Useful Darkness: Intersections between Medical Humanities and Gothic Studies.

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Medicine and the Gothic have long been entangled. Many Gothic classics are fantastical depictions of the ethical perils of medical ambition: Mary Shelley's *Frankenstein*, for example, is a paradigmatic text of medical ambition gone wrong, and Robert Louis Stevenson's *Strange Case of Jekyll and Hyde* is partly a reflection on the ethics of pharmaceutical experimentation.[1] The field of Gothic studies has long grappled with suffering bodies and with trapped protagonists, and while the earliest texts in the Gothic literary 'canon' emphasise the vulnerability of victims tormented in remote castles or monasteries, much nineteenth-century Gothic shifted the locus of the threat to cities and the newly-emerging professions. Ever since, the mysteries and power of medicine and law have been rich material for fantasies of bodies and minds constrained. Gothic literature and film has long had an interest in the way medical practice controls, classifies and torments the body in the service of healing. Medicine itself can be seen as an incorrigibly Gothic project - as David Punter notes, 'Gothic knows the body .... It knows about physical fragility, about vulnerability'.[2] The fragility of the human body in the grip of these discourses continues to be manifest in a wide range of Gothic literature and film.[3]

The direction of influence goes both ways: while medicine has influenced the dramas and settings of Gothic, so too have Gothic forms shaped medical writing. This is seen most clearly in nineteenth-century medical discourse, when the new genre of the clinical case study was being

redefined in terms of realist literary modes against the romantic and Gothic novelistic forms of the early nineteenth century. Yet as Meegan Kennedy has shown, the genre of nineteenth-century clinical case study is veined through with traces of a Gothic and Romantic mode: the rhetoric of the 'interesting' and 'curious' case can be seen as a direct successor to the romantic grotesqueries of earlier Gothic.[4] In multiple ways, the Gothic mode and representations of medical practice and experience have long been entangled. In this second decade of the twenty-first century, it seems apt to freshly examine intersections between the two fields of study.

Before exploring their conjunction, we need to define both terms -- a challenge in both cases. The Gothic mode of representation is notoriously as slippery as its transgressive subjects, but negative affect is at its core: these are representations of horror, terror, fear, and despair. The negative affect is typically entangled with particular spatial and temporal structures. The subjects of these texts often experience confined spaces and a sense of imprisonment, either literal or metaphorical, 'a claustrophobic sense of enclosure in space'.[5] Within these confined sites, the subjects often experience violent anachronism, in which a sense of enlightened modernity is undermined by the return of atavistic presences and practices. Gothic is traditionally preoccupied with a sense of a menacing past undermining optimism for the present or future: as Punter says, it concerns '[e]clipsed lives, lives already lived among the ruins … where darkness reigns and the future can never escape from the dread of the past'.[6] Gothic is preoccupied with the crumbling of modernity's triumphs, of rationality and science defeated.[7] This temporal structure is not as neat as the past invading and unsettling the present: rather, past and present become intertwined, and both distorted.[8] Ultimately this spatial confinement and temporal fracture can lead to a collapse of epistemological confidence: as Andrew Smith and Jeff Wallace note, texts in the Gothic mode often communicate '[t]he sense that the subject is not in possession of

itself'.[9] The subject's vulnerability is reflected in the emotional filter of the narrative perspective, whether third- or first-person. Gothic representations are not realistic: they represent highly subjective, fraught experience of crisis.

Like the Gothic, medical humanities is challenging to define, being understood variously as either inter- or multi-disciplinary, and as having diverse pedagogical or critical goals. The category originally emerged in medical schools, as an attempt to enrich undergraduate medical curricula by, among other things, helping trainee physicians empathise with patients' subjective experience – their pain, their fear, but also the individual history and interpersonal relationships within which every illness occurs, and which makes every case of illness different. Structured clinical taxonomies have enabled tremendous medical progress, but to facilitate those taxonomies, the patient's corporeal experience needed to be conceived by the physician in a different way from hitherto. Michel Foucault argues that this the standardising medical gaze that came into being at the end of the eighteenth century is a 'reductive discourse' which simultaneously confidently purports to explain – yet is inadequate to fully encompass – 'the presence of disease in the body, with its tensions and burnings, the silent world of the entrails, the whole dark underside of the body lined with endless unseeing dreams'.[10] He suggests that the medical taxonomies of modern 'classificatory' medicine 'remove … disease from the density of the body', and the complex and particular environment within which the ill subject lives.[11] This medical gaze has been critiqued for depersonalising patients, compressing diverse experience into standardised categories and eliding the emotional and social impacts of illness and medical experience: some scholars have also suggested that medical training and the work itself potentially decreases healthcare practitioners' propensity to empathise with patients.[12] As an

antidote to this detachment, illness narratives, be they fictional or (auto)biographical, may invite a reader to imaginatively engage with a particular, lived experience of illness.

This pedagogical emphasis on prizing patient experience connects with a new emphasis in the last decade, on the notion of 'patient centeredness' in medical practice and education.[13] In this vein, medical humanities can at times partly be understood as having a pedagogical role in 'humanising' medicine. In addition to nurturing empathy, medical humanities also has a valuable pedagogical contribution to practitioner training in the way it can enhance practitioners' ability to read patients' narrated histories, and to become sensitive to the issues of power and authority that cluster around the medical record and treatment decisions. In this vein, several scholars have explored the degree to which medical practice requires 'narrative competence', in Rita Charon's phrase.[14]

Yet beyond enhancing practitioner empathy and diagnostic skill, there is another crucial dimension to the medical humanities. As H. Martyn Evans argues, it is also:

> the name of an intellectual enquiry…. the pursuit of a fuller understanding of clinical
> medicine as fundamentally an encounter between people – for the most part
> [between] thinking, willing, experiencing, choosing, sometimes suffering agents.[15]

In this definition, medical humanities involves analysing medicine as a cultural and social process, and like all cultural studies, it challenges its proponents to consider how cultural forms incarnate power relations.

Such a cultural studies approach, alert to structural inequities and marginalisation, is central to intersections between Gothic studies and medical humanities. A collection combining gothic studies and medical humanities will inevitably examine disturbing aspects of medical practice, and some practitioners may read these essays as unnecessarily hostile to the many

blessings of medicine. Cultural studies of medicine are vulnerable to such misreading, attentive as they are to dangers inherent within institutional discourses, marginalisation of disempowered demographics, and the often corrosive effects of capitalist pressures on medical practice. Yet cultural studies research does not typically dismiss all medical practice as in thrall to these problems: rather, the work is trying to identify paradoxes, inconsistencies, and ambiguities. While these papers may be troubling, they do describe the shadow side of medicine: the presence of these shadows does not deny that medicine is also a thing of light.

The above definitions of medical humanities and Gothic modes of representation arguably suggest two potential points of tension. The crux of the incompatibility could be seen as the place of hope: specifically, around the notion of a patient's ability to reclaim her sense of agency, and second, faith in medical institutions and practice as fundamentally benevolent. I will briefly discuss these two areas of potential collision, show the incompatibility to be illusory, and then show how the articles in this collection seek to take dialogue between the two fields forward.

Patient agency and the Gothic mode

Creative arts have long offered patients the chance to reframe their experience on their own terms, to create representations of their experience and to, for example, build the story of their illness into a wider life narrative on their own terms. As Rita Charon says, writing illness might enable some patients 'to give voice to what they endure and to frame the illness so as to escape dominion by it',[16] and Ruth Nadelhaft argues, 'Literature offers form, structure, and the illusion of dimension to what was out of control and without limit'. [17]This effort can involve trying to

retrieve one's narrative from healthcare practitioners as much as from the illness itself. As G. Thomas Couser writes, 'As patients seize, or at least claim, more authority over their treatment, they may also be more inclined to narrate their stories … in part to reestablish their subjectivity in the face of objectifying treatment.'[18]

The Gothic can seem antithetical to representations of confident individual agency. In the Gothic mode of an illness narrative – or perhaps it would be best to say Gothic 'moment', for we would all hope that such an experience would be temporary – a patient's experience would be dominated by a sense of confinement, constraint, bewilderment and despair, a sense of their story being under the control of others – if under control at all. Yet these elements, too, are part of many patients' experiences. In illness, an individual may feel they have lost control over their own body, their own environment, and their own future; their life is constrained by the disciplines attendant on medical intervention – appointments, hospitalisation, medication, circumscribed activities, waiting rooms, as well as the restrictions of physical frailty itself. Both time and space can become strange. Spaces may become oddly carceral, and the normal passage of time may feel halted in a 'temporal caesurae', as Rita Charon says, the experience of suffering arguably 'eras[ing] all distinctions in time except for "before it started" and "now"'…. These states are neither willed nor controllable, but are only to be endured'.[19] D. H. Lawrence's poem 'Malade' uses vivid imagery to capture some of this involuntary stasis in time and place:

> What is the day
>
> But a grey cave, with great grey spider-cloths hanging
>
> Low from the roof, and the wet dust falling softly from them
>
> Over the wet dark rocks [20]

A sense of confinement and diminished agency is central to many Gothic representations. Indeed, the staple protagonist of classic eighteenth-century Gothic is a vulnerable individual desperately seeking to understand a menacing environment veined through with bewildering text -- mysterious signs which must be decoded for the subject to survive, but written in a code which cannot be deciphered. That scenario may strike a chord with many patients struggling to decipher two kinds of sign: the language of medical diagnosis and the language of their own symptoms. As in some eighteenth-century Gothic, there is an urgency to this effort of translation: lives depend upon it.

In particular, it can be argued that Gothic studies has much to bring to studies of the most disturbing form of illness narrative – that which Arthur Frank has called 'chaos' (anti)narrative.[21] Frank contrasts this despairing mode with more hopeful 'restitution' and 'quest' narrative, though all three are 'modes' rather than strictly discrete forms; all three strands are likely to feature in any one narrative, but one might predominate.[22] A restitution narrative tells the story of getting better (through the heroic agency of medical practitioners); a quest narrative tells the story of finding personal meaning within suffering.[23] Both offer a kind of solace to reader and to writer, albeit in different registers. Chaos anti-narrative, by contrast, is devoid of solace: suffering is overwhelming and the sufferer finds no meaning in pain and no hope of release.[24]

This annihilating experience destroys language: Frank subtitles that chapter 'Mute Illness', and Sarah Hagedorn proposes the term 'postchaos narrative', since by definition the experience annihilates the ability to represent.[25] Yet there are some ways in which some characteristics of this category can be cautiously used to understand written representations of illness. These texts often lack a sense of coherent causality, of progress through unfolding events, or at least through a deepening understanding of an event. Typically, even if a narrative

sequence is not linear, both reader and protagonist go somewhere: events cause other events, and something changes, something is done, through the course of the narration. By contrast, chaos anti-narrative has 'no narrative sequence, only an incessant present with no memorable past and no future worth anticipating. … In chaos stories, the untellable silence alternates with insistent "and then" repetitions'.[26] In a similar vein, Primo Levi notes that such a structure of eternal, hellish present is characteristic of some phases of trauma testimony.[27] This frozen state is connected to the second characteristic of chaos anti-narrative: the fact that nobody is clearly in control. Not only is the ill person helpless to avoid the suffering, but medicine has also failed: the only locus of power in chaos anti-narrative is the oppressive illness, pain and despair. This helplessness leads to the third characteristic of chaos anti-narrative: its profound emotional darkness. They are catalogues of obstacles and griefs that are increasingly too much to bear.[28]

The narrative characteristics I have just listed have been identified as typical of a twentieth- and twenty-first horror fiction. Roger Salamon notes that horror tends to feature 'plots of "and then" instead of "because"': these fictions tend 'to be miasmic … [and] cumulative…. [T]emporal statements involving ' and then' … approach an infinity of possibility that, in effect, destroys the idea of time as a statement of significant relationship'.[29] The second characteristic of chaos anti-narrative, too – its focus on helplessness – finds echoes in the way that Gothic traditionally represents confined, trapped protagonists, struggling to decipher a cryptic and menacing environment. The Gothic protagonist struggles for agency but is frequently flouted. Most importantly of all, chaos anti-narrative, like Gothic, is a mode alert to the dead hand of the past: Frank notes, 'Telling chaos stories represents the triumph of all that modernity seeks to repress. In these stories the modernist bulwark of remedy, progress, and professionalism cracks to reveal vulnerability, futility, and impotence'.[30]

The labels of 'Gothic mode' and 'chaos narrative' are permeable and contingent, and with either it is vital to move the discussion beyond merely affixing labels to texts. Rather, the terms may be of value in letting us loosely demarcate literary and cinematic representations which represent illness experience in particularly disturbing and challenging ways, *with a view to enabling reader engagement with these texts* in ways that recognise the ethical necessity of the act of witness, of being open to another's pain. It can be extremely difficult to read or listen to representations of such shattering experience.[31] Lawrence Langer's work has famously shown how even in cases of unspeakable collective trauma, those taking survivor statements may unwittingly encourage the survivor to tell their story through a framework of rescue and resilience.[32] Researchers working with healthcare practitioners have found hearers are likely to deny the horror of such narration and recuperate them into more positive stories, seeing the misery as linked to depression, or trying to frame the suffering as potentially alleviated in the future by scientific breakthroughs.[33] Yet moving too quickly to deny the chaos runs the risk of failing to recognise the validity of the speaker's suffering: not bearing witness to the reality of what they feel right now. Clinicians and cultural theorists alike have called for the urgency of witnessing the reality of another's experience of suffering, without the auditor/reader taking flight by diminishing or reframing it. [34]

As Brendan McCormack *et al* suggest, categories of illness narration are there to enable the reader/listener to listen differently: they are 'devices to help the listener understand the focus of the narrative and thus engage in active listening'.[35] Recognising the category might enable the reader/hearer in the challenging work of standing witness. Gothic studies may be able to contribute to that aim:

> In practical terms … scholars in our field may have the following: experience of the narrative structures and forms of language that can express *and/or tame* harrowing experience; sensitivity to the way *spaces* can construct human experience, particularly in terms of the way they can regulate, limit and control … and most of all, perhaps, a willingness to hear the language of fear, and despair, and terror. In terms of medical humanities, this latter willingness is no small thing.[36]

Being open to stories of suffering without reframing it in the defensive ways above is made harder by the way that some forms of 'empathy' can themselves be read as a kind of colonising act: the challenge is to recognise the other's unique experience without co-opting it, neither diminishing the reality of their lived experience, nor denying their alterity.[37] Such witness may also involve recognising the degree to which wider social and economic contexts like the marketization of healthcare and widening economic inequalities have intensified or even caused the particular suffering. In this regard, Gothic representations in literature and film potentially have a subversive role by representing, as often they do, medicine gone wrong: as Punter argues, 'Gothic is a mode – perhaps *the* mode – of unofficial history'.[38]

'Demonic medicine' versus institutional benevolence

The second potential area of tension between Gothic studies and medical humanities hinges on the way medicine is represented as a discipline and in its institutions. Medicine is about healing: its practitioners enter medicine to help others, to preserve and enhance life and to ease suffering. Yet the canon of Gothic literary classics is rich in texts which imagine medicine gone wrong, in

which knowledge of human anatomy is bent to terrible ends warped by human ambition. Beyond critiquing individual practitioners' detachment or ambition, the Gothic mode may be useful in critiquing institutions themselves. Contemporary medicine operates within extraordinarily powerful economic constraints and seductions. Hospital organisation, medical training, health care inequities, and the workings of globalised medical and pharmaceutical industries all shape what medicine can do.

Here, too, literature and film in the Gothic mode can be of interest to medical humanities research. Our field offers textual strategies for analysing representations of the way medical discourse, medical practices, and globalised biotechnological networks can, at times, do (inadvertent) violence to human bodies and minds – both of patient and practitioner.[39] Cultural studies of medicine analyse and unmask this violence, using, for example, postcolonial theory to critique the power imbalance between the patient and practitioner.[40] Psychiatrist and medical humanist Bradley Lewis makes a passionate case for the value of such cultural studies: 'medical discourses are real, have real effects on the world, and simultaneously are social, cultural, and political. Cultural studies approaches to medicine do not acquiesce to medicine's claim to scientific authority, but rather look behind the bioscience curtain of authority to engage more directly the effects of medical discourse'.[41] Interestingly, Lewis draws on Gothic metaphors to describe how cultural studies of medicine often engages with its subject of study: even when emerging from the social sciences, many cultural studies of medicine, 'present a kind of demonic medicine which in many ways mirrors medicine's own angelic self-image'.[42] Lewis acknowledges the binary of demonic versus angelic is inevitably incomplete, since medicine usually transforms lives for the better, and healthcare practitioners are diverse and operate within power structures differently, many working to subvert the system's inequities and to challenge its

premises. Gothic studies of medicine will inevitably explore the shadow side, while recognising that medicine is not a monolithic entity. Lewis suggests such cultural studies critique can rejuvenate medicine, rather than being 'a negative acid of destruction'.[43]

The benefits of the connection are far from one-way: Gothic studies can benefit tremendously from the work emerging from medical humanities. The sociological and anthropological strands of medical humanities can give an extra clarity, specificity and urgency to Gothic literary criticism, by helping us richly contextualise fictional works within medical processes and practices. In this regard, medical knowledge can be seen as extending the drive towards historicised and localised criticism that has characterised much in Gothic studies in recent decades. Roger Luckhurst, for example, calls for Gothic criticism to pay less attention to the 'generalised structure of haunting' and more to the 'generative loci' that give rise to the ghost, metaphorically speaking: 'we have to risk the violence of *reading* the ghost, of cracking open its absent presence to answer the demand of its specific symptomatology and its specific locale'. [44]

The articles in this special issue seek to achieve exactly this historicisation and specificity. They cover work from the eighteenth century through to the twenty-first, and a wide range of primary sources including fiction, autobiography, film, fine art, museum exhibits, clinical medical writing and medical advice literature, and each article reads medical writing alongside creative texts, be it literature, cinema or fine art. The authors contextualise their texts, making sense of how the texts' gothic effects play out within the particular geographies and histories of their production. Emily Waples' article, for example, examines intersections between eighteenth-century medical discourse and the emergence of American Gothic: she argues that plague discourse shaped a wider 'miasmatic imagination', a paranoid sense of invisible threat,

which shaped wider literature and culture beyond medical writing. Laurence Talairach-Vielmas examines literary representations of nineteenth-century anatomy collections of preserved human remains, and in the process, identifies ways that literature not only popularised certain concepts, but also played a role in shaping public engagement with medical practices like dissection. The contribution by Anthony Mandal and Keir Waddington likewise examines literary representations of nineteenth-century medicine, drawing on rarely-discussed nineteenth century anthologies and periodicals. Rather than engaging with literary representations of the heroic, experimental medical discourses often privileged in cultural analysis of medical representation of the nineteenth century, they focus on representations of everyday, domestic experience of medical treatment which -- in these popular representations -- readily metamorphoses into torture and highlight continuities rather than disruptions in how doctors and their treatments were viewed. On the other hand, ground-breaking technology is the focus of Simon Avery's article: Avery examines how Gothic metaphor and imagery were inextricably entangled with initial representations of Röntgen's 'X-rays'. Avery shows how the language of Gothic was deployed to mark the X-ray process as a boundary-disrupting force that can be read alongside the collapse of other cherished ontological stabilities of the time.

Turning to the twentieth- and twenty-first centuries, this special issue includes three articles which examine bodies constrained by both illness and medical intervention itself. Angelica Michelis analyses medical advice literature and autobiographical literature of eating disorders, and identifies how Gothic literary elements run through both genres, and serve variously as restrictive models for denying patient agency, or as subversive elements demanding readers/viewers imagine a new way of thinking about patients' experience of embodiment. Similarly, Tracy Fahey examines Gothic representations of the diabetic body in film and fine art,

demonstrating how the purification rituals of diabetic experience have parallels with Gothic iconography and that these artifacts can powerfully represent the emotional experience of living with the condition as well as helpfully subverting the standardising discourse that characterises medical representations of diabetic bodies. Finally, Sara Wasson examines how the medical act of harvesting human organs and tissue for transplant is necessarily accompanied by linguistic labour: four metaphors dominate the cultural work of recategorising the tissue as transferrable. Literary fictions of organ harvest combine these tropes in different ways, in the process unmasking some of the perils and promises of these influential tropes shaping the very real institutional processes of human tissue management today.

All these articles tend to emphasise how medical practice and discourse can, at times, be profoundly alienating and paradoxically tormenting – not only for patient, but also for practitioner. As one reads these articles, one is painfully aware that the Gothic victims they discuss have fleshly corollaries: as such, the work makes distressing reading. Yet surely this is also vital work, for these works are reaching for language to describe bodies suffering in a complex mesh of constraints, challenging to specify and disturbing to contemplate. Gothic studies and medical humanities can go to these troubling limits.

Notes

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[1] M. Shelley, *Frankenstein, or the Modern Prometheus* (London: Lackington, Hughes, Harding, 1818); R. L. Stevenson, *Strange Case of Dr. Jekyll and Mr. Hyde*, 2nd edn. (London: Longmans, 1886).

[2] D. Punter, *Gothic Pathologies: The Text, the Body and the Law* (Basingstoke: Palgrave Macmillan, 1998), p. 9.

[3] To date, research on Gothic and medicine has been particularly attentive to nineteenth-century material. Influential criticism includes: Punter, *Gothic Pathologies;* A. Smith, *Victorian Demons: Medicine, Masculinity and the Gothic at the Fin-de-Siecle* (Manchester, Manchester University Press, 2004); T. Sparks, *The Doctor in the Victorian Novel: Family Practices* (Farnham: Ashgate, 2009); T. Sparks, **'**Medical Gothic and the Return of the Contagious Diseases Acts in Stoker and Machen', *Nineteenth-Century Feminisms,* 6 (Fall-Winter 2002), 87-102; L. Talairach-Vielmas, *Wilkie Collins, Medicine and the Gothic* (Cardiff, University of Wales Press, 2009)**;** Meegan Kennedy, 'The Ghost in the Clinic: Gothic Medicine and Curious Fiction in Samuel Warren's *Diary of a Late Physician*', *Victorian Literature and Culture,* 32:2 (September 2004), 327-351; K. Waddington, 'Death at St Bernard's: Anti-Vivisection, Medicine and the Gothic', *Journal of Victorian Culture*, 18:2 (June 2013), 246-62; W. Hughes, 'Gothic Medicine', in Marie Mulvey-Roberts (ed.), *The Handbook of the Gothic*, 2nd edn. (New York, Palgrave, 2009), pp. 144-5; W. Hughes, 'Victorian Medicine and the Gothic', in A. Smith and W. Hughes (eds.), *The Victorian Gothic: An Edinburgh Companion* (Edinburgh, Scotland; Edinburgh University Press, 2012), pp. 186-201; C. M. Davison, '"Houses of Voluntary Bondage": Theorizing the Nineteenth-Century Gothic Pharmography', *Gothic Studies,* 12:1 (May 2010), 68-85; C. M. Davison (ed.), *Gothic Studies* 11:2 (November 2009), special issue examining Gothic and addiction; A. Stephanou, 'A "Ghastly Operation": Transfusing Blood, Science and the Supernatural in Vampire Texts*', Gothic Studies,* 15:2 (November 2013), 53-65.

[4] Kennedy, p. 327.

[5] C. Baldick (ed.), 'Introduction', *The Oxford Book of Gothic Tales* (Oxford: Oxford University Press, 1992), pp. xi-xxiii (p. xv).

[6] D. Punter, *Literature of Terror*, Vol. 2: *The Modern Gothic* (Edinburgh: Pearson Education, 1996), p. 171.

[7] C. Baldick (ed.), 'Introduction', *The Oxford Book of Gothic Tales* (Oxford: Oxford University Press, 1992), pp. xi-xxiii (p. xv); D. Punter, *Literature of Terror*, Vol. 2, p. 137.

[8] Punter, *Literature of Terror*, vol 2, p. 198; F. Botting, *Gothic: Routledge Critical Idiom*, 2nd edn. (London: Routledge, 2014), p. 3.

[9] A. Smith and J. Wallace (eds.), 'Introduction: Gothic Modernisms: History, Culture and Aesthetics', in *Gothic Modernisms* (Basingstoke: Palgrave Macmillan, 2001), pp. 1-10 (p. 4).

[10] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception,* trans. A. M. Sheridan (1963; repr. London: Routledge, 2003), p. xi.

[11] Foucault, p. 3.

[12] A handful of examples could include: R. Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford: Oxford University Press, 2008), p. 8; J. Halpern, *From Detached Concern to Empathy: Humanising Medical Practice* (Oxford: Oxford University Press, 2001); S. Phillips and P. Benner, *The Crisis of Care: Affirming and Restoring Caring Practices in the Helping Professions* (Washington DC: Georgetown University Press, 1994), F. Hafferty, 'Beyond Curriculum Reform: Confronting Medicine's Hidden Curriculum', *Academic Medicine,* 73 (1998), 403-7; J. Trautmann Banks, 'Foreword', in Cortney Davis and Judy Schaefer (eds.), *Between the Heartbeats: Poetry and Prose by Nurses* (Iowa City: University of Iowa Press, 1995), p. xii. For a critique of 'empathy' in medical education, see A. Smajdor, A. Stöckl and C. Salter, 'The Limits of Empathy: Problems in Medical Education and Practice', *Journal of Medical Ethics,* 37:6 (June 2011), 380-383.

[13] See for example General Medical Council, *Tomorrow's Doctors: Outcomes and Standards for Undergraduate Medical Education* (2009) <http://www.gmc-uk.org/static/documents/content/TomorrowsDoctors_2009.pdf> [accessed 5 August 2014].

[14] Charon, p. 203; K. Montgomery Hunter, *Doctor's Stories: The Narrative Structure of Medical Knowledge* (Princeton: Princeton University Press, 1991); K. Montgomery, *How Doctors Think: Clinical Judgement and the Practice of Medicine* (Oxford: Oxford University Press, 2005); J. Trautmann Banks, J. E. Connelly, A. Hunsaker Hawkins, K. Montgomery Hunter, A. Hudson Jones, M. Montello and S. Poirier., 'Literature and Medicine: Contributions to Clinical Practice', *Annals of Internal Medicine,* 122 (1995), 599–606; T. Greenalgh and B. Hurwitz, 'Why Study Narrative?' in T. Greenhalgh and B. Hurwitz (eds.), *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice* (London: British Medical Journal Books, 2004), pp. 3-16; J. Trautmann, 'The Wonders of Literature in Medical Education', in D. J. Self (ed.), *The Role of the Humanities in Medical Education* (Norfolk, VA: Bio-Medical Ethics Program, Eastern Virginia Medical School, 1978), pp. 32–44.

[15] H. Martyn Evans, 'Affirming the Existential Within Medicine: Medical Humanities, Governance, and Imaginative Understanding', *Journal of Medical Humanities,* 29 (2008): 55-59 (p. 56).

[16] Charon, pp. 65-6.

[17] R. Nadelhaft, 'The Experience of Illness', in R. Nadelhaft (ed.), *Imagine What It's Like: A Literature and Medicine Anthology* (Honolulu: University of Hawaii Press, 2008), pp. 3-5 (p. 3).

[18] G. T. Couser, *Recovering Bodies: Illness, Disability, and Life Writing* (Madison: University of Wisconsin Press, 1997), p. 11.

[19] Charon, pp. 121-2.

[20] D. H. Lawrence, 'Malade', in L. Greenlaw (ed.), *Signs and Humours,* ed. by Lavinia Greenlaw (London: Calouste Gulbenkian Foundation, 2007), p. 64.

[21] A. Frank, *The Wounded Storyteller*: *Body, Illness and Ethics* (Chicago: University of Chicago Press, [1995] 1997).

[22] *Ibid*., p. 77.

[23] *Ibid*., pp. 77-9, 115-130.

[24] *Ibid*., pp. 97-104.

[25] S. Hagedorn, 'My Father: A Postchaos Narrative', *Qualititative Inquiry,* 10:3 (June 2004), 463-474 (p. 471).

[26] Frank, pp. 99-100.

[27] Cited in R. B. Salomon, *Mazes of the Serpent: An Anatomy of Horror Narrative* (Ithaca, New York: Cornell University Press, 2002), p. 96.

[28] *Ibid*., p. 99.

[29] Salomon, pp. 85, 96-7.

[30] Frank, p. 97.

[31] *Ibid*., pp. 97-8.

[32] L. Langer, *Holocaust Testimonies: The Ruins of Memory* (New Haven: Yale University Press, 1991), pp. 58-60.

[33] See for example B. Smith and A. C. Sparkes, 'Exploring Multiple Responses to a Chaos Narrative**',** *Health.* 15:1 (2011), 38-53 (pp. 41-2); K. Vroman, R. Warner and K. Chamberlain, 'Now Let Me Tell You in My Own Words: Narratives of Acute and Chronic Low Back Pain', *Disability and Rehabilitation*, 31:12 (June 2009), 976-987.

[34] See for example: Charon, p. 113, 180-2; A. Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition* (Basic Books, New York: 1988), p. 10; E. Uehara, M. Farris, P. Morelli and A. Ishisaka, '"Eloquent Chaos" in the Oral Discourse of Killing Fields Survivors: an Exploration of Atrocity and Narrativization**',** *Culture, Medicine and Psychiatry,* 25:1 (2001), 29-61; J. Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Atheneum, 1994), pp. Frank, pp. 45-6.

[35] B. McCormack, A. Illman, J. Culling, A. Ryan and S. O'Neill, '"Removing the Chaos from the Narrative": Preparing Clinical Leaders for Practice Development', *Educational Action Research,* 10:3 (2002), 335-351 (p. 337).

[36] S. Wasson, 'Recalcitrant Tissue: Cadaveric Organ Transplant and the Struggle for Narrative Control', in J. D. Edwards (ed.), *Technologies of the Gothic in Literature and Popular Culture: Technogothics* (New York: Routledge, 2015), forthcoming.

[37] A. Frank, *The Renewal of Generosity* (Chicago: University of Chicago Press, 2004), p. 115.

[38] Punter, *Literature of Terror*, vol. 2, p. 187.

[39] See for example K. P. Morgan, 'Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization', in S. Sherwin (ed.), *The Politics of Women's Health* (Philadelphia: Temple University Press, 1998), pp. 83–122.

[40] See for example F. Aull and Bradley Lewis, 'Medical Intellectuals: Resisting Medical Orientalism', *Journal of Medical Humanities,* 25:2 (2004), 87-108.

[41] Bradley E. Lewis, 'Reading Cultural Studies of Medicine', *Journal of Medical Humanities,* 19, no 1 (1998): 9-24 (p. 11).

[42] *Ibid.*, p. 23.

[43] *Ibid.*, p. 23.

[44] R. Luckhurst, 'The Contemporary London Gothic and the Limits of the "Spectral Turn"',

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