New Generations in medical humanities

reflections and showcase

(a booklet) put together by the new generations in medical humanities cohort 2014-15
New Generations for Medical Humanities

Medical Humanities is a dynamic field that critically engages with ideas, practices, policies and evidence relating to health, wellbeing, illness and disease. As such it embraces a wide disciplinary range of influences including those from the humanities, social science and science. The field has grown substantially over the last decade in the context of the increasing importance of interdisciplinary working, and with the help of support from funding agencies such as the Wellcome Trust, the AHRC and ESRC. Emerging humanities researchers are increasingly engaging with interdisciplinary research but lack contexts in which to learn about and experience how it is done.

Durham University’s Centre for Medical Humanities, in collaboration with the Northern Network for Medical Humanities Research and the Wellcome Trust set up the New Generations Programme in September 2014 to address this issue. Supported by a Collaborative Skills Development grant from the AHRC and additional funding from the Wellcome Trust, this unique programme had the following key aims:

1. To deliver an exciting and innovative skills development package to a group of doctoral students and early career researchers in the medical humanities;

2. To facilitate the development of a supportive, interdisciplinary peer group;

3. To create career development opportunities by enabling interaction between participants and staff in key centres of the medical humanities while engaging in discussions on the full range of medical humanities career options.

14 ECRs and doctoral students were chosen from a competitive field of 57 applicants participate in this programme over the academic year 2015-16. The New Generations Cohort took part in nine themed workshops in Durham, Glasgow, London (including at the Wellcome Trust), Leeds and Dublin, and got to know key staff in all these important Centres. The final workshop in Durham intends to showcase the research of our 2015-16 Cohort and explore with them the impact of the programme on their work and future aspirations.
NewGenerationsContributors

Victoria Bates
is Lecturer in Modern History at the University of Bristol. She has research interests in the social history of medicine in modern Britain. Her primary research has been on Victorian and Edwardian sexual forensics, on medicine in late-twentieth century popular culture and—most recently—on the so-called 'humanisation' of healthcare and medical education. She is the co-editor of Medicine, Health and the Arts (Routledge, 2014) and author of Sexual Forensics in Victorian and Edwardian Britain (Palgrave Macmillan, 2015).

Rebecca Brown
is a philosophical bioethicist at the University of Aberdeen, interested in topics that relate to public health ethics. In particular, Becky’s work focuses on behaviour change interventions (often targeting everyday ‘lifestyle’ behaviours) and the legitimacy of state activity to promote health.

Matthew Colbeck
is an Honorary Research Fellow within the School of English at the University of Sheffield. He gained his PhD from the University in 2014, his research focusing upon the representation of coma and brain injury in literature and the sociological impact of misrepresentations of these medical conditions.

Luna Dolezal
is an Irish Research Council/Marie Curie Postdoctoral Fellow based between the Department of Philosophy, Durham University and the Trinity Long Room Hub, Trinity College Dublin. She recently published a monograph, The Body and Shame: Phenomenology, Feminism and the Socially Shaped Body (Lexington Books, 2015).

Michael J Flexer
is a semiotician, playwright and doctoral candidate at the University of Leeds. He’s a graduate of St Hugh’s College, Oxford, Central School of Speech and Drama, and King’s College, London.

Jana Funke
is an Advanced Research Fellow in Medical Humanities at the University of Exeter. Her research and publications cut across literary modernist studies, the history of sexual science, and queer theory. In 2015, she was awarded a Wellcome Trust Investigator Award to co-direct a five-year project on the cross-disciplinary history of sexual science with Professor Kate Fisher.
Sam Goodman

is Lecturer in English & Communication at Bournemouth University. His research interests include medicine, popular culture and Britishness since 1850. He is the author of British Spy Fiction & the End of Empire (2015), Medicine, Health & the Arts: Approaches to the Medical Humanities (with Victoria Bates and Alan Bleakley, 2013), and he is a BBC/AHRC New Generation Thinker.

Hieke Huistra

is a postdoctoral researcher in medical history at Utrecht University. She investigates how medical practices and objects shape the way we experience our bodies. Her research project uses both digital and traditional historical methods to investigate ideas on fatness and overweight in early twentieth-century Dutch society.

Fiona Johnstone

has is an ISSF Wellcome Postdoctoral Research Fellow in the Department of Art History at Birkbeck, University of London. She is currently working on a number of projects, including a monograph based on her doctoral thesis, AIDS and the Art of Self-Representation.

Claude Jousselin

has been working in the field of mental health in voluntary and statutory organisations for many years, more recently within Early Intervention NHS services where he has been particularly interested in conducting co-design quality improvement projects. Claude is completing his PhD in the Anthropology department of Goldsmiths University where he is researching the diagnostic process for adult Attention Deficit Hyperactivity Disorder (ADHD) in the UK in collaboration with a Patient Organisation (AADD-UK). His fieldwork was situated within a clinical site as well as with Adult ADHD support groups where he traced the diagnostic process as it takes place between these sites, highlighting the multiple ways that ADHD in adults is conceptualised and enacted through memory and kinship practices. Claude has presented research papers in both psychiatric and social sciences conferences, and published in scientific and anthropological journals.

Ben Kasstan

is a PhD candidate in Anthropology at Durham University. Through generous funding from the Wellcome Trust, my PhD critically engages with the unresolved issue of negotiating religious and biomedical cosmologies. This is in particular relation to the Haredi Jewish ‘community’ who are regarded as being ‘hard to reach’ by Public Health England.
**Zoë Mendelson**

is an artist and writer. She is currently Pathway Leader for Fine Art Painting at Wimbledon College of Arts, University of the Arts London. Mendelson is a collagist preoccupied by accumulations and faultlines between things. Her research focuses on the cultural construction of disorder and she creates artworks and fictions, which reflect on the borders of psychopathological attachments to ‘stuff’; psychologies inherent to accumulation; and conscious and unconscious spaces occupied by both object and analysis. Her recent Wellcome Trust funded project, *This Mess is a Place*, focuses on the psychopathology of hoarding at its intersection with rationalised collection. A 200-page edited book published as part of this project, included thirty international contributors.

**James Stark**

is University Academic Fellow in Medical Humanities at the University of Leeds. His current research projects include ‘Pasts, Presents and Futures of Medical Regeneration’, supported by a Wellcome Seed Award, and he is Chair of the Outreach and Education Committee of the British Society for the History of Science.

**Emily T Troscianko**

is a member of the Faculty of Medieval and Modern Languages at the University of Oxford. She has written a book about the psychology of reading Kafka, *Kafka’s Cognitive Realism*, and writes a blog on eating disorders, *A Hunger Artist*, at psychologytoday.com
From the new generations playlist:

Matmos. *A Chance to Cut is a Chance to Cure* (Matador, OLE 489-1, March 2001) [LP, Album]

Track 1: liposuction surgery recorded in California utilizing Bard Parker’s Scalpels, Draeger Anesthesia Ventilators and Gramm’s Medical Liposuction Equipment.

Track 2: refractive eye surgery (laser in situ keratomileusis) performed on Monica Youn and recorded in San Francisco.

Track 3: audiologist Rebecca Highlander, CCC-A reads a list of phonetically balanced words. Recorded in the hearing test booth at the Jean Weingarden Peninsula Oral School for the Deaf. Beeps and tones generated during the response curve testing of hearing aids.

Track 4: composed entirely from sounds generated while measuring the galvanic response of Martin’s skin to a constant flow of electricity.

Track 5: composed entirely from the plucked and bowed cage of our rat Felix.

Track 6: composed entirely from samples of human skull, goat spine and connective tissue, and artificial teeth.

Track 7: with the exception of the nose flute, this is composed entirely from recordings of plastic surgeries performed in California: rhinoplasty, endoscopic forehead lift, chin implant.

Med Hum-Along could also include - with no eye on quality control:

*Bad Case of Loving You* - Robert Palmer
*Dizzy* - the Vic Reeves version
*Double Vision* - Foreigner
*Dr Junk* - Joni Mitchell
*Eyes Without a Face* - Billy Idol
*Girlfriend in a Coma* - The Smiths
*Why Does It Hurt When I Pee* - Frank Zappa
Talking ‘bout my generation

by Victoria Bates

The medical humanities is not a new field, although we might be forgiven for thinking so. It was described recently in *The Times* as a ‘newish interdisciplinary area’, in part because of its increased visibility in the UK in recent years. Its current form is indeed quite different from the ‘medical humanities’ that emerged in the USA in the 1960s, which focused on medical education and the instrumental value of arts or humanities for health and for healthcare practitioners. So are we a ‘new generation’ of medical humanities scholars? If we are a ‘new generation’, then how many have come before us and what might future generations look like? The past year has led us to reflect on what the ‘medical humanities’ represents and where we sit within the field.

The ‘new generations’ cohort is diverse, including artists, historians, literature scholars, anthropologists, philosophers, art historians, linguists and semioticians. Our ‘generation’ certainly shares a passion for interdisciplinarity and dialogue, but it would be downplaying the significance of earlier ‘generations’ of medical humanities scholars to imply that they did not advocate the same. If we are a ‘generation’, we are definitely reaping the benefits of what others have sown. Medical humanities scholars are in the privileged position of working in a widely recognised field of scholarship, helped by the Wellcome Trust’s shift from ‘medical history’ to ‘medical humanities’ funding streams (although the two are of course not mutually exclusive). We can move away from endless pondering over definitions and worrying about formulating a single professional identity, or identifying our shared ‘parent’ subject; instead we are able to celebrate diversity, or – to cite Felicity Callard, William Viney and Angela Woods from the University of Durham – to ‘embrace entanglement’ and ‘take risks’.

Over the past year of training sessions, many of which have involved discussions between new and established ‘generations’, it has transpired that we have more commonalities than points of difference – in academic philosophy at least. Academics and practitioners of the medical humanities have long pushed the boundaries of their (inter-)disciplines, something that we seek to continue rather than move away from; although the same boundaries are not in place, we are
always trying to find new ways to innovate within and beyond traditional disciplinary frameworks. The more time our ‘new generations’ cohort has spent with each other and with more established academics in the field of medical humanities, the more I feel that we are part of the same ‘newish’ field of enquiry rather than a separate ‘generation’ moving on from those who pioneered it.

Feminist scholars have largely deserted the ‘wave’ analogy, and it might be productive for us also to move away from the concept of ‘generations’. There have been changes over time in the form and focus of medical humanities as a field, but medical humanities scholars are all still working together and inspiring each other in a range of ways; if we are a ‘new’ generation, it is clear that there is no ‘past’ generation that no longer holds relevance to the field. Whatever we call it, the ‘new generations’ training scheme has been fantastic in bringing together established and early career academics, all of whom have a commitment to working – and innovating – in this field. I hope that whatever the next ‘generation’, ‘iteration’ or ‘phase’ of the medical humanities brings, it maintains this collegiality.

The boundaries of ‘health’

by Rebecca Brown

Health, disease, healthcare and medicine have become increasingly integral to people’s daily lives. Alongside the expanding range of medical interventions available to treat sometimes relatively minor complaints, medical developments have boosted our capacity to turn previously fatal diseases into chronic illnesses, such that more and more people are living with managed medical conditions. Perhaps most important has been the turn towards preventive medicine directed at reducing exposure to risk factors for chronic disease. Reporting new risk factors for cancer, heart disease, type II diabetes, stroke, Alzheimer’s, and so on, has become a favourite hobby of much mainstream media. A particular focus has been on the power of food to both
Rebecca Brown

cure and cause cancer: recently, two researchers in the United States selected common ingredients from a random selection of recipes and found that articles had been published on 80% of them regarding their cancer risk. Alongside what you eat, the way you travel to work, educational level, relationship status, job title, postcode, birth month, reading habits, and most other aspects of life, have been linked to health prospects in some way.

Whilst many of these links should be taken with a hefty dose low sodium salt, some may present opportunities for health-promoting interventions. Yet the intrusion of the ‘medical’ into all domains of life may have consequences beyond health gains that must be considered. In wealthy ‘western’ democracies, the move has been towards optimisation (rather than sufficiency) in our ambitions for health. ‘Healthy’ lifestyles involving 150 minutes of physical activity per week, five portions of fruit and vegetables a day, washed down with eight glasses of water, are depicted as virtuous. Failure to complete one’s ‘active steps’ target for the day, or succumbing to the temptation of a slice of carrot cake, indicates weakness and ‘bad’ behaviour.

It has become difficult to distinguish between health-relevant activities and everything else, since ‘health’ no longer refers to merely the absence of (significant or disabling) disease, but rather, engagement in the ‘right’ kind of activities, coupled with a state of generalised well-being. Since we generally accept that states ought to be involved in the business of protecting public health, this gives those in power a basis for legitimate intervention in almost all areas of life. Maintaining a relatively narrow approach, informed by medical science and welfare economics, will likely miss the importance of these trends in healthcare. De-personalised methodologies may be well equipped to capture abstract ‘truths,’ and have often served both medicine and much philosophical research well. Yet there is a need for bio-ethics to also pay attention to the human narrative and wider meaning of health to people’s lives if we are to understand the value and disvalue of these changing trends in healthcare. To this end, it seems there is much to be gained from the kinds of multi- and interdisciplinary activities fostered by medical humanities networks and outlets, in seeking both deeper understanding and practical guidance.
More MH Scholar than MH Scholar?

CMH New Generations and the Nexus 6

by Matthew Colbeck

In Ridley Scott’s Blade Runner, Eldon Tyrell refers to his Corporation’s motto as ‘more human than human’. The ‘more- than-human’ in this case is the Nexus 6 ‘replicant’: the ‘new generation’ of genetically engineered humanoid. For some inexplicable reason, musing upon our own New Generations programme as it draws to a close, I am repeatedly drawn to the image of the Nexus 6 cohort in Scott’s movie as a metaphor to describe our own collective.

It was clear from our very first meeting that, as a group, we varied widely in academic discipline and methodological approach. Like the Nexus 6 replicants, then, we each had our own specialism. And occasionally, in discussions about interdisciplinarity and the problems that can sometimes arise from interdisciplinary working (differing theoretical perspectives or frameworks; variance in methodologies; conflicting outcomes), we occasionally discovered, amongst ourselves, some of the problems we were trying to address. This, perhaps, was no more evident than during our discussions to determine what this final event would entail: its format; its audience; its outcomes. Vacillating between alternative suggestions, it became quickly apparent that it would prove to be difficult to strike upon a perfect balance that would please or appease everyone involved.

However, like the team of Nexus 6 replicants, and in the face of difference, we have managed to form a unique bond and uncanny knack of working together. Despite the gaps between our working practices, this sense of harmony is embodied by the palpable willingness to listen to and encourage one another and to demonstrate an enormous interest in and support for what the other does, whilst simultaneously acknowledging the fact that it is not always possible to identify a mutual connection between each other’s work, despite working within the same academic field. And in this recognition of the fact that there may not always be a common link between the work of the ‘NewGens’ (the Nexus 6 of MH scholars) we were able to find the link, the unifying factor: the need to continually push the boundaries of pioneering scholarship in the field of medical humanities whilst simultaneously providing support for the work of our peers, work that moves in the same direction despite, more often than not, taking radically alternative routes.
I’m not sure whether this would, in the eyes of Eldon Tyrell, make us ‘more MH scholar than MH scholar’, but this ethos of support and tolerance for wide-ranging, innovative research, I feel, is crucial for any successful academic circle (and a genuine rarity).

Towards the end of *Blade Runner*, lead-replicant Roy Batty, when asked by Tyrell what he wants, replies, rather simply, ‘I want more life’. As the life of the New Generations programme comes to an end, I look forward to the growth of the life beyond the scheme that will continue to flourish in the relationships and connections that have formed between the cohort over the past year, and the life of new research projects that have either arisen from involvement in the programme, or been spurred on by it.

*Image: (Below) On set - the making of Bladerunner (or, a day's training with the NewGens)*
The future of the body
by Luna Dolezal

The idea that the human body can be changed at will in order to fulfil the designs and desires of its ‘owner’ is one that has captured the popular imagination and fuels the discourses and practices of contemporary futurist movements such as posthumanism, transhumanism, DIY body-hacking and Cyberpunk counter culture. Moving out of the realm of science fiction, these movements promote the idea that humanity should take the reins of human evolution and transform itself into the ‘posthuman’. The posthuman is a blend of flesh and machine, it enjoys augmented physical and cognitive abilities and a radically expanding lifespan, consciously directing evolution to its own ends.

The popular imagination of the future of the ordinary human body is infused with posthuman imaginaries. In a not-too-distant future, ordinary individuals will be able to imbue their own bodies with superior physical and mental traits in order to live longer and happier lives. It is widely believed that the future of the body will be made possible through various means including genetic engineering, artificial intelligence, implants, hi-tech prostheses, robotics, neuroscience, extra-planetary migration, nano-technology, integrated human-computer interfaces and cognitive enhancers, among other developments that are purportedly just around the corner.

Our posthuman bodies will be made possible because of our ‘morphological freedom.’ Developed by transhumanist thinkers, morphological freedom is the idea that we should have the freedom to experiment with our bodies, exercising our autonomy in order to enhance the human condition through our engagement
with biotechnologies. Underpinned by the liberal humanist idea of the individual subject being characterised by self-ownership and self-determination, and a concomitant obligation to self-actualisation, the concept of morphological freedom places the body at the centre of personal autonomy. Freedom is not just freedom of expression but, significantly, freedom of transformation. Hence the concept of morphological freedom connotes both the body’s inherent plasticity and, more centrally, one’s individual autonomy when it comes to making choices about modifying, enhancing or altering one’s own body. Exercising one’s morphological freedom is already a reality for some. Biohackers have inserted magnets into their fingertips, augmenting their sensory experience as they can now ‘feel’ magnetic fields. Performance artist Stelarc has implanted a ‘third ear’ into his forearm which will eventually hold a miniature microphone in order to digitally transmit what this ear ‘hears’, making the ear a remote listening device for people tuning in over the internet. Hi-tech prosthetic ‘blade’ legs are used by amputee athletes, rendering them arguably faster than their able-bodied counterparts.

As biotechnologies continue to develop in the realms of bioengineering and biomedicine, the medical humanities have an important role to play in interrogating the emerging possibilities that shape what might become the human body. As most body modifications and enhancements imagined and realised by transhumanists, posthumanists and DIY body-hackers involve medical or medicalised interventions, there are important questions to be asked regarding the role of biomedicine and medical consumerism in realising the future of the body.

Acknowledgement to the Brocher Foundation, Switzerland for my ‘Future of the Body’ researcher’s residency in July 2015. Image courtesy of of Fernando Vicente.

Medical Humanities — It’s how we do it.

by Jana Funke

If you work in the Medical Humanities, you will be familiar with people asking: “What are the Medical Humanities?” and “What do you actually do in the Medical Humanities?” Before New Generations, I was not always able to answer these questions with much confidence or conviction, and this was despite the fact that Medical Humanities is part of my own job title. Having participated in New Generations, I still struggle to articulate answers to questions about what the Medical Humanities are and what they are not; whether the Medical Humanities are a field or a discipline; or whether Medical Humanities research necessarily involves collaboration between scholars in the Humanities and Medicine. What I
have learned is that these questions are important, but do not cut to the heart of what the Medical Humanities are about.

What New Generations has taught me is that we need to stop worrying so much about defining the Medical Humanities. Most crucially, it has shown me how productive it is to shift attention away from the specific content or subject matter of our own research – no matter how fascinating we might find it – and to concentrate more on questions of process. It is not so much about what we study or research, but about how we study and do our research. New Generations has been a brilliant opportunity for me to learn through observation and dialogue how other people approach and conduct work in this area, how they envision, design and lead projects, how they collaborate and produce knowledge. I have been able to reflect on uses of time, space and technology with the Hubbub team in the Hub at the Wellcome Trust, witness a conversation between magicians and physicians about how to model working practices, discuss with Professor Jane Macnaughton how she built and is now co-directing her Life of Breath project, and learn about the newly emerging role of the creative facilitator in interdisciplinary projects by working with Mary Robson, to give just a few examples.

One recurrent theme that emerged during these conversations was how we can work productively across the multiple boundaries that we encounter in our work be they disciplinary, cultural, historical, linguistic, professional or hierarchical. It seems to me that this question is at the very heart of the Medical Humanities in the present moment. To answer it, we need more opportunities to discuss how we do the work we do, how we run our projects, and how we utilise space, time, technology, language and expertise.

Of course, New Generations in itself has offered us a unique and much-needed opportunity to engage in precisely these debates both with other members of the cohort and with the many people we were able to meet over the course of the programme. In showing me that the Medical Humanities are precisely about having these kinds of conversations, New Generations has enabled me to embrace, somewhat belatedly, my own identity as a researcher within the Medical Humanities. It has shaped the way in which I approach my own projects not least by demonstrating the need to engage in and create new opportunities for us to discuss how we do the Medical Humanities.
’Prawns and rocking horses’: the schizophrenic sign.

by Michael Flexer

‘Anyone who doesn’t understand this illness will think that I’m just making this up.’

For a few days in December 2013, Thamsanqa Jantjie displaced mathematician John Nash as the world’s most famous schizophrenic.

Within hours of his performance at Nelson Mandela’s globally televised funeral, the trickle of complaints and queries from sign language speakers had become a deluge of judgements from international experts, heads of deaf and sign language associations and clickbait journalists. Going two-by-two for to get out of this rain was the coupling of indecipherable language and the diagnostic term ‘schizophrenia’; two days after the funeral, Jantjie outed himself as a ‘schizophrenic’ rehearsing a familiar script of hallucinations, violence and periods of incarceration.

The pairing of the incomprehensible language and the diagnosis was inevitable. Various speakers of different sign languages have tried and failed to remould his gestures into even mere fragments of a text; prawns and rocking horses were amongst the products of this exercise in cloud-reading. Pragmatically, these impenetrable signs required the diagnosis to make sense of their nonsense, and to end their disruptive potency. Like the punchline of a joke: when is a prawn a rocking horse? When it’s a schizophrenic.

Diagnosis down the camera lens is a dodgy enterprise. Jantjie’s account of his mental health sounds like a man parroting a better-learnt script, better-tailored to its audience, after getting shot down for trying out a less competent one two days earlier. It’s ‘schizophrenia’ run through Google Translate. As a case history or an account of a personal phenomenology, it’s no less a bingo jumble of phrases and tropes than his commentary on the funeral speeches. In response to his claim quoted above, no one understands ‘schizophrenia’ but only those who didn’t know how much they didn’t understand would fail to think that Jantjie was probably making it up.

Sign language academics and community representatives fell over themselves to itemise the languages Jantjie wasn’t speaking at the funeral. Not South African Sign Language, nor International Sign, British Sign Language nor American Sign Language. So with the ‘schizophrenic’, where we painstakingly map out the languages people aren’t speaking. Jantjie was repeatedly called a ‘fake’ sign language translator. But surely, this is a grapho-syntactic error; the ironic speech marks should be around ‘sign language transla- tor’. For these critics, he may not be a real translator, dealing in real language, but he’s a real fake.

Enigmatically, Jantjie claimed he was translating (no details though of what, and to what and from what). The only way his translation is rendered sensible, comprehensible and exchangeable in our cultural semiotic is for it to become a containable sign of its unsuitability for integration, its undeserving of interpretation. Around now, someone reaches for the signifier ‘schizophrenic’.
As a sign, it is always a metasign, a sign of its own irreconcilability with any semiological system that encloses it.

In this way, the ‘schizophrenic’ sign functions to demark the limits of our culture’s willingness to engage in the social exchange of meaning. Beyond the borders of our tolerance are gesticulations we refuse to accept, fractured stories of violence read only as prawns and rocking chairs. [1]


Rogue One: Medical Humanities at the margins

by Sam Goodman

The first time I heard of ‘medical humanities’ it was said to me in just that way – in audible inverted commas, as if the speaker was grappling with a strange conjunction of words they weren’t quite sure were meant to meet. Fast-forward a few years, and Medical Humanities is far more prominent within the academic landscape, with a variety of tailored MH modules, units, and degree programmes, as well as a community of researchers supported and nurtured by organisations such as the Wellcome Trust, or by initiatives like the New Generations project. Of course, the discipline has a much longer history, and this modern growth is the culmination of years of dedicated hard work from generations of scholars (if indeed generations is the right word, as Victoria Bates wonders elsewhere in this volume). But what about those scholars working outside of these centres of MH research? Or on
However, such parts of the superhero genre – a ‘non-traditional’ approach to medical humanities, reminding me to consider how, why and where my research fits into broader cultural analyses, or reassess established theoretical lenses as a means of illustrating the benefits of the less familiar medical one within textual analysis. In fact, I would argue that MH scholars have always shown an interest in the non-canonical. Take, for instance, the number of excellent articles and book chapters dedicated to the supposed master of middlebrow Ian McEwan and his novel *Saturday* (2003), or the significant work on comics and graphic medicine engaged in by researchers such as Ian Williams.

It has always been my opinion, confirmed further by the discussions had throughout this programme, that these subjects and others like them should not be beyond our purview. The recurrent narrative of overcoming illness told by participants in numerous reality TV shows; the representation of blindness in Netflix’s *Daredevil* (2015); the depiction of global pandemic in *The Last of Us* (2013); the prominence of prosthesis in the forthcoming *Star Wars* film, *The Force Awakens* – all of these subjects emphasise the applicability of MH across genres, media, and ‘brows’. In many ways, being part of a ‘non-traditional’ university gives me greater opportunity to explore such things than my colleagues in other more traditional environments. However, much like the superhero genre where great power invariably comes with great responsibility, such opportunities are the blessing and curse of both MH and of popular culture studies alike – I have the chance to demonstrate how these subjects are legitimate areas of study, but also, apparently, the expectation to do so as well.


This is where New Generations has been the most beneficial. It has demonstrated that the MH research community transcends the institutions that host it, and that individual researchers have the potential to shape the direction that their universities have recognised as ‘important’. The discussions we have had over the past 12 months have bolstered my confidence in my own work and further augmented my perspective on the field through insight into the work of others. I am leaving the programme convinced that whilst our cohort might all take differing approaches to MH, what unites us is a common desire to push at existing boundaries, explore new areas, and cover new ground. Where better to do that than at the margins? [x]
A few questions on weight

by Hieke Huistra

1 in 3 people in the UK are ‘overweight’, and although ‘overweight’ differs from ‘obese’ (another 1 in 5), this seems bad news. But is it? In 2005, in The Journal of the American Medical Association, four researchers analysed three existing studies on weight and mortality. They found that overweight people are the ones least likely to die—which seems good news. So why do we think being overweight is bad? Here is another question. Research shows that, after five years, 95% of all dieters have regained all the weight they may have lost – and often more. So why do doctors advise fat people to eat less? A medical humanist’s answer: because our ideas on health and disease are shaped by more than just the outcomes of biomedical research. Which leads to a new question: what is this ‘more’? The medical historian’s way of finding out: travel back in time to try and unravel how what we call facts were made—not by nature, but by people.

A whistle-stop tour through the history of weight might start at the seaside, around 1900. Back then, even more than now, a trip to the coast was a day out. And hence—from we would say: yet—it included penny scales and weighing chairs, as did a day at the fair, or a visit to a department store. Look at the weighing chair: it resembles a swing. This is appropriate, because at the time the scale was a plaything and weight, a curiosity—instead of the absolute measure of health it has become today.

What changed?

Whatever the change was, it had something to do with Louis Dublin, a New York life insurance statistician. In 1908, our second stop, he started creating tables with average weight-height relations of life insurance policy-holders. After the Second World War, these tables were adopted by medicine as the first standardised measure of healthy weight. Over the years, ‘average’ weight had
become ‘normal’, ‘ideal’, ‘desirable’ and ‘healthy’ – but what, if anything, do these things have to do with each other?

Our last stop: the 1930s, where we open a newspaper and see an advertisement that teaches us ‘If you go dancing, you have to be slender.’ In particular, it explains, this applies to women, ‘because gentlemen prefer slender, gracious ladies to corpulent ones, who are only asked to dance out of politeness.’ Another ad asks ‘Are you fit to show yourself in a bathing costume?’ It warns us: ‘Don’t forget, the most beautiful bathing suit is ruined by a bad figure.’ Both ads offer the same solution: a three-week treatment with slimming pills. But what is the problem? Not health, but beauty. Our aesthetic norms and our health norms not only coincide but also emerged around the same time – is this a coincidence?

We’ve made three whistle-stops, and now we have more questions than answers. But perhaps that is the point?

Image: Weighing Chair. Credit © Kodak Collection/National Media Museum / Science & Society Picture Library All rights reserved.

Towards a Visual Medical Humanities: a provocation

by Fiona Johnstone

Recent developments suggest that it might be possible to speak of a ‘visual turn’ within the medical humanities, a field which has, to date, been dominated by the written or spoken word; consider for example the enduring authority of narrative medicine, which has only been subjected to real critical scrutiny in the last few years. Arts-based methodologies have been proposed as one possible alternative to an overemphasis on narrative techniques in healthcare; there has been a renewed interest in art therapy and the arts-in-health movement, in the efficacy of arts-based interventions in clinical settings, and in potential therapeutic and/or diagnostic applications of art and art-making. Several medical schools now run elective modules aimed at developing students’ visual literacy skills through exposure to artworks; in other programmes artists are engaged to teach students ‘soft’ skills such as empathy and communication techniques.

Visual culture – like the medical humanities, an interdisciplinary field of practice rather than a distinct discipline – emerged in the late 1980s after art history, anthropology, film studies, linguistics and comparative literature encountered poststructuralist theory and cultural studies. Its development was driven by the apprehension that spectatorship might be as difficult a conceptual problem as reading, and that visual experience might not be fully comprehensible in the model of textuality.
How might a productive relationship between the practices of visual culture and medical humanities be imagined? A ‘visual medical humanities’ must do more than simply offer analyses (historical or otherwise) of iconographies of illness and injury; nor should it be reduced to the paradigm of arts-in-the-service-of-medicine. Asking how we see as well as what we see, a visual medical humanities raises searching questions about the social, political, and ethical conditions of visibility and spectatorship; it queries how certain types of bodies come to be more visible than others; considers how medical identities are visually as well as linguistically constructed; and thinks critically about the way in which images and objects are used and displayed in (for example) textbooks and research papers, public health campaigns, and medical museums and art galleries.

Acknowledging that ‘the space where one speaks’ and ‘the space where one looks’ operate according to different sets of rules, a visual medical humanities advocates an increased sensitivity to the potential of the visible (and invisible) to articulate that which may not be expressed in words.

Furthermore, a truly visual medical humanities recognises that visual practices – including performative or arts-based practices – have a vital role to play in the construction of knowledge (as opposed to simply the dissemination of it). Gilles Deleuze described the relationship between the ‘visible and the articulable’ as fundamentally disjunctive but nonetheless united by ‘a common limit that links one to the other, a limit with two irregular faces, a blind word and a mute vision.’ A visual medical humanities does not seek to replace a text-based model, but to enrich it. An increased familiarity with – and sensitivity to the complexities of – visual methods and theories can only enhance the future potential of research in the medical humanities. 


2Woods, p. 76.


Dancing across disciplines.

by Claude Jousselin

The New Generation in Medical humanities program and its examination of interdisciplinary collaboration practices has encouraged and supported my practice in the research I am involved with. The debates and concerns that were explored in the workshops resonated with my intent to promote, conduct and engage research that bridges across and flows from Mental Health clinics into other spaces. Ultimately my hope with entering into collaborations has been to stimulate different knowledge productions, to ask different questions as well as asking them differently. I have attempted this in my PhD research that followed the diagnostic process for Adult ADHD as it moved between a specialist clinic and patient organisation/support groups, thus highlighting practices of memory and of kinship across the settings that were sometimes in accord, sometimes not. In my work as a clinical service lead with the South London and Maudsley NHS foundation Trust I am involved with an action-research project that requires collaborative work between clinicians, dance artists and patients.

The Alchemy Project (TAP) was set up in January 2015 and has offered an alternative therapeutic concept to support the recovery of young people with mental health problems. Over the course of four weeks, participants learned contemporary dance technique, rehearsed and performed an original dance work that showcased all that they had achieved to an invited audience of family, friends and health professionals at Sadler’s Wells’ Lilian Baylis Studio. They engaged in trust-building and team-building exercises, shared healthy lunches and worked as a dance company. The teaching methodology and ethos of the project were rooted in engaging and inspiring people who may be struggling in their lives and focused on wellbeing rather than deficits.

Engaging with young people who have experienced mental health problem in such a way side-stepped the discursive practices that are mostly practiced in the therapeutic environment of mental health services.

Whereas the emphasis in therapeutic encounters is often on telling and discussing what has happened, through dance and movement a different
kind of story telling could be produced by the participants through which identity and experience could be explored. Thus the creation of solo pieces within the overall choreography gave opportunities for the participants to explore connections between thoughts and feelings, body and mind in view of their lived experience of mental health problems.

Dancing in this context is learning and expressing through body and movements giving the opportunity to convey through this medium what may not be verbalised such as stories of recovery, of endurance or of struggles. The emphasis on non-verbal narrative was at the heart of the collaboration between dancers and health professionals and was also influential on the practices of mental health services. The dance team spent time with the Mental Health teams, in order to understand the environmental and theoretical context in which participants were supported and observed the clinical practices. Similarly health professionals were given the opportunity to experience the dance training offered to participants in order to understand physically their experience. From the Latin root of the word – con-labōro, (with + work), collaboration requires work and attention and in the case of the Alchemy project it was built from dance practice between three parties with the hope that it can be sustained in the long term.

Following the dance intervention, measures of well-being have been captured through interviews with participants that showed an increased positive perception of themselves and their place in the world. In addition some participants have developed a lasting involvement with dance and movement that will likely continue to support their recovery and positive engagement in the world.

Images: Photos provided by Pari Naderi ©2015

1 Funded by Guys and St Thomas Charity, Maudsley Charity and Arts Council England; co-produced with the Early Intervention and OASIS service of South London and Maudsley NHS Foundation Trust and SLAM Arts Strategy

But what does faith have to do with health, anyway?

by Ben Kasstan

Although I am an anthropologist-in-training I have felt a sense of familiarity and comfort in the medical humanities over the course of my PhD, perhaps because these areas of enquiry both champion the critical study of health and illness. Medical anthropological work continuously illustrates how health is not simply entangled within, but often hinged upon, wider processes of historical, social, economic, and political constraints. It is this holistic approach that can counter the unhelpful view of people being regarded as problems, or culture as a challenge, to implementing health interventions. Such a consideration will give rise to a state ‘when people come first’ - as has been so eloquently articulated by Joao Biehl and Adriana Petryna (2013). Faith or religious traditions are often seen as another weight on society, captured in the classic song *Imagine* by John Lennon:

*Imagine there’s no countries*
*It isn’t hard to do*
*Nothing to kill or die for*
*And no religion too*

As the Lancet’s recent series on faith and health argued, faith is typically considered to be divisive yet its potential to be enabling of health is neither fully understood nor harnessed. But what does faith have to do with health, anyway? Thinking beyond the joyous (and, not least, ex- pensive) festivities of Christmas or Hanukkah, faith offers a compass for individuals to map their lives and a guide- line within which the decisions that affect their bodies and health can be made. Rather than existing within a fixed and stubborn boundary, faith can also be like seam- line; bridging two worldviews with a sense of flux and flexibility to make health-related decisions.

Understanding how religious practitioners navigate health and healthcare services can help to avoid stigmatising them. Interdisciplinary research – whether in medical anthropology or the medical humanities – can then illuminate the complex ways in which health practices exist within a broader ordering of an individual’s (or group’s) life. This is certainly the case for the growing ultra-Orthodox Jewish community in the UK, whom I lived with for 12 months during my ethnographic field-work.
Enriched by theoretical debates, research methods, and the practical implementation of results, my education in anthropology and the medical humanities has empowered me to think critically about the complex relation between health and faith groups.

Further reading:


Paradox of Spectacular Evidence: 

by Zoë Mendelson

The most iconic visual descriptors of disorder are perhaps neurologist Jean-Martin Charcot’s methodically documented in-patients at the Salpêtrière hospital, Paris in the late nineteenth century. Inmates identified as hysterics performed their hysterical type for Charcot’s photographers, under hypnosis, and the material was then used as proof of the specifics of their diagnosis.

In his book, Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière, cultural theorist Georges Didi-Huberman discusses the problem of assigning an aesthetic to a disorder. He describes Charcot’s documentary evidence as ‘dramaturgy’ and his archive as ‘the anchoring of photography in fiction.’ (Didi-Huberman, 2003, p: 63) The temporality of the supposed hysterical attack is very much at odds with the nineteenth century camera’s need for a still, posed model. The lie is bound, therefore, to the technology of the day.

The posed ‘model’, the studio set-up and its requirements of planning, equipment, economics and location are all a part of this dramaturgy and therefore ‘the making of representational objects from the point of departure’ (ibid. p: 62). Didi-Huberman extends this to include the ‘stage directions’ - the legend or text through which Charcot’s evidence was explained. This dramaturgy has persisted in contemporary clinical diagnostic models. Randy O Frost, psychologist and Gail Steketee, sociologist, specialising in Hoarding Disorder in the US, write in their book Stuff: Compulsive Hoarding and the Meaning of Things that, ‘To make sure we had an accurate way to assess clutter, we set out to develop a nonverbal measure that did not rely on the word… the result of the project was a series of nine photographs depicting clutter in each room… We use the ‘clutter image rating’ as we now call it, in most of our ongoing research. It gives us an unambiguous marker of the seriousness of the problem and clarifies the word ‘clutter’ in the world of hoarding.’ (Frost, Steketee, 2010, pp: 59 – 61)

Intriguingly, Frost and Steketee did not use images of genuine hoards but constructs that they set up in student housing and photographed, later calling them ‘accurate’. As underlined through an examination of Charcot’s studies, Frost terming his photographic imagery as ‘unambiguous’ in its illustration of a disorder is not a new rationale within diagnostics, nor is it within the history of the photo-document. Siegfried Kracauer wrote of archived photography that it could only ever serve to authenticise or tell of the moment of its specific production rather than of the truth of the subject, from which it has been dislocated, This eradication of personal memory or experience allows that ‘The photograph gathers fragments around a nothing’ (Kracauer, 1995, p: 56).

Excluding us from its fragmented content through severed signifiers, the photograph’s image, once separated physically or historically from its
subject, ‘wanders ghost-like through the present’ (ibid, p: 56).

Using photography scientifically, anthropologically, clinically or as proof is, of course, shaky ground. Didi-Huberman puts it best and in typically poetic manner when he writes:

Photography *delivers* us, in all senses... Its superb “materialist” myth, the filmy production of the double, in fact constitutes the *passing to the limits of evidence*. Exacerbated, multiplied, magnified: evidence passes into simulacrum. (Didi-Huberman, 2003, p: 65)

Both Charcot's posed hysteric patients and Frost and Steketee's *Clutter Image Rating* are fictive, aesthetic diagnostic tools essential to my work in considering the separation of the materials within disorder from the documents assigned to its discussion or representation. These ideas about photography, representation and evidence reverberate in the cutting and cropping of photographic images inherent to (my) collagist art practice. The slices and repositionings become an act of deferral or sacrilege. Collage is tampering with *evidence*. I can't help wondering if tampering with untruths could reveal something more truthful. ☝

**References:**


**Images:**

2. (Right) *Clutter Image Rating 2* (paper and digital collage), Zoë Mendelson, 2014

1 Georges Didi-Huberman uses this phrase (Huberman, 2003, p: 59) in reference to photography’s slippery relationships to knowledge and resemblance.

2 It is useful to consider Didi-Huberman’s use of the word ‘dramaturgy’ with regard to relationships between museology, sociology and performance via the work of Canadian sociologist Erving Goffman - Goffman being the first to import the term from theatre to the humanities in his 1959 book *The Presentation of Self in Everyday Life.*
Clutter Image Rating Scale: Kitchen

Please select the photo below that most accurately reflects the amount of clutter in your room.

1  2  3
4  5  6
7  8  9
Who wants to live forever?

by James Stark

The fascination with elixirs of life and the divine ambrosia – the mythical food of the immortal Greek gods – is almost as old as recorded human history. We have continually sought out potions, preparations and products to slow, stop or reverse the ageing process. Amongst these innumerable methods several stand out from the twentieth century: hormone treatments, electrotherapy, skin care, dietary regimes, exercise plans and cosmetic surgery have all attracted would-be rejuvenators and anxious agers. Whether we were suffusing our bodies with electricity in the 1920s, depriving them of food for days on end in the 1950s or modifying our appearance through cosmetic procedures in the 1990s, homes and local clinics became laboratories where we experimented with ourselves and put to the test a combination of various fantastical claims which physicians, entrepreneurs and companies made for their products. Rigorous scientific tests of many rejuvenation treatments are now carried out, but judgement on each new cream, gadget, exercise craze or diet ultimately stems from real-world experience. Rejuvenation was and remains a results-based game. But what exactly is it, and do we even want it?

On the one hand, rejuvenation is a purely biological process, operating at the level of the organism, organ, tissue, cell, or even the individual molecule. This type of rejuvenation was and is concerned with the reversal of the physiological ageing process to create a youthful state; a classic example is the hormonal research of Eugen Steinach and Serge Voronoff, whose surgical interventions in the early twentieth century (including the grafting of monkey testicles onto ageing male patients) were held up by enthusiastic proponents as means through which youth might be recaptured.

However, rejuvenation had an equally important and subtly different meaning: the restoration of the appearance of youth. Rejuvenation of this second kind can be achieved by manipulation designed to alter only the face and body which we present to the world, for example through skincare products or cosmetic procedures. If we widen the net still further we find that salamanders’ tails, the economy, urban spaces, and careers can all be rejuvenated: refreshed and
restored to new life. We cannot help but see contemporary relevance in a history of rejuvenation. The historical cases tell us something fascinating about the human condition and they speak to ongoing anxieties about ageing, becoming old and losing our vigour and vitality. Medical humanities offers us the tools to extract relevance from histories to consider implications for policy, clinical practice and regulation in medicine. Only an interdisciplinary approach can help us best use historical research of rejuvenation to address current challenges posed by an ageing population, the many quasi-scientific claims for cosmetic products and the emergence of regenerative medicine. To rework a famous phrase about cloning: biomedical science might be able to tell us how we can all live for an extra twenty years or more, but an approach rooted in medical humanities might shed important light on whether or not that is a good thing.

Fiction-reading and eating disorders.

by Emily T. Troscianko

There are all sorts of reasons for picking up a novel: to give yourself some time out from everyday routines, to experience a different version of the world through some-one else’s eyes, or to luxuriate in beautifully inventive language. Sometimes, we might seek out books for more pragmatic reasons: because we need cheering up, say, or are hoping for insight into a difficult situation. At other times we start reading a book with no expectation that it will have any particular effect on us, but realise when we put it down that it has changed us in some unanticipated way: made us think or feel differently about ourselves or the world or other people.

It’s clear that these kinds of changes might be relevant to mental health and wellbeing, and there’s increasing interest among researchers and clinicians in the role of what’s known as ‘creative bibliotherapy’ – the guided reading of fiction and poetry for therapeutic purposes, often in a reading group format. The value of reading has been investigated among sufferers from depression and HIV/AIDS, with prison populations, and in various aspects of children’s behavioural development.
My academic training is primarily in the study of literature, but my other main area of interest and expertise (both academically and from personal experience) is eating disorders. There's a small amount of existing research and clinical work relevant to bibliotherapy for disordered eating, but a lot more remains to be learned about both the positive and the negative potential of reading for those with eating disorders.

I've started investigating these connections in partnership with the UK eating disorders charity Beat, with whom I recently ran an online survey asking people about their reading habits and any links they might see between what they read and their mental health (including their eating disorder if they have one). Over 900 respondents have helped give us insight into what types of text they tend to find helpful or harmful; how they feel reading affects their mood, self-esteem, feelings about their body, and diet and exercise habits; and how they think some of those effects might come about. The findings will feed directly into the design of controlled experiments to test these relationships empirically.

The medical humanities offers the opportunity for disciplines like literary studies, psychiatry, and experimental psychology to critique each other's methods and assumptions, but also to work constructively with each other.

There are few fields where the benefits of collaboration across disparate disciplines are so obvious, and the need so great. I'll let two survey respondents make this final point for me:

'I feel like I've magically gained weight since I started reading (so say in the last hour).'

'After reading Time Traveller's Wife, I can see my body as something that can connect with another. [...] As I had anorexia 11-22, I missed a large part of development and so I have learnt to view my body sexually through reading fiction.'

We need to understand these things better.
Thanks and praise

The New Generations cohort 2014-15 would like to heap thanks on Professor Jane MacNaughton and Mary Robson for their most valued support, advice, expertise and enthusiasm over the past year.

To Dori Beeler, without whom we would have eaten nothing, stayed nowhere and been un-transported. It was so much more than organisation and we have appreciated your joining us greatly.

To all our host venues - in Durham, Glasgow, London, Leeds, Dublin and Durham again for making us welcome and fuelling us with debate and discussion.

And to the AHRC, Wellcome Trust and University of Durham for supporting this programme through which we have had such a rich experience and made such important interdisciplinary relationships - with much expected longevity.