History and Philosophy of Health Sciences (CeHFi) of the Federal University of São Paulo (UNIFESP), Brazil and PhD student of the Postgraduate Program in Public Health (area of

Social and Human Sciences applied to Health) of UNIFESP. She still acts in the Brazilian Society of Family Medicine (SOBRAMFA), especially in educational activities and as director of scientific publications. It has been dedicated to the theme Narrative Medicine and Medical Humanities and has published articles related to these themes in Brazilian and International Medical Journals.

Isabel Fernandes is Professor of English at the School of Arts and Humanities, University of Lisbon and former Scientific Coordinator of ULICES —University of Lisbon Centre for English Studies. With a PhD in English Literature (dealing with the novelistic prose of D. H. Lawrence), she has published on several British authors: D. H. Lawrence, Emily Brontë, Jane Austen, Joseph Conrad, A. S. Byatt, Ted Hughes and Tracy Chevalier, among others. More recently her interests include inter-art studies (namely Literature and Painting) and the relations between Narrative and Medicine, an area in which she coordinates a pioneering project in Portugal.

Dante Gallian is graduated in History by University of São Paulo (USP), Brazil. Master and PHD in Social History by USP and Post doctored by École des Hautes Études en Sciences Sociales de Paris, France. He was Professor in the Federal University of Santa Catarina Department of History and since 1999 to present he has been a Professor and Director in the Center of History and Philosophy of Health Sciences in Paulista Medical School – Federal University of São Paulo. Dante Gallian was visiting Professor at EHESS – Paris, France and in the Centre of Humanities and Health – King's College London, UK. He has been doing research about Medical Humanities and Medical Education, with special interest in Medical Narratives and Literature and Humanization in Health, with research projects supported by FAPESP, CNPq, CAPES.

Lesley Gray is a Doctoral Candidate at the University of Kent, researching the interplay between mesmerism and power. Her research interests include the power of suggestion, memory, the integration of the arts, science and technology, and the medical humanities. Her article on Edgar Allan Poe and mesmeric ritual is forthcoming in the journal *Litterae Mentis*.

Brian Hurwitz was trained as a family doctor in central London where he practised as a general practitioner for 30 years. Since 2002 he has been Professor of Medicine and the Arts at King's College London where he directs the Centre for the Humanities and Health, which is funded by the Wellcome Trust. The Centre is a multidisciplinary unit offering research training at masters, PhD, MD and postdoctoral levels http://www.kcl.ac.uk/innovation/groups/chh/index.aspx Based in the Department of English at King's Brian's research interests include narrative studies in relation to medical practice, ethics, law and the logic and literary shape of clinical case reports. Prior to his current position he was Professor of Primary Health Care and General Practice at Imperial College London.

Patricia Novillo-Corvalán is Senior Lecturer in Comparative Literature at the University of Kent. She is the author of *Borges and Joyce: An Infinite Conversation* (2011) and has recently edited a collection of essays entitled, *Latin American and Iberian Perspectives on Literature and Medicine*, published by Routledge in 2015. Her publications include articles on modernism, comparative and world literature, and medical humanities. She is currently completing her second monograph entitled: *Modernism, Latin America, and Bolaño: Migration, Mobility, and Transnational Encounters*.

Maria Vaccarella is Lecturer in Medical Humanities at the University of Bristol. Previously a Postdoctoral Research Fellow in Medical Humanities at the Centre for the Humanities and Health, King's College London, Dr Vaccarella works on literature and medicine (especially neurology), narrative medicine and critical disability studies. Her most recent publication is "Disembodiment and Identity in Literary Depictions of Epilepsy Surgery," *Literature and Medicine* 33.1 (2015): 1-22.