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Critical Interventions in the Medical Humanities

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Abstract

This thesis makes three novel critical theoretical interventions in the medical humanities. The first uses Benjamin's critical theory of art in the age of its technological reproducibility to reveal that the evidence-based biomedical model's primary function is not to cure patients, but to prescribe politics. The technological reproducibility of evidence-based biomedicine transforms medicine so it can no longer perceive— or *encounter*—patients as unique, whole, and above all situated beings. The second intervention uses Sara Ahmed's feminist phenomenology to theorize ethical encounters between medicine and its "others"—patients and literature—in such a way that particularizes the *encounter*, not the other itself. This theoretical maneuver re-accounts for unique, situated patients without essentializing them. The third intervention proposes a medical *in*humanities that recognizes what conditions produce inhumanity in medicine's encounters with others, like the encounter between a mentally ill refugee and evidence-based biomedicine in Rawi Hage's novel *Cockroach*.

Lay Summary

One of the most common complaints by patients is that the medical system does not treat them as a whole person; rather, they feel reduced to just their biological disease. This thesis uses philosophy and literature to better understand how and why modern medicine fails to account for the whole, ill person and proposes solutions to this problem through the arts and humanities. More specifically, this thesis argues that modern medicine does not recognize how a patient's illness and health is not just biological phenomenon but also a socio-political one, and that philosophy and literature can help modern medical practitioners recognize this.

Keywords

Medical humanities, health humanities, medical philosophy, critical theory, phenomenology, feminist theory, Canadian literature, refugee literature.

Acknowledgments

Thank you to my supervisor, Dr. Joel Faflak, with whom this whole journey first started back in 2013. I was in the first year of my undergrad in the sciences, but was frustrated with my courses and looking to study something else. I heard about some new interdisciplinary humanities program directed by Dr. Faflak, so I visited his office which, at the time, was in a corner of the basement of an unrenovated University College. On my way there, I am quite certain that I would have crossed paths with a cockroach or two. After rambling to Dr. Faflak about all my varied and seemingly disparate interests in everything from biochemistry to literature, he told me to look into "some people at the medical school doing something called narrative medicine." I did—and now here we are, six years later. It is no exaggeration to say that I would not have gotten through my undergrad and Master's without him, nor would I be starting medical school next.

Thank you to my second reader, Dr. Susan Knabe, for providing constructive feedback and supporting this project from the start. Thank you to Dr. Christine Roulston on my examination committee who provided valuable advice at my original thesis hearing and ongoing support. Finally, thank you to all my examiners (Dr. Knabe, Dr. Roulston, and Dr. Andrea Charise, my external examiner) for serving on my examination committee and accommodating my tight defence timeline. Thank you to everyone at Durham University's Institute for Medical Humanities, where I spent the summer of 2018 writing my second chapter. I would especially like to thank Dr. Angela Woods for so enthusiastically responding to my very first email, to Professor Jane MacNaughton for turning my hope to spend time at Durham into reality, and Dr. Arthur Rose for giving such incisive and thorough feedback on my second chapter's first draft. During my time at Durham, I learned not simply how to "do" the critical medical humanities, but how to be generous with my critiques.

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Thank you to my parents, Soheila, an artist and Ali, an engineer, for raising me at the intersection of the arts and sciences. Thank you to my brother, Naveed, for bluntly reminding me that things could always be worse…or maybe better if I sold my soul to tech. Thank you to Ioana Dragomir for asking all the hard but right questions, being my personal librarian, and constantly teaching me—through her art practice—how to do literary criticism differently. Thank you to Daphné Gagnon for being the friend I so dearly needed during the oftentimes isolating experience of graduate school—the friend who walked, cooked, macramé-ed, and listened to me endlessly. Thank you to Alex Longson for helping me through every application, essay, breakdown, and break; for being "there" in all the important ways without literally being there. Thank you to my

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Preface

> I do not feel my friend's pain, but when I unintentionally cause her pain
> I wince as if I hurt somewhere, and I do. Often in exhaustion I lay my
> head down on her lap in her wheelchair and tell her how much I love
> her, that I'm so sorry she is in so much pain, pain I can witness and
> imagine but that I do not know. She says, if anyone knows this pain
> besides me, it is you (and J, her lover). This is generous, for to be close
> to her pain has always felt like a privilege to me, even though pain
> could be defined as that which we typically aim to avoid.
>
> Maggie Nelson, *Bluets* (2009), 39

Illness, like pain, could also be defined as that which we typically aim to avoid. I am writing this introduction a mere week after being admitted to medical school—the door into an exclusive club for those who are not only granted the privilege to be close to illness, but also given the authority to attempt to cure those illnesses. I feel wholly inadequate in my ability to do so. I will spend the next two years primarily studying the basic medical sciences, followed by two years honing that knowledge in clinical settings. While such an education may adequately prepare me to treat disease, I worry that I still won't be prepared to care for the people who are ill because of those diseases.[1] I worry that my medical education will not teach me what to do when I cannot cure the disease, or when a cure is not enough. Frankly, I'm not sure that a cure is ever enough. I worry that my medical education will obscure the privilege it is to be close to people experiencing illness by obscuring those people beneath their diseases. I worry that I will think of myself as the generous one—as the one offering the coveted cure—and forget that my patients are the generous ones—the ones offering me the privilege to be close to them and their illness. I worry that I will know my patient's disease, but not know their illness—what it means to be ill, how they experience illness, how illness affects their life.

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[1] By disease I mean a physiological dysfunction, whereas by illness I mean how the disease is experienced. I get this simple and clear distinction between disease and illness from Havi Carel's *Phenomenology of Illness* (2016), wherein she also offers a more nuanced account of the difference between the two.

But I also wonder if I need or should or even can know my patient's illness in order to care for them. Perhaps to care for my patients is to recognize their illness as that which I witness and imagine but do not know, as Maggie Nelson does with her friend's pain. Perhaps it is the literature and theory I have read (and have yet to read) that will prepare me for the privilege of caring for those who are ill. That is what the next three chapters are really about: how and why literature and theory help me (and hopefully others) to better care for those who are ill.

This thesis is also about the inextricable, yet oftentimes fraught and contested encounters between the humanities and medicine. The phrase "medical humanities" was first coined in the USA in 1948, partly as a response to the the landmark 1910 Flexner report which "exposed a lack of adequate scientific and clinical education across many American medical schools and recommended a root-and-branch overhaul, including the standardization of curricula" around the integration of basic and clinical sciences (Bleakley 12). The interdisciplinary field of medical humanities thus emerged and remains a kind of umbrella term for research and practice that applies the arts and humanities (and sometimes social sciences) to medicine and vice versa.[2] By the 1990s, narrative medicine developed as an especially influential approach to the medical humanities that focused specifically on the narrative basis of medical practice and education.[3] But by the early twentieth century, debates emerged around just who and what were excluded by the field's focus on medicine.[4] In response, the *health* humanities emerged with a mission to explore "human health and illness through the methods and materials of the creative arts and humanities" (SCOPE n.p.). What matters most for this

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[2] Around the same time in the mid-1990s, the history of medicine, philosophy of medicine, bioethics, medical sociology, and medical anthropology were also developing identities of their own outside the "umbrella" of the medical humanities. Moreover, it is important to note that none of these disciplines (including the medical humanities) were "new" insofar as humanities scholars and artists have always been engaged with medicine in various ways; however, the emergence of these disciplines as institutionalized entities (e.g. with their own departments in universities, academic journals and conferences) was indeed new to the twentieth century.

[3] See Kathryn Montgomery Hunter's *Doctors' Stories: The Narrative Structure of Medical Knowledge* (1991) and Rita Charon's *Narrative Medicine: Honoring the Stories of Illness* (2006).

[4] See, for example, Crawford et al. (2010) and the introduction to Jones et al.'s *Health Humeanities Reader* (2014).

thesis is that all these disciplines draw upon the humanities to shift the boundaries of what constitutes medicine as a body of knowledge. Going forward, I use the phrase "medical humanities" to refer to the myriad humanities-based methodologies and knowledges that encounter the body of medicine in many ways. I understand medicine as a body of knowledge in the same way feminist phenomenologist Sara Ahmed understands philosophy: "If we think of philosophy as a body of knowledge (and like all bodies, it is with other bodies, and with them in a certain way), then we can consider the encounter between philosophy and its others in terms of bodily processes" (139). Thinking of medicine in this way helps me to, first, recognize that medicine has others. Most relevant to this thesis are patients and the humanities (specifically critical theory and literature) as medicine's others. Second, it helps me understand the myriad ways in which medicine encounters its others. I am mostly concerned with how medicine often encounters its others by practicing upon them and by reproducing, consuming, and expelling its others. Finally, it helps me to recognize that medicine's body is permeable and thus can change with each encounter. This thesis explores how we might change the body of medicine so it may encounter its others more generously, more ethically.

More specifically, this thesis argues that critical theory and literature can, in politically necessary ways, reshape medicine's body and the way it encounters others—but only if one is careful about what and how critical theory and literature are used so that they are not simply consumed. This thesis is thus ultimately a cautionary tale about how the body of medicine is prone to consume its others. That is, how medicine can take up and fit its others within its naturalized systems and structures, thereby reproducing the same ideologies it has always espoused rather than being challenged to change by its others. The first chapter offers a caution about how illness narratives can be consumed and rendered apolitical by the technological reproducibility of evidence-based biomedicine for its capitalistic ends; the second chapter offers a caution about how an apolitical approach to medical ethics ends up consuming patients as fetishized, abstracted others; and the third chapter offers a caution about how apolitically attending to patients' stories can risk consuming those stories into evidence-based biomedicine's economy. Thus, the implicit argument running throughout my thesis is that the medical humanities must be

critical in its encounters with medicine, or risk simply being consumed by the systems and structures of its bodies (most especially, evidence-based biomedicine). Critical theory allows the medical humanities to critically approach the body of medicine insofar as it pries open the systems and structures that insidiously produce power inequities, thus opening them up for debate and intervention, rather than simply being consumed by their naturalizing and normalizing effects.

In this way, my thesis is most closely aligned with the critical medical humanities. In the introduction to the 2015 critical medical humanities special issue of the journal *Medical Humanities*, William Viney, Felicity Callard, and Angela Woods recognize an urgent

> need to reflect upon the given norms, procedures and values of our
> medical humanities research community. These include but are not
> exhausted by how 'race' and ethnicity, sexuality and gender, disability
> (and madness), technology and media, economics, and social and
> environmental inequalities are central to the production of medical
> knowledge and to the experience of health and illness […] We are more
> interested in illuminating diverse ways of doing medical humanities
> that are not only sensitive to imbalances of power, implicit and explicit,
> but include activist, sceptical, urgent and capacious modes of making
> and re-making medicine (and those domains closely allied to it)—and
> hence its ability to transform, for good and ill, the health and well-being
> of individuals and societies. (3)

Following this lead, I thus want to reflect on how the medical humanities often critiques a mere caricature of medicine (Chapter 1), deals with ethics apolitically (Chapter 2), and assumes that attending to patients' stories is necessarily and always ethical (Chapter 3). Each chapter encounters medicine in politically motivated ways, and in doing so each chapter strives to "make and re-make" the body of medicine. I began with personal reflections that grounded this work in my ultimate desire to "transform" the health and well-being of individuals by learning how to better care for those who are ill. But the

project of this thesis itself is focused on reflecting upon key issues in the medical humanities research community and offering "new ways of doing medical humanities" that are, if not politically urgent, at least politically attuned. That project alone deserves the full attention of this thesis (and more), so I leave the task of transforming health through the medical humanities as a project for my future practice and research.

In the 2016 *Edinburgh Companion to the Critical Medical Humanities*, Angela Woods and Anne Whitehead wonder how "the methodological and intellectual legacies of the humanities [might] intervene more *consequentially* in the clinical research practices of biomedicine – situating accounts of illness, suffering, intervention and cure in a much thicker attention to the social, human and cultural contexts in which those accounts, as well as the bodies to which they attend, become both thinkable and visible?" (35). This thesis offers a series of preliminary yet hopefully pointed answers to this question. And finding that answer requires a turn to critical theory. Viney, Callard, and Woods trace the influence of the turn to a *critical* medical humanities back to "the philosophical scepticism and political activism of the Frankfurt School, and its commitment to critical theory as a means to form an intellectual community and bring about social change" (3). I thus begin my thesis by using Walter Benjamin's critical theory of art to tease apart the political effects of evidence-based biomedicine's technological reproducibility. The critical medical humanities, influenced by feminist theorists like Karen Barad, has come to understand, as Des Fitzgerald and Felicity Callard argue in the *Edinburgh Companion*, that "the figures and preoccupations of the medical humanities are, in fact, deeply and irretrievably *entangled* in the vital, corporeal and physiological commitments of biomedicine" (36).[5] In a very similar way, I draw upon Ahmed's feminist theory to understand the medical humanities as being deeply entangled in its encounters with the body of medicine. Feminist theory runs throughout all three chapters, but is most prominent in Chapter 2 where I use Ahmed's phenomenology to account for difference in the clinical encounter without essentializing that difference in the body of the patient. In their call for an entangled critical medical humanities, Fitzgerald and Callard make sure

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[5] More specifically, the critical medical humanities draws upon Barad's notion of agential realism as theorized in *Meeting the Universe Halfway* (2007).

to clarify that "an entangled medical humanities does not ask for differences to be overcome; it asks how differences have come to matter in sickness and health; it tries to think how their mattering might be brought into richer understanding through specific moments of intervention" (n.p.). Throughout this thesis, I explore how differences can "come to matter" where they have been, I argue, wrongly overcome by evidence-based biomedicine (Chapter 1), a Levinasian-informed medical ethics (Chapter 2), and a literary clinical encounter (Chapter 3).

The first chapter deals with the dominant model structuring medicine's body: evidence-based biomedicine. As noted above, I use Benjamin's critical theory of art in the age of its technological reproducibility as a heuristic to unpack how evidence-based biomedicine functions and to what political effects. More specifically, I argue that evidence-based biomedicine functions through its technological reproducibility and the effect is the withering of the patient's aura. I understand the aura to be a medium of perception that enables one to perceive an object or subject as uniquely situated in and out of particular contexts. And so withering the aura is political insofar as it means that evidence-based biomedicine cannot account for the unique, situated patient—one who is uniquely grounded in particular contexts that are always influenced by political structures. As such, I argue that the medical humanities must critically re-shape medicine's body in such a way that changes medicine's fundamental problem of (ap)perception: that medicine fails to realize how it perceives patients as apolitical generalized statistics and reduced parts. If the medical humanities does not tackle this root problem, its interventions risk simply being consumed by evidence-based biomedicine's generalizing gaze. I offer the wellness industry and breast cancer illness narratives as examples of how mass interventions may be consumed by the technological reproducibility of evidence-based biomedicine.

Having outlined in greater length how evidence-based biomedicine functions and to what effects, I move to my briefer second chapter to consider the ethics of clinical encounters that occur within that medical model. Specifically, I interrogate a model for an ethical clinical encounter proposed by medical humanities scholars using Emmanuel Levinas'

philosophy. I use Ahmed's feminist phenomenology to argue that the apolitical and abstracted use of Levinas for medical ethics produces both patients and literature as medicine's fetishized others. In other words, I argue that this Levinasian model for an ethical clinical encounter fails to account for unique, situated patients, just as the evidence-based biomedical model does too. Instead, I argue that Ahmed's feminist phenomenology offers a better foundation for an ethical clinical encounter because it allows one to account for an other's difference (such as differences in race or ability) at level of the encounter, rather than as an essentialized part of the other.

The third and final chapter brings the concerns of the first two chapters—evidence-based biomedicine and the clinical encounter— together through a critical reading of the 2008 novel *Cockroach* by Rawi Hage. *Cockroach* raises fresh critical concerns for the medical humanities as it rejects the oftentimes humanizing project of the medical humanities and, instead, invites recognition of the narrator/patient's *in*humanity. I combine Viet Than Nguyen's critical theory of recognition—that one must recognize the other's humanity *and* inhumanity—with Ahmed's feminist phenomenology to argue that humanity and inhumanity do not exist *in* others, but are conditioned through *encounters* with others. I then deploy this critical methodology to reveal how the encounters between the narrator and his therapist are structured by an evidence-based biomedical economy of exchange— the clinician holds the coveted "cure" and demands possession of the narrator's stories and emotions in exchange for that "cure"—and how that economy conditions the production of inhumanity in their encounters. This chapter concludes my thesis by bringing myself, as humanities scholar and future physician, into what I hope to be an ethical encounter with medicine's others (both the novel's narrator-as-patient and the novel itself).

1   Medicine in the Age of Its Technological Reproducibility

1.1   Introduction

Walter Benjamin's seminal essay "The Work of Art in the Age of Its Technological Reproducibility" (1935) is rife with medical metaphors: he describes the destruction of the aura as "symptomatic" (22), the aura as a strange "tissue" (23), and even uses surgery as an analogy to explain how cameras function (35)—to name just a few examples. His metaphorical use of medicine seems to invite a literal reading of medicine in the age of *its* technological reproducibility. In his essay, Benjamin famously argues that the artwork's aura withers through its technological reproduction and that the significance of this process "extends far beyond the realm of art" (22). In this chapter, I will extend the significance of technological reproducibility into the realm of medicine. Thus, whereas Benjamin is concerned with the political consequences of the technological reproducibility of *modern art* destroying the *artwork's* aura, I am concerned with the political consequences of the technological reproducibility of the most hegemonic *modern medical model* (evidence-based biomedicine) destroying the *patient's* aura.[6] My argument, through a critical medical humanities re-reading of Benjamin's essay, is two-fold. First, I argue that evidence-based biomedicine relies upon technology—everything from fMRIs and statistics to the highly regularized technology/techne of taking a medical history—to reproduce highly controlled and generic medical diagnoses, treatments/therapies, research results, and even patients.[7] Second, and more urgently, I argue that the technological reproducibility of the dominant medical model assimilates the differences of unique, individual patients into a mass, statistically-derived patient (i.e.

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[6] By the aura, I understand Benjamin (through Miriam Hansen) to mean a medium that enables one to perceive the artwork as unique and authentically situated in a particular historical, cultural, and political context. I take up Benjamin's aura and Hansen's interpretation in further detail in section 1.2.1.

[7] By the reproduction of "highly controlled and generic" patients I mean that evidence-based biomedicine turns unique indviduals into generic statistics-as-patients who can fit into the medical model's similarly generic diagnostic and treatment categories. In this chapter, I argue and demonstrate how the transformation of unique indvidiuals into generic patients is continuously reproduced by the technological reproducibility of evidence-based biomedicine. In section 1.2.3, I use three case studies to further argue that these generic categories are often idealogically determined, and so evidence-based biomedicine's reproduction of patients is actually a reproduction of (often oppressive) ideaological subjects as patients.

destroys the patient's aura) and thereby shifts the social function of evidence-based biomedicine from curing individual patients to prescribing particular politics for mass patient groups.

The dominant medical model is the frequent target of critique from humanities scholars, but as medical philosopher Juliette Ferry-Danini convincingly argues, the medical humanities often "fail[s] to give credible accounts of the model" and thus ends up "critiquing what essentially amounts to a caricature" (58). Ferry-Danini goes on to contend that the medical humanities' poor conceptualization and critique of the dominant medical model has resulted in a field that focuses too closely on the clinical encounter and thereby misses the opportunity to intervene where it really matters: at the level of health systems and public health (58). Doing the latter, she argues, "necessarily raises fresh ethical and political questions, specifically regarding justice and equity" (70).[8] My critical medical humanities re-reading of Benjamin's essay strives to do precisely what Ferry-Danini outlines: I use Benjamin's theory of art in the age of its technological reproduction as a heuristic for better conceptualizing and critiquing the dominant medical model in such a way that reveals its political function, thereby raising "fresh ethical and political questions."

1.1.1 A Brief History of Modern Medicine

By the late nineteenth century, scientific medicine, also known as biomedicine, had emerged. In his 2017 PhD dissertation "The New Medical Model: Chronic Disease and Evidence-based Medicine," physician-philosopher Jonathan Fuller explains how what changed in the twentieth century was "that physicians now received an extensive scientific education during their training, and for the first time had a powerful therapeutic armamentarium with which they could cure many diseases, especially acute infectious diseases" (2). This scientific education was—and largely still is—rooted in the basic

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[8] In Chapter 2, I will argue that Levinasian medical ethics has also focused too closely on the clinical encounter and thereby cannot imagine a politically just and equitable clinical encounter.

medical sciences, which are primarily structured around organ systems and their mechanisms of function, especially at the cellular and molecular levels. Philosopher Miriam Solomon, in *Making Medical Knowledge* (2015), explains how biomedicine's newfound scientific basis results in reductionism, wherein diseases are "increasingly understood in terms of organs, parts of organs, microorganisms, and biochemical processes rather than in terms of the whole organism (as in humoral theories) or its environment (such as miasmas)" (6). This biomedical model uses mechanistic reasoning based upon this reductionist scientific knowledge to cure patients. Biomedicine seeks *cures* and is thereby best equipped to deal with acute diseases that can be cured, unlike chronic illnesses. In *Bounding Biomedicine: Evidence and Rhetoric in the New Science of Alternative Medicine* (2016), Colleen Derkatch lays out how "contemporary Western medicine is shaped predominantly by the biomedical model" (8). In doing so, Derkatch quotes medical anthropologist Howard Stein to explain that while biomedicine is not a fixed model, it is generally characterized by "rational, scientific, dispassionate, objective, professional judgement" (8). These characteristics go on to also characterize evidence-based medicine, perhaps to an even greater extent.

By the late twentieth century, the emergence of evidence-based medicine (EBM) sought to replace the mechanistic reasoning and clinical judgement of the biomedical model. The most frequently cited definition of evidence-based medicine comes from the founders themselves in their seminal 1996 article in the *British Medical Journal*: "Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al. 71). EBM has since established a hierarchy of evidence wherein systematic reviews of double-blinded randomized controlled trials are considered the "best" kind of evidence, while mechanistic reasoning and clinical judgements based on experience are some of the "worst." Fuller describes how scientific reasoning under the biomedical model relied upon basic science knowledge, whereas scientific reasoning under the evidence-based model relies upon the science of clinical epidemiology: "mechanistic thinking has been supplanted by statistical and probabilistic reasoning, and scientific expertise has come to reflect the ability to critically appraise epidemiological studies in addition to the

possession of an impressive store of biomedical knowledge" (5). As such, doctors must now first consider how a population of patients fared in a study and then apply those results to their individual patient. In this way, EBM does not replace the entire biomedical model, it just supplants its previous mode of reasoning (mechanistic) with a new one (epidemiological) that is supposed to be even more "rational, scientific, dispassionate, objective." While EBM seeks to resolve many problems with the previous biomedical model (most significantly its unreliable mode of reasoning), it also exasperates many of biomedicine's foundational problems (e.g. a fallacious sense of objectivity, reductionism, a focus on acute diseases) and even creates a new problem: the "unresolved conflict between the essentially case based nature of clinical practice and the mainly population based nature of the research evidence" (Derkatch 108).

The hegemonic medical model we are left with today is a mix of both the biomedical and evidence-based models: evidence-based biomedicine. I argue that this model cannot account for unique, individual patients for two reasons: first, because biomedicine reduces the whole patient into parts and, second, because evidence-based medicine focuses almost exclusively on statistics and populations. The biomedical side of the model penetrates too far *into* the patient—deep into the organs, tissues, cells, and even molecules—and the evidence-based side of the model focuses too far *beyond* the patient—out into the realm of mass populations and abstract statistical analyses of such populations.[9] Both processes, while opposite in some ways, rely upon the technological reproducibility of medicine to achieve the same effect: the loss of the unique, individual patient—the destruction of the patient's aura. Over the same century that evidence-based biomedicine rose to prominence, several other medical models also gained traction as patients, physicians, and even researchers sought ways to account for the unique, individual patients that were otherwise made to conform to evidence-based biomedicine. These other medical models are roughly identified as patient-centred care,

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[9] My second chapter is also concerned with the chasm between the wide view of illness (at the level of populations and systems) and the narrow view of illness (at the level of the intimate clinician-patient encounter). But whereas this chapter reveals how this chasm is produced by the modern medical model, my second chapter reveals how this chasm is produced in medical ethics.

complementary and alternative medicine (CAM), and the medical humanities, although all three frequently overlap.[10] While I do consider patient-centred care and CAM later on, I am mostly concerned with the medical humanities. We can only imagine effective ways for these other medical models to intervene in the scene of problems created by evidence-based biomedicine if we first understand—in a nuanced and robust way—what evidence-based biomedicine is, how it functions, and what its effects are. I am specifically using Benjamin's critical theory of art to do so, but I am also arguing more broadly for a turn to continental philosophy and critical theory in general to understand, critique, and then intervene in evidence-based biomedicine.

1.1.2   The (Analytic) Philosophy of Medicine: A Problem of Methodology

Philosophers of medicine are increasingly concerned with analyzing models of medical research and practice, especially since the advent of evidence-based medicine in the mid-1990s (Reiss and Ankeny 2016).[11] While the philosophy of medicine has revealed many

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[10] The evidence-based biomedical model is structured around *disease*, whereas the patient-centred care model is structured around the *patient*. That is, evidence-based biomedicine is practiced *on a disease* in a passive patient's body, whereas patient-centred care is practiced *with patients* who are actively involved in their own care (Derkatch 110). Evidence-based biomedicine provides medical care that is standardized by select accredited institutions, like the Royal College of Physicians and Surgeons of Canada. Complementary medicine provides medical care *alongside* the standardized care offered by evidence-based biomedicine, whereas alternative medicine provides medical care *instead of* the standard. CAM is mobilized as an umbrella term to encompass a "disparate range of health practices such as chiropractic, energy healing, herbal medicine, homeopathy, meditation, naturopathy, and traditional Chinese medicine" (Derkatch 1). Finally, the evidence-based biomedical model derives knowledge from science to understand disease, whereas the medical humanities derives knowledge from the arts and humanities to understand illness.

[11] Philosophers have been concerned with topics in medicine (like death and pain) for centuries, but the "philosophy of medicine" only emerged as its own field—distinct from philosophy in general and philosophy of science in particular—within the past few decades. There are now journals and professional organizations dedicated to the philosophy of medicine, making it a robust academic field in its own right. Some topics that are central to the philosophy of medicine include: definitions and categories of health and disease, clinical judgement, evidence-based medicine and randomized control trials, medical theories and explanations, animal models in therapy development, and values in medical research (Reiss and Ankeny 2016).

methodological problems in medical research and practice, it has yet to be reflexive about its own methodological limits. I contend that one such limit is politics: the philosophy of medicine's almost exclusive reliance upon analytic philosophy has resulted in a methodology that cannot effectively account for the political concerns of modern medicine. Jonathan Fuller, for example, explores two facets of what he calls the "new medical model": chronic disease care and evidence-based medicine. Fuller identifies several problems in this "new medical model" and argues that such problems are "intimately connected" to philosophical concerns (ii). But Fuller makes sure to nevertheless supplement his philosophical methodology with medical case studies and primary medical literature because while "medicine is messy and fleshy, philosophy is neat and abstract" (16). By setting up this opposition between medicine and philosophy, Fuller reproduces some of the same problems he identifies in medicine: his characterization of philosophy is reductive and takes analytic philosophy for granted as philosophy in general, in much the same way that modern medicine is reductive and takes evidence-based medicine for granted as medicine in general. Not all philosophy is neat and abstract, and especially not continental philosophy and critical theory. Phenomenology, for example, is very much "fleshy" and nearly all critical theory is more "messy" than "neat."[12]

More specifically, Fuller "restrict[s] his analysis to conceptual, metaphysical and epistemic problems of medicine and bracket[s] a discussion of ethical problems" because "the ethical problems of medicine have received far more attention" (19-20). It is indeed true that the philosophy of medicine has focused largely on medical ethics, but the discipline's treatment of ethics has been mostly apolitical. I argue that such an apolitical approach to medical ethics is inevitable when the philosophy of medicine is so heavily

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[12] In his chapter on "The Intertwining—The Chiasm" in *The Visible and the Invisible* (1968), Maurice Merleau-Ponty develops his ontology of "flesh"—that which connects the sensing body with the sensed object—as part of his greater phenomenological project. Merleau-Ponty offers the most explicit and famous example of how "fleshy" phenomenology is, but phenomenology in general is "fleshy" insofar as it accounts for an embodied and hence fleshed subject. And critical theory is "messy" insofar as it challenges the "neat" categories that structure society. Critical theories take on the "messy" task of providing "the descriptive and normative bases for social inquiry aimed at decreasing domination and increasing freedom in all their forms" (Bohman 2016).

reliant upon an analytical philosophical methodology; analytic philosophy is limited in its ability to grapple with the "messy" and "fleshy" concerns of politics. The divorcing of ethics from politics in the philosophy of medicine is untenable because so many ethical concerns in medicine arise from political contexts. For example, sexist and racist biases against women's supposed low tolerance for pain and black people's supposed inability to feel pain result in significant underdiagnosing and under-treating of these patient groups—both of which are serious ethical concerns.[13] As such, I return to the question of medical ethics through continental philosophy to begin grappling with the ethical-political consequences of the evidence-based biomedical model.

But before we can even begin to grapple with the political consequences of the medical model, we must be able to recognize that evidence-based biomedicine is doing political work in the first place. This is a challenge because, as Derkatch reveals, the evidence in EBM "seems to speak for itself, divorced from human agency and social context. This evidence appears to determine objectively, through numeric values, whether any given health intervention is safe and effective […] evidence-based medicine can affect boundary work without seeming to do so at all" (24). Derkatch deploys a rhetorical analysis of relevant medical journals to denaturalize EBM's professional boundary work. But EBM does not simply demarcate professional boundaries; it also demarcates political ones and, as such, demands a kind of analysis—like Benjamin's critical theory of art— that can denaturalize the political work EBM does. Derkatch even describes the evidence of EBM in much the same way as Marxist commodity fetishism: the evidence is "divorced from human agency and social context" just as the fetishized commodity is divorced from its material and social relations (e.g. the factory worker who produced it and the conditions under which he worked).[14] Evidence as commodity fetish is precisely

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[13] For studies on sexism and pain treatment, see: Calderone 1990, Hoffman and Tarzian 2001, and Chen et al. 2008. For studies on racism and pain treament, see: Ezenwa and Fleming 2012, Goyal et al. 2015, and Hoffman et al. 2016.

[14] In the first chapter of *Capital*, Marx famously theorizes the process of commodity fetishism. He states: "the commodity-form, and the value-relation of the products of labour within which it appears, have absolutely no connection with the physical nature of the commodity and the material relations arising out of this. It is nothing but the definite social relation between men themselves which assumes here, for them, the fantastic form of a relation between things […] the products of the human brain appear as autonomous

the kind of object that critical theory is best equipped to analyze.[15] Derkatch also importantly reminds us that the push for quantitative research methods (like EBM) after the birth of scientific medicine didn't come from practitioners themselves, but from "regulatory authorities who sought to establish 'uniform and rigorous standards' of practice and so viewed physicians' expertise, rooted in experience, as a 'valuable and dangerous commodity'" (37). This is an important reminder that the privileging of quantitative methods in the dominant medical model was not simply fuelled by a desire for "objective" and "rigorous" scientific evidence, but rather, politically motivated. As such, critiques of this medical model must account for such politics.

Similarly, Solomon observes that both patients and physicians have reacted on political terms against evidence-based medicine and scientific medicine generally:

> the criticism is that clinical guidelines—based on evidence-based medicine or consensus conferences—do not treat patients as individuals and devalue the importance of the physician-patient relationship. There is also concern, especially in the US, that such clinical guidelines are the first step toward increased medical regulation by bureaucratic organizations such as the government, health insurance companies, and the legal profession (3-4).

figures endowed with a life of their own, which enter into relations both with each other and with the human race [...] I call this the fetishism which attaches itself to the products of labour as soon as they are produced as they are produced as commodities" (164-5). Marx goes on to argue that the fetishized commodity—as an "autonomous figure" with a life of its own—enters into a particular relation with the human, and that relation is an oppressive one wherein the commodity, not the workers who produced it, holds power. In a similar way, evidence is now an autonomous figure with a life of its own that enables it to hold power. Under the evidence-based model, it is no longer medical researchers, practitioners, and educators who have power and authority over patients, but the evidence itself. And that evidence is oftentimes oppressive to patients, as I explore in section 1.2.3.

[15] In my second chapter, I use Sara Ahmed's critical theory to analyze how the patient is also produced as a fetish in the clinical encounter.

It is no coincidence that these two concerns—the loss of the individual patient and increased medical regulation—emerge together in reaction to the hegemonic medical model. Solomon's analytic philosophical methodology effectively identifies these two concerns, but does not adequately account for how the former results in the latter. My critical medical humanities re-reading of Benjamin's theory of art will reveal how political regulation is an inevitable and even inherent consequence of the loss of the unique, individual patient under the evidence-based biomedical model. Derkatch and Soloman's observations reveal how the dominant medical model both emerged from and results in politics and so our critiques of the model must be able to account for politics. This is why it is so crucial for the philosophy of medicine—and the medical humanities in general—to look beyond just analytic philosophy.

1.2   The Politics of Technological Reproducibility

1.2.1   The Technological Reproducibility of Medicine and its Aura

To begin: what exactly do I mean by the technological reproducibility of evidence-based biomedicine? I mean that the clinical diagnoses, therapies, and outcomes offered by this medical model are reproducible across patients, rather than unique to particular patients. That is: masses of patients who share signs and symptoms are offered the same diagnosis and therapy, which is then expected to result in the same clinical outcomes. And this reproducibility is achieved through the use of technologies, such as stethoscopes and fMRIs that detect the signs and symptoms used to diagnose patients, the pharmaceutical drugs used to treat the diagnosis, and even the techne of using medical charts to record the patient's progression from diagnosis to treatment to outcome. The technological reproducibility of medical practice is sustained by the technological reproducibility of medical research and education. The reliability of medical research (and scientific research in general) is based upon its reproducibility—whether the study's results can be reproduced. Statistics and randomized control trials are the primary technologies used by medical researchers to achieve reproducible/reliable results. These results are then used

as the "best evidence" to develop guidelines for medical practice and education. Medical learners are taught to use medical technologies—from stethoscopes and ultrasounds to statistically-derived evidence and medical charts—in highly regularized ways according to the technologically reproducible results of medical research in order to achieve technologically reproducible diagnoses, therapies, and outcomes in their patients. As such, the evidence-based biomedical model is not simply technologically reproducible but is actually *designed for* reproducibility, just as "the work [of art] reproduced becomes the reproduction of a work *designed for* reproducibility" (24, italics added). That is, evidence-based biomedical medicine is designed to be technologically reproducible in practice, research, and education. The technological reproducibility of evidence-based biomedicine is hailed for its scientific rigour, but achieving this rigour also sacrifices the patient's aura.

My understanding of Benjamin's concept of the aura comes from my own reading of Edmunch Jephcott and Harry Zohn's English translation of the second version of the work of art essay and Miriam Hansen's 2008 essay on "Benjamin's Aura," wherein she interprets the aura through a wide selection of Benjamin's writings, including the second version of the work of art essay.[16] In her essay, Hansen "defamiliarize[s] the common understanding" of the aura as a shorthand for the singularity, authority, and authenticity, of traditional art—a definition which she considers to be a "narrowly aesthetic understanding of aura [that] rests on a reductive reading of Benjamin" (337-9). Instead, Hansen argues that the aura is not inherent to the artwork, but is a *medium of perception*: the aura "implies a phenomenal structure that enables the manifestation of the gaze" (342). Hansen's interpretation of the aura as a medium of perception allows me to take

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[16] The second version of Benjamin's essay was written in 1936, published in Volume 7 of Benjamin's *Gesammelte Schriften* (1989), and then translated to English in Volume 3 of *Selected Writings*, edited by Howard Eiland and Michael W. Jennings (2002). Although the third version (1939) of the essay (translated by Harry Zohn in 1969 under the title "The Work of Art in the Age of Mechanical Reproduction") has been more widely anthologized and taken up, Jephcott and Zohn explain in the notes to their translation of the second version that it "represents the form in which Benjamin originally wished to see the work published; it served, in fact, as the basis for the first publication of the essay" (42). Miriam Hansen also uses the second version of the essay for this reason and argues that a "narrow understanding of aura is particularly pronounced" in the essay's third version (337). The essay's first version was published in German in 1935.

Benjamin's theorization beyond the aesthetics of art and into the realm of medicine, where I will identify perception as the fundamental problem with the evidence-based biomedical model. Furthermore, Hansen turns to the etymological connotations of aura as Greek and Latin for "breath" and "breeze" to emphasize that the aura as a medium of perception is not just visual: the "gazing subject is breathing, not just seeing" and like breath, the aura is a "medium that envelops and physically connects—and thus blurs the boundaries between—subject and object, suggesting a sensory, embodied mode of perception" (351). Thus, through Hansen, I understand the aura as a medium that intimately intertwines the perceiving subject with that which is perceived (e.g. an artwork or patient) in such a way that deconstructs the hierarchical boundary between the perceiver and the perceived. And this kind of perceptual intertwinement occurs at more than just the visual level: it is wholly embodied and thereby fundamentally phenomenological. This interpretation of the aura may seem to entirely collapse any distance between the perceiver and the perceived, especially as Hansen goes on to consider the biblical and mystical connotations of breath and breathing "to understand that this mode of perception [the aura] involves surrender to the object as other" (351). But surrendering to the object *as other* actually requires maintaining a critical distance that does not appropriate, colonize, nor fetishize the other—that allows one to perceive the artwork/patient as a unique whole situated in its own particular context.[17] Returning to Benjamin's own words allows one to better appreciate how critical this distance is to the aura.

Benjamin famously defines the artwork's aura as "a strange tissue of space and time: the unique apparition of a distance, however near it may be" (23). Through Hansen, I interpret this "strange tissue" as a medium that enables one to phenomenologically perceive the artwork/patient as unique and at a distance necessary to perceive the

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[17] Hansen's phenomenological understanding of the aura as a mode of perception that "surrenders" to the other is highly evocative of Emmanuel Levinas' phenomenological descriptions of ethically encountering the other *as other*. I take this up again in Chapter 2 as I critique how Levinas' phenomenology has been used to produce a medical ethic that does indeed risk appropriating, colonizing, and fetishizing the patient as the other. Instead, I use Sara Ahmed's feminist phenomenology to bring a critical distance back to the ethical clinical encounter.

artwork/patient as a whole situated in a particular historical, cultural, and political context. Benjamin goes on to argue that the modern masses seek to overcome this distance and uniqueness through the technological reproduction of art; and it is this "desire of the present-day masses to 'get closer' to things, and their equally passionate concern for overcoming each thing's uniqueness by assimilating it as a reproduction" that withers the artwork's aura (23). It seems particularly relevant for my present concerns that Benjamin uses surgery as an analogy to theorize how cinematography (the epitome of technologically reproducible art) overcomes the critical distance necessary for maintaining the artwork's/patient's aura:

> The attitude of the magician, who heals a sick person by a laying-on of hands, differs from that of the surgeon, who makes an intervention in the patient. The magician maintains the natural distance between himself and the person treated; more precisely, he reduces it slightly by laying on his hands, but increases it greatly by his authority. The surgeon does exactly the reverse: he greatly diminishes the distance from the patient by penetrating the patient's body, and increases it only slightly by the caution with which his hand moves among the organs. In short: unlike the magician (traces of whom are still found in the medical practitioner), the surgeon abstains at the decisive moment from confronting his patient person to person; instead, he penetrates the patient by operating.—Magician is to surgeon as painter is to cinematographer. The painter maintains in his work a natural distance from reality, whereas the cinematographer penetrates deeply into its tissue. The images obtained by each differ enormously. The painter's is a total image, whereas that of the cinematographer is piecemeal. (35)

Benjamin emphasizes that there exists a "natural distance" between the one who perceives (e.g. the medical practitioner) and the reality which is perceived (e.g. the

patient). That distance is maintained by the authority of the magician[18], whereas it is overcome by the surgeon when he penetrates the patient's body rather than encountering his patient "person to person." The effect of overcoming that "natural distance" is that the surgeon can only perceive a "piecemeal" image of the patient, whereas the magician perceived a "total image." Overcoming that distance penetrates and hence withers the auratic tissue of reality.

While Benjamin's point is metaphorical, in medicine, the patient's aura is both a literal and figurative tissue. Literally, the patient's aura is composed of various unique tissues that enable one to perceive the patient's interconnected organ systems as part of their whole body. Figuratively, the patient's aura is composed of the patient's unique experiences, circumstances, and beliefs that enable one to perceive the patient as situated in a unique cultural, historical, and political context. Consequently, the technological reproducibility of evidence-based biomedicine withers the patient's aura at both the literal and figurative levels: biomedical technologies (e.g. a surgeon's scalpel or an fMRI's magnetic waves) penetrate the patient's literal tissues in order to diagnose and treat them according to evidence-based medical technologies (e.g. statistical analyses and clinical trials) that assimilate the patient's figurative tissues into generic diagnostic, therapeutic, and risk categories. As a result, evidence-based biomedicine only perceives a "piecemeal" image of the patient. In seeking to "get closer" to the patient through technologically reproducible medical interventions, the evidence-based biomedical model ends up withering the patient's aura and thus treats a statistically-produced average patient instead of the unique, authentic, and whole patient. As such, the technological reproducibility of the dominant medical model, like the technological reproducibility of modern art, "substitutes a mass existence for a unique existence" (Benjamin 22): the unique existence of the patient is substituted by the mass existence of a statistically-derived average patient.

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[18] I return to explore, in detail, what Benjamin means by "authority" later in this section.

Benjamin argues that the withering of the aura is the "signature" of a modern perception that "extracts sameness even from what is unique" and that the transformation of perception in modernity through technological reproduction is analogous to the transformation of theory through its increasing reliance on statistics (23-4). Benjamin remains vague about what kind of transformation theory has undergone through statistics, but in medicine, the connection between statistics and perception is clear. As medicine increasingly relies upon statistics to determine "best" practices for using its technologies to yield reproducible results (i.e. diagnoses, therapies, and clinical outcomes), it "extracts sameness" from what were once unique patients, but who are now perceived by medical practitioners, researchers, and educators as statistically-produced averages. Derkatch eloquently describes how two of the most significant technologies of evidence-based-biomedicine—randomized control trials and statistics—"extract sameness" from unique people, practices, and effects through variable standardization:

> When variables are standardized, they are rendered similar enough to be compared […] The numbers produced in biomedical research are emptied of their social [and political] interest through their method of production, the randomized control trial (RCT), which transforms a variable range of health problems, treatments, practitioners, and patients into measurable phenomena by operating in accordance within a set of rigid criteria and procedures. This transformation of people, practices, and effects into measurable phenomena allows us to compare 'disparate objects' according to a shared metric. (32)

A once unique social and political object or subject (such as a disease or patient, respectively) is rendered an abstract number where nearly all difference is erased so it can be statistically compared under the evidence-based biomedical model. As a result, patients and their diseases are perceived as statistically-analyzable data that are fallaciously rendered asocial and apolitical.

Benjamin argues that "*just as the entire mode of existence of human collectives changes over long historical periods, so too does their mode of perception*" (23, italics original). The problem with the hegemonic medical model is, thus, a problem of perception—of how medical practitioners, researchers, and educators perceive unique patients as apolitical statistical averages and reduced parts. As such, any intervention by the medical humanities to restore the patient's aura (i.e. the medium of perception that enables one to perceive the patient as unique and at a distance) must tackle the root problem of perception. Otherwise, the medical humanities' interventions risk simply being assimilated by the hegemonic medical model's problematic mode of perception. In *The Birth of the Clinic: An Archaeology of Medical Perception* (1963), Michel Foucault argues that the clinic is a material and discursive institution that was both the result and manifestation of the birth of biomedicine. Clinical medicine is discursive insofar as it produces a medical gaze that penetrates patients' bodies to uncover the biophysiological disease at the root of their illness, which thereby constitutes medicine's scientific, disease-centred knowledge base. Foucault argues that medicine exerts its power over patients through this discursive medical gaze and hence functions ideologically. This chapter builds upon Foucault's work by arguing that the medical gaze replaces the auratic mode of perception that withers due to the technological reproducibility of evidence-based biomedicine. In the age of the aura, medicine perceived the patient as a whole, unique patient situated in a particular context; whereas in the age technological reproducibility, evidence-based biomedicine perceives the patient in a generic, reduced, and piecemeal way. The emergence of evidence-based biomedicine and its technological reproducibility is a result of the birth of the clinic. That is, the clinic discursively and materially institutionalized medical practice in such a way that enabled evidence-based biomedicine to develop as a systematic, hegemonic, and technologically reproducible medical model. I understand the auratic mode of perception (via Hansen) to be primarily phenomenological, whereas I understand the medical gaze (via Foucault) to be primarily discursive. Thus, in considering how medicine might seek to in some ways recover the patient's aura, I am really calling for medicine to be phenomenological in its approach to patients. I return to this point at greater length in Chapter 2.

1.2.2   Medicine's Pathological Unconscious and Ritualistic Basis

Benjamin asserts that "it is through the camera that we first discover the optical unconscious, just as we discover the instinctual unconscious through psychoanalysis" (37). Benjamin uses the term unconscious in the psychoanalytic sense, but also more literally to convey all that human perception cannot see when unaided by technology. Film cameras, through technologies like optical zooms and slow-motion, enable us to see aspects of reality that previously passed us by unconsciously. Just as film technology opens up an optical unconscious, medical technology opens up what I call the pathological unconscious. Benjamin describes how the film camera "brings to light entirely new structures of matter" and this is literally true of biomedicine as biomedical technologies bring to light previously "unconscious" structures in the human body. For example, fMRIs have brought to light the previously "unconscious" structure of neural networks in the brain (37). This is also true of the evidence-based side of the hegemonic medical model: the technologies of statistical analysis and clinical trials bring to light previously "unconscious" structures, like correlations and causal relationships, across mass patient populations. As such, the pathological unconscious opened up by medical technology lies both deep *within* the human body—at the molecular level—and far *beyond* the human body—at the level of trends across populations.

Yet a crucial facet of illness still remains "unconscious" to the evidence-based biomedical model: chronic illness. Chronic illnesses often present without any kind of "organic" pathology or etiology that can be perceived by biomedical technologies.[19]

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[19] Chronic fatigue syndrome (CFS) and fibromyalgia syndrome (FMS) are especially "notorious" in this regard. CFS is characterized by extreme tiredness that cannot be explained by another underlying medical diagnosis, while FMS is characterized by widespread musculoskeletal pain that also canot be explained by another diagnosis. The third edition of *The American Psychiatric Association Publishing Textbook of Psychosomatic Medicine and Consultation-Liaison Psychiatry* states that "the history of CFS and FMS has been notorious for disputes about whether these disorders are 'organic' or 'psychogenic'." Organic disorders are those with a biopathological etiology that can be detected by biomedical technologies and are usually acute, whereas psychogenic disorders have a psychological etiology that cannot be so "objectively" detected and are usually chronic. The textbook goes on to explain how "the extreme psychological [psychogenic] view may encourage the doctor to dismiss the patient's symptoms as 'all in the mind'."

Chronic illnesses are not well studied by evidence-based medicine either. Patients with chronic illness often suffer from multiple diseases and patients with multiple diseases are frequently excluded from clinical trials (Fuller 12). Moreover, chronic illnesses are not offered much relief from biomedicine, but interpersonal care offered through alternative medical models has been shown to help; however, evidence-based medicine does not easily account for health interventions dependent on interpersonal care because they are almost impossible to investigate through the "gold standard" of randomized controlled clinical trials (Derkatch 107).[20] In these ways, chronic illness still remains "unconscious" to the evidence-based biomedical model. And this is not simply a medical problem; it is a political one as chronic illnesses are so often the result of and/or exasperated by social and economic inequality. Ultimately, the dominant medical model's technologies are still unable to capture the most marginalized in our societies because of the model's inability to adequately account for chronic illnesses. Patients with chronic illness are thus left to perform in front of a medical apparatus that cannot see them or the root cause of their illnesses: political inequity.

Recognizing the political roots of a patient's illness requires a return to the ritualistic basis of medicine/art. Benjamin argues that before the age of technological reproducibility, art found its social function through ritual: "the uniqueness of the work of art is identical to its embeddedness in the context of tradition… In other words: *the unique value of the 'authentic' work of art always has its basis in ritual*" (24, italics original). Benjamin argues that "whereas the authentic work retains its full authority in the face of a reproduction made by hand, […] this is not the case with technological reproduction" (20). That is to say, the ritual function of the auratic artwork is the artwork asserting its authority as *the* authentic work of art. By authenticity, Benjamin does not simply mean the unique existence of an original work of art; rather, authenticity "is the quintessence of all that is transmissible in it from its origin on, ranging from its physical

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[20] Randomized control trials (RCTs) are a kind of clinical trial wherein "a population of individuals who might benefit from a new medical treatment are [randomly] divided into a treatment group—the group whose members receive the new treatment—and one or several control groups—groups whose members receive either an alternative or 'standard' treatment or a placebo" (Reiss and Ankeny 2016). According to the evidence-based medical model, the results of RCTs are considered to be evidence of the highest quality.

duration to the *historical testimony* relating to it" (22, italics added). Thus, authenticity and historicity are intimately intertwined for Benjamin. In "Benjamin, The Image, and the End of History" (2016), Chiel van den Akker, drawing upon Hansen, argues that "the aura only comes into being as a result of an attentive perceptibility, a historicizing gaze," which he defines as a "present awareness of [the artwork's] existence in time, stretching backwards into the past and possibly forwards into the (unknown) future" (48, 46).[21] This gaze makes us aware of the artwork's authenticity (its "historical testimony") and thereby invests the artwork with its aura—its unique existence which "bears the mark of the history to which the work has been subject" (Benjamin 21). Benjamin emphasizes that "what is really jeopardized when the historical testimony is affected is the *authority* of the object, the weight it derives from tradition" (22, italics added). By authority Benjamin means the historical, cultural, and even political situatedness of the artwork. Thus by asserting its authority as *the* authentic work of art, the ritual function of the art is to assert its historical, cultural, and political situatedness. Put in terms of the perceiver/perceived encounter, I understand art's ritual function as an ability to percieve the artwork's situatedness. Locating Benjamin within the medical context of my present discussion, we can thus say that medicine, when based in ritual, can percieve the patient's assertion of their authority and authenticity—that is, their situatededness in a particular historical, cultural, and political context.

Keeping within Benjamin's context, it is not only the patient but also the one who perceives the patient who can assert authority. As Benjamin argues when using surgery as an analogy for cinematography, the magician increases the distance between himself and the patient "by his *authority*" (35, italics added). Thus, medicine finds its basis in ritual when it perceives the patient's situatedness, but also when it relies upon the practitioner's authority. Derkatch explains that evidence-based medicine "emphasizes the low value of knowledge based solely on authority" and thereby implies that not following its standards "takes medicine back to the dark ages of authority-based medicine and anecdotal

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[21] Sara Ahmed understands historicity in a very similar way to van den Akker insofar as historicity involves not only going back to the past, but also considering possibilities for the future. I take up Ahmed's notion of historicity in relation to medicine's encounters with others in Chapter 2.

(unsystematic, low quality) evidence" (111-12). While EBM claims to no longer practice medicine based upon authority, it fails to recognize how it still depends upon the naturalized authority of a fallaciously objective and neutral evidence base. EBM has not eliminated the role of authority in modern medical practice and research; rather, the basis for its authority has simply shifted from magic/spirituality to evidence. While evidence may seem like a justifiable reason for a medical model (and its practitioners, researchers, and educators) to hold authority, it is not when this authority is attained through an uncritical reliance upon an evidence base that is actually ideologically determined. Thus, while the authority of the hegemonic medical model's evidence purports to only offer patients cures, it actually also prescribes ideologies.[22]

Benjamin further relates the ritualistic basis of art to its cult value in the prehistoric era, which lies in opposition to the artwork's exhibition value in the era of technological reproducibility (25). Whereas an artwork derived its cult value from being kept out of sight of the masses, its availability to the masses determines its exhibition value. Similarly, medicine derived its cult value from keeping the patient's body largely out of sight; the shaman or medical practitioner could not—and often did not need to—see inside the patient's body in order to perform her diagnosis and cure. The age of technological reproducibility instead exposes everything inside the patient's body—from organs to cells and even molecules—to medicine's gaze. At the same time, while the shift from cult value to exhibition value destroys the artwork's aura by severing art's roots in ritual, the technological reproducibility that causes this rupture also "emancipates the work of art from its parasitic subservience to ritual" (Benjamin 24). Similarly, technological reproducibility emancipates medicine from its subservience to the practitioner's authority as well as the patient's situatedness. Yet this emancipation does not necessarily liberate the patient from medical authority because, as I have argued, authority has simply shifted to evidence itself, such that medicine no longer treats the patient as uniquely situated in a particular historical, cultural, and *political* context. In short, in the case of medicine, severing medicine's subservience to ritual severs the

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[22] I provide specific examples of how evidence is ideologically determined in section 1.2.3.

patient's situatedness, thereby leaving the patient vulnerable to interpolation into a new context wholly determined by medicine's politics.[23]

The emancipation of art from ritual means that the "whole social function of art is revolutionized. Instead of being founded on ritual, it is based on a different practice: politics" (25). For Benjamin, modern art's social function is political insofar as its technological reproducibility results in mass engagement with art, thereby allowing fascism, capitalism, or communism to disseminate their ideologies to the masses. That is to say, art's technological reproducibility in-and-of-itself is neutral; how systems and their ideologies co-opt art via technological reproduction makes art political. Evidence-based biomedicine, under the guise of its supposed objectivity, often fails to recognize this crucial insight with regards to its own technological reproducibility: like modern art, modern medicine's technological reproducibility renders its social function primarily political. And like modern art, modern medicine is political insofar as its technological reproducibility results in mass engagement with medicine, thereby allowing medicine to be co-opted by politics in order to disseminate—or *prescribe*—ideologies to the masses. As Benjamin argues, "*the technological reproducibility of the artwork changes the relation of the masses to art*" (36, italics original). For example, whereas in a previously ritualistic era art was largely experienced by individuals, technologically reproducible art like film is collectively experienced in a theatre such that each individual's reaction ends up being organized and regulated by others in the mass. The technological reproducibility of medicine has also fundamentally changed the relation of the masses to medicine. We now collectively experience medicine insofar as medical research (and, in turn, practice) establishes standards for what counts as a "healthy" and "abled" body for mass patient groups, as well as a standard recovery narrative for the ill mass's return to "health" and "ability" through medical intervention. Masses of patients then regulate themselves, or are regulated, in order to meet medicine's standards. These standards for "health" and

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[23] In making this argument, I want to make clear that, like Benjamin, I am not claiming nostalgia for a "better" past when patients and art still had auras. Rather than re-romanticizing some sense of aura, I am instead deploying aura, particularly via Hansen, to indicate the importance of situatedness for medicine. In this way, I mean to re-politicize a notion of aura for the medical humanities.

"ability" are not just based in an "objective" medical evidence base—one that is supposedly wholly emancipated from its basis in ritual/authority; rather, these standards are based in ideologies and thereby serve modern medicine's new social function of politics. In other words, evidence-based biomedicine interpellates indviduals as patients.[24] The next section will exemplify the political function of modern medicine by exploring three cases of medicine's technological reproducibility and their interpellation of patients: online health websites, pregnancy testing, and assisted reproductive technologies.

1.2.3   The Political Function of Medicine: Three Case Studies

Feminist artists and scholars are especially cognizant of the political consequences of the technological reproducibility of the dominant medical model. Artist and scholar Bee Hughes critically analyzes the menstrual norms reproduced by UK-based online health websites in her article "Challenging Menstrual Norms in Online Medical Advice: Deconstructing Stigma through Entangled Art Practice." Online health websites—from WebMD to government health services—constitute a major technology of modern medicine used to reproduce political and normative medical standards under the guise of "objective" evidence-based health information. Hughes' analysis reveals that the medical information presented on these health websites implies a politics that assumes and thereby reproduces a particular patient as the subject of ideology: a (cis)sexist and heteronormative standard around who menstruates. Moreover, these websites reproduce standards of what "normal" menstruation is and should be: a regular 28-day cycle that is both physically and emotionally painful and lasts for approximately 5 days. Any

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[24] In "Ideology and Ideological State Apparatuses" (1970), Louis Althusser famously theorizes that ideological state apparatuses (like the police) exert their power not only through coercion and violence, but also the more insidious method of interpellation wherein an individual is made to mis-recognize themselves as a subject within that ideological system. Put another way, systems (like evidence-based biomedicine) enforce their ideologies by interpellating individuals into subject positions it has created for them (like patients).

deviation from this standard is thus impliciltly pathological. As such, these websites implicitly invite readers to seek *further* medical technological interventions (most typically the birth control pill) to "normalize" their menstrual cycles, even if their "original" cycle posed no health risks. The menstrual standard put forward by these websites is produced through the evidence-based medical model which establishes its generalized standard for menstruation from studies of mass populations of menstruators. The logic of evidence-based medicine here is doubly suspect: there may, in fact, not be a single individual in the populations studied who ever met the generalized standard in the first place (that is how averages work after all), and the population studied most likely excluded trans, intersex, and queer people. Ultimately, these health information websites technologically reproduce particular political and normative ideas around menstruation in ways that incite the masses to seek *further* medical technologies (e.g. the birth control pill) to actualize such ideas in their bodies.

The technological reproducibility of medicine transforms menstruation into pathology so it can regulate not only the physiological process of menstruation, but also ideologies of gender and sexuality. Writer and theorist Paul B. Preciado describes this process poignantly in his 2008 book *Testo Junkie: Sex, Drugs, and Biopolitics in the Pharmacopornographic Era*: *"*the success of the contemporary technoscientific industry consists in transforming our depression into Prozac, our masculinity into testosterone, our erection into Viagra, our fertility/sterility into the Pill, our AIDS into tritherapy, without knowing which comes first: our depression or Prozac, Viagra or an erection, testosterone or masculinity, the Pill or maternity, tritherapy or AIDS" (34-5). For Preciado, as for Benjamin with regards to art, the technological reproducibility of medicine is not inherently problematic, but becomes a problem when it is co-opted by oppressive systems like capitalism or what he dubs the "pharmacopornographic regime." As such, Preciado remains hopeful that the pharmaceutical technologies of medicine might still be co-opted by a different kind of politics: "the fact that the Pill must be managed at home, by the individual user in an autonomous way, also introduces the possibility of political agency" (208). An excellent example of this possibility for medical technologies is the pregnancy test. In his article "The feminist appropriation of pregnancy testing in 1970s Britain,"

Jesse Olszynko-Gryn reveals that under the control of medical institutions, pregnancy testing technologies were used—or strategically *not* used—for particular political ends: to control abortion, women's roles as mothers, heterosexual relationships, monogamy, capitalist economies, and more. For example, in 1940s Britain, married woman in heterosexual relationships were not offered pregnancy testing because it was assumed that they should be trying to get pregnant, and so testing these "healthy" women would be a "waste" of resources under the newly funded, yet already financially overstretched National Health Service (Olszynko-Gryn 3). In this case, the biomedical model reproduced a politically-constructed "healthy" subject: one that is deemed to be not only physically "healthy," but also socially "healthy" by meeting societal expectations around gender and sexuality. But when pregnancy testing technology was made accessible to the masses and could be managed at home, it was politically co-opted by feminist activists against the medical institution's own politics by using pregnancy testing for early, informed abortion decisions, family planning, and more.

The fact that many medical technologies—from pregnancy tests to health advice websites—now reach patients in their homes parallels how the technological reproducibility of art "enables the original to meet the recipient halfway" (Benjamin 21). Benjamin goes on to emphasize that "*in permitting the reproduction to reach the recipient in his or her own situation, [technological reproducibility] actualizes that which is reproduced*" (22, italics original). Similarly, the reproduction of menstrual norms through health websites prompts patients—who are presumably browsing the web from home—to go out to a medical clinic, hospital, and/or pharmacy to get a pill that they can use at home in order to actualize those menstrual norms in their bodies. As such, however, medicine in the age of its technological reproducibility does not entirely meet the patient "halfway" in their "own situation"; rather, it still demands that patients leave their home, the primary site of healthcare prior to the birth of modern scientific medicine. The technological reproducibility of medicine depends upon material medical institutions that are fully equipped with x-rays, surgical tools, and more—as well as being centralized sites (oftentimes connected to universities and/or research centres) where the dominant medical model can most efficiently be reproduced across research labs and medical

learners. These medical centres are mostly located in cities and can vary greatly depending on funding and/or donations from regional institutions and individuals. In this way, the material conditions that make the technological reproducibility of medicine possible presume and exacerbate many economic and political conditions. Thus, medical technologies that "meet" the patient at home still depend upon material economic and political conditions. Pills, pregnancy tests, and internet access cost money—and even if one has the financial means to buy a pregnancy test, for example, one may not be able to do so anonymously in a small, rural town where they are likely to run into someone they know at the local drug store. Assistive reproductive technologies (ARTs) are especially problematic in this regard as they are notoriously expensive, rarely available outside major metropolitan centres, and come with the stigma of infertility. [25]

But the material conditions of access are not the only politics to be considered with regards to ARTs. In "Racial Aura: Walter Benjamin and the Work of Art in a Biotechnological Age" (2007), Alys Eve Weinbaum also deploys Benjamin's critical theory of art as a heuristic to understand medicine, but her analysis is specifically focused on the ideological effects of race-based biotechnologies, like ARTs. Weinbaum's central argument is that, despite science's claims to having ushered society into a post-racial eutopia by proving that there is no genetic and hence biological basis to race, genetics-based medical technologies like ARTs still reproduce race as a biological essence (211). Weinbam explains how consumers of ARTs use race, without exception, as a primary criteria in selecting the genetic materials necessary for the biomedical technology and thus technologically reproduce and reify geneticized ideas of race as biologically essential (210). As such, ARTs not only reproduce a "'defect-' and 'disability-' free child but, as importantly, [. . .] [creates] a child who is identifiable as the same 'race' as the social 'parents' to be" (210). In other words: ARTs technologically reproduce ableist and racist ideologies. As such, Weinbaum argues that "just as notions of hand-madeness, authority, and uniqueness haunt the mechanically produced object of which Benjamin

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[25] ARTs include, but are not limited to: artificial or intra-uterine insemination, in vitro fertilization, and embryo transfer—most of which require the purchase of genetic materials.

wrote, rendering aura spectral, notions of race as a biological, genetic, and scientifically quantifiable essence haunt the biotechnological practices and products that this essay describes [like ARTs], rendering race spectral" (217). The political implications of this spectre of race remain invisible to the masses because ARTs "have become so completely integrated into Euro-American culture" that they are now, to a large extent, naturalized and normalized parts of reproductive medicine (210). But what will never feel natural or normal to the masses is how they are made to perform in a fractured way for the medical apparatus. And this is where one might crucially find the opportunity to denaturalize and thereby subvert evidence-based biomedicine's ideological effects.

1.3 Where and How the Medical Humanities Might Intervene

1.3.1 Performing for the Apparatus: A Problem of (Ap)perception

To better understand the patient's performance, we must return to Benjamin's analysis of the film actor's performance. The stage actor performs in front of a "randomly composed audience,"[26] whereas the film actor performs in front of an apparatus that is a constellation of technologies—most notably the film camera—and a "group of specialists—executive producer, director, cinematographer, sound recordist, lighting designer, and so on" (Benjamin 30). When performing for an apparatus, one forgoes their aura, which often results in "relinquish[ing] their humanity in the face of an apparatus" (31), as in the case of factory or computer workers. For Benjamin, the notable exception to this is film, wherein a successful or accomplished performance by a film actor can still "preserve one's humanity in the face of the apparatus" (30-31). Moreover, "interest in the [film actor's] performance is widespread" as the working masses go to the cinema to

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[26] I could problematize Benjamin's assertion that a theatre audience is "randomly composed." A variety of factors, like socioeconomic class, already pre-determine who will be in a theatre audience. But my argument does not depend on whether a theatre audience is truly "randomly" composed; rather, what matters is that a stage actor's audience differs from a film actor's.

"witness the film actor taking revenge on their behalf" by asserting his humanity in the face of the apparatus (31). In the case of medicince, however, I would argue that "interest in this performance" is different and even more widespread than Benjamin recognizes because the masses not only relinquish their humanity through work, but also through illness in the face of the medical apparatus. Both patients and workers perform in an arena governed almost exclusively by a constellation of technologies that includes, but is not limited to, stethoscopes, CT scanners, scalpels, surgical lights, randomized control trials, and even the medical chart, which is increasingly digitally recorded.[27] And this complex system of technologies used by evidence-based biomedicine to prevent, diagnose, cure, and manage diseases is endlessly reproducible across patients. Moreover, the patient also performs for the group of specialists who use these technologies and who, like the situation of the film actor, "are in a position to intervene in his performance at any time" (30).[28]

This intervention dictates that the film actor and patient are compelled to re-assert their humanity in different ways. Benjamin describes how "for the first time—and this is the effect of film—the human being is placed in a position where he must operate with his whole living person, while forgoing its aura" (31). Yet despite the film actor being able to re-assert his humanity because of this constraint, the patient, like the worker, cannot. For

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[27] Benjamin famously proposes that ideas are like constellations in the "Epistemo-Critical Prologue" of *The Origin of German Tragic Drama* (1928). In a *Dictionary of Critical Theory* (2010), Ian Buchanan explains that Benjamin means "ideas are no more present in the world than constellations actually exist in the heavens, but like constellations they enable us to perceive relations between objects" (n.p.). This doesn't mean that ideas are entirely subjective or just in one's head; there is, after all, something in how the stars are objectively positioned motivated humans to construct images out of them. The names for the constellations were also motivated by history, tradition and myth. But Buchanan makes sure to emphasize that Benjamin's theorization of ideas as constellations does not mean that ideas (and philosophy) are systematic, like math or science; rather, they are discursive (n.p.). Drawing upon Benjamin's understanding of ideas as constellations, I understand the evidence-based biomedical apparatus to be a constellation in three key ways. First, it is both objectively and subjectively constructed insofar as is composed of both material medical technologies and the people (generally clinicians) who use them. Second, the medical apparatus comes out of a particular history and tradition insofar as the medical technologies and how they are used come out of a particular Western biomedical tradition of scientific progress. Last, the medical apparatus is discursive insofar as it constitutes medicine's knowledge of the patients and disease more broadly.

[28] On average, for instance, physicians interrupt their patients within seven seconds of the patient speaking (Derkatch 111).

Benjamin the film actor's "performance is by no means a unified whole, but is assembled from many individual performances" (32), which allows the film actor to re-assemble her identity. The patient's "performance is by no means a unified whole" either, but her performance remains fractured by the medical apparatus. First, a patient is often under the care of many different health professionals (e.g. a nurse and a physician at the very least) who rarely have the chance to communicate about their shared patient. Moreover, biomedicine fractures the patient's body into parts (e.g. organs, cells, and biomolecules) and evidence-based clinical guidelines fracture care according to disparate diagnostic and treatment categories for every disease, despite increasing numbers of patients suffering from multiple interrelated diseases at once. Finally, evidence-based biomedicine treats the patient's diseased body as fractured from the patient's experience of illness and life as a whole.

This is perhaps one cause of the proliferation of illness narratives since the birth of modern medicine: such narratives, like the pieces of a performance brought together in a completed film, allow patients to re-assemble whole selves fractured by the medical apparatus. In doing so, they ultimately seek to re-assert their humanity in the face of the evidence-based biomedical model, although illness narratives do not necessarily change the hegemonic medical model's fundamental problem of perception. In section 1.2.1, I argued that the fundamental problem with the evidence-based biomedical model is one of perception—of how medical practitioners, researchers, and educators perceive unique patients as apolitical statistical averages and reduced parts. This problem of perception is inextricably tied to evidence-based biomedicine's lack of apperception, or conscious perception[29]: medical practitioners, researchers, and educators are not aware of nor

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[29] I understand the difference between perception and apperception through Gottfried Leibniz, who states in *Principles of Nature and of Grace* (1714) that apperception "is *consciousness*, or the reflective knowledge" of that which is perceieved (208 qtd. in Jorgenson n.p., italics original). Leibniz later elaborates on this difference in *New Essays on Human Understanding* (1765), wherein he explains that he "prefer[s] to distinguish between *perception* and *being aware* [*apperception*]. For instance, a perception of light or colour of which we are aware is made up of many minute perceptions of which we are unaware; and a noise which we perceive but do not attend to is brought within reach of our awareness by a tiny increase or addition" (134 qtd. in Jorgenson n.p., italics original). In the context of my discussion, I am concerned with not only the apperception of things in the world, but also their political and historical contexts.

reflective about how they perceive patients as apolitical statistical averages. Benjamin argues that "the function of film is to train human beings in the apperceptions and reactions needed to deal with a vast apparatus whose role in their lives is expanding almost daily" (26). As the medical apparatus continues to expand its role in patients' lives daily, I am thus incited to ask: can Benjamin's theory of film inspire new ways to train medical practitioners, educators, and researchers in the apperceptions needed to deal with the vast medical apparatus in such a way that preserves the patient's—and even the practitioner's—humanity in the face of the medical apparatus?

One answer to my questions may be found in Benjamin's discussion of Luigi Pirandello's understanding of estrangement[30]:

> *The representation of human beings by means of an apparatus has made possible a highly productive use of the human being's self-alienation.* The nature of this can be grasped through the fact that the film actor's estrangement in the face of the apparatus, as Pirandello describes this experience, is basically of the same kind as the estrangement felt before one's appearance in a mirror. (32-33, italics original).

Benjamin argues that it is, rather unexpectedly, through the experience of estrangement in front of the apparatus that the film actor is able to preserve his humanity. Similarly, perhaps estrangement can preserve a patient's humanity in the face of the medical apparatus. This is precisely the inspiration for one of the most cited and compelling medical humanities interventions. Physician Arno Kumagai and literary scholar Delese Wear argue that art should be used in medical education to "'make strange'—that is, to trouble one's assumptions, perspectives, and ways of being in order to view anew the

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[30] Luigi Pirandello is best known as a dramatist who won the Nobel Prize in Literature in 1934. Here, Benjamin is referring to his novel *Si gira ...* (1915) which was later published under the title *Quaderni di Serafino Gubbio operatore* (1925). The novel tells the story of an Italian film camera operator and is one of the first novels to reflect on filmmaking in modern Europe.

self, others, and the world" (973). Kumagai and Wear's intervention is particularly compelling because it tackles modern medicine's fundamental lack of apperception, particularly where, recalling Benjamin's theory of art, it seeks to close distance and overcome each thing's uniqueness. Kumagai and Wear begin with Vicktor Shklovsky's theory of familiarization, which posits that perceptions become habituated such that we end up perceiving most of the world unconsciously. For Shklovsky, literature—and art more generally—can defamiliarize the world through the process of estrangement.[31] Taking Shklovsky's theory in an economic and political direction, and echoing Pirandello's notion of estrangement, dramatist Berthold Brecht (one of Benjamin's most well-known interlocutors) argues that the habituated and deeply entrenched perceptions of structures such as capitalism naturalize and thus blind us to the oppressive nature of the world as it really is in our everyday lives. Inspired largely by Marx, Brecht developed a critical theatre that sought to alienate or distance the audience from the performance so they could recognize the injustices at play not merely in the performance, but in their own lives as well.[32]

It is from here that Kumagai and Wear argue how "making strange" can play a critical role for the arts and humanities in medical education, particularly by training a new generation of physicians in a practice that estranges and defamiliarizes and thus repeatedly critiques assumptions of and about the medical gaze. Hansen teases apart

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[31] In *Theory of Prose* (1929), Schklovsky, a Russian literary critic and theorist, develops his theory of *ostranenie*. The term can be translated as defamiliarization or estrangement and is a neologism for both "making strange" and "pushing aside." It refers to the techniques writers use to transform ordinary language into poetic language, forces readers outside their typical habits of perception by making the familiar appear strange (Buchanan n.p.).

[32] Brecht was best known for his highly political, Marxist-inspired "epic theatre" which sought to inspire political debate by "constantly reminding the audience that what they are seeing is both artificial and contrived and something that should be evaluated and judged" (Buchanan n.p.). Brecht coined the term "estrangement-effect" (sometimes translated as alienation-effect) to describe "the moment in a work of art [especially in epic theatre] when that which used to appear natural suddenly appears historical" (Buchanan n.p.). That effect is inherenty political in the same way my critique of evidence-based biomedicine is: it challenges one to see the structures (like evidence-based biomedicine, in this chapter's case and capitalism, in Brecht's case) that normalize and naturalize how things have supposedly always been, and hence allows one to recognize that those structures can and indeed should be changed.

Benjamin's "later definition of aura as the experience of investing a phenomenon with the ability to return the gaze," which "attributes the agency of the auratic gaze to the object being looked at, thereby echoing philosophical speculation from early romanticism through Henri Bergson that the ability to return the gaze is already dormant in, if not constitutive of, the object" (343). Hansen characterizes this auratic return of the gaze as an "unsettling force" insofar as it

> exceeds and destabilizes traditional scientific, practical, and representational conceptions of vision, along with linear notions of time and space and clear-cut, hierarchical distinctions between subject and object. In this mode of vision, the gaze of the object, however familiar, is experienced by the subject as other and prior, strange and heteronomous. Whether conceptualized in terms of a constitutive lack, split, or loss, this other gaze in turn confronts the subject with a fundamental strangeness within and of the self. (345)

Yet as I suggest above, we must also be careful not to equate the complexly and often arduous estranging and defamiliarizing work of apperception with an immediate liberatory politics, especially the kind supposedly offered by capitalism. I thus want to end this chapter by outlining two traps embedded within capitalism's troubled and compromising relationship with medicine, particularly as it is symptomatic of the kinds of otherwise beneficial solutions offered by the medical humanities.

1.3.2   Capitalism's First Trap: The Wellness Industry

Benjamin makes sure to emphasize that "there can be no political advantage derived from this control [by the masses] until film has liberated itself from the fetters of capitalist exploitation" (33). The same is true of medicine, wherein "wellness" has become a new model of healthcare that is supposedly liberated from the control of medical professionals, but plays into the hands of capitalism. The wellness model purports to give

control of healthcare back to the masses by meeting their demands for more holistic healthcare that attends to the whole, unique individual; however, the entire model is driven by a highly capitalist wellness industry that serves the financial interests of an elite minority—not the health of the masses. The wellness industry, much like the film industry, performs for an invisible mass that controls it. That is: the masses are demanding a new medical model that attends to whole, unique individuals—precisely that which is assimilated by the evidence-based biomedical model—and the wellness industry offers this back to the masses by selling them yoga, a plethora of alternative medical practices, green smoothies, personalized supplement regimes, individualized allergy tests, and more. The masses' demand for a new medical model that attends to whole, unique individuals is important, and I do not want to dismiss that. But the wellness industry does not actually confer any advantage over the hegemonic medical model because it is still tied to capitalist exploitation.

Benjamin goes so far as to compare the capitalist film industry to fascism, arguing that "the same is true of film capital in particular as of fascism in general: a compelling urge towards new social opportunities is being clandestinely exploited in the interests of a property-owning minority" (34). This comparison reveals the fascist logic behind the wellness industry as well: wellness offers a compelling urge towards new social opportunities (e.g. for self-care, alternative medicine, the patient's voice, etc.) that are clandestinely exploited in the interests of a bourgeois minority (e.g. mostly rich, white, heterosexual cis-women like Gwenyth Paltrow). Benjamin further theorizes that "fascism seeks to give [the masses] expression in keeping [property] relations unchanged. *The logical outcome of fascism is an aestheticizing of political life*" (41, italics original). In a parallel way, the wellness industry seeks to give expression to the masses by superficially meeting their demands for a new medical model, all the while keeping capitalist relations unchanged and aestheticizing the political life of attaining health or "wellness" as overwhelmingly clean, white, and sleek. The wellness aesthetic is typified by photographs of green "super food" smoothies on sparkling marble countertops, white women doing yoga on pristine white beaches, meditation retreats in contemporary log cabins, and so forth. This aestheticizing dangerously renders health and illness as

apolitical. This is especially true with respect to self-care—a practice that was first developed by black, queer feminists like Audre Lorde as a form of activism in the face of oppression,[33] but is now aestheticized by the wellness industry as a supposed cure-all that is, in fact, often only accessible to the rich. Wellness aestheticizes the politics of illness such that the burden of attaining health ("wellness") is placed solely on the shoulders of individuals: if you just eat "clean" enough, exercise enough, meditate enough, and visit your naturopath enough, then you will achieve peak wellness, so the industry story goes. In this way, the wellness industry dangerously elides how illness and health are deeply political: illnesses disproportionally affects people who are politically marginalized, and this problem is doubled as these are very people have the most limited access to healthcare under both the evidence-based biomedical model *and* the wellness industry.[34]

By taking various medical issues out of the direct hands of medical authority, the wellness industry apparently "democratizes" self-care and hence empowers patients, but it really just transform patients into customers. This supposedly alternative model and remedy to evidence-based biomedicine still relies upon technological reproducibility for oppressive ideological ends, but through the technologies of social media, vaginal jade

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[33] In the epilogue to "A Burst of Light: Living with Cancer" in *A Burst of Light: Essays* (1988), Lorde famously states that "caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (131). For Lorde, self-care is an act of "political warfare" insofar as it sustains her energy for political activisim in the face of the intersectional oppression she faces as a Black, queer, ill woman. In *The Cancer Journals* (1980), Lorde consistently ties her experience of breast cancer back to political concerns, like her experience with the essentialist and coersive expectation for post-mastectomy cancer survivors (like herself) to desire breasts, as well as the obscured environmental causes of breast cancer due to capitalist corporations that pollute the environment. Thus, for Lorde, caring for herself through cancer is inextricably tied to caring about challenging the politics that shape her illness experience.

[34] Chronic obstructive pulmonary disease (COPD) especially exemplifies this point. COPD is an umbrella term for many progressive lung diseases that are characterized by increasing breathlessness (e.g. emphysema and non-reversible asthma) and it is one of the leading global causes of death and disability. COPD disproportionately affects people in low- and middle-income countries where the air is more polluted because global political power has concentrated mines and factories in these countries. Moreover, most families in these countries live in poverty and thus use biomass and coal for energy in their homes, which further pollutes the air. And because the people who are most affected by COPD are already so politically marginalized, COPD receives disproportionately low levels of attention and funding for research and treatment compared to other major global causes of death and disability, like cancer. Death and disability from COPD is predicted to grow as political inequity and environmental pollution do too. See Quaderi and Hurst 2018 for a succinct summary of the disproportionate global burden of COPD.

eggs, faux allergy tests, and the like. This approach to illness has a long history. Derkatch explains that medical

> quacks [of the eighteenth century] were not anti-establishment: they did not subscribe to their own philosophical or therapeutic systems but rather sought to capitalize on the public's newfound thirst for medical goods. They traded on the esteem of the emerging medical profession by mimicking its modes of practice and its esoteric, technical language to attract customers in a market of competing healers. (25)

The wellness industry also functions through mimicry. A quick browse through the website for Gwenyth Paltrow's company *Goop*—the epitome of the wellness industry— reveals the same appeal to technical language, practitioner credentials, and "evidence" that the dominant medical model also relies upon.[35] But instead of selling you pharmaceutical drugs, *Goop*—and the wellness industry in general—will sell you "sex dust" and unnecessary supplements. Moreover, the wellness industry does not simply mimic evidence-based biomedicine, it also mimics complementary and alternative medicines (CAM) in fetishistic ways. The wellness industry quite literally cashes in on appropriating, white-washing, and then selling CAM (often dubbed as alternative "modalities" by *Goop*) to its predominantly white and upper-class market. In this way, the wellness industry also assimilates difference across medical practices—not just patients. CAM practices—not the whitewashed versions—do indeed offer a supplement to evidence-based biomedicine and, in doing so, reveal flaws in the hegemonic model's logic. Derkatch explains how "in contrast to biomedicine, [CAM] practices view patients as fundamentally unique, so two people with the same ailment might be treated altogether differently, depending on their unique constellation of symptoms and personal characteristics" (39). This is precisely the kind of intervention that is most difficult for

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[35] *Goop* began in 2008 as a weekly e-newsletter and incorporated in 2011. Goop now has website that offers wellness advice and sells an extensive array of wellness products, hosts events and pop-up shops, and produces a podcast series, print magazine, and documentary series.

randomized control trials to study and statistical analyses to standardize. As such, CAM cannot be properly accounted for as part of the evidence base of the dominant medical model and as such reveals where the model's "gold standard" of evidence falls short.

Furthermore, it is interesting to note that Derkatch uses the term "constellations" to describe the patient's symptoms and personal characteristics. Though evidence-based biomedicine tries to render patient symptoms and personal characteristics as objective data that can be scientifically and statistically analysed, it is more apt to understand patient symptoms and personal characteristics as constellations in the Benjaminian sense—that is, as simultaneously objective and subjective phenomena that come out of particular histories, traditions, and myths. For example, pain (a symptom) and race (a personal characteristic) are often reduced to supposedly "objective" facts by medicine (e.g. a numeric scale for pain or genetics/ancestry for race). Even how medicine perceives a patient's pain and/or race is largely subjectively determined. And the subjective determination of pain and race is influenced by histories, traditions, and myths—for instance, those of Black slaves not being fully human and its influence on one's subjective perception of a Black patient's pain. Or the history of the "one drop rule" and its influence on one's subjective perception of who does and does not count as Black. Such examples demonstrate evidence-based biomedicine's lack of apperception is thus an inability to recognize how it perceives patient symptoms and personal characteristics in this subjective, historically determined way. Understanding patient symptoms and personal characteristics as constellations also allows one to recognize that they cannot be understand systematically (even though evidence-based biomedicine continuously tries), but rather must be understood discursively. Evidence-based biomedicine thus must not only recognize its problem with (ap)perception, but also its problem with discourse.

Derkatch quotes rhetorician Charles Anderson to elaborate on how evidence-based biomedicine has a problem with both (ap)perception and discourse:

although the patient is 'the centre of the medical event,' he or she, as a person, tends to be taken as 'merely attached to the machine delivered up for repair.' Compounding this limited view of the patient as a machine is a limited view in contemporary biomedicine of the patient as an interlocutor. Clinical encounters can frequently be rhetorically disabling for patients because they occur within well-established hierarchies under circumstances generally beyond the patient's control. In such a dynamic, anthropologist Christine Barry and colleagues explain, 'The voice of medicine has doctors maintaining control within a power imbalance. As a result the coherent and meaningful accounts of patients are suppressed,' resulting in 'disruption and fragmentation of communication.' (111)

Whereas Derkatch identifies the hegemonic medical model's problem of perception as a "limited view of the patient as a machine," I would add that this "limited view" is, more specifically, a limited (ap)perception of the patient as merely part of a medical apparatus that includes all the medical technologies that obscure or substitute for the patient, like statistics. Derkatch also identifies a limited view of the patient as an interlocutor, which is where evidence-based biomedicine's problem of (ap)perception slips into a problem of discourse as the doctor controls what can or cannot be said in the clinical encounter. As the doctor (and modern medicine as a whole) "supresses" the patient's "coherent and meaningful accounts," the patient is discursively fragmented, further denying their humanity. Derkatch concludes that "patient-centred care is predicated on the idea that we need to offset the technoscientific, doctor-oriented discourse that pervades much of medicine today, to restore the whole patient, as an individual agent, to the medical encounter" (112). Derkatch's analysis reminds us that the technological reproducibility of the evidence-based biomedical model is a matter of discourse as well as a lack of (ap) perception, which are in many ways co-constituted: what we perceive is often influenced by the language we use to describe what we perceive, and our discourses reflect how we perceive the world.

1.3.3   Capitalism's Second Trap: Narrative Regulation

The medical humanities are also invested in "offsetting" evidence-based biomedicine's limited "technoscientific, doctor-oriented" discourse of disease, especially through illness narratives that centre the patient's perspective and widen the discourse around illness. But the power of illness narratives are too often taken for granted in the medical humanities (i.e. that illness narratives can change the discourse around illness and thereby change the way patients are perceived and treated by evidence-based biomedicine). Just as a CAM and patient-centred care risk being co-opted by capitalism through the wellness industry, illness narratives also risk being co-opted by capitalism. The evidence-based biomedical model is often characterized as "cookbook medicine" by its critics, especially practitioners of other medical models like CAM and the medical humanities. Solomon explains how the implied criticism of "cookbook medicine" is that "the medical practice is 'one size fits all' rather than nuanced to individual cases and also (to my ear) that those who practice 'cookbook medicine' are not really thinking about it or taking its human implications seriously" (185). I broadly concur with Solomon's observation, but want more specifically to argue that the "cookbook" approach of evidence-based biomedicine doesn't take its *political* implications seriously. Many books like James Meza and Daniel Passerman's *Integrating Narrative Medicine and Evidence-based Medicine* (2011) suggest "that evidence-based medicine provides the general background knowledge and narrative medicine does the work of tailoring this knowledge to particular cases" (Solomon 196). But Solomon is rightly critical of such a tidy and simple bridge being drawn between evidence-based medicine and narrative medicine. Such simplistic accounts too often fall back on reductive understandings of narrative, such as the pervasive assumption in the medical humanities that narratives are singular and thus can provide insight into singular (unique) patients. Solomon contends that "narrative medicine promises to treat each patient 'as an individual,' with attention to their unique identity. This is a heady promise, especially in [...] liberal democracies, which value uniqueness and individuality. But narratives are not completely singular" (197). I concur with Solomon that narratives are not singular, and especially not illness narratives which tend to follow similar plot structures (often towards recovery) and deploy similar tropes

(e.g. the common military metaphors for "fighting" illness). Solomon identifies that promises to treat patients as individuals through attention to narrative are wrapped up in relevant political contexts, but her caution ends there without further grappling with the consequences of such politics.

This is where Solomon turns to critical theory through Judy Segal, a rhetorician and theorist of health. Here is how Solomon summarizes Segal's essay on breast cancer narratives:

> Segal argues the ubiquity of similar breast cancer stories and the negative reactions to stories that depart from the norm are evidence of 'narrative regulation' that suppresses other kinds of narrative [...] The standard story may be an improvement on older narratives of physician authority and patient passivity. However, as a recognized narrative type, it has come to play a normative role in discouraging other narratives, such as those that focus on the environmental causes of breast cancer and what the community can do to address them. It also discourages narratives that describe personal struggle and do not end in personal victory. And it discourages narratives that talk about prevention rather than about detection and cure. (199)

Segal traces the role technologies have played in this regulation of breast cancer narratives, especially illness blogs and patient websites. She describes how most blog and site users feed off each other's similar stories and many moderators even go as far as to censor stories that don't fit the repeated "survivor" or "fighter" individual recovery narrative (5-6). So in Benjamin's words, the technological reproducibility of illness narratives online assimilates difference into the same standard breast cancer narrative. This narrative regulation of breast cancer echoes Benjamin's discussion of the masses regulating their reactions to films by virtue of experiencing the art form together in the movie theatre. If even just a few people in the cinema start laughing, the rest inevitably do too. Segal's analysis reveals how a similar kind of regulation now also happens online

as masses of patients regulate their reactions to—and hence narratives of—breast cancer by virtue of experiencing the illness together in the virtual theatre of the internet.

Segal thus argues that the standard breast cancer narrative is at the very least repetitive and prescriptive, and at its very worst "coopted – by business and industry in general, and by pharmaceutical companies in particular, who advertise anti-cancer drugs directly to consumers, using the very terms of the standard story itself" (6). The technological reproduction of breast cancer narratives online does not simply assimilate the difference of unique narratives into the same standard story, but also dangerously leaves that standard story open for cooption by capitalism. Segal argues that capitalist corporations have now successfully made breast cancer related marketing and philanthropy a naturalized subplot of a standard breast cancer narrative, which ends up "pink-washing" the illness: this "foregrounds a certain kind of femininity, sponsoring docility; it highlights appearance and activity, and keeps attention from being focused elsewhere: on activism" (11). Here we get back to the fascist characteristics of the film and wellness industries: the political life of breast cancer is dangerously aestheticized pink through capitalism's cooption of the standard breast cancer narrative. Or to put it more poignantly: the politics of breast cancer are *an*aestheticized such that consumers do not feel the politically-motivated anger they ought to feel towards the companies that are selling them a pink-washed docility—the very companies that are so often responsible for the environmental crises and economic inequities that cause so much of the suffering from breast cancer in the first place. Illness narratives are thus not necessarily a remedy to evidence-based biomedicine's problems as capitalism can coopt them too.

1.4   Conclusion

I do not mean to paint such a bleak, hopeless picture of the dominant medical system. I have genuine hopes for the possibility to get beyond the grasp of evidence-based biomedicine's assimilative sameness and capitalism's cooption—especially through the

medical humanities. But this is not going to happen if we remain ignorant of how the hegemonic medical model's technological reproducibility may simply consume our efforts, especially illness narratives, and use them for its own oppressive political ends. In the next chapter, I will move from interrogating the evidence-based biomedical model's politics to interrogating the politics of a model for ethical clinical encounters—specifically, the apolitical ethical model proposed by medical humanities scholars through Emmanuel Levinas' philosophy. I will argue that the medical humanities' Levinasian model for an ethical clinical encounter, like the evidence-based biomedical model, fails to account for unique, situated patients.

2   Medicine's Strange Encounters with Patients and Texts

2.1   Introduction: Levinas in the Medical Humanities

In the 2016 literature and bioethics special issue of *Literature and Medicine*, Olivia Banner identifies a significant problem in the way medical humanities scholars treat race in literature: not only is race often overlooked by the field, but when it is treated, race is reduced to an interpersonal concern rather than structural problem. Inspired by Banner, I contend that a similar problem can be traced in the way humanities scholars have used Emmanuel Levinas' philosophy for medicine. Since the turn of the twenty-first century, Levinas' phenomenology of the Other has been increasingly used to theorize an ethical clinical encounter.[36] My contention is that such scholarship abstracts ethics from politics and thereby is unable to account for a truly ethical clinical encounter that tackles social injustices, such as racism in medical institutions.[37] Banner identifies the problem of race in the medical humanities by critically tracing "the historical neglect of African-American literature in seminal scholarship in the field, and how that literature, when it does appear, is framed and interpreted" (28). In a similar way, I critically trace how Levinas' phenomenology of the Other has been used in the medical humanities to propose an ethical clinical encounter that ultimately reproduces both patients and literature as medicine's fetishized Others—that is, as Others encountered at an interpersonal level that neglects how structural problems, such as racism, shape such

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[36] Humanities scholars have taken up an immense variety of Levinas' writing and interviews to theorize a more ethical clinical encounter (see Tauber 1999, Komesaroff 2001, Clifton-Soderstrom 2003, Nortvedt 2003, Frank 2004, Irvine 2005, Burns 2017), but the key texts in which Levinas famously develops his phenomenology of the Other are *Totality and Infinity: An Essay on Exteriority* (1961) and *Otherwise than Being, or Beyond Essense* (1974). Each scholar takes up either or both of these works. I, however, do not take up Levinas directly myself because I am concerned with analyzing how his work has been taken up by the medical humanities and how it can be taken up differently through Sara Ahmed's reading/critique of Levinas.

[37] This use of Levinas in the medical humanities reflects increased interest in Levinas in the 1990s by literary critics such as Derek Attridge and Robert Eagleston. Their mobilization of Levinas produced an abstractly ethical mode of literary criticism that neglected political particularity. This evacuation of politics from ethics through Levinas is precisely the same problem that emerges a mere decade later in the medical humanities.

encounters.[38] As such, the ways in which the medical humanities have mobilized Levinasian phenomenology thus far fails to adequately account for illness as an experience that intersects with structural issues such as racism and sexism.

Banner argues that the neglect of race in medical humanities scholarship is especially problematic when the field purports to foster empathy and listening in clinicians: "those skills, whatever their value, can do little to overcome the racist practices and biases embedded in medicine, which are institutionally reproduced, not intrinsic to interpersonal relations" (27). While I agree with Banner that racism is institutionally reproduced, one must not forget how such institutional problems are implicated at the level of interpersonal relations. Whereas Banner argues that the medical humanities must shift its attention from the interpersonal to the institutional, I argue that the field must deconstruct such binaries between the interpersonal and the institutional (or the particular and the general) in the first place. I thus will turn to Sara Ahmed's phenomenology in *Strange Encounters: Embodied Others in Post-Coloniality* (2000) as a heuristic for an ethical-political mode of analysis that brings particularity back into Levinas' phenomenology without risking essentialism, implicates the institutional in the interpersonal, and widens the application of Levinasian ethics to literature as well as patients.

Alfred I. Tauber's *Confessions of a Medicine Man: An Essay in Popular Philosophy* (2000) is one of the earliest and most seminal books to explicitly make a case for the value of philosophizing about the doctor-patient relationship. Tauber is also the first scholar to take up Levinas for medicine and dedicates an entire chapter to this project. Yet Tauber's book entirely erases the contribution of women to philosophy (it is titled *Confessions of a Medicine Man*, after all). While reflecting on his frustrations at having to constantly justify the value of philosophy to medical school, Tauber half-jokingly asserts: "I have often fantasized of handing out tee-shirts to our entering medical students: In bright colours on the front I would have emblazoned the slogan, 'Medicine

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[38] I capitalize the term "other" when I am mirroring another author's use of capitalization and/or I am referring to a fetishized, abstracted Other as a philosophical category.

must become philosophical,' with an imprint of Locke or Hume or Kant or Nietzsche on the back" (92). Tauber—like the very philosophers he cites—takes for granted the fallacious neutrality and generalizability of the white, male, Euro-American philosophical canon. By taking for granted the philosophical canon upon which he draws in order to make the doctor-patient relationship more ethical, Tauber reifies the very hierarchies—masculine/feminine, white/colour, mind/body, etc.—that render his claim to ethics untenable in the first place. This apolitical and neutral approach to Levinasian ethics continues to plague the medical humanities.

Michelle Clifton-Soderstrom's "Levinas and the Patient as Other: The Ethical Foundation of Medicine" (2003) is a key example of the ways in which the medical humanities have mobilized Levinas to theorize an ethical physicial-patient encounter. Asserting that "medical practice is first and foremost an ethic" rather than a science (448), Clifton-Soderstrom explicitly mirrors Levinas' philosophical project of situating ethics as prior to—rather than a derivative of—ontology and epistemology. This move is a radical challenge to medicine for two reasons. First, shifting medicine's foundation to ethics in the Levinasian sense means considering medicine's foundation as *prior* to knowledge, thereby significantly challenging medicine's knowledge seeking and producing enterprise. Second, using Levinas to shift medicine from science to ethics is a specifically phenomenological move, one which grounds medicine in questions of (inter)subjectivity and experience, thereby allowing Clifton-Soderstrom to subvert medicine's claims to objectivity and universality. This reconsideration of medicine as a fundamentally ethical discipline is ubiquitous across all the essays that have taken up Levinas for medicine thus far—and for good reason. My contention lies not with privileging ethics as the foundation of medicine, but with the current shape Levinasian ethics take in medicine.

Clifton-Soderstrom argues that medicine should strive for the kind of ethical encounter entailed by Levinas' phenomenological description of simultaneously being called to responsibility by the face of the other (coming into proximity) and respecting the radical alterity of the other (maintaining distance). This phenomenological manoeuvre of

maintaining both proximity and distance between physician and patient is also largely consistent across all the papers that take up Levinas for medicine. As Clifton-Soderstrom describes it: the patient as the other "calls to me [the clinician] first in her transcendence, and I am ethically obliged to serve her. This moral obligation that arises from the other is grounded in the face-to-face encounter, which is essential to medical practice" (455). The other's ability to so powerfully call upon the physician's moral obligation is dependent upon a face-to-face encounter with the other's radical alterity: "the face, in essence, transcends culture and history and all that is dependent on them" and the moral moment for medicine lies in this transcendent capacity of the other's face (454). My critique (via Ahmed's critique of Levinas) will take on this peculiar abstraction and essentializing of the other, the dangerous slip from ethics to morality, and the fallacious idealization of a transcendence of difference.

Clifton-Soderstrom ultimately argues for narrative discourse as a way to achieve a Levinasian ethics in medicine. She draws largely upon the seminal work of medical sociologist Arthur Frank in order to conclude that "narrative allows the Other to be herself" (459). In other words: narrative allows one to simultaneously bring the Other close and yet maintain the Other's alterity. While I believe that Clifton-Soderstrom's work is an important starting point for discussions about the value of philosophy and narrative in medicine, it is not nearly rigorous or nuanced enough today. Two years after Clifton-Soderstrom's article, Galen Strawson published his landmark essay "Against Narrativity" (2004) wherein he argues against normative claims (like those by Frank and Clifton-Soderstrom) that living a life through narrative or listening to others' narratives is necessarily good—and that all humans live their life narratively in the first place. Strawson's essay has had significant reverberations in the so-called "narrative turn" across numerous disciplines, including the medical humanities. In "Beyond the Wounded Storyteller: Rethinking Narrativity, Illness and Embodied Self-Experience" (2013), Angela Woods takes up Strawson's argument to challenge the medical humanities' uncritical elevation of narrative through a close critical reading of Frank's *The Wounded Storyteller* (1995). Thus, in the intervening years since Clifton-Soderstrom's initial publication, I am compelled to consider how a feminist phenomenological framework can

address such problems by providing medicine a more critical and ethical way to engage with texts (narrative and otherwise).

2.2   Bringing Sara Ahmed Into the Medical Humanities

2.2.1   Ahmed's Critique of Levinas

The crux of Ahmed's critique of Levinas reveals a fundamental contradiction in his phenomenology[39]:

> To describe 'the other' as having the character of 'otherness' is to recognize the other in a certain way: the other is abstracted from particular others (the 'the' turning the other into an article of speech). Through that abstraction, the other becomes a fetish: it is assumed to contain otherness within the singularity of its form ('entire being'). Such a cutting off of 'the other' from the modes of encounter in which one meets an-other allows 'the other' to appear in Levinas's texts as an alien being, whom one might then encounter, in the *entirety* of that very form. (143)

As Ahmed argues, Levinas' phenomenology rather paradoxically thematizes the other *as* other while concealing that thematization by defining the other as beyond thematization. In this way, Levinas' phenomenology ultimately describes the other as an alien/strange being despite asserting that the other comes before ontology and epistemology. Ahmed's critique even plays out at the level of grammar: where Levinas writes of encountering *the* other, Ahmed writes of encountering *others* or *an other*. For Ahmed, it is precisely

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[39] In *Strange Encounters,* Ahmed understands, builds upon, and critiques Levinas' philosophical project by engaging with the following works: *Totality and Infinity: An Essay on Exteriority* (1979) translated by Alfonso Lingis, *Ethics and Infinity: Conversations with Philippe Wemoi* (1985) translated by R.A. Cohen, *Time and the Other: And Additional Essays* (1987), translated by R.A. Cohen, and *Otherwise than Being or Beyond Essence* (1991) translated by Alfonso Lingis.

Levinas' abstraction of the other (claiming to not know the other in any particular way) that ultimately represents the other as precisely *someone* who possesses alterity as an essential trait. Whereas Levinas may seek phenomenologically to describe an encounter with the other that is *prior to* knowledge, Ahmed argues that his figure of the other is already constructed as a fetishized stranger *through* knowledge: "The stranger is someone we know as not knowing, rather than some-body we simply do not know. The stranger is produced as a category within knowledge, rather than coming into being in an absence of knowledge" (55).

The concept of stranger fetishism is central to Ahmed's critique: "it invests the figure of the stranger with a life of its own insofar as it cuts 'the stranger' off from the histories of its determination." Ahmed draws largely upon Marx to develop her argument about stranger fetishism: fetishization involves the displacement of social relations through the transformation of objects or subjects into figures, which thereby cuts those figures off from their social and material relations (5). The stranger as a fetishized figure in the philosophies of thinkers like Levinas risks homogenizing and universalizing the stranger, thereby erasing important forms of difference—how and why some bodies are designated as *stranger than others* (5-6). Without taking such forms of difference into account, ethics cannot adequately account for concerns such as racism, sexism, or ableism. It is from here that Ahmed begins to develop her own phenomenology focused on the particularity of the encounter with others rather than an other as such. For Ahmed, an encounter is a meeting that involves surprise and conflict involving the "*coming together of at least two elements*" (6-7, italics original). The fact that Ahmed does not limit the encounter to two human subjects, but leaves it open as simply a contact between "elements," will be crucial in Chapter Three, which deploys her theories in relation to medicine's encounter with literary texts. Such a meeting also involves surprise insofar as there is an "absence of knowledge that would allow one to control the encounter, or predict its outcome" (8). This moment of surprise (understood as an absence of knowledge and hence expectation/control) is fundamental to both Ahmed and Levinas' phenomenological descriptions of an ethical encounter with the/an other, albeit in subtly yet significantly different ways. Whereas Levinas' phenomenology describes *the other*

itself as prior to ontology and knowledge, Ahmed's phenomenology describes the *encounter with others* as prior to ontology and knowledge. And whereas Levinas locates the ethical possibility of surprise as an absence of knowledge about *the other*, Ahmed locates surprise as an absence of knowledge about *the encounter* with others.

2.2.2   What Ahmed Offers Medicine's Encounters with Patients

Ahmed brings this much-needed particularity back into Levinas' phenomenology by making sure to emphasize her concern with the particularly of *encounters* with others, not the particularity of an other as such:

> We can move our attention from the particularity of an other, to the particularity of modes of encountering others. Such an approach would avoid assuming that we can gain access to the individual expression of the 'real' of her body. Particularity does not belong to an-other, but names the meetings and encounters that produce or flesh out others, and hence *differentiates others from other others*. (144, italics original)

This phenomenological shift away from descriptions *of the other* toward descriptions *of encounters with others* is crucial to ensuring that Ahmed's call for particularity does not risk essentialism. Ahmed's phenomenology allows one to critically consider how difference (e.g. race, gender, ability, etc.) is produced and implicated in encounters with others, without assuming that such differences are essential to others. This attention to particularity without essentialism is crucial to theorizing a clinical encounter that can critically and ethically attend to difference. Currently, medicine and health sciences more broadly are mostly concerned with issues of difference when framed as social determinants of health (SDOH), which the World Health Organization defines as "the conditions in which people are born, grow, live, work and age. These circumstances are

shaped by the distribution of money, power and resources at global, national and local levels."[40] Health inequity is thus understood as the result of issues such as urbanization, gender, racialization, or poverty. Yet SDOH are often only considered in terms of public and global health agendas; that is, at the generalized level of policy and program development rather than the particular level of the face-to-face clinical encounter. The problem with this uneven deployment of SDOH—as a conceptual framework for understanding patient populations rather than individual patients—is that SDOH risk getting construed in essentialist terms at the level of particular clinical encounters. Clinicians risk treating differences (e.g. socioeconomic status, gender, race, etc.) as a condition the patient *has* rather than considering how such differences *condition* the encounter.

Ahmed's phenomenology thus urges one to consider how difference, typically accounted for by medicine as SDOH, always already conditions the very possibility for a clinical encounter. I argue that an ethical clinical encounter requires clinicians to ask the same kind of questions that Ahmed poses: "What are the conditions of possibility for us meeting here and now?" (145). What conditions led not only to a patient's illness but also to the patient entering this particular clinical encounter? What conditions gave them access to—or impeded their access to—this particular clinic or operating room or waiting room? What conditions made it possible for this clinician to enter this encounter as the one providing care? These are questions of historicity, yet for Ahmed attention to the particular modes of encounter must also open up the encounter to a yet ungraspable future: "we could ask, not only what made this encounter possible (its historicity), but also what does it make possible, what futures might it open up?" (145). What future possibilities might this clinical encounter open up—or even impede? What conditions the encounters that the clinician and patient will have after the present encounter? What

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[40] This definition of SDOH, from the World Health Organization's (WHO) website, is one of the most commonly cited definitions in both research literature and educational materials. The WHO is mostly obviously known for promoting health around the world by setting global goals, lobbying governments, working with non-governmental organizations, funding research, and implementing healthcare related programs. But the WHO also impacts health across the globe in less obvious ways, especially through discourse as it defines and structures how people understand health in the first place.

conditions the encounters that the patient will have with other others later on? It is important to note that Ahmed's questions of historicity and future possibilities are characterized by a productive kind of failure—by the failed historicity of post-coloniality in the former (11)[41] and the failure to grasp the future in the latter (145). Such questions do not point to history or the future as some kind of totalizing project that can be wholly revealed or understood; rather, they point toward the incomprehensible complexity of an other through the inevitable failure to ever wholly comprehend an other's history and future.

It is in this spatial and temporal movement beyond the present face-to-face encounter that Ahmed locates "the possibility of facing something other than this other, of something that may *surprise*" (145, italics added). Surprise (the moment beyond expectation and hence knowledge) lies not *in* the other, but as something "other than this other." Yet again, Ahmed's phenomenology makes sure to avoid essentializing the other as a strange being, as someone one "knows as not knowing" because they essentially contain surprise. Rather, surprise lies in the *encounter*. It is from here that Ahmed is able to develop her theory of generosity:

> a generous encounter may be one which would recognize how the encounter itself is implicated in broader relations and circuits of production and exchange (how did we get here? how did you arrive?), but in such a way that the one who is already assimilated can still surprise, can still move beyond the encounter which names her, and holds her in place. (152)

Here we see Ahmed's phenomenology at its best: her theory of generosity calls for attention to the particularity of the encounter while still leaving space for an other to

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[41] Ahmed understands post-colonialism as a "failed historicity" because it "re-examines the centrality of colonialism to a past that henceforth cannot be understood as a totality, or as a shared history" (11). In other words, Ahmed finds post-colonialism to be productive in her work precisely because it reveals how any attempt to historicize the present will always fail to some extent.

move beyond such particularity—to move into new encounters which may yet again surprise. As such, Ahmed can account for difference without claiming to grasp it fully.

In *The Renewal of Generosity: Illness, Medicine, and How to Live* (2004), Arthur Frank also takes up Levinas, in tandem with the dialogism of Mikhail Bakhtin, to develop a theory of generosity in medicine:

> If the stories I tell in this book need a label, I call them moral nonfiction, a category best described by Levinas: "it makes a demand on me." The written text shows the reader a face that "looks at me and calls to me. It lays claim to me. What does it ask? Not to leave it alone. An answer: here I am." The moral moment is when the text calls on the reader—on *me*—just as the patient calls on those who offer care. The here-I-am of the writer is a generous offering of self as witness… The dialogue of author and reader is the beginning of other dialogues: in the multiple sites where medicine is offered and received, where care is given, and where healing occurs. (86)

Yet here Frank (like Clifton-Soderstrom before) also slips from ethics to morality by speaking of the "moral moment" when the text calls on the reader (even Frank's title, "how to live," seems moralistic). In contrast, Ahmed opens her analysis of Levinas by emphasizing how his writing importantly distinguishes ethics from morality: whereas morality is a set of codes, ethics asks how one can encounter others as other (138). In the opening pages of his book on *Levinas' Totality and Infinity* (2015), William Large also makes sure to emphasize that Levinas is writing about ethics and not morals: whereas morality is the laws and principles by which one might live by, ethics is the encounter with the other (2). The danger with such a mis-reading of Levinas' ethics as morals is that it closes off the encounter with others through moral prescriptions rather than opening it up through ethical questions. Whereas Ahmed's theory of generosity arises from many questions about what conditions encounters with others, Frank's theory of generosity arises from the other making a singular demand upon the I ("do not leave me alone"),

who then gives a singular response ("here I am"). Plurality and the possibility for surprise are erased from Frank's theory, thereby sedimenting and essentializing the other's position as other. For Frank, encountering the other (both patients and stories) is always about the dialogical—about staying here in this face-to-face present for a dialogue, never moving temporally or spatially beyond it to question the conditions that made such a dialogue possible in the first place. Moreover, this static and essentialized account of the other comes out of an erasure of difference: "alterity is an intrinsic quality of being human […] it *precedes* such specific differences as gender, age, ethnicity, or state of health" and this kind of alterity is precisely what "drives the dialogical relationship" for Frank (115-16, italics added). This is not to say that the dialogical does not have an important role to play in creating an ethical clinical encounter, but rather to suggest that Frank's theorization of the dialogical as driven by a fallaciously neutral alterity is highly problematic. This fundamental lack of consideration for difference is precisely how Frank can believe that merely witnessing and dialoging better with patients and stories is all medicine needs in order to become generous and ethical—as if medicine's ethical issues with racism, sexism, or ableism can simply be resolved if physicians just have more conversations with their patients or read more illness narratives.

2.2.3   What Ahmed Offers Medicine's Encounters with Texts

I thus argue that medicine needs a more robust theoretical foundation for its ethical encounter with its others (both patients and texts), which we find in Ahmed's phenomenological approach. As I mentioned at the opening of this chapter, Olivia Banner importantly calls for a literary criticism that "elucidate[s] how ideologies of race, gender, and disability inform social, political, economic, and institutional structures, which then inform health and illness" (27). This is where a feminist phenomenological inquiry into reading literature that depicts illness becomes crucial. For Ahmed, encounters with others are not limited to encounters with other human subjects; rather, her phenomenology expands Levinas' ethics to consider how one may also ethically encounter the other as

text. As literature is increasingly taken up for medical education and research with claims of reinvigorating medicine with more humanistic, empathetic, and ultimately ethical approaches to and understandings of illness, it is crucial to critically interrogate not only how medicine encounters patients but also texts. The ability for literature to somehow make clinicians more empathetic and understanding of their patients' experiences is still far too often taken for granted. As Banner forcefully argues with respect to racism, how medicine takes up literature, as well as how it engages with those texts isolated from historical, cultural, and political context, often reifies systems of power and otherwise problematic modes of perception through the texts it chooses as its subject (mostly the Euro-American male canon). Medicine thus needs to ethically encounter texts as well as patients.

For Levinas, both literature and medicine totalize the other by representing it. Yet Craig Irvine argues that this is precisely—and paradoxically—why literature is so important for medicine: by mirroring medicine's representational structure, "literature thus teaches medicine, by example, to regard itself critically" (15). In particular, Irvine draws upon Italo Calvino's *The Uses of Literature* (1980) to argue that literature allows medicine to recognize how language functions in more ambiguous and metaphorical ways than medicine typically realizes. But Irvine takes for granted the self-reflexive criticality that literature can offer medicine. While it is important for medicine to be broadly critical of how language functions as a slippery system of signs, medicine must also be specifically critical of how it represents the other in gendered, racialized, ableist, and other oppressive ways. Not all literature will mirror medicine in a way that engenders such self-reflexive criticality about such specific ethical-political concerns. Moreover, simply presenting clinicians with literature that mirrors medicine's, for example, sexist or racist thematization of patients as others will not in-and-of-itself incite the radical self-reflexivity and re-orientation necessary to achieve a more ethical medical practice. Rather, drawing upon Ahmed's phenomenology, I argue that medicine must critically engage with how it *encounters* such texts as others. Irvine concludes his essay by asserting that "establishing the primacy of the ethical does not remove physicians from the rocky road of morality: on the contrary, it reminds them that this is *where they are*

placed" (17, italics added). Irvine's ethics reminds medicine where it is presently placed—in morally demanding encounters with patients—while Ahmed's ethics demands a more radical questioning of how medicine got to that place (encounter) in the first place and what possible futures may arise.

2.3   Conclusion

So where does the transformative potential of literature lie, if anywhere at all? Just as Ahmed argues that the ethical potential of the other lies not *in* others but in *encounters* with others, I argue that the ethical potential of texts lies not *in* the texts themselves but in *encounters* with those texts. This is how Ahmed gets around the fundamental problem of essentialism in Levinas' phenomenology (where alterity is figured as somehow essentially contained within 'the other')—and this is also how medicine can develop an ethics grounded in encounters with others (patients and literature) that attends to difference without risking essentialism. Ahmed's chapter on "Ethical Encounters" is broken up with phenomenological descriptions of her own encounters with Mahasweta Devi's writing (translated by Gayatri Spivak). In these passages I find a compelling example of how medicine may ethically encounter texts. Ahmed's descriptions are particularly focused on her encounter with the story "Douloti the Bountiful": the story of a peasant women who is sold into prostitution and becomes gravely ill with tuberculosis and venereal diseases (Ahmed 153). Ahmed begins by describing the particular conditions that made it possible for her to encounter this text in the first place, such as the historical and colonial legacy of translation that made possible (and necessary) Spivak's translation of Devi's texts (148). Yet Ahmed's phenomenology of reading is not just limited to critiques of the global publication and circulation of texts. Ahmed goes on to also describe how "to touch your body [Doulati's body] as the stranger's body, to love your body as the stranger's body, would be to forget how your body has taken shape" (160). That is to say: an ethical encounter with texts requires attentions to the conditions (both within the text itself and beyond) that shaped this character as that which one

encounters in reading. How is the body I encounter in the text structured through particular figures and forms of writing? Through particular encounters with other characters and even other texts? Through the modes of production and circulation of texts? Through the prior encounters I bring to bear upon the text? Through the structures of culture, history, and politics? Banner's article on racism and reading in the medical humanities importantly calls for "a mode of [literary] interpretation that illuminates structural racism" and uses Audre Lorde's *The Cancer Journals* (1980) as a notable example of how structural racism has been problematically erased from her work by medical humanities scholars' (including Arthur Frank). By drawing attention to particular modes of encounters with and within literary texts, Ahmed's phenomenology allows one to bring to literature a reading of difference enacted at both structural and individual levels. I would argue that medicine would benefit greatly from this kind of literary encounter as a way not only to enrich its encounter with patients and literature but to make of this encounter something radically ethical.

The next chapter serves as a case study for the kind of literary encounter I call for. I deploy the critical theoretical framework I have devlopped in this chapter to read Rawi Hage's *Cockroach* (2008), which depicts the clinical encounters between a mentally ill refugee and his therapist. I have argued that literature has critical potential for medicine insofar as it can help one recognize the politics of the encounter *as* encounter, rather than only thinking about the identity politics of those involved in the encounter. I demonstrate this in the next chapter by using the feminist phenomenological framework to trace how humanity and inhumanity are conditioned through the novel's clinical encounters, rather than being essentialized facts of the patient's or therapist's identities. Deploying the critical theoretical framework from this chapter in Chapter 3 inevitably brings us back to the central concerns of Chapter 1 insofar as my reading of *Cockroach* also reveals how the politics of evidence-based biomedicine condition the clinical encounter between the refugee and his therapist.

3   The Medical Inhumanities

3.1   Introduction

The call for papers for the Canadian Association for Health Humanities' 2019 conference asks "Cultural Humility and Contemporary Medical Practice: (How) Can the Humanities Help?" and goes on to posit that the humanities "has the potential to redefine the outcomes of culturally-focused physician training, rebalance the power dynamics between physicians and patients, and to influence the quality of healthcare provided to a variety of communities," notably including refugees. This call for papers is just one of many examples of the medical humanities positioning itself as the "cure" Western biomedicine needs to better care for patients—like refugees—who are racially, culturally, and religiously "other" to the hegemonically white, Western, and Christian medical practitioner. My contention is that the medical humanities too often takes the humanities for granted as a window into humanity: for example, that empathetic clinical encounters are necessarily achieved by recognizing the patient's humanity through attention to narratives. This kind of logic, while well-intentioned, too easily assumes that narratives necessarily reveal one's humanity, that narratives always elicit empathy, and that empathizing with another's humanity is the ultimate ethic. Viet Thanh Nguyen argues in his 2016 essay "On the Inhumanities" that a more radical ethics of recognition "demands that we remember our humanity and inhumanity, and that we remember the humanity and inhumanity of others as well" (97). My reading of Rawi Hage's *Cockroach* (2008) explores Nguyen's provocation as it relates to the novel's portrayal of the encounters between a mentally ill refugee and his therapist.

Cockroach is set in the winter of Montreal and is narrated by its protagonist, an unnamed male refugee from an unnamed Arabic Middle Eastern country. The novel begins after the narrator's failed attempt to commit suicide by hanging himself from a park tree. We learn that he was rescued against his will by the police, forced to stay in a hospital for some time, and then mandated by the court to attend sessions with a therapist named

Genevieve. The novel depicts the narrator's day-to-day life which primarily includes his experiences with poverty, time spent with his mostly Iranian friends, his habit of breaking into privileged people's homes, and—most important to this chapter—his therapy sessions. The novel's title reflects how the narrator self-identifies as a cockroach and oftentimes imagines himself transforming into the very vermin that privileged society imagines him to be. I've chosen to analyze this text for how it reappropriates of the racist stereotype of the refugee as vermin through its reappropriation of the social and mental "illnesses" that society so often pathologizes: poverty and schizophrenia. In these ways, *Cockroach* tempts a double criminalization of the narrator: first, as a poor refugee who breaks into homes, and second, as someone with schizophrenia, a mental illness too often criminalized by society. *Cockroach* rejects any empathizing impulse by readers and, instead, leaves us to grapple with the narrator's *inhumanity* as both a refugee and patient. That leaves the medical humanities to grapple with a far more radical ethical demand: to care for precisely that which rejects empathy—the inhuman.

Much of the scholarship on *Cockroach* notes the novel's resistance to meta-narratives on migration, refugees, or multiculturalism. Lisa Marchi, for example, argues that the novel counters hegemonic representations of the "melancholic migrant, as a subject fatally trapped within a deeply hurting past and paralyzed by nostalgic grief" as well as the "successful immigrant who finds comfort and fulfillment in his/her new homeland" (50). I generally agree with such readings, but am more specifically concerned with how the novel's rejection of the grateful and assimilable refugee meta-narrative depends upon the novel's rejection of the mental illness recovery meta-narrative. That is: the narrator refuses to be a grateful, "productive" Canadian citizen precisely by refusing to be "cured" by his government-mandated therapist, Genevieve. I first revise Nguyen's ethics of recognition by reading his theory alongside bell hooks' 1992 essay "Eating the Other: Desire and Resistance" and Sara Ahmed's critique of Levinas in *Strange Encounters*. I argue that a radical ethics of recognition does not recognize humanity and inhumanity *in* ourselves and others, but instead recognizes how humanity and inhumanity are conditioned through our *encounters* with others. Next, I read how inhumanity is produced in Genevieve's encounters with the narrator through her malignant desire to possess and

consume his stories and emotions. I reveal how her desire is not really so different from the narrator's desire to possess and consume women and other people's homes and objects through his habit of break-ins and robberies. Finally, I trace Genevieve's desire for stories and emotions as part of an economy of encounters in which the narrator must exchange stories and emotions for a supposed "cure" from Genevieve. This final section reveals how capitalist economics condition the production of inhumanity in the narrator's encounters with Genevieve. Through this reading of *Cockroach*, I ultimately seek to deploy an ethics of recognition that recognizes what conditions produce inhumanity in encounters with others.

3.2   A Revised Ethics of Recognition

Nguyen contends that "identifying with the victim and the other in an act of sympathy, or identifying as the victim and the other in an act of empathy, has the unexpected, inhuman side effect of perpetuating the conditions for further victimization" (72). My reading of *Cockroach* will reveal that victimization is not the only "inhuman side effect" of identifying with or as the other; this sympathetic or empathetic identification also desires to possess the other's stories and emotions, especially painful/traumatic ones. In "Eating the Other" bell hooks argues that contemporary mass culture's desire for the Other and Otherness (that is: cultural, ethnic, and racial difference) is not a result of political progress, but the result of the successful commodification, consumption ("eating"), and then forgetting of the Other and Otherness.[42] hooks concludes her essay by asserting that

> [w]ithin a context where desire for contact with those who are different
> or deemed Other is not considered bad, politically incorrect, or wrong-
> minded, we can begin to conceptualize and identify ways that desire
> informs our political choices and affiliations. Acknowledging ways the
> desire for pleasure, and that includes erotic longings, informs our

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[42] I capitalize "Other" here to reflect bell hooks' capitalization of the term.

> politics, our understanding of difference, we may know better how
> desire disrupts, subverts, and makes resistance possible. We cannot,
> however, accept these new images uncritically. (380)

hooks is mostly concerned with erotic desire, but her argument still applies to the kind of desire I am primarily concerned with in *Cockroach* and the medical humanities: a desire to possess the other's stories and emotions. In today's healthcare context, where the "refugee crisis" has made global health and culturally-sensitive healthcare particularly "trendy," there exists a desire for contact with patients who are different or deemed Other. While many scholars have critiqued healthcare professionals and learners from the "global north" who travel abroad to "save" Other-ed patients in the "global south," there has been lesser focus on how such desires to "save" play out when it is the patient, not the practitioner, who travels or migrates to the "global north" (e.g. when the narrator in *Cockroach* migrates to and becomes a patient in Canada).[43] The medical humanities often strives to encounter such patients not simply at the level of their diseased body (as evidence-based biomedicine does), but also at the level of their illness narratives. Yet, as hooks cautions with regards to erotic desire, the medical humanities must be critical of how its own desire for patients' stories risks "eating" the other's stories.

In *Strange Encounters*, Ahmed uses eating as a metaphor to understand philosophy's encounters with the other: "we might consider the ontological encounter as a form of *eating* and digestion: the other is valued as that which one is *with*, but only insofar as it can be taken in by, and incorporated into, the philosophical body (or into the thinking of being)" (139). Ahmed takes up Levinas' metaphor of eating to distinguish between the ontological and ethical encounter: the ontological encounter *eats* and *grasps* at others, whereas the ethical encounter *desires* others. She goes on to identify that Levinas defines desire as "beyond need and the assimilation of the other" so that his ideal ethical encounter is that which "does not satisfy the ego – that does not fill it up – but which is

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[43] For critiques of volunteer medical missions abroad, see McLennan (2014) and Sullivan (2016).

beyond its grasp" and that which "cannot be assimilated or digested into the ego or into the body of a community" (139). But in my reading of *Cockroach*, desire is not so easily separated from grasping and eating: the narrator's desire often manifests as a literal grasping at women's bodies without consent, and Genevieve's desire manifests as consuming her patient's stories and emotions, ultimately assimilating them within a Christian and capitalist therapeutic model.

Nguyen, like Ahmed, is ultimately dissatisfied with how Levinas' abstracted, idealized ethics avoids the reality of encounters with others, for

> [t]o deal with actual others, we would have to confront their lives, their cultures, their particularities, their names, and so on. In doing so, we would see that they are, like ourselves, generally self-interested. Their self-interest brings with it the uneasy, contradictory contaminations of worldly politics and histories. (78)

As such, Levinas' other is an ideal kind of other that can be "desired" without the uneasy contradictions that "contaminate" desire in the situated world of *Cockroach*—a literary world wherein messy politics and histories make Genevieve's desire for the narrator's stories a contradictory desire to both heal and consume him. Nguyen notes further that Levinas' abstracted ethics is never "explicit about adjudicating justice, or at least the dirty, impure, pragmatic justice that actual others may care about" and instead Nguyen's "ethics of recognition aims not only at the utopian world of infinity but also at this disagreeable and dirty world of totality" (78). As the setting of *Cockroach*, this is precisely the world in which justice must be adjudicated. The narrator poignantly reminds Genevieve that "pacifism is a luxury," reminding us that while pacifism may seem like the most just ethic in a "utopian world of infinity," it is oftentimes untenable in the "disagreeable and dirty world of totality" where violence is sometimes the only means for the underprivileged to survive or get justice (Hage 98). The narrator seeks this adjudication at the end of the novel on behalf of his friend Shohreh when he kills the man

who imprisoned, tortured, and raped her back in Iran—a man who was otherwise free to travel and do business in Canada without any repercussions for his horrific and unjust actions.

But *Cockroach* also pushes back against Nguyen' critique of Levinas' inability to "deal with actual others." The narrator remains unnamed for the entire novel and his particular city or even country of origin is never revealed, just merely implied as somewhere broadly Arab. Nearly all the narrator's "particularities" that we, as readers, get to "confront" are revealed during his appointments with Genevieve—appointments where he is quite literally confronted by a hostile, interrogative therapist who demands his stories and emotions in exchange for her services/cure. The reader's "dealing with actual others" is thus mediated by Genevieve's problematic desire to possess and consume the narrator's stories and emotions. As such, I wonder if Nguyen's call to "deal with actual others" by "confronting" their particularities is really a better ethical model. Instead, I return to Ahmed to offer a more compelling model for bringing particularity back to Levinas' idealized, abstracted ethics. Ahmed's alternative model cannot be understood without first understanding that she is not simply critiquing Levinas' abstraction, but specifically his fetishization of the other: "To describe 'the other' as having the character of 'otherness' is to recognise the other in a certain way: the other is abstracted from particular others (the 'the' turning the other into an article of speech). Through that abstraction, the other becomes a fetish: it is assumed to contain otherness within the singularity of its form" (143).

This fetishization removes the other from "the particular and worldly encounters in which beings are constituted in and through their relationship to one another" (143)—in other words from the social, political, and material context that conditions the possibility of encountering the other in the first place. From here, as discussed in Chapter 2, Ahmed proposes an ethics that instead accounts for difference and particularity at the level of *encounters* with others, rather than as something *in* the other. She offers the following example: "rather than thinking of gender and race as something that this other *has* (which

would thematise this other as always gendered and racialised *in a certain way*), we can consider how such differences are determined at the level of the encounter, insofar as the immediacy of the face to face is affected by broader social processes" (145). Thinking of particularity in terms of encounters, rather than "actual others," as Nguyen does, avoids essentializing others as well as feeding the desire to consume others' particularities ("individual expression" or the "real" body in Ahmed's terms). Reading Hage's *Cockroach* through Ahmed's philosophy, which together argue for a revised account of Nguyen's ethics of recognition, we learn to read humanity and inhumanity not as characteristics *in* the other, but as conditions that shape our encounters with others.

So far I have mostly considered subject-to-subject encounters. But both Ahmed and Nguyen also consider how philosophy and theory, as bodies of knowledge, encounter others and, in turn, how the philosopher or theorist or even literary critic, like myself, encounters others through texts, like media, film, or literature. As such, I must not simply consider the encounter between the narrator and Genevieve, but also my own encounter—as literary critic and theorist—with the narrator through the text. More specifically, I must be especially careful to not encounter the narrator as victim. This caution informs Nguyen's critique of Judith Butler[44]:

> seeing the other only as a victim treats the other as an object of
> sympathy or pity, to be idealized or patronized. Existing as the object of
> or excuse for one's theory or outrage, the other remains, at worst,
> unworthy of study, and, at best, beyond criticism. Not critiquing others
> and theorizing on their behalf further subjugates them by relegating the
> real work of empathy to ourselves. (76)

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[44] Here, Nguyen is referring to Butler's *Precarious Life: The Powers of Mourning and Violence* (2004) wherein she demands, in the aftermath of the 9/11 attacks, for mourning around violence and war to be reframed such that it accounts for the loss of others.

This is perhaps Nguyen's most controversial yet important point: as a theorist supposedly attentive to the concerns of others and otherness, one must also be willing to criticize the other or else risk reproducing the other as a perpetually passive victim of not only political violence or economic inequality but also of the theorist's patronizing and idealizing sympathy, pity, or empathy. Treating the other as victim misrecognizes as ethical the theorist's power as *master* of empathy. Or in Nguyen's words, the theorist is the only one who does the "real work" of empathy. Similarly, the medical humanities too often uncritically positions itself as the master of empathy in healthcare—as the discipline that can do the "real work" of empathy for a healthcare model that lacks the necessary tools for empathy (e.g. insight into humanity through narrative). My point is thus not to treat the narrator as an idealized victim of a broken mental healthcare model (although in many ways he is), but rather to critically trace how humanity and inhumanity condition the narrator's encounter with the mental healthcare model as personified through Genevieve. On that note, I will begin my reading of *Cockroach* with a critique of the narrator's treatment of women.

3.3   Reading Inhumanity in *Cockroach*

The narrator reveals what frustrates him most about his therapeutic relationship with Genevieve early on in the text:

> She did not understand. For her, everything was about my relations with
> women, but for me, everything was about defying the oppressive power
> in the world that I can neither participate in nor control. And the
> question that I hated most — and it came up when she was frustrated
> with me for not talking enough — was when she leaned over the table
> and said, without expression: What do you expect from our meeting? I
> burst out: I am forced to be here by the court! (5)

The narrator's outburst reveals that what Genevieve fails to understand are the particularities of their encounter—that is: the conditions, like the court's mandate, that make their encounter possible in the first place. Meanwhile Genevieve's question reveals how she mistakenly thinks their encounter ("meeting") is conditioned by the narrator's expectations, when it is actually conditioned by the exertion of power, like the court's mandate and Genevieve's desire for the narrator to talk "enough." What is left notably unsaid is how "enough" is a fallacy that can never be attained since it depends upon Genevieve's insatiable desire for the narrator's stories and emotions.

At the same time, the narrator fails to recognize that he does indeed "participate in and control" some of the "oppressive power in the world"—specifically, patriarchal oppression. His patriarchal oppressive power is most explicitly apparent when he assaults Shohreh on their walk home from a party. The two start by gently wrestling in a snowbank, but then the narrator tries to kiss Shohreh without her consent, pressing his body down onto hers and not letting go of her face even as she repeatedly yells at him to let go and tries to shake herself free from his grasp (74). The assault is described by the narrator in a matter-of-fact tone that does not offer much reflection upon his or her actions and feelings; he seems to move onto the next morning without giving the assault a second thought. The only minor reflection he offers is when he describes Shohreh shaking "her whole body *violently*" against his grasp (74, italics added): here, the narrator characterizes *Shohreh's* actions as violent while failing to recognize that *he* was the one violently holding her down. The narrator's encounter with Shohreh is conditioned by his "oppressive power" and violence, not hers.

This scene epitomizes the narrator's inhumanity as he not only acts violently towards Shohreh, but also fails to feel anything in relation to this act. At the novel's outset, the narrator admits, "I need to seduce and possess every female of the species that comes my way. When I see a woman, I feel my teeth getting thinner, longer, pointed. My back hunches and my forehead sprouts two antennae that sway win the air, flagging a need for attention" (3). By naming women as species, the passage introduces the reader to the

narrator's inhuman desire to violently possess and consume women, which, in turn, dehumanizes the narrator himself as he transforms into a cockroach, a point to which I'll return later in the chapter. In the first instance, however, his malevolence extends to his desire to possess others' homes and objects through his repeated break-ins and robberies across Montreal. And as we have seen, the novel also reveals the less obvious but equally problematic inhumanity of Genevieve (and perhaps even us as readers): her (and maybe even our) desire to possess and consume the other's emotions and stories. So to adapt Nguyen's ethics of recognition: when we recognize the narrator's inhumanity as the desire to possess (women, homes, objects), then we can start to recognize Genevieve's— and maybe even our own—capacity for inhumanity as the desire to possess (stories, emotions, etc.) as well. In this way, inhumanity is not an essential trait *in* the other, but is conditioned by how one encounters others through a malevolent form of desire that seeks to possess and consume.

Just before the narrator assaults Shohreh, a train passes the two of them and prompts Shohreh to remark that trains make her sad. The narrator asks her why, but she refuses to answer and instead asserts that "there are some feelings that are only one's own" (74). Shohreh's possession of her own feelings lies in stark opposition to Genevieve's desire to possess the narrator's feelings. In their therapeutic encounters, the narrator's feelings are never his own; rather, they are Genevieve's as she demands and expects explanations for his feelings as though she has a right to them, as though they are hers. She even assigns feelings to the narrator as though she is the one who possesses emotions in the first place and so controls how she distributes them among her patients. To the narrator, however, this process feels utterly arbitrary even as it asserts its domination:

> She always started with an assessment: you look tired, happy, sad, or
> good. And I knew her words had no relevance, no connection to how I
> looked; they were always just an excuse to start the conversation. I
> usually nodded and I always agreed, but I also knew I could look like
> all of the above at the same time, as if I were a cocktail of emotion that

was not defined, that had no scientific term, that needed a new space to
exist in, a kind of purgatory that no medical paper had ever described.
(257)

By assigning emotions to the narrator at the outset of every appointment, Genevieve
seeks to possess the narrator's emotions in two ways. First, she controls the conversation
by asking questions that seek to break into the narrator's mind. Second, she controls
whatever emotions she "finds" in his mind by defining them in terms of medico-scientific
categories. Genevieve thus controls the discourse in their encounter: she controls the
conversation as the one who asks particular questions that demand particular answers, as
well as the terms and interpretation of this conversation (i.e. Western, medico-scientific
terms). In another appointment, it is clear that she controls the therapeutic encounter
through a Euro-Western framework when she interjects "Nietzsche!" in response to the
narrator's reflection that "Maybe [his] sister wanted to bring a fighter into this world"
(78). The narrator does not understand Genevieve's outburst and she does not bother to
explain it to him because the narrator does not need to understand; it only matters that she
understands—that she remains in possession of—the narrator's innermost thoughts and
feelings in order for her to determine and prescribe a cure.

More specifically, Genevieve seeks to control their therapeutic encounters according to a
framework of Christian redemption. The narrator describes this framework with his
typical sarcastic and dark humour:

you are going to confess something — something evil that was done to
you, something evil that you did. If you sit, wait, behave, confess, and
show maybe some forgiveness and remorse, you, my boy, you could be
saved. Jesus shall appear from behind one of those office doors in a
skirt and stockings, holding a file of lives in his hand […] Jesus knows
every thought in your head. (231-2)

Like Jesus, Genevieve seeks to possess every thought in the narrator's head, as well as all her other patients whose lives she possesses in her files. This reveals the third way in which Genevieve controls the discourse of the therapeutic encounter: she controls what gets recorded from each appointment in her filed notes. Her desire to possess and control her patient's innermost thoughts is motivated by her belief that she can "cure"—or more aptly "save"—her patients' *humanity* by getting them to confess their *inhumanity* (i.e. the "evil" thing that they did or had done to them). But it is precisely through seeking to redeem the narrator's humanity that Genevieve ends up revealing the inhumanity of her own desire to possess and control the other's emotions and stories, in much the same way the narrator desires to possess women.

It is thus apt that the narrator describes his chair in Genevieve's office as an "interrogation chair" (47), which suggests a psychological violence inflicted upon another with the underlying desire to obtain an admission of guilt or some incriminating piece of information. During their final therapy session Genevieve tells the narrator, "you have anger, you have guilt, and you have to deal with your loss" and that he attempted to commit suicide because of his sister's death, even though he repeatedly denies her reasoning (258). This time, Genevieve is not simply assigning emotions to the narrator, but also reasons for these emotions. As she continues to interrogate the narrator on how he feels about his sister's death, the narrator simply stays silent. Frustrated by her unfulfilled desire to possess the narrator's deepest feelings, Genevieve invites the narrator to leave the appointment. The narrator does indeed take this opportunity to leave the clinic for good, but not without first implying that he has broken into Genevieve's home:

> You lost your slippers. You can't find your old slippers. [The narrator says to Genevieve.]
> It is grave, very grave, if you are implying what I think you are implying. Very grave.
> There is nothing wrong with offering some hospitality, I said.
> I never invited you into my personal life.
> No, but I went anyways.

> This therapy is over, she said. She looked deeply sad and
>
> alarmed. (259)

This encounter is a striking inversion of their usual therapeutic encounters. Whereas Genevieve is the one typically "breaking into" the narrator's personal life, this time the narrator reveals that he has literally broken into Genevieve's personal life; and whereas Genevieve desires the narrator's most intimate feelings and stories, the narrator desires some of Genevieve's most intimate possessions, like her slippers and lipstick. The narrator enters Genevieve's life ununivited just as he never invited her into his life.

Nguyen's ethics of recognition states that "When we recognize our capacity to do harm, we can reconcile with others who we feel have hurt us" (73). Genevieve fails to recognize her own capacity to do harm—her own inhumanity as she desires to possess the narrator's emotions and stories—and thus cannot reconcile with the narrator—the other who has hurt her by breaking into her home and stealing her slippers. *Cockroach* thus posits a radical ethics of caring for others, a radical model of hospitality that is figured by letting uninvited strangers break into our homes, and in doing so, recognizing that we are strangers who can—or already do—break into other people's homes. But Ahmed importantly cautions against ending our ethics there: "The model of hospitality based on 'welcoming the stranger' [or welcoming 'the other'] assumes that to welcome the stranger *is* to welcome the unassimilable: it hence conceals how that very act of welcoming already assimilates others into an economy of difference" (150). Ahmed argues that one must problematize such a model of hospitality by analyzing the "*economies of differentiation that already assimilate others as the strangers* (which is economic in the precise sense of involving circuits of production, exchange and consumption)" (150-1, italics original). In other words: a radical ethics of welcoming strangers to "break in" is only radical if one also recognizes how such an other as stranger is never really anybody, but is rather an other already assimilated through an economy of difference. In the case of *Cockroach*, the economy of difference is a "circuit of

producing, exchanging, and consuming" stories and feelings—a circuit that is never neutral, but is fueled by relations of power.

3.4   The Economy of Inhumanity in *Cockroach*

In another appointment, Genevieve asks the narrator if he wants to tell her more about his childhood, and when he does not respond, she cautions: "If we do not move forward, if we do not improve, I might have to recommend that you go back to the institution. Frankly, you do not give me much choice with your silence. I have a responsibility towards the taxpayers" (60). This encounter yet again reveals Genevieve's inhumanity as her desire for the narrator's traumatic childhood stories manifests as a threat. Moreover, Genevieve's expectation for moving "forward" and "improving" reproduces the hegemonic mental health recovery narrative: that after a mental health crisis (e.g. the narrator's suicide attempt), the "ill" patient must follow a linear, forward progression towards a recovered state of "health" by accepting the "cure" offered up the Western mental health model (i.e. the "talking cure" offered through psychology/psychoanalysis and/or the pharmaceutic "cure" offered through psychiatric medicine). This time, the narrator actually resigns himself to Genevieve's demands, thinking to himself, "I will tell her stories, if that is what she wants" (60). In his resignation, the narrator crucially reveals how the hegemonic recovery narrative depends upon an economy of stories and emotions: you must give up your stories and feelings to the therapist in exchange for her to "cure" your mental illness. This reveals the fallacy of the state's supposed beneficence in using taxpayer funds to "cure" refugees, like the narrator, who may not be able to pay taxes, but must instead enter into the capitalist economy of the therapeutic model by spending the only other currency it accepts: one's stories and emotions.

The narrator most strongly identifies Genevieve's desire to possess and consume his emotions when some spicy Pakistani food makes him cry and sarcastically consider "getting a little jar, collecting [his] tears, walking to Genevieve's office, opening her door, and showing her the bottle" (142). The narrator then imagines asking Genevieve

"Here—is this what you want? Here—these are my tears. Does that make me sane, normal, cured?" (142). The narrator's question may be rhetorical, but the triple substitution of "sane, normal, cured" raises important questions. Does the equivalence between sanity, normality, and cure hold true? Can one ever truly just be sane, normal or cured as if they are final, stable states? What signifies sanity, normality, and cures in society? And who decides how they are defined/identified? The narrator humorously imagines gathering all his tears in little spice bottles and labeling them for Genevieve: "tears from laughter, tears from spicy food, tears from pain, tears from nostalgic memories, tears from broken hearts, tears from poverty" and wonders "why all cultures demand tears. The industry of tears! Tears must be seen then buried. Even Genevieve wanted my tears!" (143). Apart from representing himself as a kind of orientalized other who trades in spice, the narrator also calls attention to the *industry* of tears, reminding us how his emotions are part of an economy of exchange in his encounters with Genevieve as she desires to consume those emotions.

bell hooks argues that "the commodification of difference promotes paradigms of consumption wherein whatever difference the Other inhabits is eradicated, *via* exchange, by a consumer cannibalism that not only displaces the Other but denies the significance of that Other's history through a process of decontextualization" (373). By offering to bottle up his tears, the narrator commodifies (as spice), displaces (from body to bottle), and ultimately decontextualizes tears from emotions. And all this must be done to satisfy Genevieve's desire for his tears—for his emotions—in exchange for the "cure" to his mental illness. hooks then goes on to analyze the film *Heart Condition* (1990) and asserts that the film "insists that white male desire must be sustained by the 'labor' (in this case the heart) of a dark Other.[45] The fantasy, of course, is that this labour will no longer be "exacted *via* domination, but will be given willingly" (374). In *Cockroach*, Genevieve's desire to consume the other's stories and emotions must be sustained by the literal

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[45] *Heart Condition* is a comedy directed and written by James Dr. Parriot. It is about a racist police officer who receives a heart transplant from a Black lawyer he hates. After the transplant, the lawyer continues to haunt the officer as a ghost.

(putting tears in spice bottles) and figurative (bottling up feelings) emotional labour of the narrator and her patients more generally. The narrator thus imagines (literally fantasizes) Genevieve's fantasy that such labour is voluntary.

During yet another appointment, Genevieve asks the narrator how he feels about his sister sleeping with the man she works for, and the narrator responds, "Nothing. I felt nothing" (139). Genevieve then questions his feeling of nothingness until the narrator retorts, "I am asking you, doctor…Genevieve. How are we supposed to feel?" (139). When Genevieve vaguely answers that "it depends," the narrator completes her sentence by remarking that "it depends on class" (139-40) and thus, in the first place, upon material economic circumstances as well as emotional currency. Genevieve fails to recognize how economics condition her encounters with the narrator, especially what emotions she desires from him in these encounters. Economic circumstances condition how the narrator feels, but also his experience of mental illness, which Genevieve also fails to recognize. Genevieve warns the narrator that drugs might be triggers for episodes of delusion and delirium, which the narrator denies ever having experienced (166). It is tempting to follow Genevieve's lead to diagnose the narrator's experiences as a cockroach, for drugs do seem to trigger his episodes of delusion and delirium. For example, slightly later than the early depiction of the narrator as a cockroach who menaces, Hage describes him as transformed into a cockroach after smoking a joint: "I lay in bed and let the smoke enter me undiluted. I let it grow me wings and many legs" (19). After seeing his six legs and whiskered face in the mirror, the narrator tucks himself into bed to think about the "dilemma" he faces (19). Again, the narrator may be delusional, but at the same time that the transformation offers a momentary release from the reality of his life, the episode makes it clear that his real dilemma remains poverty: "My welfare cheque was ten days away. I was out of dope. My kitchen had only rice and leftovers and crawling insects that would outlive me on Doomsday" (19). The reason the narrator lit a joint in the first place was to warm his body in his unheated apartment. Thus, as much as he dehumanizes women, he is also himself dehumanized by the welfare system, which is described poignantly when he goes to the welfare office to fill out some papers because "the bureaucrats want to make sure that you move your ass out of bed

once in a while, shuffle your feet in the snow to prove that you are alive" (121). The novel thus highlights how poverty conditions the narrator's inhumanity—his inability to feel what he is "supposed" to feel and his transformations into a cockroach.

There is, however, one way in which Genevieve seems to recognize that economics conditions the narrator's feelings and mental illness: in order to progress towards "recovery," Genevieve strongly believes that the narrator must get a job. For example, when the narrator tells Genevieve that he interviewed to be a server at an Iranian restaurant, she enthusiastically responds, "It will be such a good step for you to reintegrate into society" (76). Genevieve's remark implies that currently the narrator is not integrated into society and it is unclear whether this is because he is a poor, unemployed refugee or because he is a mentally ill man who thinks he is part cockroach. This ambiguity is precisely the novel's point as the narrator's experiences as a refugee in poverty cannot be separated from his experiences with illness. But one must be careful not to mistake this intersectional approach to healthcare with Genevieve's remedy that the *narrator* must be triply "cured" of his poverty, his refugee status, and his mental illness, rather than recognizing that it is in fact *society* that is "sick" in the way it treats the poor, refugees, and the mentally ill. Genevieve's problematic understanding of how poverty and illness are intimately intertwined comes out most clearly when she tells the narrator that if he had a job, he could have afforded to buy a gun to kill himself with (79). Participating in the capitalist economy (e.g. by getting a job) is thus revealed for what it really is: a poison for the patient that simultaneously functions as a nefarious "cure" for a society that seeks to eliminate the "sickness" from its body politic—in this case the poor, the mentally ill, and the refugees.

The use of prescription drugs in the novel also functions in this way: the drugs are really only a "cure" for a society that seeks to render the mentally ill invisible. The narrator is warned about pharmaceuticals by a woman whom he knew from the psychiatric institution and who now takes six pills a day (148). This woman warns the narrator not to take any pills because "they will transform you into what you are not" and they will make

you "believe that you don't exist unless you look at yourself in a mirror. You will disappear and the only thing you will be able to see is your clothes" (153). These drugs, like the invisible mirror and mirroring of the technological apparatus in Benjamin's essay, not only render the mentally ill invisible to society by numbing them enough to be assimilated into "normal" life (like the woman who now seems "normal" in her job at a clothing store), but they also render the mentally ill invisible to *themselves*. This reveals how prior encounters that produced inhumanity (e.g. the woman's encounters with psychiatrists at the institution) ultimately condition the other's encounter with herself: the woman now encounters herself as inhuman—as nothing but the clothes that covered where her human body should be.

3.5   Conclusion

After the narrator finishes recounting one of his most painful life stories to Genevieve, he asks if she is shocked by it. Genevieve replies: "Believe me, nothing surprises me in this job. People come with all kinds of stories" (103). The possibility of surprise is conditioned out of Genevieve's encounters with patients; she has already consumed so many patients' stories that she can now quickly assimilate each new patient's story, like the narrator's, before there is even a chance for surprise. As a result, Genevieve's desire for stories does not open her up to new perspectives or ways of being; her desire merely feeds her control over the encounter. Ahmed considers how a truly generous, or ethical, encounter with others requires the possibility for surprise:

> A generous encounter may be one which would recognise how the
> encounter itself is implicated in broader relations and circuits of
> production and exchange (how did we get here? how did you arrive?),
> but in such a way that *the one who is already assimilated can still*
> *surprise*, can still move beyond the encounter which names her, and
> holds her in place. (151-2, italics original)

An ethic that recognizes what conditions our encounters with others must still be humble in its recognition; despite seeking to understand what conditions such encounters, one must still be humble enough to recognize that one can—and indeed should—still be surprised by others. Otherwise, one risks still assuming mastery over the encounter. Works of art, like *Cockroach*, are perhaps at their best when they surprise their audience. Nguyen concludes his essay by reflecting on Rithy Panh's film practice and, more generally, the role of artists in an ethics of recognition: "for artists, looking, remembering, and creating art are themselves ways of recognizing the ambiguities of the human and inhuman […] we need the artist as well as the philosopher to sketch for us an ethics of recognition, to create for us a picture of the inhuman face" (99). As I conclude this final chapter, I want to also emphasize this broader point: that we need not only theorists, but also artists—like Rawi Hage—to not only create a picture of the inhuman face, but to make us aware of what conditions our encounters with inhumanity in the first place in a way that still surprises us—that still unsettles, defamiliarizes, and estranges us. This thesis is ultimately a culmination of my surprising encounters with literature and critical theory (I never expected, for example, to find Benjamin's theory of art to be so relevant to medicine). All the authors I have taken up have unsettled, defamiliarized, and estranged my understanding of not only medicine, but also the humanities. As I transition into medical school and eventually my career as a physician, the very least I can hope for is that literature and critical theory will continue to help me be surprised by my patients as I strive to care for them as ethically and generously as possible.

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