



**A University of Sussex PhD thesis**

Available online via Sussex Research Online:

<http://sro.sussex.ac.uk/>

This thesis is protected by copyright which belongs to the author.

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the Author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the Author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Please visit Sussex Research Online for more information and further details

Playing in the Medical Encounter with  
Kathy Acker and David Foster Wallace  
or  
A Thesis of the Whole Person

Ross Owens

Submitted for the degree of Doctor of Philosophy

University of Sussex

November 2020

**University of Sussex**

**Ross Owens**

**Submitted for the degree of Doctor of Philosophy**

**Playing in the Medical Encounter with Kathy Acker and David Foster Wallace  
or  
A Thesis of the Whole Person**

**Abstract**

This thesis starts from the premise that Western medicine incorporates the twin epistemologies of the scientific and artistic methods but while the scientific method has dominated, the artistic side of medicine has been historically neglected or actively suppressed. It outlines how the disciplines of medical humanities and narrative medicine emerged as a restorative to this institutional sickness in Western medicine. It proposes that the ludic texts of Kathy Acker and David Foster Wallace contribute to, and exemplify, a new canon of fictions under the rubric “Sick Literature” in accord with the medically humanist demand for a ‘medicine of the whole person’, as part of this restorative measure. The concept of “Sick Literature” is shown to emerge from a canon of post-war American literature that covers issues such as the narrativization of depression and suicide, the role of the female body, questions of addiction, sexuality, trauma, sexual desire, masochism, pain...

I present this thesis as an exercise in ‘narrative medicine’ and it consists of a series of critical reflections on medically humanist articulations of the medical encounter, which, in an act of mimesis, utilize the “Sick Literature” of Kathy Acker and David Foster Wallace in conjunction with the author’s personal testimony of experiences in the medical encounter. Part of its contribution in this regard is the proposition that ‘the arts’ and ‘artworks’ have inherent medical, or medicinal value. That this value has been overlooked and dismissed in the field is because of a failure of imagination within extant medical praxis to identify, deconstruct and democratize the parameters by which it institutes its orthodoxies and constructs its patients as medical objects through an idealized medical epistemology, rather than an individualized one.

Its major contribution is to present “Sick Literature” as an artistic methodology or medically humanist praxis of ‘creative-destruction’ (formulated in line with D.W. Winnicott’s notion of ‘play’) that challenges the exclusions of strictly scientific approaches to questions of physiological and psychological “sickness”. It offers the disorderly pleasures of the ludic – the playful – as another mode of medical theory, one which is more open, inclusive, complex, and constructive and provides for both the quantifiable and qualitative nature of human experience to confirm the “artistic method” *must* be an integral component of medical practice, not an addition to.

## Declaration

*I hereby declare that this thesis has not been, and will not be, submitted in whole or in part to another university for the award of any other degree.*

Signature: .....

*Ross Owens*

## Contents

<b>Abstract .....</b>	<b>2</b>
<b>Declaration .....</b>	<b>3</b>
<b>Contents.....</b>	<b>4</b>
<b>Acknowledgements.....</b>	<b>5</b>
<b>The Forewarning.....</b>	<b>7</b>
<b>The Medical Humanities: A History [Patience] .....</b>	<b>7</b>
<b>The Great Dichotomy: Art versus Science .....</b>	<b>9</b>
<b>Medical Practice: A Sensible Approach .....</b>	<b>12</b>
<b>Integrating Methodologies: A Medicine of the Whole Person.....</b>	<b>14</b>
<b>Differential Diagnosis.....</b>	<b>18</b>
<b>Narrative Medicine: A Patient's History.....</b>	<b>20</b>
<b>A Warning on Patient-Centered Care .....</b>	<b>21</b>
<b>Good Talking to You .....</b>	<b>24</b>
<b>Having Been Forewarned.....</b>	<b>26</b>
<b>Prefacing Connections.....</b>	<b>28</b>
<b>Formal Introductions.....</b>	<b>31</b>
<b>The Waiting Room: A Sort of Play (In Parts).....</b>	<b>40</b>
<b>The Rules of the Game .....</b>	<b>41</b>
<b>A Transitional Route into The Clinic .....</b>	<b>50</b>
<b>The Beginning of His Story .....</b>	<b>63</b>
<b>Suicidal Narrative Disorder .....</b>	<b>85</b>
<b>A Heady Cocktail; A Genuine Mix-Up .....</b>	<b>93</b>
<b>Accursed Depression .....</b>	<b>97</b>
<b>Suicide as a Sort of Gift .....</b>	<b>100</b>
<b>A Clinical Intervention in Visible Women.....</b>	<b>109</b>
<b>"Sick Literature" as Figurative Disorder, Literally Speaking .....</b>	<b>116</b>
<b>Bodily Material .....</b>	<b>119</b>
<b>Concluding His Story.....</b>	<b>135</b>
<b>Bibliography.....</b>	<b>140</b>

## Acknowledgements

My first and fervent thanks to Doug Haynes, whose support was instrumental in getting me this far, and whose guidance, humor and intimidating recall helped bring me through the early stages and set me off in new directions with an eager buzz about myself as each little milestone approached. Thanks for sticking with me, Doug; I'm sorry it took so long.

My thanks too to all my wonderful colleagues, cohorts, and peers in Arts B. To Bill, Charlotte, Harriet, Jo, Kieren, Mike, Tom, and all you numerous others who flitted in and about in fleeting meetings between us – you are the best, kindest, most giving and accepting people I have ever had the good fortune to meet. You've learned-me-up something proper. I love you all. Thanks too for finding me when I needed you and making the rare hours I spent in the confines of our little hovel or good ol' Larry Trask pass all the more easily; I've missed being out and about with you, let's hope we can do something in the world together soon.

To Mum, Mark, Carl, Luke; to Katie, Laura, Debbie, Lana; to Margot and Melinda; to Polly:

I owe you all a little piece of everything; everything I am; everything I might yet be. I am only here because of you. Thank you for listening. Forever yours, with love. Go well.

You never reach any truth without making fourteen mistakes and very likely a hundred and fourteen. And a fine thing, too, in its way; but we can't even make mistakes on our account! Talk nonsense, but talk your own nonsense, and I'll kiss you for it. To go wrong in one's own way is better to go right in someone else's.

– Fyodor Dostoevsky, *Crime and Punishment*

## The Forewarning

Forgive my being forward but according to convention, or orthodoxy, forewords are written by people other than the author of the proceeding work themselves. They are typically written by experts in the field to add credibility to the work and might tell of some interaction between the writer of the foreword and the work's primary author, or the story the work tells ('Foreword, n.').

As the author of *this* foreword, I concur with these conventional understandings of the term, but not exactly. So, consider yourself forewarned: this foreword is also unconventional. It is unorthodox, to a certain extent. Unorthodoxy is important to this thesis.

Let me begin to explain:

It is true that Ross and I know each other very well and have interacted almost our entire lives. In fact, it often feels as though we are the same person; I am certainly an expert in him.

It is also true that I am here to give credence to this thesis and am able to do so because I have witnessed a lot of what he has been through and although I have not been able to share in all of his experiences – in many cases, I was simply an observer in the room – I have made it my life's work to read as much as possible about the subjects of his experiences in hope of learning all I can to help him understand them.

To prepare you for his thesis I thought it best – as his partial expert observer – to provide some context to the work and the field to which it contributes; that field is the medical humanities, so let us start there.

## The Medical Humanities: A History [Patience]

To put it mildly, medicine is a complicated, contested, and diverse field. From Galen to Florence Nightingale, from the bedside to the laboratory, the breadth of medicine and its practice is breathtaking. Paleomedicine; Hammurabi's Code of Laws; Ayurvedic and Chinese medicine; Alexandrian science; Islamic medicine of the Middle Ages; the Renaissance, Scientific Revolution, and occult sciences; clinical and preventative, unorthodox and alternative; the science of surgery; microbiology and ever-increasing advances in biomedicine, genetics and genomics... Charting the history of medicine is to chart the history of humanity and an undertaking greater than the scope of this thesis. What is pertinent to the argument is the concept of medicine in contemporary practice, after the advent of so-called modern science and the scientific revolution of the 15th-17th centuries and the formulation of a professional medical practice in the 18th-19th centuries, but which is rooted in the



20th century and the emergence of a new field of medical inquiry: the field of medical humanities (French and Wear; Magner; Porter; Bynum, *History of Medicine*).<sup>1</sup>

The term ‘medical humanities’ was first circulated in the United States in the 1940s, emerging some 30 years after recommendations in the *Flexner Report* (1910) produced a state-wide revolution in medical education. The report outlined the importance of consolidating the medical curriculum whilst suggesting a significant expansion in training – particularly in science and the scientific method.<sup>2</sup> The standardization of training (Kirklin and Richardson; Bleakley and Bligh), combined with the implementation of new regulation in the aftermath of the report’s publication, led ultimately to concerns about a widening split between scientific understanding and humanist medicine that was reflected by the decline of doctors as so-called ‘gentleman physicians’ (McManus; Warner).

In the UK, the field of medical humanities was only tentatively formalized in the 1990s having been inculcated by the first edition of the General Medical Council’s *Tomorrow’s Doctors* (1993), and the first arts in health seminar organized by The Wellcome Foundation (Evans and Greaves, ‘Exploring the Medical Humanities’; Greaves and Evans, ‘Medical Humanities’; Evans and Greaves, “‘Developing the Medical Humanities’”). *Tomorrow’s Doctors* provided the framework for a comprehensive overhaul of the undergraduate medical curriculum in the UK, with a new emphasis on evidence-based medicine (EMB) and self-directed learning (Arnott 33). Among the most important outcomes of this outline for a new curriculum was the opportunity to stimulate learning in the history of medicine. The University of Birmingham was a leading proponent of this new occasion in undergraduate education, offering integrated health science modules as part of its core curriculum:

One of the attractions of all these modules and degree programmes is that they helped students to begin to realize that there were other intellectual dimensions to university and student life, outside the narrow confines of modern biomedicine, local teaching hospitals, and general practitioners’ surgeries (Arnott 34).

The pursuit of ‘intellectual dimensions’ beyond the ‘narrow’ scope of biomedicine remains a key factor in the development of medical humanities in both the US and UK, and, in the latter, culminated in the creation of the University of Durham’s Centre for the Arts and Humanities in Health and Medicine (CAHHM) in 1999; the inaugural publication of the Institution of Medical Ethics

---

<sup>1</sup> For surveys of the history of science, the advent of modern science and medicine’s place within it, see: Lawrence; Hall and Hall; Bynum and Porter; Halliwell. It is also important to reference the role of gender in the historiography of science, the creation of science’s epistemologies, issues of marginalization and oppression and current discourses between ‘strong objectivity’ and ‘new objectivity.’ Harding is particularly important here, as is Haraway who, along with Karen Barad, developed theories to define the human, non-human, technological, and natural as agents that jointly construct the parameters of our common world. For an introduction to these topics see: E. F. Keller; Haraway; Harding, ‘Feminism and Theories’; Harding, ‘After the Neutrality Ideal’; Harding, ‘Rethinking Standpoint Epistemology’; Harding, ‘European Expansion’; Harding, *The Feminist Standpoint Theory Reader*; Naples.

<sup>2</sup> For detailed assessments of the report’s impact, see: Beck; Hiatt and Stockton; Cooke et al..

and BMJ journal, *Medical Humanities*, in 2000; and the establishment of the Association for Medical Humanities (AMH) in 2002 (Arnott et al.; Meakin; Kirklin, 'The Centre for Medical Humanities').

The AMH was created to promote 'understandings of both the human condition and practices of patient care through critical dialogue between medicine and healthcare, and the arts and humanities' ('Mission Statement'). However, since its inception, the AMH's ambition for a 'critical dialogue' has been stifled by debate about the dichotomy between the very disciplines it sought to unite (Evans and Finlay, sec.1; Greaves and Evans, 'Medical Progress'). This, combined with exponential advances in medical science and technology, has served only to further dislocate the art of medicine from biomedical science (Smith and Taylor; Saunders; Halperin).

## The Great Dichotomy: Art versus Science

The OED has the origin of the term 'art of medicine' circa 1300 AD ('Medicine, n.1' 1), and yet in centuries BC, Hippocrates (circa 460-375 BC) spoke of medicine as an art, an 'art [that] has three factors, the disease, the patient and the physician. The physician is the servant of the art' (qtd. in McDonald 47). Whatever the facts of the term's coinage however, that medicine has been considered an art by learned physicians and scholars since its inception is beyond doubt (Slattery and Langerock; Panda; Galen). As Paracelsus (1493-1591) had it: 'medicine is not only a science; it is also an art. It does not consist of compounding pills and plasters; it deals with the very processes of life, which must be understood before they may be guided (qtd. in McDonald 76).<sup>3</sup>

Despite this provenance however, in 2009 European Society for Person Centered Healthcare (ESPOCH) Senior Vice President and Secretary General/CEO Professor Andrew Miles wrote:

It would seem [...] we are in the midst of a battle for the heart and soul of medicine itself between two increasingly separate philosophies whose future is surely not to exist as polar opposites, but rather to function as a united whole, integrated then, in the direct service of patient and clinician, medicine and human progress (942).

The philosophies to which Miles refers are 'scientific' rationalism, and 'holistic' humanism; the loss of the latter he attributes to a reductive, 'technical application of procedures and administration of drugs which now typifies modern medical practice in the Western world' (942). In short: in the rush to embrace the benefits offered by better and better medical science, the benefits to medicine of

---

<sup>3</sup> It is pertinent here to bear in mind that the constitution of Western medical history itself is a highly contested discipline. For an insightful introduction to Western medical epistemology and its historiography see: Bates, 'Scholarly Ways of Knowing'; Conrad; Dean-Jones; García-Ballester; Hankinson; Lloyd; Wallis; and A. Wear in Bates, 'Knowledge and the Scholarly Medical Traditions'.

the arts have been forgotten, to the extent that its practitioners ‘disintegrated *caring* from *curing*’ (Miles 943 [italics in original]).

In an editorial for the journal *Medical Education*, Dr Mark Jackson traces this disintegration to two of medicine’s persistent myths. The first myth concerns the rhetoric that was conceived to justify what the ‘art of medicine’ entailed, which was held to consist of two aspects of doctors’ professional work: the application of technical skills and those features that sit beyond the strictly scientific. This latter ‘art’ is what now falls under the domain of the medical humanities but was previously a nebulous desire that medical students and doctors comprehend the complex relationship between medicine and the law; the ethics of medical practice; and the political, social, and cultural dimensions of their profession (395). The second and most pertinent myth – as it is the one that underpinned the creation of the AMH and maintains throughout much of the critical discourse in medical humanities today – is driven by medicine’s veneration of the language and methods of science.

Of course, Michael Foucault’s *Birth of the Clinic* (2010 [First English Edition: 1973]) perhaps represents the seminal critical inquiry into the institutionalization of Western medicine and corollary emergence of a language of medicine. It charts the reorganization of medical knowledge in ‘modernity’ as the preserve of a developing academe that inculcated a distinction between a patient’s body and a patient’s identity through the prism of the ‘medical’ or ‘clinical’ gaze. To precis Charles Scott, this process replaced rational inference and an emphasis on the history of disease with a pathological anatomy, such that the physical body – specifically, the corpse – became the ‘space’ of modern medical knowledge (335). This development naturally moved further and further away from the medical knowledge held by itinerant healers, lay-persons, and surgeons in so-called ‘classical medicine’:

For clinical experience to become possible as a form of knowledge, a reorganization of the hospital field, a new definition of the status of the patient in society, and the establishment of a certain relationship between public assistance and medical experience, between help and knowledge, became necessary; the patient has to be enveloped in a collective, homogeneous space (Foucault, *The Birth of the Clinic* 242)

For Foucault the new medical language was ‘that of a perpetual and objectively based correlation of the visible and the expressible [...] – to say what one sees’ (242), a stance that Jackson embellishes and adapts in describing an ‘inexorable rise of laboratory experimentalism and biomedical reductionism [which] has led to a belief that good medicine is scientific medicine (Jackson 395). Jackson calls this a ‘professional myth’ (396) that gains legitimacy in relation to its reverence of doctors’ ‘meticulous training’, ‘professional mystery’, and the orthodoxy of ‘medical expertise and authority’ (396).

A similar professionalization within medicine occurred in the United States (Cassedy; Tannenbaum), and likewise in the US as in Europe the process of institutionalizing medical education and practice from the 1700s onwards reflected the privileging of scientific empiricism, which served to ostracize and deliberately prohibit from practice vast numbers of extant medical practitioners who were suddenly ejected from medical orthodoxy (Apple; Harding, 'Gender'; Morantz-Sanchez; Warner and Tighe). Attention to these 'arts' was construed as a means of producing better doctors, but Jackson is again critical of this notion, suggesting that a rhetoric of artistry was appropriated by an 'educational and professional structure that emphasized the need for practitioners [...] to be broadly educated, humanist gentlemen' (Jackson 395), which – as we see in Apple, Morantz-Sanchez, and Warner and Tighe especially – is always in service of the existing hierarchy and preserves the dominance of elite Royal Colleges and excludes women and the poor from the profession (Lawrence; Bynum and Porter, chap.3; Bynum, *Western Medical Tradition*).

To return briefly to Foucault's *The Birth of the Clinic*, it is evident – in summation – that the 'clinical gaze' frames and foregrounds institutional orthodoxy, prohibiting critical and self-reflective analysis and the corollary advances that such practices can provoke. Therefore, the medical institution can only offer an 'incomplete' form of practice because it restricts its epistemologies by ignoring how the artistic method and artful practices can be utilized methodologically as a route to greater knowledge and better practice. Furthermore, the external regulation or government of medicine – as opposed to its internal or self-regulatory governance (Evans; Petersen et al.) – has fueled misgivings that increased administrative requirements within primary and secondary care units are to the detriment of biomedicine and scientific research (Warden; Salter; R. L. Smyth), let alone the medical humanities project. As medical historian Lois N. Magner notes, 'public debates about medicine today rarely seem to address fundamental issues of the art and science of medicine; instead, the questions most insistently examined concern health care costs, availability, access, equity, and liability' (Magner vi).

What emerges from this is that Professor Miles is not alone; a growing field of research by medical professionals, philosophers and theorists perceives the growth in an all-powerful 'scientism' to the exclusion of medicine's innate 'humanism' (Crawshaw, 'Humanism in Medicine'; Kirklin, 'Humanities in Medical Training and Education'; G. Bolton, 'Medicine, the Arts, and the Humanities'; Dittrich). In fact, Miles argues that the aspirations of the medical community when a 'medical humanities' was first coined and conceived have gradually ebbed away to the extent that medicine has been divorced from holistic practice as a direct function of the 'growing scientific reductionism in medicine in the face of a dramatically increasing complexity' (942). It is therefore a fallacy to consider medicine a science in the realist Newtonian sense, because such exacerbates the expectation that medical

knowledge is invariant, objective and always replicable. Instead, medicine operates at the intersection of the disciplines we simplistically conceive as art and science; for Miles, ‘the real conceptual divide is not between the science base and the arts base of medicine, but rather between a complete form of medical practice and an incomplete one’ (947).

## Medical Practice: A Sensible Approach

This adherence to orthodoxy, this promulgation and propagation of the status quo, is the commonality between Jackson’s two myths and which permits their perpetuation. Examining discourses from the field of medical humanities since the foundation of the AMH, it is possible to build upon the work of Alan Bleakley, Professor of Medical Humanities, Falmouth University, to address the dichotomy between ‘humanism’ and ‘scientism’ and reintegrate and invigorate the arts (and humanities) in medicine.

In his “Introduction” to *Medical Humanities and Medical Education* (2015) Bleakley identifies a fault-line in the culture of medical practice, namely: ‘the continuing inability for the culture of medicine to democratize in order to improve healthcare, in the face of mounting evidence that such democratization is necessary’ (1).<sup>4</sup> The primary concern this mounting evidence points to is a ‘fault-line’ in the *methodologies* of medical education and its pedagogical culture, coupled with medicine’s extant clinical culture. While Bleakley acknowledges that medical curriculums have responded to such concerns in recent years, he contends that efforts have been – in part – counterproductive. This, he argues, is a consequence of the existing institutional framing, or orthodoxies, of hierarchical and authority-led medical organizations; an undemocratic culture in which doctors ‘place “cases” and smart diagnoses before persons and feelings’ (2). It is this dehumanizing, institutional and undemocratic framework that medical humanists demand be reformulated, and which Bleakley asserts can only be achieved by the provision of the medical humanities as an integral and core component of Western medical education (4).

In the chapter, “The Distribution of the Sensible”, Bleakley presents his argument, linking ‘a political call to democratize medical practice with an aesthetic call to promote education of the sensible, or

---

<sup>4</sup> The assessment of patient care and patient satisfaction has been of fundamental importance for successive UK governments and NHS England. In 2000 the Picker Institute was established as an international charity in health and social care and in 2002 was appointed by the Department of Health to design and establish the English NHS National Survey Programme for patient experience. The vision for healthcare in the UK was presented in *NHS Five Year Forward View* (NHS England; Maruthappu et al.), setting out a framework for new models of care that included a goal to ‘increase the direct control patients have over the care that is provided to them’ (NHS England 12) – to offer ‘personalized’ healthcare. This drive was in response to data showing ‘only half of patients say they are as involved as they wish to be in decisions about their care and treatment’ (13). For evidence on the need for greater democratization in healthcare, see: Coulter; Coulter et al.; Coulter and Richards.

sensibility' (60) – a response to the 'insensibility' produced by the existing orthodoxy. To wit: the medical humanities provide a means to resist insensibility and the unfair distribution of 'sensibility capital' among expert clinicians at the expense of marginalized healthcare practitioners, patients, and students.<sup>5</sup> Bleakley develops his Rancièrian approach by detailing how these orthodoxies are the product of medical institutions' maintaining control over knowledge capital, a fundamentally unfair privileging by a minority in authority (the empowered) of what has been determined *a priori* to be worthwhile. In accordance with Rancière, this 'does not simply occur as a transparent or natural process,' rather, 'what is considered worth noticing and, more importantly, who is given the privilege to notice and appreciate, is determined socially' (Bleakley 67).<sup>6</sup> As I have already noted above, this process is to the detriment of the majority who are disempowered, whose lack of or unorthodox knowledge capital implies their inability to produce affect in the existing orthodoxy. Therefore, the existing orthodoxy is perpetuated and self-sustaining. In short:

While [orthodox] pedagogies appear to become outwardly more 'student-centered' and medical practices more 'patient-centered', this does not necessarily disrupt the underlying structure of the distribution of the sensible, where forms of perception (aesthetics) and modes of relations (politics) resist redistribution shaped by equity (fairness and justice) and equality of opportunity (Bleakley 71).<sup>7</sup>

A number of case studies have been conducted in the US, UK and internationally to assess the impact of such a configuration, demonstrating both instrumental and non-instrumental outcomes with regards to the role the field can have (Macnaughton, 'The Humanities in Medical Education'; Skelton et al., 'Teaching Literature and Medicine to Medical Students, Part I'; Skelton et al., 'Teaching Literature and Medicine to Medical Students, Part II'; Grant; Shapiro, Friedman, et al.; Louis-Courvoisier and Wenger; Shapiro, Coulehan, et al.). Among the recurrent themes to emerge from these qualitative surveys is students' appreciation of the opportunity to broaden their educational experience if they so choose. Currently, the UK's SSM structure supports this freedom of

---

<sup>5</sup> Bleakley has accredited his notion of sensibility and the 'sensible' exclusively to Jacques Rancière's 'modes of perception,' see: Rancière, *The Politics of Aesthetics*; Rancière, *Dissensus*; Rancière, *Aisthesis*.

<sup>6</sup> There is a growing awareness that the field of medical humanities itself is culturally limited by its extant pedagogical approach, often emphasizing Western cultural and scholarly artefacts that may contribute to the marginalization of certain patients and medical workers (Lokugamage et al.); Claire Hooker is a prominent voice within this area of critical inquiry and for an introduction to her problematization of cultural difference in the field see: Hooker and Noonan; Hooker.

<sup>7</sup> While Bleakley's work is highly critical of extant medical education – and he is far from alone in his efforts – it is worth highlighting that there is a concerted effort to resist a polemic of 'doctor bashing' throughout the critical literature. Bleakley is at pains to modify his criticism of medical institutions' production of insensibility by promoting it as a 'largely unintended consequence' (61) of unexamined practices – a failing in (or lack of) reflexive critical methodologies throughout the field of medicine. Indeed, the accrual of medical knowledge through the passing-down of clinical expertise offers a 'legitimate and standard form of appropriate distribution of sensibility capital' (71), so rather his position – and the one I uphold here – is in opposition to a system suffering from an endemic blindness and resistance to democratic structures.

choice, and it is important to note that in many cases students failed to see the value in a broader educational base. There are a multitude of reasons that this should be so, not least the fact not everybody is need be – or is – interested – in the fields of arts or humanities, but also, the inherent difficulty in reliability of non-quantitative experiment.<sup>8</sup> It is worth mentioning here though the possibility that such disinterest is a direct consequence of exactly the type of structural orthodoxy that medical humanists' rail against, and consequent with sensibilities extant in medical education.

The movement to challenge these extant sensibilities in medical education of course includes the work of medical humanities bodies such as the AMH, CAHHM, and ESPCH. Their efforts have seen the proliferation of the field across several medical schools and higher education institutions; however, skepticism remains, especially when – as iterated above – medical orthodoxies are ostensibly the preserve of proponents of EBM and constrained by the paradigm of the scientific method. As I have forewarned throughout, the alternative to this as-yet insurmountable outcome/impact assessment demand has been the work Bleakley and his peers have conducted to strengthen the rationale for the field of medical humanities, validating why it should be included as a core, integrated component of medical education. It is this last quality that is of vital importance to the project: the concept of integration – that the medical humanities become integral to medical education. It is held as a maxim that such an approach provides the framework upon which a better understanding of illness can be built, offering insights into its nature, causes and outcomes by – for example – adopting and emphasizing a reflexive approach to the didactics of teaching medical students; a move beyond the “Two Cultures” dichotomy’ (Polianski and Fangerau) of medicine as either art or science.

## Integrating Methodologies: A Medicine of the Whole Person

The “Two Cultures” standpoint is drawn from a long oral history of medical practitioners, from Hippocrates’ ‘it is far more important to know what person the disease has than what disease the person has’ (qtd. in Egnew 174), to the so-called father of modern medicine, Sir William Osler, who said: ‘The good physician treats the disease; the great physician treats the patient who has the disease’ (qtd. in Porter 124).<sup>9</sup>

---

<sup>8</sup> Bleakley points to a possible solution to our insufficient body of evidence in a paper with Robert Marshall. They suggest that the body of evidence available from communication science and patient safety studies might be mobilized to inform the impact of medical humanities (Bleakley and Marshall 132). A framework for assessing the impact of medical humanities is provided in the final chapter of *Medical Humanities and Medical Education*, “Evaluating the Impact of Medical Humanities Provision”.

<sup>9</sup> For a comprehensive biography of Osler, his pivotal role in the development of primary care medicine and the founding of Johns Hopkins Hospital see: Bliss.

From Bleakley's formulation we can discern that integrating medical humanities as a core component of medical education acts as a counterweight to the dominance of a 'reductive' biomedical science by reinvigorating the 'art of medicine' and exploring a holistic science. It educates for empathy and ethics provision, and it provides a realist philosophical alternative to the utilitarian notions of healing, health, and wellbeing, i.e. that illness may have meaning and be productive. Similarly, it educates for tolerance of ambiguity. However, this position is not without its problems, the root of which is how the relationship between medical humanities and medical practice should be conceived. Evans and Greaves identify this root as the conflict between two conceptions of what the medical humanities is:

[The] "additive" view, whereby an essentially unchanged biomedicine is softened in practice by the sensitised practitioner and an "integrated" view, whereby the nature, goals, and knowledge base of clinical medicine itself are seen as shaped by the understanding and relief of human bodily suffering (Evans and Greaves, 'Exploring the Medical Humanities' 1216).<sup>10</sup>

Whilst the concept of an 'integrated' approach might appear hard to contest given the persuasive arguments presented by Bleakley and the like, the ongoing controversy surrounding the justification of medical humanities' role in the curriculum is predominantly related to the perception that it lacks legitimacy as a discipline (Ousager and Johannessen; Chiavaroli and Ellwood). This apparent lack of legitimacy results in the 'additive' approach, whereby the predominant curriculum of scientism maintains authority and is merely supplemented by additional content from the field of medical humanities. Evidently this returns us to Bleakley's warning against the persistence of extant sensibilities in medical education; the orthodoxies of scientism demand that unorthodox humanism be made to justify itself according to the rules of science, and thus, the art-science dichotomy perseveres. In addition, the additive approach encourages an interpretation of arts' worth to medicine only by what has been determined *a priori* worthwhile. That is: the additive approach sustains orthodoxies about the value of the arts and humanities *in toto*, raising obvious questions about what such orthodoxies are, and how are they configured by those who support their incorporation into medical practice through the domain of the medical humanities; to what extent is Bleakley's polemic on the production of insensibility by medical authorities transferable to the arts and humanities and those that authorize knowledge capital therein?<sup>11</sup>

---

<sup>10</sup> Whilst this is not a definitive position, it is a prevalent one in the U.K. For a survey of the developments and alternatives in definition see: Evans and Greaves, 'Ten Years of Medical Humanities'; Brody; Chiapperino and Boniolo. A similar debate exists in the US, where the contested models are routinely presented as 'additive' and 'compensatory,' see: Shapiro et al..

<sup>11</sup> As evident throughout this "Foreword", among the most prevalent and problematic of orthodoxies with regard to the role of art in medicine is its association with empathic development – that art makes us more humane in contrast to the perceived inhumanity of science, see: Calman; Macneill; Zazulak et al..



Boudreau and Fuks provide an important insight on this problem by dismantling the proviso for a dichotomy between the humanities and the sciences. Their claim makes assiduously clear the danger inherent in the basic presumption that scientism is dependent on neutral detachment whilst humanism fosters intersubjectivity, of which the corollary is that something in humanism makes us more humane. Such argument is aphoristic and represents a simplistic and misconstrued promotion of humanism within medicine; their claim is that it is a misjudgment to contemplate 'a medicine dissociated from humanity' (Boudreau and Fuks 322). Dismissing the preoccupation with integration within the existing discourse they strive instead to demonstrate that the arts, humanities and sciences are reciprocal, and 'to conceive of the humanities as simply a counterpoint to the natural sciences diminishes both disciplinary traditions' (328). This line follows Jeffrey Bishop's 2007 paper, "Rejecting Medical Humanism: Medical Humanities and the Metaphysics of Medicine", in which he argues against the so-called curative view of the medical humanities, that its adherence to a metaphysics of efficiency means it can only act as 'compensatory mechanism for the mechanical thinking that has dominated and continues to dominate medicine' ('Rejecting Medical Humanism' 16). In short, Bishop asks that,

[W]e stop perpetuating the Western metaphysics of efficient causality and think differently from the *theoria*–*praxis* divide and from the subject–object divide that dominates so much in the way of Western instrumental thinking. In medicine, we have not yet heard, let alone taken seriously, the critique offered by the 20th century phenomenologists, namely that the thinking of our being is essential to human being (17).

What he is warning against is the move to integrate a field of medical humanities before that field has defined its disciplinary parameters. Only once its disciplinary parameters are defined will such material 'be explicitly located and, against which, course attributes [...] clearly aligned and coherently taught' (Chiavaroli and Ellwood 253). In effect: all the while the proponents of medical humanities remain in dispute over whether an 'additive' or 'integrated' model is best, and all the while debate remains about what constitutes humanities content vis-à-vis the dichotomy of art versus science, the medical humanities projects of the UK and US are likely to fail (Bishop, 'Rejecting Medical Humanism'; D. Wear, 'The Medical Humanities' 212, 218–19). Similarly, Chiavaroli and Ellwood attest that 'the promise of integration is great [...] Yet there is a real danger in sacrificing the coherence of disciplinary self-containment for the lure of the greater, or at least more apparent, relevance through integration' (252). Instead, by admonishing the art-science dichotomy in favor of a pedagogy focusing on the means and path to learning, rather than the conflict between epistemologies that is the preoccupation of current discourse, Boudreau and Fuks promote a methodology of the 'relational space' (334) in which mutually reflexive development can take place. What is needed then is a new paradigm, one that takes us beyond the nexus of misapprehensions

that provoke the continuing art-science dichotomy. We also need to challenge the orthodoxy that sustains the notion of an ‘additive’ or ‘integrative’ concept of medical humanities to instantiate a model that approaches the ‘art of medicine’ from the unorthodox – because lacking in authority – standpoint that it already pervades medical practice.<sup>12</sup>

A further intersection can be made here by considering the work of Professor Paul Crawford and the field of ‘health humanities’ – an appellation that is in turn responding to the aesthetic and political sensibilities and orthodoxies of the *medical* humanities. Health humanities addresses the need for a more inclusive discipline. It represents a more outward-facing and applied discipline that embraces interdisciplinarity and pursues contributions from marginalized practitioners and allied health professionals (Crawford, B. Brown, Tischler, et al.; Crawford, B. Brown, Baker, et al. 1; Crawford, B. J. Brown, and Charise). Crawford sets out a vision of the health humanities that responds to the lack of consensus [below] as to what the medical humanities is and what it contains, and which inclusivity is a measure of the field’s sympathies with Bleakley’s call for a democratizing movement that redraws medicines boundaries to consider previously excluded areas of knowledge capital (Crawford, B. Brown, Baker, et al. 10).

Of principal to Crawford is a ‘consideration of meaning’ and the correlation between healthcare and the humanities by which people turn to narrative as a means of ascribing specific values to their experiences – a process that ‘forms the individual’s current sense of reality’ (Crawford, Brown, Baker, et al. 4). Drawing extensively from the work of Bruner, Crawford addresses meaning as a ‘dynamic, situational and dialogical concept’, which interactive and dialogic qualities ground it firmly in the territory of the humanities (5).<sup>13</sup> It is from this position that practitioners in the health humanities can borrow from disciplines beyond medicine. For example, anthropological traditions of inquiry show the participant, client, or anyone else how framing meaning according to one’s own terms can empower us to pursue treatments or remedies to our problems that are affirming because they are in accord with self-actualized meaning. In short: all of us have a story to tell, so, similarly, the use of literature – of fiction – in healthcare offers an obvious route to such self-understanding, actualization and meaning-making and for that reason is widely championed in the field. Fiction,

[C]an tell us not only about medicine or doctors, but also about the experience of health, sickness, illness, encounters with clinics and clinicians, the reactions of significant others, the

---

<sup>12</sup> This work is being done, with more recent inquiries have seen the likes of Julia Kristeva lead questions about the conventional distinctions between the natural sciences and humanities via the rethinking of the our concepts of ‘evidence’ and the body, but it is apparent that the dichotomy between ‘additive’ and ‘integrated’ concepts maintains. See: Kristeva et al.; Schillace; Engebretsen et al.; Scott-Fordsmand.

<sup>13</sup> See: Bruner, *Acts of Meaning*

support found in the strangest of places, the role and impact of informal caring, and the radical reordering necessary after the dramatic rift that significant illness causes through an individual life (Crawford, Brown, Baker, et al. 38).

In seeking to create unity among different healthcare specialisms, and by embracing the methods and practices of all disciplines, the field of health humanities offers a platform of innovative research, a 'range of theory and practice which can link human and artistic studies to the implementation of health and welfare' (Crawford, Brown, Baker, et al. 13). As health humanists then, the aim is to introduce a politics to medical education that incorporates the unorthodox sensibilities and critical thinking provided by medical humanities, a redistribution or Rancièrian 'dissensus' that disrupts the current 'fabric' of medical practice 'to make medical students and doctors think again' (Bleakley 72). The failure or refusal to countenance such a revolution can only serve the interests of the existing pedagogy, exacerbating the production of yet more insensibility and through which, skepticism towards the medical humanities and the art of medicine is upheld. A truly democratic medical practice can only exist if the paradigm of medical humanities is among its core components.<sup>14</sup>

## Differential Diagnosis

According to the existing literature then, the institution of medicine is undemocratic and incomplete because its orthodoxies are constructed in the conscription of scientific fact. It privileges the scientific method because principles such as EBM determine data sets of empirically verifiable fact, which, when incorporated by medicine, provide benchmarks of health and wellbeing against which a patient's pathology and relative health can be measured and assessed. Medical orthodoxy in this instance necessarily relies upon scientific fact because such facts provide the structure and substance against which advances in scientific knowledge and expertise and practice can be measured:

Thus, the mathematical table, the geometric rules, and the mathematical statistical models are the unmoving, timeless certainties on which the flux and fluidity of the chaos of real things can be mapped, for what is mapped becomes stable as knowable. Through the process of mathesis, the chaotic reality of things and people — giving themselves in appearance and open to interpretation — becomes the stable objects of knowledge (Bishop, 'Foucauldian Diagnostics' 343).

---

<sup>14</sup> For the remainder of this thesis Ross will return to the designation 'medical humanities' as it is his ambition to compliment the ethos of health humanists in this thesis, to lend his voice to those who are pursuing the reconfiguration of a medicine-centric discipline by offering insight into the application in medicine of humanistic paradigms and practices that are more inclusive and democratic, that are – to put it bluntly – altogether healthier.

This epistemological tenet codifies the ethical imperative to do no harm by constituting an ethics upon efficacies of scale, i.e. *what is good for the many*... This *many* however, does not and cannot reflect the complexity of 'the patient as a whole person' (Miles 941), but instead an average of all patients, not the individual patient then, but the ideal patient.<sup>15</sup> Undeniably, and no matter how assiduously the medical profession has built its tenets on the principles of that Greek physician, above all to 'do no harm', the inexorable progress of the networks of interlacing lines that are culture, science, society, technology... have produced a sea-change in medical education and practice which, according to its practitioners, risks negating the human subject at the heart of the matter.<sup>16</sup>

Ross' thesis contributes to this field by pursuing medicine's innate humanism and argues that our medical institutions' requisite construction of an ideal patient means the absolute denial of a medicine that attends to each patient as an individual, the denial of the patient as a whole person. Addressing this denial is the impetus for Ross' thesis. We would say: it is the reason that this thesis exists. Perhaps the principle question he attacks therefore, is how to address this denial; how does one attend to and treat a patient as a whole person? What does that mean?<sup>17</sup> If the impetus for this thesis is medicine's denial of the patient as an individual, then what else is there to do but examine the very individual experiences Ross has undergone as a patient. To that end, his contribution takes the form of one of medical humanism's principal disciplines: narrative medicine. So, before we begin in earnest, let me briefly turn to that.

---

<sup>15</sup> Assessing the full extent of the factors at play in the provision of Western medicine is beyond the scope of Ross' thesis, but of course fundamental in our institutions constructing 'ideal' rather than 'individual' patients is the collection of medical data, the influence of the pharmaceutical industry and the role of capital market forces; for an introduction into these subjects see: Marchant; Criado-Perez.

<sup>16</sup> The Hippocratic Oath is itself a subject of much dispute among medical and non-medical professionals alike, with even its attribution to Hippocrates disputed given its text emerged a century after his death. For more detailed information on the subject; the oath's numerous revisions, modernizations and the like, see: Crawshaw, 'The Contemporary Use of Medical Oaths'; Crawshaw, 'The Hippocratic Oath Is Alive and Well in North America'; Loudon; Orr et al.

<sup>17</sup> Evidently, philosophical questions about the nature of humanity in Western culture and medicine are closely associated with the issue of Cartesian dualism, its influence on the emergence of academe and the framing of knowledge of the world. Histories of Western medicine inform us that among the most pertinent influences on the development of contemporary medical practice was Rene Descartes' "*cogito ergo sum*". In this philosophy the self is configured as an absolute; one's ontology is formed by the notion of a subjective, individual self whose experience of the world exists in their innate ability to think. That this provokes a distinction between one's self and other selves helps further the dichotomies of subject-object and – in relation to medicine more crucially – a separation between mind and body. For insight into this problematic topic and its influence, see: Porter; Charon et al., pt.II; Magner, chap.6.

## Narrative Medicine: A Patient's History

In short, narrative medicine's ambition is towards empowering patients with the tools to tell their own stories and educating medical practitioners in the skills required to listen with empathy and understanding to those stories (McLellan and Jones; Jones, 'An Evolving Canon'; Jones, 'Narrative Ethics'; Jones, 'Narrative in Medical Ethics'; Jones, 'Why Teach Literature and Medicine?'). Perhaps its leading proponent is Rita Charon, the executive director of Columbia University Medical Center's first Program in Narrative Medicine, and whose work – first encountered during an MA in Contemporary Literature and Culture at Birkbeck University – provided the inspiration to Ross to explore the field of medical humanities and his consequent pursuit of this doctorate. In the *Preface* to her seminal work, *Narrative Medicine: Honoring the Stories of Illness*, Charon states:

When we human beings want to understand or describe singular people in particular situations that unfold over time, we reach naturally for narrative, or storytelling, to do so. When we try to understand why things happen, we put events in temporal order, making decisions about beginnings, middles, and ends or causes and effects by virtue of imposing plots on otherwise chaotic events. We hail our relations with other human beings over time by receiving and alluding to stories told by others – in myths, legends, histories, novels and other sacred texts (Charon, *Narrative Medicine: Honoring Stories* vii).

'Narrative' in this context is widely understood in relation to human development and in correlation with notions of selfhood and identity and features prominently in Western theories of cognition (Caracciolo; Adler, Waters, et al.), cognitive development (Adler, Lodi-Smith, et al.), consciousness (Bruner, *Actual Minds, Possible Worlds*), genetics (Nowaczyk), mental illness (Jones, 'Narratives of Mental Illness'), personality (Waters and Fivush), physical illness (McLellan) social development (Brockmeier and Carbaugh), and the regulation of emotions (Josselson and Lieblich). In the medical humanities the effort is considered part of the broader push towards patient-centered care – though *person*-centered care is gaining traction here too – as it intends towards a medicine of the whole person and not the construction of the person as a patient (G. Bolton, 'Medicine and Literature'; Hughes et al.; Cowie; Louw et al.). There are strong oppositions to this view however, with Paul Atkinson warning that the application of narrative sensibilities in clinical settings too often overlooks basic assumptions concerning human actions and social action, of which narrative is but one form (343). Similarly, Galen Strawson, who is perhaps most prominent among its critics, follows Atkinson to take against the notion of the self as a perpetually rewritten story (e.g. Dennett) and argues that the conceit that we order our lives according to narrative is a fallacy and entirely 'misses the point' (450). Angela Woods' application of Strawson goes further in providing a survey of the ongoing difficulties of precisely defining narrative and narrativity, provocatively identifying seven questions

yet to be comprehensively addressed by medical humanities scholarship and a range of possibilities ‘beyond narrative’ (Woods 73–74).

In empirical matters, evidence in support of self-understanding through narrative truth is still formative, raising as many questions as it does answers (Hunter et al.; Androutsopoulou; Bochner, ‘Narrative’s Virtues’; Bochner, ‘Resisting the Mystification of Narrative Inquiry’; C. Thomas; Walker).

A In practice too, there are problems with narrative medicine’s approach, not least because the ‘translation from scholarship to practice has been slow’ (D. Wear, ‘Toward Negative Capability’ 181; Schiff; Kumagai) but because in practice, participants must have agency and interest in opening themselves to what narrative can offer (Charon, ‘Narrative Medicine: A Model’; D. Wear, ‘The Medical Humanities’; Jones et al.). Consequently, for many, incorporating the paradigm of narrative medicine and framing the patient as a text to be analyzed is precisely not required. In fact – following Wear – we might recognize once more that the effort towards patient/person-centered care appears to maintain a relational hierarchy perpetuating the fallacy that “texts” are wholly independent objects, as well as bias as to which kinds of texts have been determined, *a priori*, worthy of analysis.

## A Warning on Patient-Centered Care

Christopher Mayes addressed just this point in 2009, publishing a paper that addresses the worthy move in medicine from a pathology-centered healthcare to a patient-centered one. He notes that in a shift in the mode of communication – from *doctor-* to *patient/person-centered* – it is expected that the patient will be respected as an autonomous person capable of sharing responsibility and power in the medical relationship. In addition, patient-centered communication addresses the social and psychological elements that contribute to the patient’s wellbeing, an understanding of which assists the patient and physician in diagnosis and treatment (483).<sup>18</sup>

Précising the extensive work conducted by Mead and Bower, Mayes defines the impetus of patient-centered care thus: ‘In order for the physician to obtain the “vital” information about the patient’s life the patient needs to be allowed, encouraged and asked to speak’ (Mayes 491).<sup>19</sup> This literature champions the patient’s voice and the confessing of their selves as a restorative step towards the biopsychosocial model and a patient’s humanity. The pursuit of this ideal has seen the emergence of narrative medicine as a principle discipline in medical education, with doctors encouraged to

---

<sup>18</sup> For first-hand testimonies and examples of integration in practice, see: Frank, ‘Reclaiming an Orphan Genre’; Greenhalgh and Hurwitz; Frank, ‘The Standpoint of Storyteller’; Meza and Passerman.

<sup>19</sup> See: Mead and Bower, ‘Patient Enablement’; Mead and Bower, ‘Measuring Patient-Centredness’; Mead and Bower, ‘Patient-Centred Consultations’; Mead et al.

develop their analytical, critical and interpretive skills as part of a medical hermeneutics (Charon, 'At the Membranes of Care'; Arntfield et al.; Hurwitz and Charon; Charon et al., pt.IV). Meanwhile, Crawford et al. extend the scope of specifically textual narratives to suggest that the arts and humanities in general provide a multitude of forms of 'creative expression and craft [that] can narrate health and illness experience and viewpoints' noting:

Doctors have for a long time been turning to literary texts and ways of thinking that help us to enter the subjective worlds of patients, see others' experience from their own perspectives, appreciate the metaphorical as well as the straightforward communicative power of words, and be moved by what we hear' (Crawford, B. Brown, Baker, et al. 6; Kirkland and Craig).

If the techniques of literary analysis, textual inquiry and so on have indeed been an element in practitioners' skillsets for such a 'long time,' and if narrativity is developmentally foundational in the construction of our very selves, then we can readily uphold Boudreau, Fuks and Bolton's warnings against a pedagogy that positions the arts as the humanist salve to the inhumane practices of science (Brockmeier and Meretoja). Charon's position, in line with the testimonies of those practitioners and students experienced in courses of narrative medicine, appears consistent with this understanding and articulating the specificities of her practice, Charon draws on the work of Jonathan Culler:

[O]ur "reading" of disease takes place at the level of the body's surface and its pathopsychological structure underneath the skin, while our reading of what a patient says takes place at the level of the evident meaning of the words and their implications buried in the clinical and/or personal state of affairs represented (Charon, *Narrative Medicine: Honoring Stories* 109).

It is not therefore that the techniques of literary criticism and analysis are necessarily paramount to an understanding of the 'patient as a text', rather, that medical and healthcare practitioners be made cognizant of their interrelationship with patients, which can be framed from the position that they are always 'readers' – that interaction with 'the other' ensures that a 'diagnosis' is not necessarily a materially *true* case but rather subject to the mutability of contextual doubt (Boyd; Charon, *Narrative Medicine: Honoring Stories*, chap.11). This is precisely because the very orthodoxies of Western medicine that maintain the extant discourses as a dichotomy of art versus science, of the measurable and immeasurable, or as a question of 'additive' or 'integrated' provision, are a fallacy in theory and an abstraction of the processes of power relationships in practice.

It is the power relationship that Mayes' paper problematizes, recognizing that narrative medicine does not dismantle the clinical gaze's idealized patient. Mayes draws on Foucault to argue that the prevalent view of the doctor-patient relationship is akin to 'sovereign power,' but this is a misdiagnosis that would be better understood via Foucault's 'pastoral power'. He rejects that

patient-centered care eradicates the power divide but instead creates new, subtle power relations that maintain the pastoral role of the doctor and the subjugation of the patient. In effect, patient-centered communication ‘multiplies the avenues and capillaries through which power can affect the patient’ (486). ‘Pastoral power’ in this sense is relational rather than repressive and permits ‘an intimacy that is foreign to the relationship between the sovereign and the subject’ (Mayes 487). The product of pastoral power is the creation of an individual that is engaged in a matrix of power relations with similarly empowered individuals as the process of pastoral power multiplies and disperses. The critical aspect of this process as relates to its suitability as a model for the doctor-patient exchange is the confessional, which Foucault regards as the technique by which secrets hidden in the individual are coaxed out from within – which framework is evident in the literature of, for example, Meza and Passerman. This is because the individual is unable to divine meaning from the truths hidden within them without the pastor’s interpreting the meaning, or significance, of what has been revealed. The pastor then is a hermeneutical figure, with access to a language and order of signs whose role is one of ‘hearing and interpreting the confession such that they can guide the individual toward self-understanding’ (Mayes 487).

That medicine employs the tools of the confession is evident upon even a cursory investigation of models of practice, whereby a patient’s records and consultation are strictly bound by confidentiality and secrecy (Dreyfus et al.; Holt). As Mayes notes, the confessional template enshrines the notion that an individual may only know the truth of themselves in relation to the wisdom and insights of experts, or – returning to Bleakley – it is ‘institutions and their representatives who hold power and authority to shape the fabric of the sensible’ (Bleakley 3). Just as Foucault proposed the confessional as a ritual in which the relationships of power reproduced a truth about the confessor but also institute in the other ‘the presence of a partner who is not simply the interlocuter but the authority who requires the confession’ (Foucault, *The History of Sexuality* v.1 61–62), Ross proposes that institutions of medicine reproduce this dynamic by framing the practitioner and the patient along the same hierarchical axioms; the consultant, the surgeon, the physician – each medical practitioner is framed as the authority whose interlocution reifies a perceived truth about the patient in the service of ideologies and orthodoxies of the state and its institutions. Vital to this argument is the idea of configuring medical power as something quantitative – something that can be possessed by either or both of the clinician/practitioner and patient – which restricts our awareness of its operation to one established by the extant orthodoxies of medical education and practice. This is the same concern we saw previously in Bleakley, and so to dismantle the medical orthodoxies that engender the patient’s marginalization, we must first reconfigure our approach to the institutional and linguistic structures that create these orthodoxies.



## Good Talking to You

The clinical setting appears to avow a metaphysics through which the patient's willingness to speak is inherently 'good,' because upon speaking the patient affirms their personhood and, with the move from a biomedical to biopsychosocial framework, the speech act becomes necessary for the medical diagnosis itself. However, following Mayes, the turn towards patient-centered medicine and its ethics of narrative communication does not wholly support claims of a medicine of the whole person because it maintains the extant authority of the clinical gaze which supplants the patient's agency as a storyteller with the clinician's interpretive, or hermeneutic function. Furthermore, it risks extending 'medical power from the clinic and the biological body to the home, the bedroom, the kitchen and the bathroom, to the everyday life of the patient' (Mayes 490-491). The conclusion to draw is not that the patient-centered approach is 'just-as' controlling, dominating or oppressive as the previous paternalistic encounter; nor need we be in fear that its model is a masquerade of intimacy. Instead, what is evident is the importance of understanding the patient-centered approach as one that maintains a matrix of power relations that form and mold the patient to think and act toward their self in a particular way, according to a particular teleology.<sup>20</sup>

Through encouraging the patient to confess, the physician is not openly manipulating the patient, rather, there is an implicit organization and production of the patient to participate in the medical encounter in a particular manner. Regardless of the skills of the medical or healthcare practitioner then, how does the patient conduct their confession in the utilitarian terms required by patient-centered-care? On the problem of this exchange and our attitudes to human connectedness, Jane Macnaughton gets to the heart of the matter when addressing the relationship between doctor and patient or clinician and client. She asks if empathy or a genuine dialogic method is even possible when the existing praxis frames these relationships as object (patient) and subject (doctor), where the patient is the object of the physician's scrutiny who thus remains at an objective distance from the patient ('The Dangerous Practice of Empathy').

In Mayes' formulation and following both Strawson's and Woods' concerns that the injunction to narrate may be misguided, even harmful, because the patient is still subjected to the clinician's

---

<sup>20</sup> This concern emerges in a wealth of existing literature, with evidence in relation to, for example, chronic pain (Wasson), depression (Mallinson and Popay), disability (Garden, 'Disability and Narrative'; Garden, 'Telling Stories about Illness and Disability'), the DSM (Tekin), epilepsy (Cenci and Mecarelli), neurology (Iniesta) and problem-based learning (Kenny and Beagan), all of which provoke aforementioned concerns about the privileging and extension of extant power relationships and orthodoxies surrounding 'traditional' narrative frameworks such as the 'hero journey' (Wentzer and Bygholm; Lamprell and Braithwaite). The pioneering work of Arthur Frank points to the subtle differences provided by alternatives within narrative methodologies in, for example, 'Asking the Right Question about Pain'; similarly, alternatives can be found in the salutogenic model (e.g. Griffin; Garista et al.); and the field of reception research (e.g. Davin).

expert gaze and their invitation to speak governed by an orthodoxy in which the truth of their ailment is revealed only by the interpretation of the clinician, once again, we are returned to a sense of an incomplete medicine and the maintenance of extant power relationships. This is in agreement with Bleakley's warning that the existing orthodoxy permits revolutions only when it has determined beforehand what is worthy of consideration, as such, we are faced with what Bishop identifies as a new dualism, one that replaces 'mind and body' with 'meaning and material' (Bishop, 'Rejecting Medical Humanism' 18). We can garner some insight into this model by returning to Crawford et al. who articulate a modal approach to the application of narrative:

Through the incorporation of multiple stories, meaning can develop a dynamic quality which is not exclusively based on the participant's experiences, but evolves in a process of co-creation, where the individual responds to those around him or her as well as the stories they encounter [...] meaning in healthcare is a joint construction [...] In this sense, the concept of meaning is the result of the integration of the experiential, pre-reflective dimension with the discursive, narrative dimension (Crawford, B. Brown, Baker, et al. 7).

Co-created meaning reflects a more acute understanding of the intricacies of narrative medicine, not only addressing the problem of conscripting the techniques of literary analysis in service of an existing pedagogy (e.g. Whitehead et al.) but also the assumption that the arts and humanities are 'additives' to make medicine perform 'better' in a narrow technical sense, or provide professionals with narrative competencies that they might otherwise miss acquiring.

As it is an intention of the narrative medicine movement to reify the patient's story, to evaluate the narrative they offer in the medical encounter as a mode of reading the disease, the illness, malady or sickness afflicting them (Charon, 'Narrative Reciprocity'), what is needed is a subject-to-subject relationship, or an intersubjective praxis. This praxis would reflect concerns of hierarchical bias in which meaning is contingent on the 'empowered' medical practitioner, its diagnoses contingent on constructing the patient as a medical object further reduced to a materiality of mind and body itself abstracted through evidence-based medicine.<sup>21</sup> This praxis would recognize that notions of 'meaning and material' are contingent on the relational exchange that emerges in the medical encounter as the co-created products, or objects, of subjectively-ordered entities only as consequence of the very medical spaces in which the exchange occurs. This praxis would recognize that meaning in the medical encounter is necessarily a fabric of material *and* mutably true construction.

---

<sup>21</sup> Work in the health humanities contributes substantially to this effort, reconfiguring orthodoxy from medical evidence-based practice towards practice-based evidence. See: Crawford, Nolan, and Brown; Brown et al.; Crawford, May, Brown, et al.; Saavedra et al.

As previously stated: this demands we introduce a politics to medical education that incorporates the unorthodox sensibilities and critical thinking provided by medical humanities in a redistribution or Rancièrian ‘dissensus’ to disrupt the current fabric of medical practice and make medical practitioners and educators think again.<sup>22</sup>

Woods refers briefly to the work of Brian Schiff, from whom I would like to borrow a simple principle, but one Ross and I both to take to heart for its worth in relation to everything at stake in this thesis.

*Me: Our mistake is to think that everyone must be like us.*

This *is* the heart of the matter as far as Western medicine is concerned as it reflects the very basis of the debate between the ideal and individual patient; it reflects and informs the epistemologies of medicine and the medical humanities; it sets up the problematic route into dichotomic thinking and therefore informs our debate about art versus science, humanism versus scientism, subject and object, self and other; it suggests what is approached in quantitative and qualitative measurements of human nature and being, and what exactly is at stake in any claims of material and mutable knowledge. What exactly is similar between you and I; where do we differ; who decides where to mark the boundaries between what is constructed in an ideal medicine and how do we reflect in fact, what determines the limits of the individual patient’s experience?

## Having Been Forewarned

Let me remind you that this thesis is about an individual, a whole person. It is about one human subject and their unique contribution to the pool of knowledge. It is about Ross.

As outlined above, I have a certain critical distance from Ross’ experiences and that is why I am here, writing this. I am playing a role for him. In this role I mark the “academic” aspects of this thesis – I am the brains of the piece, if you will. You will find me hereabouts and in the footnotes. I am quite conceited.

Even though I am the brains of the piece however, I cannot explain the full extent of Ross’ thesis on my own; that is the problem with my critical distance – there is a lot that I do not understand because I have not experienced it for myself. I can only speculate, or theorize, and so, beyond my academic contributions are those that come from Ross himself, the “personal” aspects that reflect

---

<sup>22</sup> For an example of a failure or unwillingness to countenance the sensibilities of the disempowered, see, for example: Sheldon et al.

his “whole person” and which experiences are material to the matter and contribute to the body of this thesis.

These experiences are too personal for a simple academic like me to relay and so instead, where Ross leads, I follow, providing explanations and evidence for his experiences. We felt it necessary to divide the work in this way because without me, this would just be a piece of art. We felt my voice better placed to provide you with the evidence necessary for an academic piece of work, and so that shall be my role ongoing – to operate as Ross’ interlocutor and provide you with the information you need to know to understand his story.

That said: the most important thing to know about this thesis is that it is playful. I am an example of its playfulness, whether you like it or not. Ross and I both appreciate that not everybody enjoys playing the same games or by the same rules, but you are playing our game now and will have to play by our rules.

Much like a work of art, Ross’ story is speculative and indeed, much like a work of fact, in fact; facts at the boundaries, where the science is happening; where, to the best of our knowledge there is more to be discovered; where we need more data; where the evidence is... in progress.

So, let us progress.

Whether this thesis proves entirely academic, or not, rests on the simple conceit of its creation: everything Ross has to say for himself is true, but does it matter what he has to say?

## Prefacing Connections

It has been a real struggle to know how to begin this. I have thought of lots of different openings, experimented with different structures and voices, and again and again I have found myself starting from scratch. I have had a lot of concerns, chief among which is the concern I will be misunderstood; it is my biggest fear. I am concerned that I will not be able to express myself clearly. I am concerned that even if I do express myself clearly, clarity will still not be enough. I am concerned that no matter what, I will not be able to connect with you and I am desperate to connect.

We seek connections among things through metaphor and other forms of figural language. By telling stories to ourselves and others – in dreams, in diaries, in friendships, in marriages, in therapy sessions – we grow slowly not only to know who we are but also to become who we are (Charon vii).

I include this quotation at the outset because it states exactly how I feel about the importance of connections and the role of storytelling in making them. It reflects Rita Charon's validation of narrative medicine. I think I understand Rita Charon's position innately; my feeling is that my desire for connection is a fact of my life as far as I am concerned.

Among this thesis' many complications, informing each new beginning I have made, is knowledge – the knowledge that mine is an interdisciplinary, confusing argument. It touches on lots of different topics from lots of different disciplines and I have felt the need to read a lot within each of these disciplines. The more I have read, the more the limits of those differences have slipped and blurred and broken, and so a considerable part of my effort in this has been trying to triage the blood and bones of the thing and restore some sense of order to its sick, disorderly narrative.

Maybe I should have expected that – this is a doctoral thesis after all – but all the while the topics it touches on are topics often at the boundaries of disciplines, where the work is being done, where the margins are in constant flux under the impetus of new knowledge, I will remain concerned that I simply do not know enough and that I do not know just how much I do not know.

This thesis is about the medical humanities; it is about the arts, humanities, and sciences; it is about an understanding of experimental, ludic fictions; it is about a whole canon of – as-yet – undefined literature.<sup>23</sup> This thesis is about subjectivity and objectivity, the self and other and the transition from one to another; it is about transition of all kinds – my own not the least. This thesis is about a story: my story. Above all else, it is about playfulness... And so, as I have said, it has been a real struggle to know how to begin; I have given a great deal of thought to this story and how it to tell it.

---

<sup>23</sup> Which is to say that among the aims of Ross' thesis is to identify a canon of literature under a new rubric.

Let me give you an example.

As far as storytelling goes, I am going to keep it very simple: this story is an attempt at mimesis.<sup>24</sup>

From the opening chapter of Erich Auerbach's *Mimesis*, we are presented with a textual analysis and evaluation of the difference between the mimetic styles of *The Odyssey* and *King James Bible*. The former is described as a story in which 'everything is visible; and not less clear – wholly expressed, orderly even in their ardor – are the feelings and thoughts of the persons involved' (3); the latter, in contrast, describes a story that 'unrolls with no episodes in a few independent sentences whose syntactical connection is of the most rudimentary sort' (9). In short, Auerbach provides an extensive evaluation of two distinctive mimetic styles to articulate how one offers the reader 'everything' on the page; the other offers the reader 'independence,' in a space beyond the page.

These are just two examples from Auerbach's book – there are numerous others – but it is my contention that anyone who has read a story recognizes at least some aspects of these conceits: that a story might be conceived as comprising what is provided by its author and what is understood in that provision by its reader. Where the distinction lies between an author's words and a reader's mining them is a matter of criticism, imagination, structure, style, technique... We need only consider the great monuments of literary "Modernism" and literary "Postmodernism" to recognize that fact: one asserts significance in authorial authority, the other revels in its death.

For the purposes of this thesis, I have tried to put it all on the page.

I think it is equally true that we readers – whoever we are – we all happily capitalize on the conceit that – for example – the "subjects" of "content" and "form" can be assessed on their own merits; that they can be assessed with such specificity as to become disciplines of study and areas of exquisite expertise. We are not averse to analyzing these concepts with a precision that occludes the influence of the other. In other words: we countenance and play with the idea that "content" and "form" are distinguishable. But by the same formulation they are also relational because the interrelationship between "form" and "content" constitutes something other, something by another name. It might be "narrative". In a narrative sense "form" and "content" are at play, with each constituting or co-creating aspects of the other. So, then we might say that for the purposes of this thesis, what is distinguishable by matters of "form" and "content", are only abstractions of what is really the case. Wonderfully useful abstractions. Nonetheless.

---

<sup>24</sup> I.e. imitation of another person's words, mannerisms, actions, etc.; an instance of this; the representation or imitation of the real world in (a work of) art, literature, etc.; the production of symptoms characteristic of one disease by another ('Mimesis, n.').

Just as we derive great insight from these acts of abstraction and appear to consider subjects – all subjects – in this way, then so too we find that with time these abstractions inform news acts of definitive specificity, with each adding more form and more content to our epistemologies in all fields in evermore intricate expansion. Progress. The more we create spaces of specialization in which to singularly explore and mine for new knowledge, the more we establish new spaces of evermore definitively refined fields of study, subject specialisms, disciplines, and topics in isolation. But also: in relation.

There appears to me no limit to how specific we can be, no limit to our capacity to determine the extent of our knowledge; to define, or draw the boundaries, or mark what and just where the limits are if it suits us. If it is in our interests. I am interested in the nature of our existence as it seems explicable to me in terms of what *is* and *is not* acceptable according to order, or not; is conventional, or not; according to orthodoxy, or not; according to what is contextual, or not; according to who has the power to determine, or not.

*Me: That's not a science – not a proper science; that's a soft science.*

*Me too: I agree, but is it art?*

From whatever contention I may claim, there will surely be someone with an equally vehement claim in opposition; that is as it should be, I believe, or rather: it cannot be otherwise. From my position in the world, I see points of opposition as a matter of fact; I see the sides of our divides as aspects in interrelational play. Everything is a matter of play. Everything is in play. Its expression otherwise is just its emergence in abstraction and depends on where we imagine the limits of our understanding. It depends how we look at it. The way I look at the world *now* makes it possible for me to live. I mean that literally and figuratively.

So, let it be understood that this thesis emerges as an object of my innate playfulness, a playfulness that this thesis will encapsulate and try to express in ulterior terms. As I conceive it, it expresses everything I understand about the world – in sickness and in health. When I say that of course, I run the risk of being misunderstood, because whilst it expresses exactly what I mean it to say, it leaves so much open to the possibility of interpretation. The words say everything, but risk conveying nothing, so then who I am writing for; who am I writing to?

My doctoral journey has been one of coming to know who I have been and who I have become today because of slow, painful growth. I have written this thesis because I want to tell a story of myself and to tell it to you, and when I conclude this work I will hope to have made myself understood.

## Formal Introductions

I thought I would start with a conventional beginning as it speaks to one of this thesis' themes: the concept of 'narrative order'. This expression is used analogously – there are lots of analogues at play in this thesis – and so narrative order is taken here to imply 'the conventional way of doing things'; it is meant to convey every sense in which there is an order to the narrative in play, and which adheres to certain orthodoxically instituted agreements. For example, the use of a formal "Introduction" at the beginning of a piece of work is one such sign of this orthodoxy, and I hope suggests the sense in which a narrative conforms to order – in this context, one that I hope you will happily accept as an order instituted according to the conventions of the academe. To continue in this vein, I will now outline what my thesis proposes and how I intend to demonstrate its propositions; just as an introduction should.

The problem at the center of this thesis is a 'sickness' in Western medicine. This sickness is presented in the work of medical humanists, including prominent figures such as European Society for Person Centered Healthcare (ESPOCH) Senior Vice President and Secretary General/CEO Professor Andrew Miles. Miles has argued that the aspirations of the medical community since medical humanities was realized as a discipline have gradually ebbed away such that Western medicine has been divorced from holistic practice: 'aetiologically, the loss of holism in medicine has occurred as a direct function of a growing scientific reductionism in medicine in the face of a dramatically increasing complexity' (942). This reductionism has seen a growing number of patients rejecting the sufficiency of current medical practice and which Miles suggests is not necessarily because its practice is ineffective, but because 'it has become inhuman and depersonalized' (942). Medicine has been transmogrified from an 'entirely necessary' holistic practice to a practice driven by the fallacy of a 'scientism' that assumes medical knowledge is 'invariant, objective and always reliable' (942). Miles' position is that,

[M]edicine is decidedly not a science, but rather primarily a human endeavour which employs science – and only in part. Medicine, then, is a science-using practice, but science cannot represent or be equated with the essence of medicine in any fundamental sense. In describing medicine, we must therefore draw the distinction between the word scientific (which correctly describes much of medicine's knowledge) and the word science (which falsely describes medicine's nature)' (941).<sup>25</sup>

In order to address this position, medical humanism developed as part of the need to return to a more holistic approach to medicine, but whilst efforts like patient-centered care offer potential

---

<sup>25</sup> For more extensive scholarship on this formulation of medicine, the limits of its epistemologies and misdescription as a 'science' vis-à-vis 'scientism' as 'an epistemological criterion of reality' (Nagel 15), see: (Leggett; Montgomery; Loughlin et al.; Whatley; McHugh and Walker).



towards this aim, there is concern that attending to the individual – the genomic profile of the individual patient, for example – risks furthering the advance of scientism by adding exponentially to the science base and concentrating clinical attention upon the wealth of interventions made possible thereby. Here it would be ‘the intervention that is made personal to the disease and not the relationship made personal between doctor and patient, so that the disease is seen as the whole and not the patient acknowledged as such’ (945). In short, argues Miles, the answer to these variegated problems in medical practice is a return to the ‘philosophical and methodological basis of medical holism’ (946), which necessarily means abandoning the dichotomic model of medicine that distinguishes its scientific knowledge base from its artistic knowledge base rather to see these conceptually realized positions in an integrated practice that attends to the material and mutable methods of science and art by working in service of the whole person of the patient. A similar position is presented from the U.S. sphere of medical humanism, a 2014 editorial by Samyukta Mullangi in the *AMA Journal of Ethics* outlining:

[A]n ever-growing sense that medical education—and the practice of medicine—would flourish if student and resident learning took place within a culture infused with the study of art and literature (592).

With healthcare funding in the U.S. and U.K. under increasing scrutiny (‘Biden Defends Obamacare as Top Court Hears Case’; Holpuch; Oliver), cuts to centralized arts funding and intensifying pressure upon the arts to demonstrate its value covalent to economies of capital and production (Dempsey; Hickmore; Wright), the omission of ‘creative subjects’ from the U.K.’s English Baccalaureate (‘Post-Debate Briefing’; Hill) and the coalescence of these issues in relation to our burgeoning understanding of ‘mental health’ as a factor in all aspects of the social fabric (Corry et al.; Johnson et al.; Kingsland; Lund; Marsh and Hill), the need for a new approach to our medical practices that recognizes the intrinsic value of the arts and situates them as an integral component that is always ‘in play’ in the medical encounter is paramount (M. C. Nussbaum).<sup>26</sup>

In the essay “Art in the Age of Mechanical Reproduction” Walter Benjamin identifies the ‘aura’ of an artwork as that which is diminished upon its reproduction, which is to say ‘the authenticity of a thing is the essence of all that is transmissible from its beginning, ranging from its substantive duration to its testimony to the history which it has experienced’ (215). In other words: the process of reproduction separates the artwork from its historicity; a reproduction bears no trace of the unique creative act that formed the artwork in a particular time and space, and which bears the traces of its

---

<sup>26</sup> Ross defines ‘the medical encounter’ as the intersection between our selves, our communities – or societies – and our healthcare or medical systems, both institutional and personal. It also defines instances at those intersections when, as patients, we are made into the objects of our medical institutions by their orthodoxies.

original being throughout the course of its existence *through* time and space. Benjamin means that an artwork is always representative of, and in relation with, the point and position in time of its creation and engaging with an original artwork reminds us of this distance (in spacetime). The permanence of that historicity is what provides the artwork with its authenticity; it is a material fact in the world. If we so choose, we can play with this historicity in the artwork because the distance between it and ourselves is immediately apparent and mediated by our subjectivity at the point and position in time when we engage with it. When we engage with an artwork we can bring to bear upon it the multitude of things that we understand to have happened as part of the narrative order of its historicity and we can examine it beyond those contexts to include all the plurality of things our subjective experiences of being in the world have taught us have occurred since its creation; we can look at it differently; we can engage with it by playing with it.

Such is what John Berger identifies in *Ways of Seeing* (1990), when he says that we are ‘always looking at the relation between things and ourselves’ (9). Berger is speaking of the subjective position of the observer and their relation to the artwork's objective existence. According to these conjectures, this relationship is privileged only in relation to original artworks – not reproductions – because for both Benjamin and Berger the excision of historicity in the act of reproduction destroys the authenticity of originality. Conversely, in this sense, the original artwork can never change; it is stable, it has a material reality, or essence, that represents an objective factuality in the world. What is unstable in this exchange is the subjectivity we bring to it at the point of our engagement with it, and furthermore, if we extricate that artwork from the point and position of its creation, and deny its existence, we expose the artwork to multiplications of its meaning, or fragment its essence into many meanings, such that no critical interpretation can attain precedence; because all new interpretations have significance, paradoxically, “none” are significant. In Berger, the reproduced artwork, unlike the original, always lends itself to this multiplicity of interpretations. In other words: original artworks possess or are imbued with an elemental quality or essence absent in the reproduction because in the latter, the distance between it and our selves is destroyed.

Donald Kuspit disagrees with Benjamin and Berger on precisely this point. He argues that the imposition of a singular essence in an artwork – its historicity – and its being situated as an ‘objectifiable’ entity, is tantamount to saying that “this artwork is complete”, it is done; finished. By ordering the artwork according to the narrative of its creation in time and space, by imbuing it with objective significance, it becomes a unit of historical record and therefore loses its aliveness, because in fact it is always in play in relation to a ‘diversity of historical forces, no one of which amounts to a grand narrative, even in its own terms’ (Kuspit, ‘Disintegrated’ 18); ‘that is the lesson of postmodernism’ (Kuspit, ‘The Contemporary’).

Kuspit reasons that postmodernism brought about the disintegration of interest in art because ‘there is no “mystical” depth’ to the interest: no privately urgent reason for making it a serious part of life’, indeed our relationship to art through postmodernism seems ‘to strip it of the aura that is the true – subjective – point of entry into it’ (‘Disintegrated’ 19). Paradoxically then, Kuspit’s argument ensures that only the act of our continual personal engagement and consequent introjection of our multiple interpretations keeps the artwork alive, because it is thereby kept in play by the discourse between the subject’s many potential readings, and the continually shifting subject of the artwork. I contend that we can understand this conceit in terms of a dichotomy between ‘materiality’, which is the act of historicity implicit in the ordering of artwork’s narrative according to objective fact, and ‘mutability’, which is how we keep artworks alive – how we keep them subjectively ‘in play’.

I will provide a response to this problem by examining D.W. Winnicott’s cognitive psychological theory of transitional phenomena through a corpus of playful texts and articulate how these texts are ‘in play’ with the medical encounter. I will testify that the medical and medicinal functions of ludic fictions are an emergent property of the material and mutable exchange that occurs between an author and a reader.<sup>27</sup> In this corpus, which comprises<sup>28</sup> selected texts by Kathy Acker and David Foster Wallace, I will provide evidence of a canon of “Sick Literature”, that is a model for points of exchange via intersubjective co-creation. I argue that Winnicott’s concepts of transitional objects and spaces can be understood in relation to ‘the subject’ and ‘the other’. These are my testimonies to understanding. As a testament to this understanding I believe a new model of the practitioner-patient exchange can be realized, a model by which the disjunctions of medically humanist discourses – such as the problematized aspects of narrative medicine’s intersubjective praxis – can be overcome.<sup>29</sup> For example: in aforementioned discourses on the medical encounter, the practitioner-patient exchange is ordered according to an extant power relationship whereby the empowered construct of the medical gaze ‘objectifies’ patients to the point of denying the subjectivity of their medical experiences.<sup>30</sup> We can see something of this problem in the asymmetry in power between professional mental health narratives versus those of people with lived

---

<sup>27</sup> This is my testimony.

<sup>28</sup> [...but is not limited to].

<sup>29</sup> Ross’ concept of “Sick Literature” is congruent with similar efforts in this area, not least the literary position on Kathy Acker and ‘postmodern madness’ in Baker et al., *Madness in Post-1945 British and American Fiction* (2010). Professor Paul Crawford has been equally influential in driving scholarship in this field, documenting a diverse range of human experience that falls within the category, “madness”. A special issue of the *Journal of Medical Humanities* was published in 2011 in evidence of this research, and demonstrated the considerable scope and benefit of “health-humanities-as-praxis” for sectors of the healthcare workforce, see: Baker et al.; Crawford, C. Baker, and Brown; Donohue-Smith.

<sup>30</sup> I did forewarn you.

experience of mental distress. In the medical encounter what is the measure of personal testimony; what doctorate best accounts for the doctor of their own subjectivity? What can you make of my testimony?<sup>31</sup> This is the consequence of what is instituted by the narrative order of the medical encounter and can be understood as the disjunction that occurs when the whole personage of the patient is disordered by 'sickness' in relation to the 'idealized' personage of the institutionally ordered 'healthy' medical body. Who is the measure of the sick mind? Where do you measure what my health is? This is my measurement. Thesis<sup>32</sup> the only way I know how to express it.<sup>33</sup>

To this point, work in the fields of auto-ethnography, self-writing, autobiography, memoir – all provide valuable contributions to the narrative forms of "self-representation"<sup>34</sup>. In the human sciences I would consider this – "my thesis" – a contribution. It might be foremost in this regard and perhaps most pertinent here to recognize "auto-ethnography", as it pertains to scholarship that attempts to 'describe and systematically analyze personal experience in order to understand cultural experience' (Holman Jones et al.; Bochner and Ellis). My thesis is a testimony of personal experience to the best I can understand it and express it. It is also an attempt to describe and systematically analyze my personal experience in order to understand it.<sup>35</sup> My understanding includes the fact that this thesis is bound by the requirements of providing<sup>36</sup> "academic merit", and "originality", and "offering an original contribution [to knowledge]". I also understand that there are traditions at stake, or conventions. There are prescribed ways of doing this. Thesis: an "[un]orthodox way" of doing it.<sup>37</sup> This is that; that thesis. This thesis is also bound by my having – only now – concluded the scholarship I needed to pursue to begin to understand what I have been through producing it.<sup>38</sup>

Herein is my debt to auto-ethnography, with Bochner and Ellis fundamental in recognizing the field's importance beyond the personal/cultural parameters. They include its relational value as a contribution to knowledge in order to note the impact of postmodernism in troubling sciences "truths". Their methods reflect Foucault's *The Birth of the Clinic*; reflecting that such "truths" are 'inextricably tied to the vocabularies and paradigms the scientists used to represent them', and are

---

<sup>31</sup> Further to which: what can you make of *my* testimony?

<sup>32</sup> Ross loves a pun. I do too. Sum times. Sometimes writing is only for oneself; is divisible by one and one alone. It is primary.

<sup>33</sup> I.e. "My [Ross'] thesis"

<sup>34</sup> I understand that – to Ross – this document is a contribution to his understanding of the field of "[self-]identity politics" too (but he is not a proper doctor in that).

<sup>35</sup> I.e. "My [Ross'] praxis"

<sup>36</sup> Demonstrating?

<sup>37</sup> i.e. "A thesis"

<sup>38</sup> Torture: psychological, physical, sexual. Abuse. Disassociation. Suicidal ideation. Rape. Self-mutilation. Self-annihilation. Revelation: PTSD. Freedom.

no less valuable for it (Ellis et al.). In short: this thesis is bound by the rules of the game. I have been [predetermined to be] playing. In line with postmodernism's creative destruction of so-called "grand narratives", the work pushes to consider how [social?] sciences might be reconfigured if they were considered knowingly 'value-centered', rather than in conscription to the canonical, privileged position of empiricism or 'value-free' (Bochner, 'Perspectives on Inquiry II'). To play has value, free from, free form. In an infinite jest and an empire of the senseless: play is the thing.

From Bleakley and Mayes we might understand that attempts to democratize medicine risk reinforcing or reconstructing extant power dynamics between those with knowledge capital and those without it. So too, auto-ethnography recognizes the inherent mediating power of the one who tells the story and its debt to "story-telling". In fact: the storyteller is necessary and provides the work with its power. Furthermore – it is hoped – that articulating one's personal stake in the game at play sensitizes readers to issues of identity politics and 'forms of representation that deepen our capacity to empathize with people who are different from us' (Ellis and Bochner). Auto-ethnography therefore places the individual's subjective testimony at the heart of its research inquiries.

So too, my thesis might contribute to inquiries and scholarship about certain aspects of memoir. If we turn briefly to writers such as Paul Kalanithi, doctor *and* patient: in contrast to an "auto-ethnographic" inquiry, Kalanithi's work might be said to represent a "journey of self-acknowledgement and acceptance; of self-understanding". It is not an attempt to turn the self "outwards",<sup>39</sup> and make what is subjective and personal a reflection of the social, or cultural. It is a piece of self-testimony, or introspection – and to each of us, our own reflections. Following his diagnosis, Kalanithi, examining the imaging of his lungs reveals how he 'went through each sequence again [...] as [he] had been trained to do, as if I might find something that would change the diagnosis' (Kalanithi 4). As a doctor, he knows there is no alternative diagnosis, but as a patient he hopes for one. He 'refused to believe', there is a second opinion (4). This is a divided self.<sup>40</sup>

My thesis will advance the canon of "Sick Literature" as an intervention to this multivarious fields of self-inquiry and as a curative to a medically humanist 'sickness' in Western medicine which is this

---

<sup>39</sup> It is not a gift for the world, but a gift to oneself, to be able to tell one's own story [This is how I might understand the gift of a memoir: "Speaking to oneself of experiences from a point distant in time and space, communicating upon the nature of self-reflection, about one's experiences as described therein". A self-reflective process and practice [See also: Kleinman; Rose; Anyaegbunam J. A. et al.; Carel]. As I understand it, Ross' thesis is intended as an attempt at praxis, because the scholarship, the stories, the narrative of his life experiences – all the work, and research – *that* is what this is. Was that my idea? Or his? Or was it all the work, and research?

<sup>40</sup> Which page is that on?

thesis' [orthodox] original contribution to knowledge.<sup>41</sup> Part of this contribution is the proposition that 'the arts' and artworks have inherent medical value; that they have medicinal value.<sup>42</sup> This value is evident in the 'mystical' depth inherent to them and which is – according to the principles of narrative medicine – subjectively apparent and vital to my engagement with them. However, I do not think myself unique in this regard; I think their inherent medical, medicinal value is available to all and any as the case may be. It all depends on *your* story. That these values have been often overlooked and dismissed in Western medicine is because of a failure in its extant models of medical praxis, a failure of imagination that persists in Western medicine's inability to identify, deconstruct, and democratize the parameters by which it institutes its orthodoxies and constructs its patients as medical objects, to the neglect of its patients as whole people.

According to Boudreau and Fuks, 'to conceive of the humanities as simply a counterpoint to the natural sciences diminishes both disciplinary traditions' (328) and so by dismissing the preoccupation to integrate dyadic concepts within the existing discourse, my model instead presents the humanities and the sciences as reciprocal. This then is a pedagogy that focuses on the means and path to learning, rather than the conflict between epistemologies that appears to be the preoccupation in current discourse. I promote a 'relational space' (334) in which mutually reflexive development can take place and the 'humanistic and scientific aspects of medicine, married with an eye to patients' well-being, merge into one coherent, stereoscopic image' (334). Such a model could prove vital in attending to the aspects of disjunction that have emerged from medical humanities scholarship, including the field of 'narrative medicine', which, whilst it compels and formulates an intersubjective praxis based on its petition to the personal narratives of patients, is still problematized by what is instituted or ordered by medical practice as the orthodox narrative of the medical encounter.

This thesis' presentation consists of a series of critical reflections on medically humanist articulations of the medical encounter, which, in an act of mimesis, utilize the "Sick Literature" of Kathy Acker and David Foster Wallace. My reading recognizes that – taken together – these two authors emerge from a canon of post-war American literature that includes authors such as William Burroughs, Ken Kesey,

---

<sup>41</sup> There is too much in play in the designation "Western" to be broached in this thesis, but Ross trusts that it is an acceptable sign to employ here because it is among the most easily identified and common metonyms for the society and culture into which he was born. This thesis bridges medicine in the United States and the United Kingdom under the "Western" rubric, and whilst it is true that there are stark and markedly different ways in which the economies of medicine operate in those nations, the commonalities by which they institute their patients as idealized medical objects, and which has been addressed in "A Forewarning" are the stakes of the game. Their dissimilarities are for another thesis entirely.

<sup>42</sup> '[T]he arts' is used here and throughout as a conflation of 'the arts and humanities' in line with the medically humanist argot and which in turn is a metonym for the so-called "non-scientific" disciplines according to principles described in the dichotomy between 'humanism' and 'scientism' and the 'scientific method'.

Thomas Pynchon, Karen Yamashita, Leslie Marmon Silko... but which is beyond its focus. The scholarship approaches the authors from the rubric of 'Cold War studies' and which cover issues as diverse as institutions of The State, the narrativization of depression and suicide, the role of the female body, questions of addiction, sexuality, trauma, sexual desire, masochism and the pain-experience... While "Sick Literature" addresses these issues, I suggest that its remit extends far beyond the 'Cold War' narrative because central to the designation is the conceit that 'sickness' is contingent on the contexts by which 'materiality' and 'mutability' are constructed in intersubjectivity as products of co-creation between an author and a reader. In this sense "Sick Literature" should be understood as a case-by-case mode of 'narrative disorder' – or 'disordering' – by which notions of the 'narrative order' of objectivity are problematized and played with. This is in accord with the individual case, not the ideal case. To compliment these critical reflections, I will present case studies – critical, literary analyses or readings in "Sick Literature" – with the objective of reviving and revalidating forms of narrative and modes of writing that subvert inherent orthodoxies in medicine's institutional exclusions and the regulatory discipline of the scientific approach. These readings affirm that the ludic, the playful, the self-referential, the punning, the digressive, the parodic – all constitutes a form of inquiry that is embodied by works of "Sick Literature".

In conclusion, this thesis presents "Sick Literature" as an artistic methodology or medically humanist praxis of 'creative-destruction' (formulated in line with D.W. Winnicott's notion of 'play') which challenges the exclusions of strictly scientific approaches to questions of physiological and psychological pain, and instead offers the pleasures of comedic language, the ludic and the playful as another mode of medical theory, one which is more open, inclusive, complex and constructive and provides for both the quantifiable and qualitative nature of human experience to contribute to the ambitions of medical humanism in integrating the artistic and scientific disciplines and their methodological pursuits.

In short:

I think much in Western medicine is sick.

I think I have a treatment for that:

Play.

All that being said, regardless of the contentions of its original contribution to knowledge, this thesis is inherently valuable to *me*. It is a very personal thesis.<sup>43</sup>

---

<sup>43</sup> It saved his life. N.B. Throughout this thesis Ross employs what he hopes is an inclusive means of expression but, to the best of his education and understanding, he can only really claim to speak for himself, which is the

Now you might imagine that is a prerequisite of all of doctoral study but what I mean to convey is that beyond its arguable, original contribution to knowledge, this thesis is informed by something inarguable: my experiences as a patient of Western medical practice. These experiences are instrumental to this thesis because they directly address its assertion that our medicine is broken, and it is for that reason that I present this thesis as an exercise in narrative medicine. It is a thesis of my whole person.

As with many a medical encounter, the first step is to enter it, which, in its most banal edifice, typically takes place in the spaces of the Waiting Room, and The Clinic; in consultation with a doctor, maybe. There is something subjectively disruptive about disease, illness and the pain-experience that orders many of us in this way, I think. As though something in the narrative order of our lives, whatever *that* may be, has been thrown into disorder, and all that we understand about ourselves by that narrative order, rendered insufficient, or lacking in some way – that we are not enough, in ourselves, to maintain the order we are accustomed to and so we reach out, beyond ourselves, I think; to seek help. And it is as if, in the very act of our agential engagement beyond ourselves, in the spaces of the medical encounter, we affirm within us the teleological progression of our eventual return to wellness.

This narrative adheres to that selfsame conceit, for now. Who I am to go against convention?

---

irony, because in the novels of Kathy Acker and David Foster Wallace, Ross found other voices that spoke for him. In the course of arguing the point, we hereby apologize for the assumptions we make, and to every person whose position we misrepresent or whose experience is dissimilar to ours and for whom we do not speak; we know nothing. Although we hope not to prove that.



## The Waiting Room: A Sort of Play (In Parts)

**HELP: GOOD MORNING.**

*Me: Good morning.*

**HELP: AND HAVE YOU BEEN HERE BEFORE?**

*Me: No, this is my first time.*

**HELP: DO YOU HAVE AN APPOINTMENT?**

*Me: No. No I don't. Should I have?*

**HELP: NO THAT'S FINE; WE'RE HERE FOR EVERYONE.**

*Me: You must be busy.*

**Help: ...**

*Me: Sorry.*

**HELP: CAN I HAVE YOUR NAME?**

*Me: It's Ross. Ross Owens. Do you need an address?*

**HELP: NO, NO THAT'S FINE; WE DON'T DO CORRESPONDENCE; EVERYTHING HAPPENS ON SIGHT ON-SITE. WHAT WE DO NEED IS A LITTLE INFORMATION ABOUT THE PROBLEM – FOR THE RECORDS.**

*Me: Sure, although I'm not sure it is a problem, exactly. How much do you need to know? I mean where should I start?*

**HELP: JUST AN OUTLINE'S FINE, AS I SAY, THIS IS JUST FOR THE RECORDS. WHY DON'T YOU START WITH THE BASICS, TELL ME: WHY ARE YOU HERE?**

*Me: I can't stop playing with myself.*

**HELP: ...**

*Me: I do it all the time.*

**HELP: ...**

*Me: I'm doing it now...*

**HELP: DO YOU MEAN...**

*Me: Oh god! No! – Sorry! No I mean literally 'playing', as in*

## The Rules of the Game

There are lots of theories about play and playing (Spariosu) and all of them are troubling in one way or another, because – as any German might tell – ‘play’ belongs to *das stumme Wissen*, which is to say: knowledge that is tacit. If I had to concern myself here with all of the particulars of play in the existing scholarship, I would need a far bigger word limit than is currently permitted, which seems ironic, given the expression. And so, for the purposes of this thesis, I will focus my attention on just a few of the texts that brought me here. For the sake of expediency: I have already stated that this thesis is *all* about play and specified that D.W. Winnicott’s cognitive psychological theory of transitional phenomena would be integral to my analyses of certain playful texts. I also stated that this method of analysis can be expressed, simply, as a mode of ‘creative-destruction’ that is formulated in line with Winnicott’s own, and which is brought to bear in his concept of play. What does that mean? In short, it means “everything”, but that takes some explaining so I will begin introducing you to my concept of play by outlining some of the integral components of its heritage. The first component is the nature of my approach to play and what is constituted by that term. The second is how play thus constituted relates to the fictions in this thesis.

The “Foreword” to *Homo Ludens: The Play Element in Culture* (1998 [1949]) refers to play as a ‘cultural phenomenon’, its author – which is Huizinga himself<sup>44</sup> – sets out the intention to push beyond the ‘ancient wisdom’ of a metaphysics that calls all human activity “play” because ‘it is clearly a little cheap to do so’ (Huizinga). I do not think it is ‘cheap’ to do so; I think Huizinga does not go far enough. Besides: despite his protestations, it is worth noting that it was the [unidentified] translator of that text who decided upon ‘the more euphonious ablative’ “...in Culture” for the subtitle, whereas Huizinga always insisted on the genitive “...of Culture”. So Huizinga clearly *is* invested in the metaphysics of play, certainly more than he is interested in play as a biological phenomenon, because ‘even in its simplest forms on the animal level, play is *more* than a mere physiological phenomenon or a psychological reflex’ (1 [My italics]). He states that ‘the very fact that play has a meaning implies a non-materialistic quality in the nature of the thing itself’ (1) and this, for me, *is* the point. Huizinga’s is not a strictly definitive concern about how we determine the value of play at its obvious metaphysical level, but more a restorative to the concern that play ‘must serve something which is *not* play’ (2 [Italics in original]). Drawing his concerns from readings in psychology and physiology, Huizinga bemoans how these fields privilege ‘quantitative methods of experimental science’ and so miss ‘the *fun* of playing’ (2) when they attack play for its purposelessness. Huizinga is quite taken with fun because fun ‘resists all analysis, all logical

---

<sup>44</sup> Odd.

interpretation', as such, it should be taken as a 'totality' (2). The totality is such that it has to imply an acknowledgement of what Huizinga refers to as 'mind', which is the absolute center of his concept of immateriality, and which play encapsulates in its abundance of irrationality, beyond the limits of what physically exists, 'for whatever else plays is, it is not matter' (3-4). In fact, Huizinga was quite skeptical in general towards any material concept of play:

Summing up the formal characteristics of play we might call it a free activity standing quite consciously outside "ordinary life" as being "not serious," but at the same time absorbing the player intensely and utterly. It is an activity connected with no material interest, and no profit can be gained by it. It proceeds within its own proper boundaries of time and space according to fixed rules and in an orderly manner (13).

Roger Caillois provides an extensive critique of Huizinga's theory in this regard and draws out more forms of playfulness to define his own theory of play in *Man, Play, and Games* (2001 [1961]). In fact his thesis addresses perceived oversights in Huizinga with regard to the diversity of play-forms and its utility in certain cultural contexts, including an explicit interest in the material aspects of play-forms from gambling to games of chance (Caillois, chap.1). Caillois' effort was to produce a 'typology' of play according to the categories of 'agon', 'alea', 'mimicry', and 'ilinx' (competition, chance, simulation, and vertigo), with each categorization operating on a continuum and related to its others under given contexts. These categorizations make it evident that Caillois' primary focus is on 'games' of play and is much more concerned with the deployed action of playing. His has much less of the metaphysics of Huizinga about it. However, he does accede to the idea that play is 'a free and voluntary activity, a source of joy and amusement' and one that is 'engaged in with precise limits of time and place' (*Man, Play and Games* 6). We can say then that for Caillois and Huizinga both, there has to be a playground.

**HELP: AHHH, I SEE; YOU MEAN PLAYING GAMES.**

*Me: Yes, exactly! I can't stop playing games, for sure. I love playing games. I'm always playing games. But it's about more than game-playing; it's more serious than that – in a manner of speaking – more complicated; it's gone way beyond game playing – game-playing is just one way of looking at it.*

**HELP: I UNDERSTAND.**

*Me: You do?*

The differences between 'play' and 'games' as Huizinga and Caillois present them can be problematized by another phenomenological investigation of playfulness, synthesized from readings in Bourdieu and Wittgenstein and their respective inspections of the dynamic form of 'play' and the defined functions of 'games'. In their works the term 'games' expresses aspects of sociocultural ordering that are understood as 'games' in the immediacy of experience as they are sensed and

perceived directly, e.g. “This is all a game”, rather than “This is all a play” (Bourdieu, *Logic*; Bourdieu, *Outline*; Wittgenstein). Curiously however, what Bourdieu and Wittgenstein present as the immediacy of experience and emergent perception of ‘the game’ that arises in us indicates an ontological notion of phenomenological “embeddedness” within ‘games’ that might better be understood by transitioning from the term ‘game’ to ‘play’ – we play *a* game, not vice-versa. If we take this approach then we can see many points of correspondence between Huizinga and Caillois, Bourdieu and Wittgenstein. It is just such a correspondence that reading Kurt Dauer Keller reveals, and for this reason he reminds us that the German word ‘*Spiel*’ is a helpful substitute in these terms as it provides the same dynamic structuring of a recognizable order of phenomena without having to articulate the differences between ‘play’ and ‘games’ (175–78).

Alas, my German is terrible, so, ongoing, I will consign myself to ‘play’ and assume some level of familiarity on your part with the tacit knowledge that ‘play’ is evident in all sorts of practices that may not emerge immediately – or even ever – in experience or consciousness as ‘play’. What is consistent between these thinkers, their various philosophic distinctions, and the theory of play that I am concerned with, is that play is a curious, obscure, and slippery *phenomenon*.

**HELP: IT SOUNDS MENTAL.**

*Me: What - crazy?*

**HELP: SORRY, I SHOULD SAY: PSYCHOLOGICAL – I MEAN I’M NOT AN EXPERT BUT**

Turning to a more explicitly phenomenological position then, in theory, I lean towards Eugen Fink when it comes to play.<sup>45</sup> Fink’s treatment can be said to culminate in his seminal text, *Play as Symbol of the World* (1960).<sup>46</sup> His work has been read as a ‘hermeneutics and ontology’ of play (Krell 63), an ethical rejoinder to a Western metaphysics and contemporary philosophy that has ‘forgotten the world’ (Homan 287), and as a cosmological reality homologous with the structure of the world (Halák, ‘Towards’; Halák, ‘Beyond’). It is this last iteration – where play has within it some cosmological essence – where Fink and Huizinga are closely aligned. Indeed even Huizinga said that ‘play only becomes possible, thinkable and understandable when an influx of *mind* breaks down the absolute determinism of the cosmos’ (3 [Italics in original]).

**HELP: ... HOW LONG HAVE YOU FELT THIS WAY?**

---

<sup>45</sup> Phenomenology is the study of “phenomena”, literally; the appearances of things, or things as they appear in our experience or the ways we experience things and thus: the meanings things have according to our experience. It examines conscious experience from the subjective point of view, as distinct from, say, ‘ontology’ (the study of being); ‘epistemology’ (the study of knowledge) or ‘ethics’ (the study of right and wrong) (D. W. Smith).

<sup>46</sup> Originally published in German as *Spiel as Weltsymbol* (Kohlhammer Verlag, 1960). All references in this thesis are from the edited collection of Fink’s works, *Play as Symbol of the World and Other Writings* (Indiana University Press, 2016).

*Me: A long time. I can't remember not thinking this way to be honest. It's like I don't have a choice.*

**HELP: AND YOU SAID THAT YOU WEREN'T SURE IT WAS PROBLEM?**

*Me: That's right*

**HELP: BUT THEN SO YOU'RE COMING TO US NOW, BECAUSE...?**

*Me: ...*

**HELP: ...**

*Me: ...*

**HELP: IS IT THAT YOU WANT TO STOP PLAYING?**

*Me: Oh no. No. Definitely not. I don't think so. I feel a little peculiar – I don't know if I feel "right", you know? Like I don't how to be in the world without playing, and if I didn't play, I wouldn't want to be in the world... But then that's what I mean – that's not necessarily a problem, is it? Because I can play. So I don't necessarily feel "wrong" – I just don't know what to feel about it, exactly.*

**HELP: ...**

*Me: I think I'm probably fine but... I guess I just wanted to see someone for another perspective; to see how serious it is, or if it's unusual really – how I feel. I want to know if other people feel like me; like, is it a "good" thing?*

**HELP: I UNDERSTAND. YOU CAME TO THE RIGHT PLACE.**

Halák, reading Fink in conjunction with Caillois and Huizinga, has it that play is 'virtual', which is set against what is 'actual' life. His survey of the literature begins from Huizinga, with the revelation that there is no purpose towards play but there is purpose towards life. From this perspective play is 'automatically endowed with an index of inferiority in regard to life as it is supposed to be' such that life is more than play and when we play, we are in some sense 'distant or even absent from what life itself is about' because when we play, we do not 'produce anything' (Halák, 'Towards' 402). It is clear that Halák's argument is framed by an ontological assessment of what the essence of reality is, or the question: "what" exactly is the nature of our being towards reality – should we live with a purpose towards something; should we live teleologically? Halák's contention is that the narrative of 'play' is assumed in opposition to the 'serious' matter of teleology:

[I]f the value of play is assessed positively in our civilization, the normative measure against which such an appreciation is developed is usually again the serious domain of purposeful action, which transforms the realities around us or penetrates into their intelligible essence by knowledge. Play is, for example, supposed to teach us to respect rules, and thus it enables us to develop rule-governed social interaction,' ('Towards' 402)

However, Fink's intervention is what disrupts this narrative order of things and in fact moves to extinguish the metaphysical fires of what it means 'to be' in the world altogether because for Fink *that* question is assumed upon the rational principle that there is an order to it ('Towards' 403–04). For Fink, play exists outside of this teleological mode of being precisely because it does not adhere

to the assumption that one's existence is intended towards a future goal or meaning, 'play is characterized by calm, timeless "presence" and autonomous, self-sufficient meaning' (*Play as Symbol* 21). In other words: it is not dependent on reason for being. It is meaning in and of itself. In this imperative for self-sufficiency, I think Fink is getting at something altogether more universally ontological, and which Halák best expresses as play without mediation ('Towards' 401). To my understanding 'without mediation' means beyond the bounds of any material position we can imagine or any mutable perspective we can conceive, but because we are the mediators of such things, it is impossible to escape the paradox of the position we are bound to – any phenomenologist (or neurobiologist) is likely to tell you that.

**HELP: I'VE MADE YOU AN APPOINTMENT WITH ONE OF OUR MORE EXPERIENCED PRACTITIONERS. I THINK HE'LL BE ABLE TO HELP YOU – HE'S VERY GOOD AT LISTENING. A GOOD OBSERVER. HE'LL CERTAINLY HELP YOU UNDERSTAND, I'M SURE.**

*Me: Really? That's fantastic, thank you. Honestly. I've wanted to talk to someone about it for such a long time and just but... well... you can go a little stir crazy when you're just playing it out in your head all the time – You know?*

**HELP: NO. I DON'T I'M AFRAID.**

*Me: ...It's not important. It's silly really. There's probably an obvious solution to it all and not worth troubling him with but*

As Fink attests, play is 'a phenomenon of life that everyone is acquainted with first-hand', not some 'object of research that must first be discovered and laid bare'; it is, 'from the testimony of our experience', a symbol of the world (*Play as Symbol* 15). But so as much as it is a symbol of the world, Fink also spells out that the 'world and thing are incommensurate' (210). So: if, by his philosophy, the symbolic order of play in relation to the world is out of proportion, does he mean that play is 'lesser than', or 'more than' the world for which it is a symbol? What is reduced by that formulation – is it play, or the world? Fink clarifies any doubt thus: '[I]t is never a matter of a quantitative relation of the small to the large or vice versa. The relation between the world and the thing cannot be reduced to something quantitative' (210). So really then, Fink's concept is that play is immeasurable; play is unquantifiable; play is limitless. If 'play' cannot be reduced to 'the world' but is *its* symbol, then it must be *more than* [so to speak] and so then 'the world' must be expressible in all its finite entirety, in and through 'play'. Fink's position is more akin to: "play as symbol of the universe". Or, as I would have it: "play is a linguistic expression of the constitution of the universe" but then I did say that play means everything to me, it just turns out that I meant that figuratively *and* literally.

I am not concerned with deconstructing phenomenological discourses; this is not the thesis for that. All I want to do, for now, is explain the position of play in this thesis. In that regard I would like to examine what Fink means when he expresses play as a 'phenomenon of life' because – as a phenomenologist – he is concerned with a specific orientation of the concept of phenomena.

Thankfully, I think I can parse this pretty quickly with reference to Witold Płotka, who has already done the heavy lifting. Płotka synthesizes the philosophies of Husserl, Fink and Patočka to articulate this ‘phenomenon of life’ in accord with the general concept of a ‘phenomenology of phenomenology’.<sup>47</sup> He takes the position that each of these esteemed contributions to the phenomenological discourse has an intrinsic relation to the concept of ‘reduction’, which can be framed as the interrogation of the ‘essence of philosophy’ (603). This ‘essence’ is the will to question what appears obvious in the world:

The obvious does not provoke questions, which is to say that it provides no motivation to initiate philosophical reflection. It is only from this perspective that the obvious, accounted for *as* the obvious, can be problematized (604–05 [My italics]).

Problematizing the ‘obvious’ can be thought of as a ‘reduction’ to subjectivity, an account of the ‘transcendental field’, wherein meaning in the world is constituted by our consciousness and our being conscious of things (605). The direct observation from Fink is that what is obvious from playing is the creation of the imaginary dimension of the play world, after all, ‘play does not form a curtain or a wall between us and all that is around us, it does not obscure or hide the real world’ (*Play as Symbol* 23-26). Precisely. Playing is often our first effort at coming to understand the real world; it allows us to see what is given in reality and make it different. It is a systemic or methodological or joyful or... it is an expression of the phenomenological truth of the world being obscured by our very experience within it, which is in our capacity to exist – theoretically – as both conscious and sub-conscious beings who are always being or doing something, consciously, or not. That we can intellectualize and abstract our experiences of the world into experiments in material and mutable formulations but accept that the results of such experiments are just as contingent on the mediating factors that produce them – a fact all the more problematized by their being conducted at a point and place in time, which itself is an obvious abstraction of, or intercession into, our experience of being – all is an aspect of play.

If we understand ‘consciousness’ as the manifestation of what we assume to be the natural order of the world, then phenomenological ‘reduction’ is the change in attitude that consists of suspending

---

<sup>47</sup> Fink was an assistant to Edmund Husserl and latterly keenly influenced by Martin Heidegger, with whom he convened in 1966-67 for a seminar on Heraclitus (Fink, ‘Phenomenology of Edmund Husserl’; Heidegger and Fink). His phenomenological philosophy was invested in broaching the problem of phenomenological reduction and attempted the so-called ‘phenomenology of phenomenology’ to tackle the problem of ‘complete reduction’ (Bruzina, ‘Transcendental Theory of Method’ 75; Depraz) in a so-called ‘third way’ that suffused the methods of Husserl and Heidegger (Bruzina, *Beginnings and Ends* 133). This contribution informed much of the contest between Husserl and Heidegger and was a significant influence of Merleau-Ponty (Toadvine and Embree), although whether that influence was positive (e.g. Bruzina, ‘Eugen Fink and Maurice Merleau-Ponty’), or negative (e.g. B. Smyth), rests on your reading of *Phenomenology of Perception* (Merleau-Ponty) and the *Sixth Cartesian Meditation* (Fink and Husserl).

what is assumed about the natural order of what simply exists – ‘the obvious’ – and what Fink constitutes in his ‘symbol[s] of the world’. So ‘reduction’ is transitioning from the ‘natural attitude’, or unthinking, to the ‘philosophical attitude’, or thinking, which problematizes that assumption:

Hence, in the philosophical attitude [...] what changes after reduction is the need to understand adequately the meaning of the natural attitude which, in turn, was not explicitly described. Thus, the essence of reduction is that it remains unmotivated and, as such, it is an expression of the philosopher’s freedom. Broadly speaking, freedom is here understood as a possibility of being distanced from the natural attitude (Płotka 608–09).

In other words, the ‘freedom’ expressed here is the conceit that it is possible to be freed from the natural or the obvious; of being distanced from – let us say ‘orthodoxy’, so long as you understand ‘orthodoxy’ from the perspective that it is specifically the quality or character of your being in agreement with whatever constitutes your beliefs, doctrines, opinions, practices – of all the things you hold to be true... or obvious, or natural. It is ‘freedom’ from whatever is constituted in and by *your* ‘subjective’ being in the world.

My theory of play definitively incorporates the freedom implied by “playing for the fun of it”, but that is not the sum of it. In this sense, I do not concur with Fink when he claims:

‘Play has only internal purpose, unrelated to anything external to itself. Whenever we play "for the sake of" physical fitness, military training, or health, play has been perverted and has become merely a means to an end’ (Fink et al. 21).

Because it leans towards an absolute claim that privileges the primacy of interiority, as though subjectivity was entirely ordered according to one’s inner sense of self and so ‘play’ entirely contingent on the isolation of the self in the world. It also returns us to the problem of defining differences between ‘play’ and ‘games’ [above] and besides, I learned very young – from my mum – to be wary of absolute claims.<sup>48</sup> Instead, I would argue that rather than ‘perverting’ play by Fink’s expression, one is utilizing play in another form, or playing with another of the limitless aspects of the material and mutable forms of play by redrawing its boundaries. From the perspective that we may each have a ‘personal orthodoxy’ – a capacity to have freedom from that ‘personal orthodoxy’ is what is at stake in my iteration of playfulness.

To return to the terms of Fink et al., rather than play being a ‘freedom’ qua ‘reduction’ from our natural attitudes, I would prefer to conceive of it as an ‘abstraction’ from the natural attitude,

---

<sup>48</sup> Ross’ mum told him: “Always question.” He took that to heart. Also: I am not sure how much of Ross’ irony is intended here but it does seem to speak to the paradox of the thing. I suppose what he is suggesting is that there must be an absolute claim in order even to conceive of the non-absolute something against which you intend to measure it, or – to borrow the language of his “Formal Introductions” – there has to be a ‘material’ position in order to constitute the ‘mutable’ position in opposition to it.



because ‘reduction’ – to me – connotes a greater sense of a qualitative or quantitative lessening; it conveys some semblance of a pejorative tone. While ‘abstraction’ retains much of the same qualitative or quantitative connotations however, I prefer it because it conveys the agency to consider something independently of its associations or attributes, the process of isolating properties or characteristics common to a number of diverse objects, events, etc., without reference to the peculiar properties of particular examples or instances. In short: the process of “playing with”, until “it” is entirely different. In its broadest terms then: ‘abstraction’ is a playful method of inquiry; play is an act of ‘abstracted’ inquiry; is a form of ‘abstracted’ thinking; abstracted being.

**HELP: IT’S OKAY. HONESTLY. STOP WORRYING. IT’S GOOD YOU CAME – THAT’S WHAT WE’RE HERE FOR AFTER ALL. TO HELP. PEOPLE COME TO US ALL THE TIME, WITH ALL SORTS OF PROBLEMS. BIG AND SMALL. AND WHO’S TO SAY WHAT’S BIG OR SMALL WHEN IT COMES TO THAT. BESIDES, WHAT MAY APPEAR SIMPLE, OR OBVIOUS TO SOME ...WELL, ALL I MEAN TO SAY IS: YOU’RE HERE NOW, YOU’VE TAKEN THIS STEP. YOU SHOULD SEE WHAT COMES OF IT. EVEN IF JUST FOR PEACE OF MIND.**

*Me: ...Yeah, you’re right. Thank you.*

**HELP: YOU’RE WELCOME. NOW, DO YOU KNOW ANYTHING ABOUT THE PROCESS?**

*Me: No. No, I know nothing about it.*

**HELP: WELL IT’S ALL VERY SIMPLE: JUST GO THROUGH THE DOUBLE-DOORS AND WAIT. I CAN’T TELL YOU HOW LONG THE WAIT WILL BE I’M AFRAID, THAT WILL DEPEND. IF OFTEN TAKES TIME TO BE SEEN. IT CAN BE A LITTLE DISCOMBOBULATING AT FIRST SO DON’T BE CONCERNED IF IT FEELS DISORIENTING, OR IF YOU FEEL UNUSUAL; THAT’S WHAT IT FEELS LIKE – SO I UNDERSTAND – IT’S NOT REALLY LIKE ANY OTHER SPACE YOU MAY HAVE BEEN. OH AND THERE IS NO LIGHT SO JUST FOLLOW THE GUIDE PROVIDED. IT MAY SEEM PECULIAR BUT IT IS ALL A NECESSARY PART OF THE PROCESS; THE DARKNESS HELPS THE TRANSITION; IT HELPS BEING SEEN. YOU’LL BE CALLED THROUGH WHEN READY. ALL CLEAR?**

*Me: All clear...*

My concept of play *allows* playing for the sake of “physical fitness”, or “well-being”, or “wellness”, “morale”, “happiness” – all of these are constituents of the interrelated aspects of “good health” that are expressed in our medical encounters. I cannot think of these as perverted forms of playing because they are integral to the internal purpose of many a person’s life and so in everything that my play reflects, it *must* reflect both Fink’s sense of a psychological state of being un-self-conscious and without purpose, but in order to address the gaps and offer something more universally beneficent it should also permit play as a consciously purposeful and act with agency towards the external world. Perhaps, rather, what I mean to say is that Fink’s expression of what play is, risks masking its potency because – as an expression in language – play cannot escape the abstract, artistic method of translating the real into the symbolic. In its articulation here, my argument reflects perhaps too much of Płotka’s ‘transcendental field’ and it would serve me better to return us to a more material concept of what play means in relation to the possibility of ‘freedom’ from ‘subjective being’. For this, my favorite analogue is to be found in D.W. Winnicott’s theory of

‘transitional phenomena’ – a theory in ‘object relations’ that is intrinsic to his ontology of play, as expressed in *Playing and Reality*.<sup>49</sup>

**HELP: IS THERE ANYTHING ELSE I CAN HELP YOU WITH?**

*Me: No, I don't think so; I think that's everything. Thank you.*

**HELP: THEN I HOPE YOU FIND WHAT YOU'RE LOOKING FOR.**

---

<sup>49</sup> Originally published in 1971 by Tavistock Publications. All references in this thesis are from the Routledge Classics edition (2010).

## A Transitional Route into The Clinic

*Me: Is this the right place?*

*Hello?*

*Is anybody there?*

*ur-Me: You are here.*

*Me: Where are we?*

*ur-Me: Everywhere*

*Nowhere*

*You are here is all*

*Me: What is this place?*

*ur-Me: Somewhere else*

*Me: It's so dark*

*ur-Me: There is nothing to see*

*Me: Where are you?*

*ur-Me: I am with you*

*Me: I can't see you*

*ur-Me: I am nothing to see*

*Me: What is happening?*

**NOT ME: A FEAR OF BREAKDOWN. THE ORIGINAL AGONY. A PRIMITIVE AGONY.**

*Me: Are you, my guide?*

*ur-Me: Be patient*

*Me: What should I do?*

*ur-Me: Listen*

'Object relations theory' is a psychoanalytic model that expresses the psychological process of developing a psyche in relation to others in the childhood environment (Greenberg and Mitchell). It is commonly held that Melanie Klein instantiated the field as "a theory" by developing Freudian concepts of subjective experience in relation to people who were the object of 'drives'. In Freud 'object relations' was an expression of the medium through which a subject could describe, emphasize or satisfy their 'drives', whereas Klein positioned objects at the center of the development of a subject (Freud; Klein, *The Psycho-Analysis of Children*; Klein, *Love, Guilt, and Reparation and Other Works 1921-1945*; Klein, *Narrative of Child Analysis*). Following Klein a rupture emerged within the community of psychoanalysts whose focus was childhood psychology, with a split between those who privileged the 'Id' and those, such as Anna Freud, who privileged the realm

of the 'Ego' (Gay; Young-Bruehl). Out of this schism emerged the 'Middle Group' of psychoanalysts whose work provided the impetus to move away from the Freudian gratification of 'drives' and assert the primacy of 'object-seeking' as the primary instinct of the child (Hughes). As an influential member of the 'Middle Group', this schism led to D.W. Winnicott's own object relations theory vis-à-vis play (Spelman; Abram and Hinshelwood; Lenormand 83–84).

Much has been written about Winnicott's theories and the influence upon them of Melanie Klein, from Freud, including the notion that instinctual drives in the "Id" served no purpose until there was an "Ego" capable of self-identifying. However, Winnicott strove to free himself from this orthodoxy.<sup>50</sup> For example, Winnicott saw 'no possibility whatever for an infant to proceed from the pleasure principle to the reality principle or towards and beyond primary identification [...] unless there is a good-enough mother' (*Playing* 13).<sup>51</sup> According to Winnicott, "Ego" denoted the beginning of a person and so talking about any aspect of "humankind" meant nothing without this consideration taken onboard. Similarly, upon positing the "Ego", one could begin to talk of the "inner psychic reality" of people. During early-stage childhood, the outer physical reality – the 'not me' – was separated from the inner psychic reality – the 'me' – to establish objectivity, from which the world of external objects emerged in material permanence. In Winnicott's developmental schema, the maturational process is effective insofar as there exists the 'good enough' facilitating environment that adapts and develops alongside the infant. In such an environment the infant can be classified as 'integrating' with external reality, or 'indwelling' (*Psycho-analytic Explorations* 89) and in turn gains a capacity to survive its disillusionment over a loss of omnipotence and learns responsibility for its actions. This accords with Freud's work on the transition from the pleasure to the reality principle and Winnicott accepted that the transition from pleasure to reality could be painful for the child because the reality principle is the fact of the world as it is, in existence: the objective world, which – along the lines of Husserl – is the world available to all. In this real world,

---

<sup>50</sup> In scholarship of psychoanalysis there is a wealth of literature that explores and assesses the interrelations between the theories of Freud, Klein and Winnicott – among countless others in the field. One can begin with Winnicott's own discussions of his distinctions from Klein and Freud in the early chapters of *Playing and Reality*. For additional material, see: M. Jacobs, chaps2–3; Meline; Seligman.

<sup>51</sup> The 'good-enough mother' here is taken to mean the effective facilitation of, and active adaptation to, the needs of the infant and which – as the infant matures and adapts to fulfil its own self-needs – require less and less 'devotion' (*Playing* 14). Winnicott is at pains to note that the 'mother' does not mean the infant's biological parent necessarily – although that there is an additional influence in the biological aspect and bond that it is likely cannot be overlooked – but we might also understand the term "mother", equally, as "caregiver". When the facilitating environment breaks down, so the child risks a fear of breakdown, but Winnicott is keen to assert that psychotic illness is not a breakdown, rather it is a defence organization that emerges from primitive agony. See: "Fear of Breakdown", in *Psycho-analytic Explorations* (2018).

'other-than-me' artefacts could become absorbed or incorporated into the child's personal pattern of existence and experience, suffusing outer reality with inner reality.

*Me: I can hear nothing*

**NOT ME: A RETURN TO AN UNINTEGRATED STATE. DISINTEGRATION.**

*ur-Me: There is nothing here*

*But us*

*We are here*

*Me: Please. Tell me what is wrong with me.*

**NOT ME: THE FEAR OF A BREAKDOWN THAT HAS ALREADY BEEN EXPERIENCED.**

*ur-Me: Fear not, you will soon be seen*

*Me: But what does that mean?*

*ur-Me: Everything*

Winnicott's primary focus is the maturational process by which an infant develops a psyche, or inner sense of self, and transition occurs when the child begins to develop a theory about the minds of others and realizes that it is not alone in the world; nor indeed is it itself the world alone. The maturational processes Winnicott describes are said to occur from the perspective of a child at the developmental stages of between four and twelve months; the 'transitional' is taken to be a phenomenon that expresses what is simultaneously part of the child's inner sense of self but also part of the relational world beyond the child and the external world of objects.<sup>52</sup> We can see an approximation of this in Fink's philosophy too, which states:

[T]he play world is an imaginary dimension, whose ontological meaning presents an obscure and difficult problem. We play in the so-called real world, but while playing there emerges an enigmatic realm that is not nothing, and yet is nothing real (*Play as Symbol* 23).

To explain this in *Playing and Reality* Winnicott offers his model of transitional phenomena, which comprise the 'transitional space' and the 'transitional object'. The 'transitional space' is a 'designation of the intermediate area of experience [...] between primary creative activity and projection of what has already been introjected'; it defines that which is 'between [the infant's] primary awareness of indebtedness and the acknowledgement of indebtedness [to the caretaker]'. The 'transitional object' defines 'objects that are not part of the infant's body yet are not fully recognized as belonging to external reality' (*Playing* 2–3). The 'transitional' is clearly an analogue of 'liminal' and as such should be understood by according to its nature: it is *always relational*. However,

---

<sup>52</sup> For more articulations of these basic principles, see: Hodgkin.

the 'transitional' includes an inflection of the being and doing of things via the agency of the subject, which necessarily places it squarely in agreement with the phenomenologically minded ontologies of Husserl and Fink and is a consequence of our being in the spacetime of existence and "transitioning" through life, which is where it is positioned in alterity to the more anthropologically inclined order of 'liminality':

Playing has a place and a time. It is not inside by any use of the word [...] Nor is it outside, that is to say, it is not a part of the repudiated world, the not-me, that which the individual has decided to recognise [...] as truly external, which is outside magical control. To control what is outside one has to do things, not simply to think or to wish, and doing things takes time. Playing is doing (*Playing* 47).

As stated, Winnicott's articulation begins with Freud and the idea of symbolic play standing not in opposition to reality, but as something intrinsic to the creation and maintenance of reality. Somogy Varga champions Winnicott's ideas of symbolic play and intersubjectivity in pursuit of the 'intrinsic connection between symbolic play and other minds' but takes issue with his 'theory-theory' approach to the position of the emergence of the inner sense of self (625–26). Varga takes 'symbolic play' to mean something very specific in Winnicott, which is derived from the object that symbolizes the union between the infant and its caretaker, an object that represents the caretaker and their function, which object is 'played with' by the infant to allow for the continued presence of the caretaker and their function even as they transition away from the caretaker's immediate, physical presence. Specifically: it is *not* symbolic of socially constituted orders or collections of symbols and shared rules but represents a proximal relationship with the specific other of the caretaker and their presence in the life of the infant (626–27). Varga challenges aspects of this position because it endows the infant with a preternatural state of being that understands itself from a theoretical stance in relation to the world; it suggests that the infant understands itself as a mediating entity because the model relies on the process of cognitive self-reflection (630). This assumes the existence of a state anterior to any demarcation of 'subject' and 'object' but which Winnicott does not address (cf. Loewald); a problematic 'theory-theory' thesis because, as Varga explains, it is a model that describes the emergence of intersubjective awareness as the result of an infinite regress by which the anterior 'non-objectifying self-awareness' (629) is made possible, only if a pre-theoretical understanding of the context and behavior of other people is already present (630). I think this criticism fails to account for the 'obvious' presence of the infant's body as an aspect of its self-awareness however, which confirms the presence of the infant's whole person as a product of mediated sensory perception, regardless of its cognate 'theoretical' self-perception. There is a sensory relationship with the world *in utero* and so I think Varga's 'theory-theory' contention merely

reifies this dichotomy of mind-body dualism and forgets the material and mutable matter of the thing. It forgets the whole person.<sup>53</sup>

**NOT ME: IT WILL BE FOUND THAT NON-EXISTENCE HERE IS PART OF A DEFENCE.**

*Me: I don't understand*

**NOT ME: IT CAN BE SAID THAT ONLY OUT OF NON-EXISTENCE CAN EXISTENCE START.**

*ur-Me: Who did you come to see?*

*Me: I don't know. They never said.*

*ur-Me: It is not for them to say*

*Me: Then what do you mean?*

**NOT ME: THE EGO IS TOO IMMATURE TO ENCOMPASS SOMETHING. IN SOME EMPTINESS NEEDS TO BE EXPERIENCED, AND THIS EMPTINESS BELONGS TO THE PAST, TO THE TIME BEFORE.**

This is exactly the problem Descartes established when faced with his own conundrum of existential self-perception. His '*cogito ergo sum*' necessarily drew the lines of Cartesian dualism that inform much of this sense of "me" and "not me" that persists in our instituted epistemologies to this day. Histories of Western medicine inform us that it is among the most pertinent influences on the development of contemporary medical practice, a division of 'self' and 'other' in which the self is configured as an absolute and one's ontology formed by the notion of a subjective, individual self whose experience of the world exists in their innate ability to think and think of themselves. That this provokes a distinction between one's self and other selves helps further the subject-object dichotomy and more crucially – framed in a general sense with regard to medicine – a separation between mind and body. These disjunctions solidify a sense of distinction between what we may measure in the world in relation to a measurement of myself, and what is immeasurable in the world as a measurement in relation to myself; what can I confirm is 'real', suppose is 'real', and affirm is *not* 'real'. From this formulation we might well understand Descartes position as a forebear to the scientific revolution, the scientific method, and indeed much of Western medical thinking to this day. Edward Bullmore's influential *The Inflamed Mind* (2018) confirms as much (45–55), teaching us that Descartes' philosophies underpin much of our academic and scientific orthodoxies on the so-called "mind-body problem" and which are performed as a mode of Cartesian dualism.

---

<sup>53</sup> The 'theory of mind' concept contributes significantly to the scholarship in this field and refers to the abilities underlying the capacity to reason about one's own and others' mental states. There are many routes of inquiry into this extensive field of research as relates to the cognitive development of children and the maturational process, whether in relation to behavioral synchrony (Baimel et al.), the function of mirror neurons, in empathy and language development (Rizzolatti and Craighero; Dinstei et al; Arbib) or the relational lexicon between caretakers and children (Rollo and Sulla). Substantive support for the 'anti-Cartesian' embodiment framework in early forms of psychological self-consciousness is forwarded by, for example, Gallagher and Meltzoff; Gallagher, 'Earliest Senses'; Marraffa and Meini.

This understanding of how the body works returns us to its conception in Classical Greece, where evidence tells us there was no separation between mind and body; indeed, the references to mental ill-health that we might recognize today – melancholy, mania etc. – these had no place in the brain so-to-speak but were instead brought about by physiological and physionomical afflictions with symptomology attributed to *aspects* of the head or brain. As for psychic disorders, the fluid theory was equally valid for somatic manifestations as well. According to Hippocratic modelling, an imbalance in fluid proportions was considered responsible for a peculiar temperament, possibly leading to severe depression, while a healthy subject, the 'good humor[ed]' man, has the four humors in appropriate proportions. Aetiologies of depression and other psychiatric conditions were therefore considered 'organic disorders' (Fornaro et al. 4). This classical understanding of the body is not accurate in terms we understand now; the humors, whilst conceptually useful, proved entirely without merit once philosophy gave way to the academy and institutional orthodoxy developed its science, which attacked the humoral view of Aristotle whilst instantiating a mechanical model of the body whereby "bad" or "confused" behavior, feelings, and thoughts were attributed to the defects in sense organs and their nervous networks.<sup>54</sup> As medicine developed from Classical Greece and the unprecedented influence of the Hippocratic texts extended across Europe and beyond the Mediterranean, so the doctrines of the Hippocratic corpus established the principles from which modern medicine emerged. That is, until very recently, we "understood" (worked according to the principle that) there was a 'real' separation between mind and body, which Bullmore articulates in relation to the blood-brain barrier model. Developments in the field of – for example – immunology have taught us that the blood-brain barrier model is a falsehood in "real" terms. That is: it is not 'materially' the case but rather a 'mutable' case. It is an abstracted model of what is actually going on; there is no separation between these bodily constructions in "real" terms, there is only interrelatedness.<sup>55</sup>

Following Winnicott we can see that each arm of the dichotomy must be said to 'exist' only insofar as it is understood, conceptually, as a sign or language-object that provides constitutive, "material reality" to a linguistic model that attempts to describe some "Other" materially real phenomenon of which it is an abstraction. So, to return to the case of 'subject' and 'object', we can propose each as an equally transitional phenomenon because, as language-objects, they are interrelated as 'measurements' in the linguistic model that attempts to describe the material "Other" that is 'me' and 'not me'. We can derive an empirical reality from such a model because it structures what is

---

<sup>54</sup> There is some return to a classical order of things in so much as the 'organic' sense of a disorder is becoming better reflected by the whole 'organism' of disorders, as Ross shows from Bullmore.

<sup>55</sup> For additional insight on this topic and the specific function of the body's role in cognition and perception, see: Gallagher, 'Prenoetic Constraints'.



agreed upon by consensus as a material fact (and which is necessary in the first instance in order for the model to communicate anything at all). But equally, any empirical reality we do derive from such a model can be made mutable as a consequence of the transitional quality inherent to the 'measurement' itself, which, as a language-object, reveals its transitional status by operating in the play-ground space of intersubjective exchange. This has the potential to keep our material 'measurements' in play by declaring, demarking, qualifying and quantifying what is constituted by them anew, with each new exchange that takes place.

*ur-Me: Do you see now, Ross?*

**NOT ME: WHAT IS NOT YET EXPERIENCED DID NEVERTHELESS HAPPEN.**

*Me: I think I see*

**NOT ME: TO UNDERSTAND THIS IT IS NECESSARY TO THINK NOT OF TRAUMA BUT OF NOTHING HAPPENING WHEN SOMETHING MIGHT PROFITABLY HAVE HAPPENED**

*ur-Me: And what do you see?*

*Me: I see...*

Winnicott's 'transitional' attends to both the material and mutable aspects of our being, which is why he pushes beyond the spaces and objects of transition to the aspect of 'phenomena', which is intended to reify that both the space and the object are equally and always relationally in transition with one another. Whether we refer to the 'space' or the 'object' is not an essential concern specific to this thesis as such, because the more crucial aspect of the 'transitional' term is that it necessitates the acceptance of a fundamental, conceptual paradox. The paradox is that an entity – a phenomenon – is considered in relation to its constituent parts – however many they may be – with the simplest constitution being designated by that phenomenon's abstraction into two relational but distinguished, typically mutually exclusive elements. As I have demonstrated throughout this thesis through its utilization, the simplest expression of the interrelational qualities at play in this paradox is the dichotomic model.

*Myself*

It is nigh-on impossible to address the relationship between 'subject' and 'object' without reference to theories of postmodernism. Briefly then: Jean-François Lyotard's *The Postmodern Condition* (2005 [1979]) might best be summarized as the deconstruction of narrative knowledge into a game between two distinct types of language – that of the expert, who knows what they know and what they do not know, and that of the philosopher, who poses questions (Aylesworth).<sup>56</sup> Lyotard posits

---

<sup>56</sup> Ross is sick and tired of talking about postmodernism; as far as he is concerned it is "merely" another means of interrogating knowledge – another example of our innate playfulness manifesting in the proposition of world and word systems – it is not a category of knowledge-making itself. Even in its earlier articulations,

the requirement of a pragmatics so that mutual communication can occur but, applied in relation to the subject-object dichotomy, he makes clear these ontological positions are constituents within the language game and as such 'legitimation' of any knowledge, at either binary, is problematized. Aylesworth's survey positions Lyotard's philosophy as the 'cultural perspective of the West' by interlinking languages of science, ethics and politics with government and administration (Lyotard 6–8). This formulation defamiliarizes ('delegitimizes') the modernist notion of 'grand narratives', which Lyotard couples to advances in post-war 'techniques and technology' (37–41). As scientific denotations, these advance to the exclusion of all others because of the primacy of 'rationalized' knowledge, displacing so-called 'narrative knowledge' as 'science' disconnects from classical models of epistemology and leads to Lyotard's definition of the postmodern as 'incredulity towards meta-narratives' (xxiv). 'Meaning' is thus traduced from a modernist narrative order to one of disintegrated linguistic games and heterogeneous language elements that displace the subjective, moment-to-moment, in defiance of coherent or cohering identities.

*I see only myself*

*In agony*

**NOT ME: IT IS EASIER TO REMEMBER TRAUMA THAN TO REMEMBER NOTHING HAPPENING WHEN IT MIGHT HAVE HAPPENED.**

Returning to Winnicott's focus on the infant; he posits that in its earliest stages of maturity the infant's identity is such that the objects in its external world are in fact wholly constituted within its internal world; that there is no complete 'subject' but nor is there a complete 'object'. This is because 'external objects' are constituted, or configured, according to the infant's immediate needs and therefore belong to its sphere of omnipotence. In a sense we might think of this as a primordial state of presence in the world or 'primary inter-subjectivity' (Varga 634), which, if we consider it from the position of the infant's ontological state, is what Winnicott defines as the product of the infant's 'magical' control (12). This is a product of the infant's as-yet undeveloped awareness of the

---

postmodernism was problematized for its variform contradictions, Brian McHale's *Postmodernist Fiction* (2004 [1987]) cataloguing these from John Barth to Jean-Francois Lyotard; from Ihab Hasen to Frank Kermode and suggesting that its discursive complexity risked its meaninglessness (4). Fredric Jameson's postmodernism marked endings without beginnings (30) as signs decoupled from material referents to ensure the 'image' of things, not the 'reality', become the more valued commodity of exchange and thus the world decoupled from history. The difference between Jameson and Lyotard appears to reside in the position of the underlying truth of things, which Jameson – in accordance with Marxist scholarship – sought to preserve by finding a way through the 'logic' of postmodernism in hope of restoring the history is assumed lies behind it (416). Lyotard was less attached to this historicity, as his position on the loss of grand narratives and totalizing systems makes plain.

world at large – the facilitation of the caretaker ensuring that its needs are met as and when they occur (*Human Nature*).<sup>57</sup>

*I see*

*I have never been enough*

*I am not enough in the world*

**NOT ME: THERE IS NO END UNLESS THE THING FEARED HAS BEEN EXPERIENCED.**

As the infant matures its ‘magical’ control is disturbed by a naturally occurring ‘frustration’ provoked by a maturing awareness that its needs are not met instantly and which behavior might be evident when the infant cries because it is hungry, for example. What emerges from the maturational process then, is a frustrating or ‘destructive’ element tied to the infant’s advancing understanding of reality vis-à-vis its subjective self – indeed the creation of its very sense of self. Over time, suddenly, there exists a realm outside of the omnipotence of its magical control. Within this realm the entity of the object – the ‘not me’ – emerges in independence. The corollary frustration this independence creates has a crucial role to play in relation to the infant’s self-awareness. As Winnicott states:

*If all goes well* the infant can actually come to gain from the experience of frustration, since incomplete adaptation to need makes objects real [...] The consequence of this is that *if all goes well* the infant can be disturbed by a close adaptation to need that is continued too long, not allowed its natural decrease, since exact adaptation resembles magic and the object that behaves perfectly becomes no better than a hallucination [...] unless this is so it is not possible for the infant to begin to develop a capacity to experience a relationship to external reality, or even to form a conception of external reality (*Playing* 14 [Italics in original]).<sup>58</sup>

As well as stirring the development of the infant’s self-awareness, in this passage Winnicott suggests how object-relating agitates an alternative measure of how the destructive element is in play, which is derived from the infant’s relationship with objects themselves. The key point is the claim that exact adaptation equals magic, wherein Winnicott espouses the absolute necessity that the object retains some element of externality. This is so that it is not considered entirely under the realm of the infant’s magical control because for Winnicott the maturational development of the child incorporates an awareness that objects in the external world over time begin to lose their potency with regards the infant’s needs. If the object does succumb entirely to magical control, it resembles a ‘perfect’ object because of its destruction in externality; it is in this sense that object becomes a ‘hallucination’. Whereas if the object retains some element of externality, i.e. “becomes real”, it has

---

<sup>57</sup> It may be worth reminding you here that this thesis’ playful conceit is that it privileges *the means and path* to learning, and is not concerned with conflicts that are a consequence of the multitude of epistemologies that stake a claim to knowing exactly what happens in a baby’s head during the maturational process. As we saw from Varga [above].

<sup>58</sup> See fn59. It is worth reminding you.

material and mutable potential.<sup>59</sup> It is this potential that suffuses objects with their transitional qualities because, in short, the reincorporation of an object within the subject's experience at once familiarizes the prior standpoint to make it 'material', but also begins the process of defamiliarization which acts to combat that materiality, i.e. it makes it mutable too. And so, as Lyotard might say of Winnicott's privileging a system whereby objects combat their material aspects: 'The novelty of an external 'move,' with its correlative displacement [...] can supply the system with an increased performativity' (15), which, following Kuspit's articulation of 'aliveness' in artworks, means the potential of objects is to be kept 'in play'.

*When does it appear*

*How can I experience it*

**NOT ME: REMEMBER.**

The artistic fiction is destroyed in much the same way that Winnicott describes the transition from 'relating' to 'using' (*Playing*, chap.6), arguing that in play, the external object only retains value if it survives the transitional process from being alive (a referent to, and interpolation within, the subject's ontology) to being dead (an entirely external object in the real or factual or natural world). Winnicott is therefore suggesting the absolute importance of the need to recognize the terms in the dichotomy and the dichotomy itself, but, upon recognizing it, reconfigure it to invoke the transitional space in which its terms coexist in mutual reflexivity or as "reflexions" in the same model. In other words: the subject needs an object to act as a referent against which to assess, confirm or measure itself; without the referent the object world can be said to have collapsed into one of pure subjectivity:

This thing that there is between relating and use is the subject's placing of the object outside the area of the subject's omnipotent control; that is, the subject's perception of the object as an external phenomenon, not as a projective entity, in fact recognition of it as an entity in its own right (*Playing* 120).

It is through this formulation that Winnicott illuminates what I consider the most important aspect of transitional phenomena: that there can be agency and utility in the process of creative-destruction and the reciprocal relationship between the subject and object/object-relating, which is what occurs in play. And it is play that underpins our nature. Indeed, Winnicott regarded his very profession, psychotherapy, as the 'the overlap of two areas of playing' that occurred between the

---

<sup>59</sup> Kendall L. Walton provides an extensive treatise on this function of object-relations by transitioning from 'objects' to 'props' in an exploration of games of make-believe in *Mimesis as Make-Believe: On the Foundations of the Representational Arts* (1990). He maintains that early symbolic play and the use of props – 'generators or fictional truths' (38) – lays the foundation for our ability to appreciate cultural items such as novels and works of art.

patient and the therapist (Winnicott, PR 51). Of course, this 'overlap' speaks to the liminality of what occurs in the transitional spaces of play. In short, Winnicott's model frames the subject-object dichotomy on the paradoxical conceit of creative-destruction: the destruction of one's magical control during the maturational development of an understanding that there exists without 'me' a world that is 'not me'. Conversely, this destruction begets creativity, because, once the omnipotence of a pure subjectivity is destroyed, and an external world ratified thereby, a new subjectivity is created, one that is aware of the world at large, of the world of objects. Those objects can be utilized as desired, whether physically or metaphysically; once the object survives its destruction (its collapse into hallucination) it can be understood as relational to 'me', and not as a projection of myself; and each new meeting with an object that is 'not me' creates the transitional space in which that object presents itself with the possibility of being introjected within subjectivity, creating it anew each time. This is play.

We can think of this in literary terms by considering the literal material quality of a novel. A novel is a material thing; it has permanence because as an object comprised of text that does not change, with a narrative order that does not change, as far as an 'external object' is concerned, the novel exists outside of my magical control. Every time I come to it is the same material object. However, when reading the novel, I am exerting some aspect of control over it, which is to say that I approach the text from a subjective point and position in time and relate to it from that understanding, parsing it with my 'interpretation'. My interpretation is a *de facto* thing in the material world; assuming I do not entirely absorb the novel – such that it becomes the perfect, hallucinatory object of Winnicott's nightmares – then it retains its external-to-me essence and I can take its narrative, and whatever its narrative says to me, as a material reference point in the world at large. If I so choose I can consign it to the external world as a point of public record with all of its attendant historicity and return to it each time knowing that 'it' is the narrative of the novel, because the novel has not changed; it survived. If I follow Kuspit's advice to keep the novel in play and return to it however, I have imbued it with a new potential, despite its material fact. The novel's material has not changed; it is constituted of the same literal text as it was on my previous encounter with it, but what *has* changed is my subjectivity in relation to it – I am a different subject from that point and position in time when I first came to it and am different having read it (however you choose to accept that that difference is irrelevant). As such, when I approach the novel anew, it transitions from the material object of my past point of reference to one of mutability, because there is the potential within it that I can see it differently. It is a transitional object because it is always 'in play' with the materiality and mutability of the world.

**NOT ME: REMEMBER.**

*That is why I am here*

*To be seen by someone else*

This is *Playing and Reality*'s pivotal contribution as it establishes a theory vital to the understanding of our maturational development in infancy, through childhood, and beyond. Through transitional phenomena play is revealed to be central to the liminal tensions of being in the world. Transitional phenomena express the processes of 'relating inner and outer reality' (15) through the spaces or objects that offer relief from this strain by operating as the interstitial phenomena of inner and outer reality. In this Winnicott establishes how dichotomies of 'self-other' and 'subject-object' are constituted through the paradox of creative-destruction; that 'play' is at the very heart of ontology, mind and body.

*To matter*

To conclude, I contend that Winnicott's transitional phenomena clearly provide a coherent model for Boudreau and Fuks' concept of the 'relational space' – the space in which the medical humanities can address the strain that exists between its own dichotomies of 'art' and 'science', 'humanism' and 'scientism'. So where Winnicott coins the 'transitional space' as the area in which play occurs, so we can draw a connection between what Boudreau and Fuks champion in their call for a new path and means to learning and from which we can conceive of a medical practice comprised of the relational interplay of humanities and sciences, which is clearly not to denigrate the pertinence of science in favor of the humanities, but rather the sufficiency of the natural sciences as the sum total of what is required in the medical encounter. By embracing this paradoxical interplay, we can establish a better medicine, driven by:

[K]nowledge that is idiographic as well as nomothetic and is enriched by the language of the human sciences. Knowledge of persons as well as personhood is needed for the medical student and the practicing physician to develop optimally his or her persona as a *phronimos* (Boudreau and Fuks 334).

Authors Davis and Wallbridge reflect on this Winnicottian space as the 'potential space' (63–66), as it consists of a relational sphere of common ground; a space that offers the potential for communication through mutuality-of-experience, or mutability-in-experience. We can define this process more acutely as a praxis of intersubjectivity. Their work offers scope for the author-reader dyad as it grounded in the principle that it 'is impossible to discuss human nature free from the subjectivity of the author and reader' (ix). What is fundamental to this theory is that the language object is understood as a transitional phenomenon that can be both material and mutable. That is: it can adhere to a very definitive and affective idea of the "signified" through which some space of

certainty – or material fact – is expressed in the not-me world in order for communication to begin at all. For example, we can between us can agree that the color red signifies “danger” that can be communicated as a material real fact of the world, and which affects us as accordingly, our behavior, our impulses... but we can also push beyond this agreement and say that red signifies “anger,” and “passion” and so on and so on... This is the paradoxical quality of language objects being material and mutable and is precisely analogous to Winnicott's exploration of the change in a subject's relating to an object to its using an object. As we saw, he describes it as the subject “destroying” the object, which destruction occurs because the object has moved beyond the transitional space and is established as an object in the entirely external not-me world. Crucially however, if the object does survive this destruction, it is able to be reincorporated into the subject's personal pattern, to transition back into the recursive relating-to/using process that is an essential part of play.

*To make myself matter*

What I want to formulate in accordance with Fink and Winnicott's philosophies of play is the consideration of how methods of play might occur with purpose in the transitional spaces created by writers, and which are realized in the form of ludic literature. I want to transgress what Fink sees as “perverted forms of play” and include in my formulations what he has abjected. I want to provide a fuller articulation of the ways in which play is integral to our ontological being according to Winnicott's placing primacy on the playful transitions that occur in us in our maturational development, and which are constituted by and through play, to argue that playing is integral to our being *of* the universe and must, therefore, be an integral component of our medical practice. Such will become evident in the following efforts to express my story and the methods of material and mutable artistic play from the canon of “Sick Literature”.

*I am ready to be seen*

**HELP: [FROM ANOTHER SPACE ENTIRELY] THIS IS A CALL FOR ROSS. ROSS OWENS. YOU ARE READY. THE NOT-YET-A-DOCTOR WILL SEE YOU NOW. PLEASE GO STRAIGHT IN ...OH AND DO HELP YOURSELF TO ANY OF THE READING MATERIALS**

*I was hoping you would say that. That much is clear. It is time to tell my story. I am ready to be seen.*

## The Beginning of His Story

Earlier I introduced the idea that my thesis will advance a canon of “Sick Literature” as an intervention and curative to a ‘sickness’ in Western medicine that disregards the patient as a whole person because, according to the tenets of medical humanism *qua* narrative medicine, it cannot attend to its patients’ stories. I proposed that the ludic fictions of Kathy Acker and David Foster Wallace provide evidence of this sickness by reflecting the orthodoxy by which patients are medically instituted as ideal objects, rather than individual subjects. This evidence is framed in accord with Foucault’s notion of the medical gaze and in my literary analyses I will demonstrate how we can see the orthodoxy of medical institutions at work; I will show that our bodies and psyches are efficiently and effectively constructed in the medical encounter; molded, manipulated, controlled and coerced by the instituted practices of medicine and its practitioners. Whether by surgery, drugs, technologies, or techniques deployed in medical spaces – to borrow from Bishop – my critical engagements will reflect the extant and so-called ‘curative’ model of the medical humanities, a view that misapprehends and undermines the value of ‘the arts’ as merely a ‘compensatory mechanism’ (‘Rejecting Medical Humanism’ 16) for the mechanical thinking of ‘scientism’ that dominates Western medicine. At the forefront of this model, it is necessary to demonstrate how “Sick Literature” adheres to the medical orthodoxies described by medical humanists as the ‘sickness’ that is in need of a cure and which – in line with the tenets of narrative medicine – emerges from the fiction as the reification of patients’ stories in the medical encounter. This presents as the extant ‘narrative order’ of medical humanism, which maintains the ‘additive’ status quo by determining – a priori – what ‘scientism’ permits to contribute to medical discourse.

As evident from the readings of Bleakley, Charon, Miles, Woods et al. a medical praxis for the whole person cannot begin by adhering to the status quo; to pursue a remedy to medicine’s ‘additive’ malady whilst maintaining the orthodox discourses that oppose epistemologies of ‘the arts’ and ‘the sciences’ ensures the continuation of that discordant mode of thinking. We can see this in its dichotomic analogues – on whatever side of the divide one stands, there is ‘the other,’ a realm of distinction that is definitively ‘abjected’ or ‘denied’ or ‘outside’, and ne’er the twain shall meet. Furthermore, because these are oppositional terms, whatever is instituted at the poles of ‘art’ and ‘science’ or ‘humanism’ and ‘scientism’ exerts primacy over the domain for which it is a metonym, which primacy is maintained from a position of hierarchical, relational power.<sup>60</sup> Having established this narrative order of things, I will propose an alternative to the ‘curative’ view; I will explain how

---

<sup>60</sup> This idea of the constituted subject and the constituting subject – the ‘empirico-transcendental doublet’ – is more clearly articulated by Foucault in *The Order of Things*, (chap.9), and Althusser and Balibar (36).



the ludic fictions of Kathy Acker and David Foster Wallace offer a model of the ‘integrated’ concept of medical humanities, which transitions from an extant “order” to one of “disorder” and allows the texts a ‘mystical’ depth that is always in play. This is in answer to the medically humanist need to reconfigure the dichotomic and dualistic prison of ‘art’ versus ‘science’ and ‘humanism’ versus ‘scientism’. Instead, it will confirm that “Sick Literature” is a transitional phenomenon that deconstructs and democratizes the parameters by which medicine institutes its orthodoxies and constructs its patients as medical objects by providing a model of intersubjective praxis through which the medical imperative to treat the whole person can be reified.

*It is time to tell my story.*

That our medicine is broken is not this thesis’ original contribution to knowledge. That assertion is informed by the field of medical humanities, which – as I believe you’ve been forewarned – argues that Western medicine is undermined by its failure to democratize the processes by which it produces and sustains its epistemological orthodoxies. To explicate this more fully we can start with an examination of physical spaces in the medical encounter, which institute medical objectivity *qua* ‘truth’ through the person of the medical practitioner, the expert in their field:

Doctors tend to enter the arenas of their profession’s practice with a brisk good cheer that they have to then stop and try to mute a bit when the arena they’re entering is a hospital’s fifth floor, a psych ward, where brisk good cheer would amount to a kind of gloating (Wallace, *Infinite Jest* 68).

So begins one of *Infinite Jest*’s (2006 [1996]) earliest sections.<sup>61</sup> It introduces the novel’s first examination of space in the medical institution proper, which, in a few brisk paragraphs, hints at some of the constraints inherent to the institution of medicine and how its ‘arenas’ prohibit efforts towards a more democratic medical practice. It illustrates how institutions prescribe the expectations carried into patient encounters by presenting the reader with a general truth about the structure of institutional constructs: they adhere to a particular set of rules or codes of practice to advance a specific teleology, or with an intended outcome. The intended outcome is something like a “return to health” or a “return to wellness”. To construct this thesis along its literary lines, I have argued that we can state this position as the “return to the narrative order” of one’s existence. The many strands of this teleological bent are imprinted upon both practitioner and patient and Winnicott’s model provides another crucial insight into play’s relation to the clinical setting, which can be taken from its reliance on trust. Winnicott has it that play ‘implies trust, and belongs to the potential space between (what was at first) baby and mother-figure [caretaker], with the baby in a state of near-absolute dependence, and the mother-figure’s adaptive function taken for granted by

---

<sup>61</sup> Hereafter referred to in-citation as ‘IJ’.

the baby' (*Playing* 69); it is clear from this that the practitioner-patient relationship can be framed as operating on similar lines, with the patient having near-absolute dependence on the adaptive function of the clinician in meeting the need to return to the narrative order of their 'healthy' life.

Besides the obvious fact this episode is a literal medical encounter, we can see the figurative impositions of the medical institution in how Wallace represents the position of the medical professional. 'Doctors', in accordance with the Hippocratic imperative to "do no harm", must 'mute' their behavior with respect to patients who might be ill-served by 'good cheer'. The implication is that disease, sickness, illness – all is necessarily 'bad' and being 'bad' is akin to a disordering of the patient's 'good' life such that a return to the narrative order of 'wellness' is the only solution:

And this is why a hospital M.D. [...] approaches any psych patient under his care with a professional manner somewhere between bland and deep, a distant but sincere concern that's divided evenly between the patient's subjective discomfort and the hard facts of the case (*JJ* 68)

Confirming the point here, in less than fifty words, Wallace elicits the foundational concerns of medical humanism in relation to the sickness of Western medicine. He presents the core of my encounter with 'The Clinic': that medical spaces institute a necessary – because 'professional' – division between the medical practitioner and the patient, which is marked in the 'psych ward' by a distribution of concern between the person in 'subjective discomfort' and the medical objects expressed as the 'hard facts of the case'. Wallace asserts that this distribution is 'divided evenly' and it is not for me to doubt the sincerity of any medical practitioner's desire to help someone in need. However, I would question whether this distribution of concern can ever be 'even' within the confines of institutionalized medicine as described above because the alleviation of the patient's discomfort is contingent on the doctor's ability to determine such facts as to identify the cause of the discomfort and only then find themselves in a position to help. The hard facts of the case have to be privileged in order to ascertain by what measure the patient's discomfort can be alleviated. It is as if to say, "I can't help you unless you tell me what's wrong" and the corollary of such is to countenance that if all the power and practices of medicine can find nothing wrong, and there are no hard facts of the case... Well then, "I'm sorry. There's nothing I can do for you," because your discomfort is not a medically objective, hard fact, it is "only" subjective. So what are the 'hard facts of the case'?

*"Ever since I can remember, I have wanted to kill myself, although it may be more accurate to say: I have wanted not to be alive. We call this 'suicidal ideation'."*<sup>62</sup>

---

<sup>62</sup> According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is the standard reference for Western clinical practice in the mental health field, 'suicidal ideation' is not recognized as a

Every suicide is a tragedy ... Every single life lost to suicide is one too many. The way forward is to act together, and the time to act is now. I call upon all stakeholders to make suicide prevention an imperative (Saxena et al. 2)

This quotation is taken from the director general of the World Health Organization (WHO), Dr. Margaret Chan, from the “Foreword” of that institution’s *Preventing Suicide: A Global Imperative* (2014). Effectively it represents the hard facts of the medical orthodoxy on suicide: prevention is imperative. Suicide cannot be countenanced. That this is the instituted position might be obvious given the ethical and moral obligations required of an international body for health and wellbeing, but while this is an ethically attenuated stance, it is important to state that trends in the 1990s and 2000s suggested 20/100,000 males and 10/100,000 females committed suicide per year – the numbers increasing among the young and elderly alike.<sup>63</sup> At the same time, socio-cultural drives to relax the moral and social prohibitions on suicide resulted in an acceptance that the suicidal act is an occasionally ‘rational’ one in the face of adversity. Often this is driven by considerations of euthanasia and the contexts of mental and physical impairments and ageing.

Despite aspects of progress in this arena and legislative change in relation to euthanasia (Netherlands, Belgium, Luxembourg, Colombia, and Canada) and “Physician-Assisted Suicide” (PAS) it is abundantly evident that no quarter should be given to the idea that suicide is acceptable beyond those exceptions limited to voluntary cases in which the patient is considered mentally competent and explicitly requests to die (Emanuel et al.).<sup>64</sup>

In the U.S., data suggests that public attitudes to euthanasia and PAS are consistently more favorable than among physicians. Taking just Oregon’s example, in accordance with U.S. law, Oregon’s Death with Dignity Act, allows terminally ill residents to obtain prescription medication

---

disorder but as a comorbid factor in other mental disorders. ‘Suicidal Behavior Disorder’ requires the essential manifestation or act of an attempted suicide (American Psychiatric Association 801–06). Ross’ thesis is not going to address the multitude of highly problematic issues related to, or in the practice of, diagnosing mental disorders, which are acknowledged in each section of the manual itself (e.g. “Preface”, “Cautionary Statement for Forensic Use of DSM-5”). Nor is Ross’ thesis going to provide an analysis of the wealth of scholarship that problematizes the DSM (Ben-Zeev et al.; Uchtenhagen; Bolton; Earle) and diagnoses more generally. It is taken as given that the DSM is a product – or object – that institutes the very epistemology of ‘scientism’ I forewarned you about, above, and which the field of medical humanities is an attempt to redress. This is to be understood at the outset. It is one of the rules of the game.

<sup>63</sup> The data provided in *Preventing Suicide*, which was reviewed in 2017 (‘Suicide’), suggests close to 800 000 people die due to suicide every year and that suicide is the second leading cause of death among 15–29-year-olds. It is worth noting the caveat that the unreliability of mortality data from a number of the 172 member states of the WHO; the manner in which death is recorded by coroner for example, and the simple fact that suicide is still illegal in a number of states, means that figures could well be significantly higher.

<sup>64</sup> The contributions of E.J. Emanuel prove a significant resource on the subject of both euthanasia and PAS in the U.S., providing meta-analyses of the legislation and provision across its states as well as abundant scholarship on the ethics of the matter. See: Emanuel, “Benefits of Legalization”; Emanuel, “Euthanasia”; Slutsman et al.; Agrawal and Emanuel; Hampson and Emanuel.

from their physicians for self-administered lethal doses. However, this does not constitute 'suicide' according to the institutions of law and medicine:

PAS occurs when lethal drugs are prescribed or supplied by the physician at the patient's request and self-administered by the patient with the aim of ending his or her life. In the United States there is debate as to whether the appropriate term for this practice is PAS, physician-assisted death, or physician aid-in-dying (Emanuel et al. 80).

If this demonstrates anything it is that even at the lexical level, the language-object 'suicide' is to be prevented as an imperative. The DWDA prohibits euthanasia (where a physician or other person directly administers a medication to end a life) and in order to request PAS the person must be 18, a resident of Oregon, diagnosed with a terminal illness that will lead to death in six months, and declared medically "Capable", which is defined by an ability to make and communicate health care decisions for oneself. This data supports the view that attitudes towards euthanasia and PAS – towards suicide – are largely contingent on the perception of patient's prognosis, with the majority of those surveyed privileging 'no chance of recovery' as a determining factor in their support for the procedure, and even then, the samples show that support represents between 50%-70 of the sample size. There are clearly multiple factors at play in the collection of this data and the framing of the survey questions is a clear example of the efficacy such data sets. However, none of the data refutes my claim that suicide is framed in accordance with the medical orthodoxy that life is precious, and can be countenanced only in accordance with predetermined narratives; narratives that have been configured by the accumulation of multiple sociocultural factors which have in turn been transposed into a medical ideology and language that configures medicine according to its stated teleology.

Emile Durkheim was among the first to encourage suicide to be understood in consideration of its sociological factors as well as its physiological factors. His seminal work, *Suicide: A Study in Sociology* (2005 [1952]), suggested suicide be grouped in three main categories, 'egoistic', 'altruistic', and 'anomic' although the 'egoistic' category might also be said to include a sociological 'fatalism' that requires its own category. The aim was to explain why rates of suicide were higher in some groups and why these rates were varied. 'Egoistic' suicide was a consequence of the deterioration of social and familial bonds. It occurred when an individual was detached from others in their community; among individuals not sufficiently tied to social groups or had little social support and therefore tended to commit suicide. The bonds that normally integrated individuals into the group had weakened, leading to a breakdown in social integration (105–74). 'Altruistic' suicide was taken to occur among tightly knit groups when they came under severe threat; in such situations, members were prepared to die in the group's defense. Here individuals were integrated into the social group to such a degree that they lost sight of their own individuality; they were willing to sacrifice

themselves to the group's interests, even if that sacrifice was their own life (175-200). 'Anomic' suicide reflected disillusionment and disappointment – a sense of 'normlessness' that emerged when the narrative order in society completely broke down; he supposed the lack of norms and restrictions on behavior would engender suicidal behavior (201-239). 'Fatalistic' suicide occurred within tightly knit groups whose members sought escape but could not attain it. This is positioned as a rare phenomenon in his sociology – including individuals with over-regulated, unrewarding, and painful lives; enslaved people, for example, might commit suicide in order to demonstrate control over their lives that has been denied them (239). Problems highlighted in evaluating Durkheim's work include concern that its categorizations struggle to elucidate why only some members of a group commit suicide even while arguing that all in a social group are subjected to same factors. Effectively: why did some succumb to suicidal pressures and not others? Durkheim's classifications also tend to overlap, meaning 'correct' identification and differentiation between classes of suicide was difficult (Taylor; British Centre for Durkheimian Studies).

Ron Brown's *The Art of Suicide* (2001) provides a comprehensive survey and explication of the multiple factors to have influenced our thinking in this regard and examines these through societies cultural artifacts and artworks.<sup>65</sup> The panoply Brown presents sees suicide in terms 'beautiful, heroic [and] bold' as well as 'ugly [and] criminally cowardly' (10). In summarizing though, the impetus for these variform portrayals comes down to two elements: Church and State. For the Church, life is sacrosanct and so suicide represents the ultimate act of refutation of divine will; the most heinous of sins (and religious implications are among the most common factors cited in opposition to euthanasia and PAS, not least the suicidal act alone). For the State the issue is more typically utilitarian and concerns the social contract and economic capital for which you have a responsibility as a member of society. Brown traces this thread to David Hume in whose philosophical writings Brown reads 'an egoistic aspect where obligation to God and to society impacts on Enlightenment deistic and social thinking, where suicide becomes associated with ideas of hopelessness' (127). This gave rise to the notion that suicide was an act of social rebellion, fueled by the impacting role of governmental and societal regulation, the birth of the clinic and its transfiguration of the body and health into objects of the medical gaze. As a consequence, in part, the act of suicide was configured as a challenge to the hegemony of the state; a direct contrivance of family values and the social institution (Althusser).

---

<sup>65</sup> For additional research on the arts and humanities import in creating suicidal narratives, how the writing of history has played a role in the making of modern suicide, and how it can have its role "unmaking" it, see: Marsh; Petrov

The fact remains that from this we observe how our institutions – academe, medical, religious, state – each exerts power in the medical encounter. The prescribing physician and a consulting physician are instituted as the arbiters of the patient's mental capabilities (Callahan). If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination. A cursory glance at Oregon's most recent statistical data reveals that of the 143 patients seeking DWDA death in 2017, only 2 were under the age of 44 – and yet worldwide statistics show that suicide is most prevalent among men below this age. On an ethical basis, from this, there is evidently a significant gap between the numbers of people who have medical provision of care in their 'suicidal act' and the numbers of people committing suicide. Where can we account for this gap in our treatment of suicide in the medical encounter; how does the medical institution account for patients who suicidally ideate?

There is much debate concerning performing euthanasia, PAS, or other life-ending procedures on patients with dementia or chronic mental illness, who are minors, who are just "tired of life," or who are socioeconomically vulnerable. In Oregon and Washington state these cases would be illegal and there are no data on such cases' (Emanuel et al. 87).

This is telling because as was evident even from the small extract from *Infinite Jest* [above], it is clear that real medical encounter privileges the institution and its assumed expertise; the patient's illness has to adhere to a pre-determined narrative with all of its corollary expected outcomes in order to be recognized. If it does not fit the narrative order, the provision of the support in the suicidal act would be 'illegal'. Furthermore:

Given that requests for euthanasia and PAS are frequently motivated by mental health considerations, such as depression and inability to engage in enjoyable activities, psychiatric evaluation might be important. In Oregon, less than 5% of patients received a psychiatric evaluation and in Washington state only 4% were referred for psychiatric evaluations (Emanuel et al. 86).

What happens to the patients who do not fit the narrative order permitted by within The Clinic; for whom a 'psychiatric evaluation' *might* be important? We can assess this by transitioning back into the medical encounter through Michel Foucault and his construct of the 'medical gaze' (*The Birth of the Clinic* 9). Foucault's thesis exposes a rupture between taxonomic and classical medicine through the mutation of the medical gaze and language. He contends that the mutation of the medical gaze was a paradigm shift in the production of medical knowledge; from an absolute nosographical value available to the clinician's eye as a surface object 'articulated exactly on the body', to knowledge produced by an emergent academe, which brought to bear on the subject-object dichotomy of the clinician and the patient its histories of disease, its burgeoning anatomical data, its institutional power – a vast multiplicity of factors and all their respective 'modulations'. In short: the surface knowledge of medical observation mutated into a logico-temporal knowledge of interpretation, or

hermeneutics. And so, to interpret the disease, the patient has to be ‘subtracted’ from the equation (1- 15).<sup>66</sup>

Exposing the rupture between taxonomic and classical medicine through the mutation of the medical gaze and language, Foucault was not simply reifying the subject-object dichotomy as the one who knows and the one who tells however; he is at pains to clarify that his ‘archaeology’ reflects an epistemic change ‘from the point of view of the rules that come into play in the very existence of such discourse’ (xiv). This, as we saw from Bleakley et al., reflects how medical practice prohibits consideration of knowledge that exists – that has been preordained to exist *a priori* – outside of medical epistemology, precisely because of the institutional restrictions inherent to the construction of that epistemology:

Kate Gompert was on Specials, which meant Suicide-Watch, which meant that the girl had at some point betrayed both Ideation and Intent, which meant she had to be watched right up close by a staffer twenty-four hours a day until the supervising M.D. called off the Specials (*IJ* 69).

Here the capitalizations in ‘Suicide-Watch’ and ‘Ideation and Intent’ reveal the institution of so-called ‘textbook’ orthodoxy that has been codified into medical practice (E. A. Thomas). These nouns have been imparted with the capital authority (Rancière, *Dissensus*) of the institution and represent the lexical representation of a series of behaviors that must be identified as symptoms of a given medical presentation. The marking of patterns of behavior in this way necessarily benefits the medical ethics of ‘best-practice’ implicit in an ideal medical ontology because it inscribes data sets of clinical trials as the determiner of efficacy and inscribes with the orthodoxy of medical truth. What it does not benefit is the nuance of the individual patient’s case. Take Wallace’s use of the word ‘betrayed’: from the perspective of the medical institution it implies an ontology of mistrust towards the patient: the patient is constructed from the position that they are concealing the truth of their illness. To ‘betray’ one’s symptoms implies that Kate Gompert is deliberately obfuscating her illness and so it falls upon the M.D. to detect the truth of the matter; once again the framing of the patient’s medical experience privileges the position of ‘expert,’ but in a way that neglects the patient’s experience, which is assumed to be deceitful from the outset – it is written into the language of the institution. In the medical encounter it is not only the practitioner who must be muted, but the patient too; a fact Wallace reinforces in his presentation of the practices instituted by staff behavior:

Staffers rotated Specials-duty every hour, ostensibly so that whoever was on duty was always fresh and keenly observant, but really because simply sitting there at the foot of

---

<sup>66</sup> For extended analyses of Foucault’s thesis in this regard, see: Scott; Machado. For specific explorations of its spatiotemporal ramifications, see: Casey; Philo.

the bed looking at somebody who was in so much psychic pain she wanted to commit suicide was incredibly depressing and boring and unpleasant, so they spread the odious duty out as thin as they possibly could, the staffers (IJ 69).

In this Wallace conveys not only how suicidal ideation endangers the vitality of the patient, but equally, the danger posed to the 'staffers' themselves, whose own vitality is threatened and 'depressed' by the patient's 'psychic pain'. We can discern a degree of satire in Wallace's presentation here as he runs the docile 'boring and unpleasant' into an excess of vitriolic hatred in 'odious duty'. This betrays a certain ironic detachment on the part of the faceless, nameless 'staffers' but we might contend that such detachment is a necessarily instituted aspect of care provision, reflecting the legitimate requirement that medical staff practice self-care; the introjection of a sort of 'gallows humour' in the face of genuine, unrelenting psychic torment. But what if we take Wallace at his word? What if we listen to his story? Is it not also possible to ask exactly what we are to make of the 'odious duty' required in a medical encounter that establishes the 'psychic pain' of a suicidal patient as 'boring'? What is lost by the ironic distancing? As a reflection of medically humanist discourse, Wallace demonstrates that what is lost is the staffers' humanity; what is lost is the care of the patient as a whole person.

Wallace makes plain that he is invested in the dichotomy between idealized and individual aspects of the patient experience by contrasting the institutional narrative prescribed by medical practice with Kate's own reporting of her experience. It is this experience that the efforts of medical humanists are – in part – attempting to reify in fields such as narrative medicine. The discontinuity between Kate's professed experience and the medical institution's record of it manifests in Wallace's playing with tropes of miscommunication. First Wallace presents the rejection of the medical diagnosis when Kate's clarifies, "'I wasn't trying to hurt myself. I was trying to kill myself. There's a difference'" (IJ 71), and latterly affirms it through repetition: "'I didn't want to especially hurt myself. Or like punish. I don't hate myself. I just wanted out. I didn't want to play anymore'" (IJ 72). The medical response to this expression is belittlement: 'The doctor asked whether she could try to explain what she felt the difference was between those two things' – there is no *actual* difference in the medical institution because its ordered to privilege only the 'return to wellness'; it cannot countenance the subject who wants to be dead. Note too, the inability of the M.D. to respond beyond the confines of instituted, or "textbook" orthodoxy, when a weighted silence is probed for clinical significance: 'The delay that preceded her reply was only marginally longer than the pause in a regular civilian conversation. The doctor had no ideas about what this observation might indicate' and the response ignored entirely: "'Do you guys see different kinds of suicides?/The resident made no attempt to ask Kate Gompert what she meant' (IJ 71).



We can this as mode of institutionalized practice by returning to the problem of diagnoses and consider further aspects of the effects of medicine's objectivism and the sickness of exchange at play in medical spaces. *Infinite Jest's* 'M.D.' first observes how 'Kate Gompert' – the patient – 'seemed both to be fighting for breath and to be breathing rapidly enough to induce hypoxia,' describing an instantaneous effort at diagnosis that dissects Kate into symptomatic behaviors, or rather, behavior that is conscripted to service a diagnosis of symptomatic behavior. Under the M.D.'s medical gaze Kate is reduced to the series of constituent or discrete medical objects of her body parts – her 'circle of arms' and 'her knees' – and, reading further, the events listed on her medical chart:

Gompert, Katherine A., 21, Newton M.A. Data-clerical in a Wellesley Hills real estate office. Fourth hospitalization in three years, all clinical depression, unipolar. One series of electro-convulsive treatments out at Newton-Wellesley Hospital two years back. On Prozac, for a short time, then Zoloft, most recently Parnate with a lithium kicker. Two previous suicide attempts, the second just this past summer. Bi-Valium discontinued two years, Xanax, discontinued one year – an admitted history of abusing prescribed meds. Depressions, unipolar, fairly classic, characterized by acute dysphoria, anxiety w/panic, diurnal listlessness/agitation patterns, Ideation w/w/o Intent. First attempt a CO-episode, garage's automobile had stalled before lethal hemotoxicity achieved. Then last year's attempt – no scarring now visible, her wrists' vascular nodes obscured by the inside of the knees she held. She continued to stare at the doorway where he'd first appeared. This latest attempt a straightforward meds O.D. Admitted via the E.R. three nights past. Two days on ventilation after a Pump & Purge. Hypertensive crisis on the second day from metabolic retox – she must have taken a hell of a lot of meds – the I.C.U. charge nurse had beeped the chaplain, so the retox must have been bed. Almost died twice this time, Katherine Ann Gompert. Third day spent on 2-West for observation, Librium reluctantly administered for a B.P. that was all over the map. Now here on 5, his present arena. B.P. stable as of the last four readings. New vitals at 1300h (IJ 69-70).

Kate is literally transcribed as the sum of discrete events that describe the previous medical encounters of her patient history, events that service the singular teleological position of what is and is not medically relevant in her construction as a suicidal patient. What is relevant in the clinic is that Kate's life is ordered according to the possibility of a narrative that presents the story of her life as the sum of diagnoses that are the objective constituents of her existence. What appears impossible in the encounter is any connection between the patient and the practitioner as human beings because there is no way of accessing a transitional space in which the suffusion of their respective inner and outer realities can occur; nothing is shared between them such that symbolic play might occur. There is no intersubjective exchange, only Kate as the medical object as she is observed and charted, and who herself, observes nothing – can recognize nothing truly external to her – but simply stares beyond the M.D., 'at the doorway' and its liminal, empty space, whilst she struggles to be heard. But also evident in these exchanges is how the institution constructs its practitioners

according to the same idealized inscriptions. Regard, for example, how the M.D.'s 'interior state was somewhere between trepidation and excitement, which manifested outwardly as a sort of blandly deep puzzled concern' (IJ 70), to see the inherent paradoxes of institutionalized modes of behavior – internal and external 'states' are in conflict, and in fact, it is the medical professional who in this instance hides the symptoms of their experience in a betrayal of symptomatic behavior.

Take, for example, the language evident in the patient history passage [above], which serves as an oppressive, inalienable figuration of the medical encounter. The phrasing is clipped and replete with abbreviations, contractions, and initialisms. The abundance of pharmacological interventions afforded brand-name recognition whilst Kate's own name is initially inverted and formalized. There is a prescribed way of doing things in the medical encounter. This demonstrates that it is not only Kate who is constructed through language in the medical encounter but accords with Foucault to show how the clinical notes are the expression of medical orthodoxy; they are its lexicon, its shorthand, and so the M.D. is constructed according to that same orthodoxy and – we might assume – the subject of his non-clinical personage denied too. Wallace even invokes this institutional framing via the doctor's physical traits; the doctor wears 'attractive but thick glasses' (IJ 72), which might seem a benign detail but within the confines of the medical institution, the glasses come to represent another mode of medically objectified inscription that alienates patients from their humanity; patients who, 'on other floors during other rotations had sometimes complained that they sometimes felt like something in a jar he was studying intently through all that thick glass' (IJ 72). A visual aid designed to enhance and restore vision here figuratively represents medicine's claim to authority and its sole capacity to see the disease. In Wallace's presentation however they reinforce a stark indication of the disjunction between doctor and patient in the medical encounter. So, Kate must be returned to wellness but that is only possible according to the rule that determines which of her behaviors is 'symptomatic', and which is 'non-symptomatic'.

There is something in Wallace's syntactical structuring here that raises doubts about just whose perspectives the reader is observing. The lack of conjunctions and phrasing in the opening lines is arrested when we reach 'Then last year's attempt –' when a literal incision in the medical jargon takes place while the M.D. looks up to observe 'no scarring now visible, her wrists' vascular nodes obscured by the inside of the knees she held.' But is this the M.D.'s or the narrator's observation – it appears to be the M.D. as 'vascular nodes' adheres to the argot employed elsewhere, but then we have: 'She continued to stare at the doorway where he'd first appeared', and thus a second observer emerges, watching both Kate and the doctor from afar... I think the confusion is deliberate here as it sustains the premise that everyone is instituted according to order by the medical encounter; Kate, the M.D. and the narrator – all are susceptible to the medical gaze, their individuality obscured and

instead objectified according to its institutional ideals. In short: there is no place for the individual in the clinic, only what is idealized by medical objectivity. See, for example, the almost omnipotent acknowledgement: 'Almost died twice this time, Katherine Ann Gompert'. This is an occluded observation from either the M.D. or the narrator, but consistent is the formalized institutional inscription of Kate's name – she is *not* 'Kate', or even 'Gompert, Katherine A.', anymore; the narrative order has it that her full name is recorded, as though marked by the attendant 'chaplain' in a litany for her death, or as on a death certificate itself.

This speaks to the medical genealogy of Foucault and we can assess its position in this exchange by returning to *The Birth of the Clinic*, in which he presents an exegesis of the dead body as the 'normative' body of medical spaces because, unlike the living body in constant flux, it offered the emerging medical academe a 'stable' template to institute its medical gaze (*The Birth of the Clinic* 127–29, 133). Ethicist and physician Jeffrey Bishop is particularly important here, reading Foucault to accuse medical orthodoxy with the view of people as machines, that it has failed to rectify that 'death thus conceived was not a static reality on which to build scientific knowledge' (*Anticipatory Corpse* 97). As a consequence of this failing, which derivations are 'nothing more than post hoc additions to the animal machine' (*Anticipatory Corpse* 97), the human organism has been constructed as a might be a temporarily animated corpses with interchangeable parts, which under the experiments, formulations, and observations of the medical gaze have created a mathesis or idealized knowledge of the body in the medical encounter:

[T]he idea of life as locomotion of nonliving matter makes death nearly impossible because the failing motion of the material of the body can be replaced by more effective machines. On the metaphysics of contemporary medicine, the body is a perpetual motion machine, potentially living forever, as long as its parts are replaced' (*Anticipatory Corpse* 97).

Thus, we can assess medical language as a kind of mathematics or 'calculus' spoken by those initiated into the space of the clinic (Foucault, *The Birth of the Clinic* 126–27). In the exchanges between the M.D. and Kate we see the false sums of its mathematics in the conflict between literal and figurative language that occur in the narrative summations of the episodes final passages. Wallace is making the point that both patient and doctor are dehumanized by the medical institution, with attempts to broker dialogic exchange doomed to failure:

The doctor was anxious that his failure to have any idea what the girl was referring to would betray itself and accentuate her feelings of loneliness and psychic pain. Classic unipolars were usually tormented by the conviction that no one else could hear or understand them when they tried to communicate' (IJ 75).

For Kate Gompert, the effect of the environment and processes of her treatment expose even the attempt towards patient-centered care as an impossible sum. For her the 'room without windows and with cages over the lightbulbs and no lock on the toilet door' (IJ 72) serves only to reinforce her position as medical object. This, in addition to the contrast Wallace creates between Kate's self-reporting and the doctor's clinical observations, deny the patient her subjectivity, rather than validating it, which instead makes a prison of her experience, much as the ward itself reflects a prison. This is the reason Kate 'can't get enough outside it [the feeling] to call it anything' (IJ 73), the medical institution denies Kate the space into which she might expel or frame her 'feeling' as something external, something other than herself, and instead simply constitutes her *in toto* as the 'feeling' or illness and which – as a matter of institutional orthodoxy – requires

[A] kind of bland compassion, the expression of someone who was compassionate but was not, of course, feeling what she was feeling and who honored her subjective feelings by not even trying to pretend that he was. Sharing them (IJ 74).

The experience is borne out again when we reach the conclusion of the scene as the 'classically' ordered Kate is forced to clarify herself once more. Responding to the doctor's suggestion that drugs may play a part in her suicidal ideation, she states: "'Not *drugs*,' [...] Stopping' (IJ 76). In the medical encounter, in spite of Kate's absolute clarification, communication, understanding, an intersubjective exchange – none are possible, and the observation of Kate's subsequent behavior reinforces the fact:

She now went through a series of expressions that made it clinically impossible for the doctor to determine whether or not she was entirely sincere. She looked either pained or trying to somehow express hilarity' (IJ 76).

Nothing adds-up in this scene, there is no mathematical solution to Kate's problem, whereas Wallace's employment of 'clinically impossible' suggests it would be possible to determine her sincerity were it not for the constraints of the medical gaze, a gaze that is privileged as the arbiter of objective truth and yet cannot discern between pain and pleasure because the institution requires an inhumane [mathematically impossible] objectivity in its practitioners in order to negate the interrelational and interpersonal exchange attendant to the situation and instead construct the patient as a sick object whose experience is delimited into symptomatic and non-symptomatic behavior: 'None of the clinical literature the doctor had read for his psych rotation suggested any relation between unipolar episodes and withdrawal from cannabinoids' (IJ 78). To conclude, as Kate's despair reaches its nadir, we see the doctor lost in his own thoughts and post-assessment

practices, inured to Kate's pain-experience as she breaks down, 'weeping for real' (IJ 78), and where Wallace ends the episode.<sup>67</sup>

The episode in its entirety then is a critical representation of medical practice and the failings of institutional orthodoxy. It demonstrates how such orthodoxies ensure the failure of medicine to recognize its subjects. As a case study it provokes the impetus among medical humanists to create a patient-centered medicine driven by the advocacy of patients' self-reporting but equally reveals how such a project is doomed unless the extant orthodoxies of medical practice are redrawn to incorporate consideration of what it denies by its very creation (Stewart et al.). At its most elementary level it offers the reader the absolute separation between the subjectivities of the practitioner and the patient: the doctor whose subjectivity is so 'muted' by the institutions of medicine that he can only act in orderly accordance with professional practice and the dogmatics of diagnosis, and the isolated patient, Kate, who is so 'totally inside' (IJ 78) her subjectivity that she can find no space of escape from it. In the mode of broad relational models then, it is clearly apparent that the medical encounter enacts a medical practice in line with discourses in medical humanism that present its ambitions in relation to a dichotomy between humanism and scientism, or "art" versus "science". In this analysis I have privileged the dichotomy in terms of 'subject' and 'object' because those terms foreground the opposition of an individual medical ontology against an idealized medical ontology and the death of the medical subject, which in the case of a suicidal patient is literal as well as figurative.

*"It's difficult to identify precisely when my suicidal ideation began but the earliest memory I can recall concerns my struggling with the meaning of a poem I read from a collection called Golden Apples (1985), which was bought for me when my family moved from London to Plymouth, before I was five years old. The poem was called "Sioux Eye Sighed." I had to look up the word "Sioux" and its pronunciation, and in so doing came to understand the punning homophone of the poem's title. I had heard the word 'suicide' before, I may even have read it before then, but so in order to understand what the poem meant, I had to first learn what the meaning of 'suicide' was. I did, and it all made sense.*

*The correlation between that word and what I was feeling took me perhaps a little longer to fully comprehend, but certainly by the time I was in junior school, I was conscious of feeling alone, in pain, and sad, almost every day of my life; and I knew I didn't want to live, feeling like that because*

---

<sup>67</sup> Pain research is an extensive and highly contested field. I will explore certain aspects of pain in more detail in the main body of this thesis, including reference to Elaine Scarry's seminal text, *The Body In Pain*, but for a critical insight into some of the opposing positions on the relationship between psyche, soma and pain, see: Douglas; Olivier; Gereau IV et al.

*Part of the feeling is being like willing to do anything to make it go away. Understand that, Anything. Do you understand? It's not wanting to hurt myself it's wanting to not hurt.*"<sup>6869</sup>

In medical ethics this position rests on the individual's autonomy and the 'right' to die as a natural corollary to the 'right' to live, and the rational assessment of one's sociocultural and economic utility, a factor which is problematized by the aetiology of suicide, which includes consideration of mental health *qua* competency (Clarke; Hewitt). Among the more influential perspectives on the 'problem' of suicide then, is the field of psychiatry and its concept of mental illness. Generally, studies suggest a correlation between mental ill-health and suicide, which is to say that, in accordance with the DSM-V, 'most people who commit suicide have a disturbance of mental functioning' (Clarke 457), commonly this 'disturbance' takes the form of addiction, depression, or psychosis, and combinations thereof.

*"From the age of about nine or ten and throughout my teens I came to read a lot of material about loneliness and pain and sadness. I don't think I sought it out necessarily, but it was there all the same; in the novels I read, and the music I listened to and the television and films I watched; I saw it in the relationship between my parents, often. I guess I was aware of, and was immersed, in all sorts of narrative sadness and subjects in pain. And in that immersion, I could glimpse something of the sort in myself, maybe not quite so invisible, perhaps, but unspeakable.*

*How I felt was not something I knew to express, or how to express, exactly. I couldn't ever speak of it. But I learned to sing when I was a toddler, and in singing I found something that could express the feeling, literally express it I mean, a cathartic express that let it out. I have sung ever since and to this day find lines from songs appearing in my mind that speak what it is I feel; back then I would sing about the house in hope of telling what I was feeling because that was easier than speaking – I didn't know how to speak from myself. I did not have the words for myself, only the words of others. And I had always the feeling:*

---

<sup>68</sup> As Ross spoke these words it reminded me of something – as like a quote from something I had heard before, or maybe read long ago, in a different time.

<sup>69</sup> In his exceptional *The Noonday Demon* (2002), Andrew Solomon is striking in his articulation of the difference between wanting to be dead, and wanting to kill yourself:

In depression, many want to die, to undertake the active change from where they are, to be freed from the affliction of consciousness. To want to kill yourself however, requires a whole extra level of passion and a certain directed violence (244).

The history and direction of violence in our narratives of suicide is described in detail in Brown's *The Art of Suicide*, in which it is distinguished along gender[ed] conventions, as will be addressed in due time, below.

*All over. My head, throat, butt. In my stomach. It is all over everywhere. I don't know what I could call it. It is like I can't get enough outside it to call it anything.*<sup>70</sup>

Hopelessness, helplessness, ambivalence, hostility, and loss of control, as well as the cognitive processes that distort, exaggerate, extrapolate and exacerbate such feelings – all are commonly recorded traits in suicidal people, as is the co-occurrence of disrupted social relations (McGuffin et al.; Mirkovic et al.). When framed this way, the 'pattern of hopelessness, pessimism, a reduced ability to consider possible solutions, and perceived reduced social support' (457), it seems no great leap to see the correlation between suicide and the aetiologies of depression that Bullmore's research for *The Inflamed Mind* presents. The medical orthodoxy has it that the majority of people attempting suicide are suffering from a mood disorder (Antypa et al.), although the research remains inconclusive with regard to the genotypic and phenotypic factors at play (Zai, de Luca, et al.; Zai, Manchia, et al.), as is the case in relation to brain function (Nock et al.; Ho et al.) and the neurobiological factors at play in figurations of the depressed-suicidal mind (Zhang and Li; Reardon; Ludwig et al.). The short of it is: "people who often feel bad often want to kill themselves". One of the major concerns raised about the APA's classifications is that diagnoses of – for example – bipolar disorder (American Psychiatric Association 123-154) disregard or reduce bodily symptoms to the status of co-morbidity (Bullmore 146), which means simply incidental, non-causal occurrences of simultaneous medical conditions.

*"When I was twenty, as an undergraduate in drama at Exeter University, I sought help from a counsellor because my suicidal ideation was becoming more acute and what I understood as 'my moods', harder to overcome. At the time, I reasoned, my worsening feelings and more prolonged periods of sadness were the result of mourning the death of my dad, who had died in front of me, from a sudden heart attack, when I was fifteen. But, following a referral and some expert psychiatric consultation, when I was twenty-one, I was diagnosed with manic depression, or as it is classified today, bipolar disorder."*

If we take from the DSM-V the view that suicidal ideation is a comorbid factor in mental disorders rather than a pathology in its own right then in the case of suicidal patients, the narrative order of their medically instituted condition does not require an extant consideration of 'death' being an outcome of their condition. There is no causal relationship then, only an incidental one. Therefore, the spaces of the medical encounter construct suicidal patients only in relation to the expected (or known) outcomes of their textbook 'sickness' and in accord with the aforementioned teleological bent of an assumed return to wellness. At the least we could say "the management of the condition"

---

<sup>70</sup> It was the word 'butt' that fired my memory – the fragment of an American idiolect that meant I knew at once from where he had taken these expressions. It was a novel, called *Infinite Jest* (78; 73).

such that a sense of life according to an ordered narrative is achievable. This is a significant problem if diagnoses of bipolar disorder neglect the 'bodily' symptoms that are merely co-morbid and *never* causal; this is a literal excision of the patient's body from the medical encounter that clearly negates their whole person.

As I have shown from Bullmore and Fornaro et al., this orthodoxy maintains the classical understanding of the human organism modelled after Cartesian dualism and the mind-body problem. Today however, our models have largely come full circle. For many years the link between the 'bodily' aetiologies of depression would have been disregarded as a matter of course, because, as we saw from our previous encounter with Bullmore, until relatively recently Western medical orthodoxy worked according to its separation from the mind: the blood-brain barrier was the 'Berlin Wall' through which none could pass (chap.5). Bullmore's work explains how this is a falsehood, that there is no separation in absolute terms. Today science provides convincing enough evidence to investigate whether there is a causal link between the immune system and depression and following extensive research there is strong evidence to consider that inflammation caused by the immune system's response to perceived threats, may contribute and even explain entirely, instances of acute and chronic depression (166-174).

On the issue of co-morbidity for example, Bullmore's call to arms is to consider how that the causal arrow could flow both ways, which allows to see with full-clarity the insidious nature of depression as a dualistic concept in its very construction; it is a duopoly that inflames both 'psychological' and 'physiological' spheres. He frames this as the causal arrows of stress, depression, and the immune system operating in a 'circular' relationship (156), which, if we return to Winnicott's model of transitional phenomena, reflects the same coexistence and mutual reflexivity of "reflexions" in a totalizing model. For Bullmore this is a substantive enough reason to

[M]ove on from the old polarized view of depression as all in the mind or all in the brain to see it as rooted also in the body; to see depression instead as a response of the whole organism or human self to the challenges of survival in a hostile world' (18).

*"When I was diagnosed with bipolar disorder I felt and unbridled relief, and reassured, as though the source of pain and shame that felt uniquely, exclusively mine, was not, in fact, mine alone. What I had always conceived as an ineluctable presence in the innate, subjective state of my being was at last recognizable; it was representable; it was a matter of fact and nameable, and to name it was enabling. It enabled me to explain wild fluctuations in 'my moods'; it was in accord with my tendency to self-isolate and withdraw when overwhelmed and it expiated a lifetime of self-doubt and self-destruction that were the products of spiraling from major depressive episodes to episodes of mania*



*and hypomania; it fit. Bipolarism was a name that I could use to communicate the experience of life as I knew it. There was a reason for my feelings: I was sick; I had an illness; I was disordered.”*

In line with Wallace, through Bullmore and Foucault, I see clear evidence of medical orthodoxy operating to a model that enshrines institutional or structural bias as a consequence of its inability, or disinclination, to deconstruct its epistemological bases in light of theoretical and practical progress. What is at stake for the APA in its resistance to a non-dualistic body map? Does it risk undermining its position by allowing that physical symptoms might indicate and even cause depression? The work still needs to be done but I believe we could rather extend the aphoristic stance that a disease of the mind is, by design, solely “of the mind” and instead reconceive the dualist abstraction of human organism into mind and body by means of Winnicott’s transitional phenomena, in which immeasurable, mutable, metaphysical components of the subjective mind interrelate with the measurable, material, physical components of mind *and* body. Not a reification of mind-body dualism then, but a duopoly or “multi-poly” that foregrounds the whole human organism and that may, in fact, provide solutions to many of the problems raised by medical humanists over the swingeing power of medical scientism in both theory and practice.

My reading will return us to the urgent need for an integrated medical humanism, where the patient – brain and body – is afforded efficacy as a whole person in an interrelational model of intersubjective praxis; it will foreground the urgent need to recognize how the practitioner and the patient are inextricably bound together and that each medical encounter requires a unique interrelational exchange between twinned subjects, which utilizes the benefits of our extant, materially ordered medical orthodoxy and its idealized epistemology in co-creation with the mutable orders of narrative produced by individual patients.<sup>71</sup> Foucault recognized this too and his reasoning lead him to the following paradox:

Through the play of primary spatialization, the medicine of species situated the disease in an area of homologies in which the individual could receive no positive status; in secondary spatialization, on the other hand, it required an acute perception of the individual, freed from collective medical structures, free of any group gaze and of hospital experience itself (*The Birth of the Clinic* 16).

---

<sup>71</sup> I did say Ross was not going to address the concerns raised by the definitive processes of the DSM-V, but I, myself, can provide a little more insight. Earlier I alluded to the fact that the “Preface” of the DSM-V accepts that ‘some symptom domains, such as depression and anxiety, involve multiple diagnostic categories and may reflect common underlying vulnerabilities for a larger group of disorders’ (American Psychiatric Association xli). This is pertinent because a wealth of prominent research suggests that the homogeneous nature of diagnostic criteria, renders much of its aetiological definitions problematic. As such, data suggests it may be beneficial to consider the heterogeneity of individual narratives of illness, especially in instances of depression, rather than statistically significant symptoms – which is to say that the material factors of an individual case may be less pertinent to the care of the whole person than the mutable experience of those factors (Moran).

This insight informs the medically humanist imperative to free the patient from the impositions and political power of the medical institution – at the very least acknowledging that such impositions and political power exist and are mediated. According to Bishop, Foucault was attempting to create a space of freedom for individuals even while their subjectivity was bound to the relational power structures involved in its constitution. As we have seen [above], Foucault was not only concerned with the object of the dead body under the medical gaze but also with the gaze of the subject and how the subject is transformed in medical spaces and shaped by what is permissible according to the imposition of orthodoxy when their body becomes ill and is subjected to medicine (Bishop, ‘Foucauldian Diagnostics’ 344). As Bishop’s critical intervention reveals, this insight extends far beyond the medical space. Foucault’s work provides insight into the power structures inherent to the medical encounter, of course, but it also speaks to the institutions of State, community, society, and the individual – all of these are informed by realizing the human condition as ‘subject and object of knowledge [...] both Sovereign and subject to that sovereignty’ (‘Foucauldian Diagnostics’ 345-46).

This positions the subject at a point both inside and outside of the institutional structures that construct them and which makes clear that we have returned to Winnicott’s transitional spaces; the ‘me’ and ‘not me’ formalize his theories of the development of subjective-objective consciousness in early-stage childhood; a theory of ‘experiencing’. Winnicott argued that this development occurred in an illusory, conceptual, or ‘potential’ space that stood for that mutable aspect between ‘the subjective and that which is objectively perceived’ (*Playing* 3). As outlined [above], the conceptual underpinning of his theory was the liminal entity of transitional phenomena, but whether it is transitional spaces, or transitional objects; the ‘potential’ in space and objects exists between perception and imagination. It is a paradoxical space where the internal and external coexist. Bullmore’s circular relationship between systems – the nervous and the immune – can be seen analogously, as a model for the reconfiguration of space in accordance with this paradoxical liminality. If the causal arrow between these systems does indeed ‘flow both ways’, then Bullmore has described a reflexivity of playful transition between the nodes of the system but which must operate in mutual co-creation, so the spatial dynamic of causation cannot exist in one space, but coexist in both as an interrelational, self-sufficient system beyond material ‘reason’. We have already taken from Fink and Winnicott that ‘play’ is this unreasonable phenomena and so from Bullmore’s formulations we have some gesture of the intersubjective model of mutual co-creation, which, if applied more assiduously in the medical encounter, or instituted as a matter of practice, would position play at the center of medical praxis and could not *but* attend to the whole person.

*"I have spent my lifetime thinking about killing myself and how to do it; I have come very close to the act three times, each time having stockpiled non-prescription medication with a view to a lethal overdose. I do not know why I have never gone through with it. As I sit here reflecting on why I am still here, I think that perhaps I was simply fortunate to be able to make do with what I could find to resist."*

If we return to the subject of Kate Gompert as a suicidal patient:

[...] 'This feeling' of wanting to stop feeling by dying, then, is –'

The way she suddenly shook her head was vehement, exasperated. 'The feeling is why I want to. The feeling is the *reason* I want to die. I'm here because I want to die. That's why I'm in a room without windows and with cages over the lightbulbs and no lock on the toilet door. Why they took away my shoelaces and my belt. But I notice they don't take away the feeling do they' (IJ 72).

We can see that medical orthodoxy's best practice offers Kate no aid whatever; no recognition; no relief; no resolution. Instead, it has imprisoned her, literally and figuratively, denying her autonomy and her agency and unable to hear – even countenance – her story because what Kate wants – her subjective treatment – means her death. What can the medical institution do, faced with this intervention? – It can only return to what it knows; what has been predetermined to be of value in the medical encounter, which, as we have seen from the 'textbook' literature, means returning to the extant narrative order that can only offer an approximation of the condition of suicide because it is not an instituted disorder; because the patient's is not a whole person, mind and body, merely a diseased mind:

'What I'm trying to ask, I think, is whether this feeling you're communicating is the feeling you associate with your depression.'

Her gaze moved off. 'That's what you guys want to call it, I guess' (IJ 73).

*"In an effort to restore me to order, I was prescribed and tried different courses of medication throughout my twenties. As well as lithium, typically, these were a form of anti-depressant designed to inhibit or manage my capacity to experience the polarizing extremes and, in the main, minimize the likelihood of my suicide. I took these medications for approximately ten years."*<sup>72</sup>

---

<sup>72</sup> Ross spent too long questioning whether to write 'extreme feelings' or 'extremes of feeling' here. He settled on the latter because it seemed a more accurate description of what he thinks about feelings. He had this to say when I asked him to explain himself:

"I have spent time thinking about this and I know, by every measure, that you and I may not feel the same way or feel *in* the same way. I try to countenance as many alternatives to my way of being as possible, at all times; to think of the world broadly; I find it very difficult to stop thinking, broadly speaking, and difficult to disconnect from a metaphysical approach to connections between things, which you might think of in terms of the cliché, 'I'm stuck in my head'. I imagine a lot of people experience the world like me, but do I mean they "exactly" experience the world like me, or is that a conceit impossible to prove? I see a lot of the material world according to spectrums informed by this idea, so I find life more manageable, and happier, if I defer my opinion, because what do I know. I can't assert myself I suppose, or I deny myself, maybe. I often wonder if

And so we are back to the short of it all, that “people who often feel bad often want to kill themselves”, which cannot be helped. As we have seen from Emanuel et al. [above] only in rare cases is it permissible to consider death as an outcome in the medial encounter and as far as suicide is concerned, only providing that mental competency of either the patient or proxy is provided. As a suicidal person I think this a curious standard, because the psychiatric impact of the desire-for-death is not often considered in requests for PAS (in less than 5% of patients) – because ‘ideation’ is co-morbid factor of mental illness, not a pathology alone. But, the patient must then justify their desire-for-death under the conditions of psychiatric competency, which means rationalizing your reasons for death. In addition to the omission of psychiatric evaluation, certain studies indicate that patients experiencing depressive episodes are less likely to have their requests granted (Emanuel et al. 87–88). If this is considered in relation to the requirements for diagnosis according to the DSM-V, which can require no pathological manifestation of the ‘sickness’ of suicide (Oquendo et al.), then the disregard of psychological symptoms as a causal factor seems particularly unethical and problematic.

*“Those ten years were a miserable living. In a manner of speaking, I lived, yes, but I still didn’t want to live. In fact, I felt worse, because all the while I was medicated I still experienced depressive episodes and periods of mania – there was still no escape from that feeling, or but instead rather it was as though I had been separated from human feelings somehow, like I had been numbed to their effects in my body – the physiological sensations I mean – like my body was missing; my empathy and compassion; like I couldn’t feel other people in the room anymore but was just an observer, witnessing an empty person and hating him more because I was, still, an observer. I was still mind enough to judge what I saw in myself and analyze the person who was that way, to deconstruct the reason for my behavior. With the loss of the material feeling of my body and no space to locate human being anymore, all there was, was a mind; the seat of my being; what was produced by what I thought. It must be what I really was. That I could still think, judge, and rationalize as a witness to all I’d lost in human being – that must be all I was – my loss of feeling human being, a human lacking. And then but there was still the feeling. I still desired to destroy myself because now, it was worse, now there was reason to destroy myself; now it was not just an innate, inner sense of self-annihilation that I could not speak, because here was reason and a reasoning – I felt nothing, for anyone. What gift was I bringing to the world?”*

If however, we could employ what we have taken from Winnicott, through Bullmore’s modelling of a reflexivity of playful transition between the nodes of this diagnostic system to establish an operation

---

this is rooted in a lesson, long ago, when I was taught to “question everything, Ross”, and I do, a lot. So I think I’ll use “extremes of feeling” because I’m interested in who determines the scope our sensory perceptions and where we draw the distinctions between where my feelings and your feelings are different, or similar.”

of mutual co-creation then we might better address the subject of a suicidal patient's 'feeling' by inverting the aetiology. I would like to pursue this inversion and propose an alternative to the narrative order formulated by medical orthodoxy. This amounts to a reading in "Sick Literature", thus: "people often want to kill themselves so often feel bad". As a hypothetical stance this bit of play helps transition away from the incidental relationship between suicide and mental health. Its conceit demands that the incidental relationship is understood as an orthodoxical myth and instead suggests that suicide and mental health are interrelational and integrated; it allows us to transition towards a new consideration – or configuration – that disorders persistent suicidal narratives and permits us to consider these 'disorders' with an alternative medical value. It allows us to consider whether we have been looking at our attitudes to suicide and mental health with the wrong frame of mind and with the wrong medical gaze.

*"Here is the crux: I do not think medication helped me. I think I know that it didn't."*

## Suicidal Narrative Disorder

There is a growing volume of research on the as yet nebulous assemblage of genetic components at the root of this realignment of depression in the material body and its relationship or influence on the suicidal patient (Kisch et al.; Breen et al.; Xie et al.). What I would like to present as an exercise in Sick Literature, is the hypothesis that the burgeoning empirical, biological evidence of a genetic component to depression supports the contention that in some way the suicidal impulse might be an essential (or at least consistent) aspect of our genetic make-up and it is simply the transitional phenomenon of human phenotypes in conjunction with hereditary or genetic components that explain why certain people commit suicide and others do not. What if the act to suicide was fundamental to our health as a species? Paradoxically: what if the act of suicide was – by some measure – crucial to our continuous existence as a species and explicable according to our genomic models and evolutionary biology? Could it be, in fact, that the suicidal act is hardwired into our biology as a necessary component of being that manifests in response to other genetic, heritable traits, which, when reproduced, represent a genomic risk? For example, what if the suicidal act was an impulse triggered by mental ill-health to negate the proliferation of such ill-health among the population? It may not be ethical to pose this question in a medical encounter attendant to the privileges of scientism and the scientific method, but it is a question we *can* pose in the playful spaces of artistic expression and the material and mutable causes of the case it makes in its artful objects.

Let me present it this way: what is “the cause of death”? I mean generally, on average: what is “the cause of death”? When someone dies of “natural causes”, what does that mean? In the terms I have used throughout this thesis, we might consider it the orderly narrative of things: that the life processes adhere to expectations of the natural order of life cycles – your grandparents die before your parents, your parents before you, you before your offspring etc., etc. This is the narrative that seems to best represent the mean experience of people in Western society. That I take this as an observable fact of existence seems reinforced by the impact on society when life processes fail to adhere to this narrative: consider how unexpected bereavements invite counselling, therapy and treatments for PTSD as indicative of the psychological turmoil that manifests when our orthodoxies are destroyed – we can make ‘no sense’ of the death; it seems inexplicable, and a large part of the bereavement and grief counselling is configured to enable the bereaved to make sense of this ‘new’ narrative; or to fit within and define one’s experience in relation to the new paradigm instantiated by trauma. This is not solely the case with unexpected bereavements of course, and I understand that my hypothesis is an extremely problematic, speculative and likely triggering conjecture but it is my hope to demonstrate over the course of this chapter how such a speculative leap is addressed in

David Foster Wallace's fiction and that the confusing and complicated interrelationship between suicide, mental ill health and death is configured as a product of the problematic dichotomy between self and other. I speculate that consciousness and self-awareness have privileged a Western tendency of self-introspection towards self-realization or understanding – a drive to understand the 'I' – that has distorted a perhaps-inherent trait of nature. I speculate that if we were not so involved or invested in the problem of 'I', perhaps suicide would be more easily conceived and understood, and its position as social taboo reconfigured to the potential benefit of a medicine that attends to the people who experience its ideation and impulse.

The data provided at the beginning of my story showed that much of the debate is concentrated on patients who are already 'terminally ill' and both sides of the ethical divide have been addressed in this regard (Lokhandwala and Westefeld; Mayo; Range; Werth Jr., 'To Clarify'). Werth Jr. contributes significant work here and attests to the possibility that suicide can be rational (Werth Jr., 'Schneidman's Ten Commonalities'; Werth Jr., 'Using Rational Suicide'; Werth Jr. and Holdwick; Werth Jr., *Rational Suicide?*). For others it is problematic ever to conceive of suicide as a rational act precisely because we have no access to knowledge of what death is, as such we can never profess that a decision that enters us into that 'state' is a rational one (Critchley and Hume 39). Effectively: what is unknown can have no purchase on rationality (Wittwer; Joseph Richman; J. Richman). This stems from a broadly understood definition of rationality being comprised of the importance of gaining full knowledge of the options and consequences and the potential problem of transient desires being inconsistent with a person's more fundamental values. It is the former criterion most at stake in Critchley's refutation, for example, and which we can see in the ontological life position Clarke instantiates: 'If the state of death is considered to be a "nothingness", then even though life might be experienced as intolerable, no rational consideration of alternatives can be made' (458). This alludes to the morality of the issue, which moves away from the notion of suicide's rational or irrational presentations one in which suicide is a 'bad mistake' (Pilpel and Amsel; Cholbi). The literature on "rational suicide" is extensive and one need only consider the infamy of the case of Dr. Jack Kevorkian (June 1990), who faced murder charges for assisting the suicide of Janet Adkins, a 54-year-old with probable Alzheimer's Disease and which utilized the doctor's 'suicide machine' to observe the ethical conundrum made real in the medical encounter (Conwell and Caine).

So, my question then becomes: why is suicide never a death by natural causes – why must there be a reason for it? Why can we never say "It was just their time" when speaking of the agential act of suicide? The ethical questions seems to reside in the fact that suicide is not an homogenous act, its impact transgresses the separation of 'self' and 'other' and, from the extensive literature designated to the subject of "rational suicide", in conjunction with the instituted, medical attitude towards

suicide offered in my opening response to the words of Dr. Margaret Chan, “life” is almost universally championed as ‘the most precious of human possessions’ (R. Brown 7). From the universal to the personal, the same ethos is provided by Jennifer Michael Hecht’s *Stay: A History of Suicide and the Philosophies Against it* (2013), which has the poet turn to history and philosophy in order to understand and cope with the recent suicides of two friends. In her “Preface”, she includes this direct address to the reader:

So I want to say this, and forgive me the strangeness of it. Don’t kill yourself. Life has always been almost too hard to bear, for a lot of the people, a lot of the time. It’s awful. But it isn’t too hard to bear, it’s only almost too hard to bear (Hecht x)

It’s this final thought that strikes me because of its implicit sentiment, namely: life is precious and to suffer through it is better than to prematurely end it. What is implied by all then, is that for all hundreds of thousands of people who have taken their own lives, regardless of the circumstances of their decision, they could have coped better; they could have borne the weight upon them... But how? What is it that Hecht imagines would have helped all those people and made their burdens easier to bear? The plea speaks to a fundamental incoherence about the act and the traumatic weight that must be borne by the people left behind.

*“Don’t be so selfish. You are not alone, Ross. You can get help. We will help.”*

*It’s like horror more than sadness. It’s more like horror. It’s like something horrible is about to happen, the most horrible thing you can imagine – no, worse than you can imagine because there’s the feeling that there’s something you have to do right away to stop it but you don’t know what it is you have to do, and then it’s happening, too, the whole horrible time, it’s about to happen and it’s also happening, all at the same time.<sup>73</sup>*

*So how you can help?”*

At the heart my ethically imperative turn is the opportunity to play with medical orthodoxy and consider that suicide can be a ‘natural’ event, one that does not surprise, just as the narrative order of death as we know it does not. We know that death is for us all, so why should death by one’s own hand be represented differently; can suicide be a ‘good death’ (Lester). This returns me briefly to the aforementioned realm of psychoanalysis and mental ill health, which is to say that treating depression or psychosis or addiction might in no way lessen an individual’s drive to suicide. Alternatively: treating someone’s suicidal ideation may in no way treat their depression, psychosis or addiction – how could it after all, if the institutional model suggests only correlation and *not* causation. I think that separating-out a concept of suicide in this way, means we can address the ethics of the right-to-die in a more appreciably more subjective way than is typical. The question becomes solely about each individual’s right to die if they so choose, regardless of the measures

---

<sup>73</sup> *Infinite Jest* (73).



made of their faculties as the constructed object of the medical gaze. Regardless of their disorder. But this in turn leads us out of The Clinic and returns us to the people beyond its walls, to the heterogeneous lived life among the subjects of our family and friends.

*"... and so It may be true that suicidal people are not alone, but it doesn't feel like that. You feel alone. You have no community. You are constructed as such in your medical encounters because the institution dictates that everything in your being is wrong and does not belong to the community of 'well' people, it must not belong. I don't think a medicine that treats the whole person can begin from the position of abjecting the people who do not fit the model of 'wellness' in the first case; it doesn't work for the individual who has been excluded because of what they are, because of what they think and feel they are. As far as I knew, my suicidal ideation was in my make-up, it was all I knew to think about it so it could it never be the case that a 'cure' was simply a matter of changing my mind."*

I would like to focus on an example of how our confused dichotomy between suicide and mental health manifests, and what a reconfigured approach to suicide allows, from the conceit that, as a depressed person, the biggest problem was the problem of my self. We saw from Bullmore that if we are to reconceive medicine to escape Descartes' dualist prison, then considering the response of the whole organism, so what if the turn in ourselves from subject to object that Freud framed as the turn from self-love to self-hate, in suicidal ideation, is a misreading? What if our attempts to self-annihilate are indicative of the inherently diabolical and unhealthy nature of the very concept of selfhood and selfdom *in toto*?

*"The guilt felt so strong. I couldn't begin to write notes because I couldn't explain myself. There was no explaining it. I did feel selfish. I felt hateful of myself for being selfish, but I just didn't want to be myself anymore. I tried to think my way out of the problem, to be mindful, to treat my cognitive behavior."*

*And I know for many it is the people that would be left behind that keep them anchored, and alive. Maybe I was fortunate to feel the guilt of it all – if I had gone through with it. Maybe because I had seen and felt the effects on my family of my dad's unexpected death; maybe it was knowing how that felt that stopped me each time.*

*I thought often about my position in the world and the self-obsession of it all. Why couldn't I escape thinking about myself, the incomparable reduction of everything in the world to a matter of my being in it and how selfish that was... What if I could dissolve my sense of self? What if I could reconfigure this strict, limiting subjective being in the world, would all the other forms of my self-obsession dissolve too; my self-abandon; my self-absorption; self-denial; self-deprecation; self-hatred – would all the aspects of myself mapped and wrapped-up in suicidal ideation disappear?"*

David Foster Wallace's *Brief Interviews with Hideous Men* (2009)<sup>74</sup> is haunted by suicide and suicidal ideation, the stories "The Depressed Person" and "Suicide as a Sort of Present" portray explicit and implicit suicides, which, in addition to its exploration in *Infinite Jest*, as I will continue to present [below], demonstrate how critical the link between mental ill-health and suicide is as a theme in Wallace's work. Utilizing George Bataille's concepts of 'abjection', 'accursed share', and 'gift' economy, which are in turn derived in relation to his science of 'heterology', I will present a new narrative of suicide that furthers my concept of 'Sick Literature' as a model for medically humanist, intersubjective medical praxis. There is much correlation between Georges Bataille and Winnicott in this regard, with Bataille's *Inner Experience* (2014 [1998]) presenting the process of establishing one's identity in accord with distinguishing oneself by difference from the environment, the same 'tension' we saw in Winnicott of relating inner and outer reality. Bataille expresses this definitively: '[As] not the subject isolating itself from the world, but a place of communication, of fusion of subject and object' (*Inner Experience* 9), which has its evident mirror in the maturational processes Winnicott describes through transitional phenomena. Similarly: Bataille writes explicitly of 'dramatization', rather than 'play', as essential in escaping the bonds of isolated inner psychic reality or totalizing subjectivity, it is part of his principles and method of community, to wit:

If we didn't know how to dramatize, we wouldn't be able to leave ourselves. We would live isolated and turned in on ourselves. But a sort of rupture – in anguish – leaves us at the limit of tears: in such a case we lose ourselves, we forget ourselves and communicate with an elusive beyond (*Inner Experience* 11)

This paragraph speaks keenly to the importance of 'dramatizing' or 'playing' as a means 'out' of oneself; it speaks directly to Winnicott's 'creative-destruction' because for Bataille the act of dramatization [play] is a double-edged sword; in our escaping isolation there is a rupture in the self, that bit of us that is embracing the other changes us (what Winnicott describes through object relations theory) through play we step outside of ourselves to create a structure or frame from which we adopt an altered perspective. In effect: through play we assume a distanced position from that experienced in non-play. This creative act of dramatizing has a necessarily destructive component because it requires a distancing from ourselves – 'a kind of rupture – in anguish' that is painful because it requires a sort of incorporation, and absorption of otherness, which – we can formulate – is a literal and figurative expansion of ourselves. If we cannot dramatize and break from our inner psychic reality – if we cannot play – then all that we are is the product of that inner psychic reality and its recursive, strange loop from self-affirmation to self-annihilation. I posit that Bataille here affirms play as an essential medicine because – transposed to the medical encounter – the inability to "get out of our heads" might easily be read as description of a state of mind during a

---

<sup>74</sup> Hereafter referred to in-text as *Brief*.

depressive episode, or a commonly vocalized expression of psychic despair by someone suffering depression. I think there is scope to advance the material affect of such an expression in light of Bullmore's research as well, which, if the research continues to identify causation and correlation between the products of the immune system – specifically inflammation in the body – and depression, then a self-report of symptoms that reflect an apparently figurative expression of inflammation in the head, of being stuck in it, of the pressure and pains and headaches localized in that site – is it not possible to conceive of vocalizations of despair as the literal product of the human organism's immune response to depression; that the language objects are the material symptoms of the disorder, mapped in the body?<sup>75</sup>

Without some transitional space in which to externalize our inner demons, or some transitional object through which to expel them and see them external to us – to have them retain some element of that externality so that they do not again become Winnicott's 'perfect object' and our relief no more than a 'hallucination' (*Playing* 14). Then we could destruct them and create them anew as something in relation to our inner, subjective being but not its entirety; we could play with them. I say again: play is fundamental to our *being*... let us consider the fiction.

I will begin by analyzing Wallace's construction of the self in relation to mental ill-health. In the story "The Depressed Person"<sup>76</sup> Wallace presents a figure whose depression is a reflexive malady causing 'unceasing emotional pain, and the impossibility of sharing or articulating this pain was itself a component of the pain' ("DP" 31). So, the depressed subject is afflicted by a pain that is self-fulfilling and

Despairing, then, of describing the emotional pain or expressing its utterness to those around her, the depressed person instead described circumstances, both past and ongoing, which were somehow related to the pain, to its etiology and cause, hoping at least to be able to express to others something of the pain's context, its—as it were—shape and texture ("DP" 31).

The fact of this expression is that it describes how the depressed person seeks escape from their pain by referring outside of the self to the common currency of shared sociocultural referents and signs. The brilliance of this formulation is that Wallace is providing a sense of depression's infinite regress; the shared sociocultural referents are necessarily inadequate – hence the 'the impossibility

---

<sup>75</sup> The role of analytical listening in the context of psychoanalysis offers some suggestion of the theory Ross is addressing here, with evidence suggesting that bilingualism facilitates, and even sharpens, the analyst's awareness of how the sound or 'poetry' of the analysand's language is as integral to meaning as 'content'. In hysteria, for example, dissociative symptoms of mind and body are mapped by dissociative dislocation between verbalization and vocalization (Connolly). For additional evidence on this material aspect of the language-object as symptom see Bjørkløf et al. who examine the patients with severe depression and the expression "being stuck in a vice".

<sup>76</sup> Hereafter referred to in-citation as "DP".

of sharing' – they may touch *'some tangible quality of the pain'* but ultimately serve only to reinforce the depressed person's isolation, their solitude. In effect the depressed subject's attempts to escape the self, fail, instead all signs are simply a reiteration of the self. There is another curious paradox in Wallace's presentation here, because – as we might imagine – the ineluctable quality of one's emotional pain registers as wholly unique; in some sense, it is an exemplary measure – or sign – of one's individuality.

Elaine Scarry's theory of pain's affect has dislocation at its heart [disturbance from a proper, original, or usual place or state]. She argues that the pain-experience brings 'about even within the radius of several feet, this absolute split between one's sense of one's own reality and the reality of other persons' (4). That is: pain is incommunicable. For the depressed person, nothing seems to construct the 'me' more than the psychic pain that has no material to it; it appears beyond any location. However, the paradox emerges because in Wallace's construction the 'depressed person' is specifically indistinguishable. Beyond the singular 'person' they are in no way discernible as an individual; their only identifying characteristic is that of 'depression' and so we are back in a recursive, strange loop of self-affirmation and self-annihilation. The whole character is 'depression'.

Multiple measures of the complex causes and consequences of pain are needed to elucidate a person's pain and inform multi-modal treatment. But no quantitative summary of these measures will adequately capture the burden or the meaning of chronic pain for a particular patient (Ballantyne and Sullivan 2009).

*"My whole character was sadness, or despair – call it depression. I had no way of feeling my way out of it, and no matter the tests we might conduct, whether what I could say about the innate 'pain' of it had any quality to it that bore relation to any pain you have felt. If you could tell me what a headache feels like. Is it sharp? Dull? Does it ache? Is it hot?"*

*'Have you ever felt sick? I mean nauseous, like you knew you were going to throw up?'*

*The doctor made a gesture like Well-sure.*

*'But that's just in your stomach. It's a horrible feeling but it's just in your stomach. That's why the term is "sick to your stomach" [...] imagine if you felt that way all over, inside. All through you. Like every cell and every atom or brain-cell or whatever was so nauseous I wanted to throw up, but it couldn't, and you felt that way all the time, and you're sure, you're positive the feeling will never go away, you're going to spend the rest of your natural life feeling like this' (IJ 74).*

*I read that chronic pain is typically defined as pain that lasts longer than six months. It can be mild or excruciating, episodic or continuous, merely inconvenient, or totally incapacitating. It appears differently to acute pain... When I cut myself, or burned my arm with a lighter, I felt pain, but a different order of pain; I could find relief from that pain with salves and lotions, ointments and unguents. I tested how much acute pain I could bear and would often experiment without applying a remedy, to see if I could take myself elsewhere, in my head, like I was dislocating from my body in*

*pain and merely an observer in the room. But I couldn't do that with the pain of depression. It was my whole self, wanting to die."*

In short: pain has more to it than a sum of discrete or continuous biomedical data. It has an obvious material *and* mutable component integral to the individual subject in pain and therefore demands a medical consideration using the material and mutable methods of the arts and its works because they have some place to account for it. We can see this at work in "The Depressed Person" by the story's almost throw-away denouement:

Several months later, when the depressed person's therapist suddenly and unexpectedly died—as the result of what was determined by authorities to be an "accidentally" toxic combination of caffeine and homeopathic appetite suppressant but which, given the therapist's extensive medical background and knowledge of chemical interactions, only a person in very deep denial indeed could fail to see must have been, on some level, intentional ("DP" 42-43)

This is Wallace's great playful swerve: the revelation that the depressed person of the story is not "The Depressed Person" of the title; it is in fact the therapist-practitioner that readers 'cannot fail to see' is the center of the story's depression. A diagnosis we can confirm if we reassess the story's opening lines in the manner of narrative medicine, as if Wallace is addressing directly, and presenting his story as a sickness we must diagnose, telling us exactly what its symptoms are and what operations his story utilizes. If we listen to the story Wallace tells we can learn all we need to know. From the perspective of the therapist, we can discern from the denouement that it is hers that is the 'unceasing emotional pain' expressed in the opening; it is never expressed or articulated to the reader directly, so *proves* an 'impossibility' to share and instead Wallace describes it through 'circumstances, both past and ongoing, which were *somehow* related to the pain'. That is: Wallace uses the therapist's patient and *her* life story as the conduit through which the therapist's pain is expressed.<sup>77</sup> As Wallace leads us to understand that the therapist is the real 'subject' of the depression of the story, so to do we understand the true nature of its inexpressibility; we are given only the 'shape and texture' of the therapist's pain by a sort of revelation-through-omission, which is that Wallace describes what the pain is by what it is not i.e. through the therapist's patient, who

[C]ould neither feel nor identify any real feelings within herself for the therapist, i.e. for the therapist as a person, a person who had died, a person who only somebody in truly stupefying denial could fail to see had probably taken her own life, and thus a person who, the depressed person posited, had possibly herself suffered levels of emotional agony and isolation and despair which were comparable to or perhaps—though it was only on a "head" or purely abstract intellectual level that she seemed to be able even to entertain this possibility, the depressed person confessed over the headset telephone—even exceeded the depressed person's own ("DP" 56)

---

<sup>77</sup> I am not sure I approve of this technique but each to their own, I suppose.

This then is a patient who is in fact not depressed but rather narcissistic and self-absorbed; she is someone who performs her illness ‘over the headset telephone’ and is, Wallace reveals in the story’s final lines, ‘[a] solipsistic, self-consumed, endless emotional vacuum and sponge’ (“DP” 58). As detailed in my analyses of *Infinite Jest*’s presentations in the medical encounter, the additive approach to medical humanities would here champion the story as a means by which real medical practitioners might gain insight into patients’ experience of mental ill-health and in so doing hope to inculcate an stronger empathic response to the patient to the benefit of their treatment. What then are we to say about the therapist’s self-fulfilling pain that is impossible to share, and how does this presentation of mental ill-health operate in our broader picture of suicide? For this I offer my first material foray into the philosophy of George Bataille, specifically his philosophy of the self, as determined by the notions of homo- and heterogeneity.

### A Heady Cocktail; A Genuine Mix-Up

Bataille’s concept of heterogeneity refers to the fluidity or dynamism of individuals and – consequently – society as well. He argues that the self is a construct of social relationships, or interrelationships, and as we saw in the correlation between his philosophy and Winnicott’s, subjectivity is definitively *not* constructed from an isolated position in the world but a place of communication. However, he begins from the psychological concept of society’s construction at its most fundamental part as *homogenous* because ‘human relations are sustained by a reduction to fixed rules based on the consciousness of the possible identity of delineable persons and situations’ (*Visions of Excess* 137–38). This means that social homogeneity is governed by the principle of “the social contract” and – for Bataille specifically – the utility and productive capital of the individual in society, with each member deemed useful in correspondence with their ability to contribute accordingly; to produce: ‘every useless element is excluded, not from all of society, but from its homogenous part’ (138). The ‘useless part’ is that part which has no project, no end-game, no purpose; the part that is without accord to a future telos, and so, being purposeless, speaks to the phenomenological position of ‘play’ addressed from Huizinga, through Caillois, and Fink. The important distinction to make is that Bataille is not against the ‘useless part’ – not at all – only that it serves no part in the homogeneous aspect of society because: ‘A useful activity has a common denominator with another useful activity, but not with activity for itself’ (138). This common denominator is money. Thus, social homogeneity is ordered to function by measurable or quantifiable products, or – as we can understand it commonly – by its capital. From this paradigm, the human ‘stops being an existence for itself: [it] is no more than a function, arranged within measurable limits, of collective production (which makes [it] an existence for something other than

itself)' (138). The individual is only a function of personal production when in the position of artisan; only here are the 'means of production relatively inexpensive and can be owned by the artisan' (138). More typically – in our industrialized nations – those who produce are distinguished from those who own the means of production; it is this latter person who is the function of the products; this latter person who 'founds social homogeneity' (138). This is the enclave of the so-called

[C]apitalist or bourgeois class [where] the tendential reduction of human character takes place, making it an abstract and interchangeable entity: a reflection of the homogenous things the individual owns' (138).

This 'reduction' is extended to the middle classes [who variously benefit from the profits industrial production realizes], but the industrial, working classes or proletariat remain [largely] irreducible. As agents of production, the workers fall within the framework of the social organization but the homogeneous reduction as a rule only affects their wage-earning activity; they are integrated into a psychological homogeneity not in terms of their general personage but in terms of their behavior 'on the job'. Outside of the factory, and even beyond its technical operations, a laborer is, with regard to a homogenous person (boss, bureaucrat, etc.) 'a stranger, a [hu]man of another nature, of a non-reduced, non-subjugated nature' (138), of a different class entirely.

This is to say that individual liberty is of cardinal importance to the narrative order of democratic structures but is disordered as a consequence of one's democratic responsibility to others under the "social contract" because it implies one's right to deviate 'from the norm' but which deviation potentially threatens to undermine and even subvert social order and control. There is instead an adherence to the more homogenous conditions of rules that demote individual liberty. The transition from this social contract to the medical encounter is easily done if we consider disease, illness, pain and sickness by the same terms as that which 'potentially threatens to undermine and subvert social order and control' – although we can recognize that it is not quite the 'social order' that is deviated but one's subjective order – unless we consider disease in the context of an epidemic or pandemic. No – for 'social order' I would like to reiterate 'order' in the sense of a narrative that states 'wellness' as being akin to the orderly narrative of life, and so in 'illness' that selfsame narrative is disordered. I raise the transposition back to the medical encounter here to suggest that the transitional processes of the circular relationship discussed previously in conjunction with Bullmore and Winnicott is the analogue of the circular relationship between the individual and social as examined here in Bataille. There is a genealogy here that speaks to a broader conceit in my concept of "Sick Literature", which is that it extends 'sickness' beyond the medical encounter and considers sicknesses of the State and its institutions in general, a genealogy that extends from works of literature canonized under the rubric of 'Cold War' studies and which I will address – in brief conclusion – in good time. And so, having outlined his sense of homogeneity, we

can turn to a *Definition of Heterology* (circa 1930s). In this paper, published in English for the first time in 2018, Bataille set out to produce a new form of science, a ‘paradoxical form’, that is amenable to the possibility of ‘L’Informe’ – what is ‘formless’ (*Visions of Excess* 31). ‘Formless’ is of crucial importance to Bataille. Effectively it was an attempt to express that the universe does not have to assume a form, an almost verbatim prefiguration of the expression in Fink that positioned play as a counterpoint to assumptions of rational principles imposing order on the universe (*Play as Symbol* 403–04). Bataille’s paper outlines this paradoxical science as ‘heterology’, which, from Marina Galletti’s “Introduction” to the piece is best understood as a science of ‘the excluded part [...] which is usually prey to censorship due also to conceptualizations developed by the need to idealize’ (Bataille, ‘Definition of Heterology’ 30). Julian Pefanis extends the description in considering Bataille as a forebear of an anti-dialecticism that moved away from Hegel; the ‘anti-project’ of heterology conceived as a duality whose terms – or objects – are presumed to be known as one node in a binary term or one term in relation to several other terms of a known group with the condition that it opposes the others – the excluded part – and is transgressional (Pefanis 1–3). This follows Bataille’s reasoning from *Visions of Excess*, which confirms:

The study of homogeneity and of the conditions of its existence thus necessarily leads to the essential study of heterogeneity. In fact, it constitutes the first phase of such study in the sense that the primary determination of heterogeneity defined as non-homogeneous supposes a knowledge of heterogeneity that delineates it by exclusion (140).

Scientific assimilation then is best placed to demonstrate this line of reasoning as it is among those facets of society in which heterogeneous elements are ‘impossible to assimilate’ (that is his very definition of the term). The ‘outliers’ must be readily excluded from data sets because science’s focus, or functions, are to establish the homogeneity of phenomena. Pefanis sheds light on this in taking the function of scientific analysis as ‘a procedure of the homogeneous mind which is constitutionally incapable of theorizing the heterogeneous. Science itself represents a limit to the experience of the impossible’ (Pefanis 44–45). In the medical encounter we have seen this made explicitly clear as a consequence of the economies in play in its epistemological capital and production of ‘textbook’ cases that prescribe what is possible.

Heterology, in short, was opposed to every possible kind of orthodoxy and so you can see its reason for inclusion in this thesis. It is worthy of note that a similar heterogeneity was at play for both Roger Caillois and Emile Durkheim, whose works were foundational to the aspects of play and suicide (respectively) discussed above. For Caillois the character of a double current of attraction and repulsion describes a heterology in the interrelationship between the sacred and profane and finds its institution in the laws of permission and taboo (*Man and the Sacred* 20–26), which itself is a



response to Durkheim's twinning captivation and terror in the prisms of the sacred and profane as absolutes so distinguished from each other but so necessarily interrelated as a consequence (*Elementary Forms* 58). Bataille was opposed to Durkheim on this issue because he saw the sacred and profane as equally excluded realms opposing homogeneity. They were 'linked at a psychic and philological level (Pefanis 49) and belonged to the Bataillean concept of '*dépense*', or 'expenditure' (*Accursed (I)* 9), a term beyond the conventional dualism of Western thought that informed his thesis on general economy and '*la part maudite*' or 'accursed share' [below].

From this framework of homo- and heterogeneity it should be clear why challenging the homogeneity of medical scientism is inherent to medical humanism; one is in care of the ideal case, the other the individual. Thus, from Bataille's model we can discern the inference of the exclusion of the heterogeneous from the homogenous in the model of the individual patient versus the ideal patient in scientism's hegemony, which is to say that the heterogeneous aspect of the individual – the human, personal, 'useless' aspect, which has utility as self-sustenance to the individual and no utility for the instituted ideal. There is validation in this according to the 'fundamental duality of the heterogeneous' – that such elements conjoin the pure ('sacred') and impure ('profane'), that there is

[A]n identity of opposites between glory and dejection, between exalted and imperative (higher) forms and impoverished (lower) forms. This opposition splits the whole of the *heterogeneous* world and joins the already defined characteristics of *heterogeneity* as a fundamental element (144-145).

'Play', after all, is the undifferentiated form of heterogeneity Winnicott 'reduces' to the dualistic expression of creative-destruction; it is the circular relationship than transitions between the inference of what is included accepted in the homogeneous ideal and the corollary necessity of what must therefore be excluded at the position of abjection in the heterogeneity of individuals. This introduces a complexity in relation to the subjective identity of a self-in-depression as Wallace's depiction in "The Depressed Person" would seem incompatible with the notion of selfhood as evinced by Bataille. I had just established how the pain of the therapist in Wallace's 'Depressed Person' refutes this heterogeneity, even when attempts are made to escape the self through interrelationships. In short, Wallace's subject – and by association depression in general – is an homogenous entity. How can the homogenous sense of self caused by depression in Wallace correspond to the heterogenous self, as envisioned by Bataille? Why is homogeneity so problematic?

I will draw directly from Bataille's concepts of 'abjection' and the 'accursed share' to provide the structure of this analysis which thinking, when applied through the works of Wallace, help elucidate a reconfigured perception of suicide. To refer back to the medical profession's orthodoxy on suicide – the narrative that every suicide a tragedy – I must consider suicide not as tragedy or

loss, but as blessing or gift in proposing the benefits of the disorderly narratives deployed in “Sick Literature”. It is the latter term ‘gift’ that expresses the central tenet of my argument. The term ‘gift’ is taken from the English translation of Bataille’s *La Part Maudite* (1949) (*The Accursed Share* (1988; 1991)). This three-volume work was developed following Marcel Mauss’s *Essai sur le don* (1925) (*The Gift* (2002 [1925])), a sociological study on gift cultures in the societies of the Pacific Northwest, Polynesia and Melanesia.

## Accursed Depression

The ‘accursed share’ is derived from a broader position on what Bataille termed the ‘general economy’. As David Kosalka’s illuminating essay reveals, ‘in contrast to the classical notion of scarcity driving economic activity, Bataille proposes a law of surplus [...] he analyzed history in terms of the expenditure of excess energy and production’ (Kosalka). Bataille describes

The living organism, in a situation determined by the play of energy on the surface of the globe [the ‘general economy’], ordinarily receives more energy than is necessary for maintaining life; the excess energy (wealth) can be used for the growth of a system (e.g., an organism); if the system can no longer grow, or if the excess cannot be completely absorbed in its growth, it must necessarily be lost without profit; it must be spent, willingly or not, gloriously or catastrophically (*Accursed (I)* 21)

So, the accursed share represents the superabundance of energy available to an organism, but particularly to humans, that must be expended in luxury, or non-productive, wasteful activities. These activities are the realm of the ‘Sovereign’, which is, in general, ‘an aspect that is opposed to the servile and the subordinate’ (*Accursed (II-III)* 197), and which basic components are:

Consumption beyond utility, the divine, the miraculous, the sacred ... The sovereign individual consumes and doesn’t labour, whereas at the antipodes of sovereignty the slave and the man without means labour and reduce their consumption to the necessities, to the products without which they could neither subsist nor labour (*Accursed (II-III)* 198).

We can assimilate this position by exploring the implications of expenditure by another term: sacrifice. Traditionally, goods and production are geared towards a future telos of the economy, that is, they are geared towards sustaining life, or the process of growth. In short, they are a means to an end serving some predictable (or imagined) future position. By destroying these goods, or abandoning the process of production, these objects no longer serve the future telos of the economy but instead are established as a means in and of themselves, they are ‘free of utilitarian domination’ (Kosalka). Bataille, expressing this idea in relation to ritual sacrifice in the Aztec civilization states:

The victim is surplus taken from the mass of useful wealth. And he can only be withdrawn from it in order to be consumed profitlessly, and therefore utterly destroyed. Once chosen, he is the accursed share (*Accursed* (I) 59).

Again it is important to note that to say that this sacrifice is somehow 'useless' is merely to say that it is useless for the victim, because in one sense, it is the basis of the life of the community, and is simultaneously the basis of the relationship between the victim and the community. Where Bataille's turn to the abject occurs is when this excess is constructed as undesirable as a consequence of 'Sovereign' power structures. The abject is a founding exclusion that constitutes a part of the population as moral outcasts: represented from the outside with disgust as the dregs of the people, populace and gutter (Bataille, *More & Less* 9), hence 'accursed'.

Professor Imogen Tyler offers a succinct precis of the central paradox in Bataille's formulation here, noting that all the while this 'useless' excess is being excluded [or expended], it is

At the same time intrud[ing] at the centre of public life as objects of disgust ... In this sense all prohibitions are inherently paradoxical since, in order for a prohibition to function, it must at the same time be continually transgressed. For example, in order for a sexual practice to be declared obscene, experienced as disgusting and regulated accordingly, it must be seen to be practised within the body politic. Social prohibitions are dependent upon the (re)intrusion of that object, practice, thing or person which has been constituted as abject, cast out and illegalized (Tyler).

This is reflected in "The Depressed Person" by the patient's use of therapy and its encouragement that she shares her experiences and feelings with her 'Support System' but is problematized by a fear that

Recounting examples ... probably sounded, she always took care to acknowledge, dreary or self-pitying or like one of those people who are narcissistically obsessed with their "painful childhoods" and "painful lives" and wallow in their burdens and insist on recounting them at tiresome length to friends who are trying to be supportive and nurturing, and bore them and repel them ("DP" 32).

Recalling how Wallace employed the tactic previously in the surprise revelation-through-omission, or inversion, of our understanding exactly who "The Depressed Person" is, we can likewise infer how depression might also be declared 'obscene' and result in [self] regulation. Like an infection or contagion, the mental disorder presents physically; the patient fears 'being a burden' ("DP" 36) and so, "as if" suffering from an infection or contagion, the truly depressed person – the therapist – feels obligated to avoid contaminating others with her depression by 'being a burden'. This supports our reading that the therapist is the center of Wallace's story as it demonstrates the self-imposed prohibition of expending her depressive excess outwards. Instead, she can only expend it inwards, within herself, which – in a literal and figurative sense – we might describe as the inflammation of her selfhood. The physical presentation constituted in her sickness, by manner of its inescapable internalization, can only add weight to her psychic turmoil and such would explain the reflexive and

self-sustaining quality of the pain and the infinite regress of self-hatred that is an aspect of the ‘textbook’ symptomology of depression.

We saw from my opening readings of the narrative orthodoxy of suicide how suicide is coded as an abject element in our sociocultural framework in the same vein; it is something practiced within the body politic but simultaneously expelled, rejected and removed. In the process of exclusion suicide is signified as an object of disgust; it is imbued with a vital toxicity and thus, suicidal ideation is to be expelled, avoided, guarded against, treated or managed. We can now see how justification or sanction is given to the medical orthodoxy established in this chapter’s opening: preventing suicide is imperative and that this is the case is ever-more evident if we consider suicide in relation to a broader assessment of attitudes to death-in-general. Thinking about death and acknowledging that everybody dies, is presented as a very different matter to that of suicide. In fact we can go so far as to say that accepting the fact of our eventual death is often encouraged; it is the sign of a healthy or “balanced” outlook and to embrace our mortality allows us to live-for-today, to immerse ourselves in the stuff of living. What is it about suicide that so violently contradicts this truism? How is the death ideation of suicide different in aspect to death ideation in general?

First: the sign ‘suicide’ signifies an *actual* or specific death in a way that the sign ‘death’ does not because ‘death-in-general’ signifies a common or shared experience; it displaces individuality. Suicide on the other hand distinguishes the individual; it signifies subjectivity in so far as all suicides reify the self who committed the act. Secondly: suicide is not easily separated from the means by which the life was terminated, and it is this *action* of suicide that distinguishes it from ideation about death in general, and which – as we can see from the DSM-V, has an explicit attribution that confirms such as ‘Suicidal Behavior Disorder’ (American Psychiatric Association 801–02). the action of embodied agency marking it in distinction to the definition of the merely ‘psychological’ constraints implied in ‘suicidal ideation’ as a co-morbid factor often evident in patients with mental ill-health. We can see this enhanced by *attempted* suicide – the failed action of a suicide – which stands out as a phenomenon between ideation and realization and empowers the sign ‘suicide’ with the tangibility of material things that is not present in the generic sign ‘death’. The suicide attempt is, in this way, written on the individual’s body in a manner wholly distinct from the death that is written into *all* our bodies, the death that comes for us all.

It would appear that the very problem at stake in suicide, its taboo, is the subjective agency of the self that acts. It appears it is the rejection of the self as a heterogeneous entity that is troubling – that the self who commits self-murder is instantiating an embodiment of the self that is homogenous. And so is it the reification of an isolated, separate, and homogenous self we abhor, because its homogeneity is an absolute negation of the “social contract” and as such marks a lack in

the community of the people left behind who, at least in the philosophies at play in this thesis, were necessarily integral in the construction of that homogenous self?

*"We didn't see it coming. It was such a terrible, awful, tragic loss. We had no idea."*

*"If only I'd have known; I could've done more."*

*The plea is to listen; please listen. There is need for stories to be told and for those stories to be heard."*

Who is to say? - I certainly don't know, but to me it would seem to tally with the morality we apply elsewhere, such as the obvious abhorrence warranted by murder; that we punish and prohibit acts towards others that result in their deaths and the literal excision of a self from its heterogeneous place in the world; it seems to lend credence to the fact that self-murder should be comparably abhorrent and disavowed. This does however neatly address the correlation between suicide and mental health in *Brief*. It establishes how the suicidal act and the illness of depression equally refute Bataille's invocation of heterogeneity. Just as the self-reflexive nature of depression prevents the self from expending its excess of mental anguish beyond the boundaries of the self; so too, suicide reifies the self as distinct from the common currency of our shared ideation of death-in-general.

## Suicide as a Sort of Gift

We can turn to the titular element of Bataille's philosophy to better examine and understand why this is so. Bataille's notion of 'gift', which leans heavily on Mauss' earlier work, represents 'gifting' as a primary means of expending excess. The paradox of his position and crucial aspect though, is that by gifting what is 'excess' one also acquires power; indeed the 'gift' would be senseless otherwise:

[H]e would not be able by himself to acquire a power constituted by a relinquishment of power: If he destroyed the object in solitude, in silence, no sort of power would result from the act ... But if he destroys the object in front of another person or if he gives it away, the one who gives has actually acquired, in the other's eyes, the power of giving or destroying. He is now rich for having made use of wealth in the manner its essence would require: He is rich for having ostentatiously consumed what is wealth only if it is consumed (*Accursed (I)* 69).

This gifting then, this form of expenditure, is of utmost importance because it is this principle that produces interaction between things. Without it, no reproduction or communication, no exchange or competition could exist. Once the concept of expenditure is established so, concurrently, is the concept of "otherness" or an "other". There has to be an "other" for the simple necessity that we need some place, or space, into which we can transition the excess energy and destroy it. We need a

recipient outside of ourselves or some external object of some kind, to get the excess out. Ignorance of this place of excess:

[C]onsigns men and their works to catastrophic destructions. For if we do not have the force to destroy the surplus energy ourselves, it cannot be used, and, like an unbroken animal that cannot be trained, it is this energy that destroys us; it is we who pay the price of the inevitable explosion (*Accursed (I)* 24)

Having already determined that Wallace's model of depression is a self-sustaining, incommunicable or homogenous entity that fundamentally negates the intrinsic "otherness" created by expenditure, this place of excess, and – using depression as our correlate – I would like to consider now how the suicidal act might be understood as the inevitable explosion – the catastrophic destruction – that occurs in response to an accursed share of psychological or mental excess that cannot be expelled through heterogeneity. To investigate this, we can turn to another story in *Brief*, "Suicide as a Sort of Present".<sup>78</sup>

As she remembered it, she had always had a hard time, even as a child. She remembered few of her childhood's specifics, but what she could remember were feelings of self-loathing, terror, and despair that seemed to have been with her always ("SSP" 241)

Here is the familiar orthodox representation of the pervasive, persistent anguish of an apparently depressed or sick person. No childhood events can be recalled, only emotional pain. This should be familiar by now because in a manner after "The Depressed Person", in "Suicide as a Sort of Present" there is a consistency between the stories that suggests Wallace's presentation of each case – each study – provides evidence of the material facts of mental ill-health as instituted by medical orthodoxy. They are 'textbook' cases that conform to the narrative order; the subject remembers only the homogeneous all-encompassing 'despair' of their self in pain and there is no sense of their being heterogeneously constituted by phenomena external to them. From this similar invocation however, Wallace moves on from a material case to a mutable one, presenting an alternative vision of the self in pain:

When she became a mother, things became even harder. The mother's expectations of her small child were ... impossibly high. And every time the child fell short, her natural inclination was to loathe it. In other words, every time it (the child) threatened to compromise the high standards that were all the mother felt she really had, inside, the mother's instinctive self-loathing tended to project itself outward ("SSP" 242).

Rather than reiterating the idea of the inexpressible, homogenous depression of "The Depressed Person", Wallace presents the same materiality of depression but in a mutable configuration; he depicts a form of mental anguish that appears at first is capable of being 'project[ed] [...] outward',

---

<sup>78</sup> Hereafter referred to in-citation as "SSP".

beyond the boundary of the self. The mother expends her self-loathing by gifting it to her child; in effect it materializes in the child's personage and behavior, and manifests as a series of typically abject or pejorative characteristics. The child is described as 'rude, greedy, foul, dense, selfish, cruel, disobedient, lazy, foolish, willful' ("SSP" 243). We can frame these traits as the cumulatively accursed share that the mother has tried to excrete, the abject traits which, whilst fueling her self-loathing, have nonetheless been expelled outside of the self. The critical point though is that these traits are only capable of being expelled because – crucially – they are constructs of shared sociocultural sign-making; they reflect Bataille's notion of the social beginning in homogeneity as the acceptable elements of the "social contract". Their pejorative connotations may not be self-contained anymore, but they still serve as a function of homogeneity. As Tyler's reading of Bataille reminds us, these abject terms only function as abject because they exist 'within the body politic' their potency as signs is dependent on their existing as material facts of homogeneous agreement transitioning to the heterogeneous interplay of what sociocultural coding determines is desirable and undesirable.<sup>79</sup>

Reading further:

She took the child's grotesque deficiencies upon herself, rewarding the child's tears and self-recriminations with an unconditionally loving forgiveness that made her seem to the child to be his lone refuge in a world of impossible expectations and merciless judgment and unending psychic shit ("SSP" 244).

There is clear evidence of Bataille's concept of 'gifting' in these lines; the child's 'grotesque deficiencies' in the first instance can be read as the self-loathing and undesirable characteristics gifted by the mother to her child when she projected them outwards, and in the second instance, can be understood as being gifted back to the mother by the child and which she takes 'upon herself'. By seeking to protect her child from the abjected traits of human being she must – following Winnicott – destroy the externality of these [language] objects and reincorporate them, fully absorbed within, so as to leave no trace of them in the external world she shares with the child. As objects that would – *'if all goes well'* (*Playing* 14 [Italics in original]) – reify the external world, instead, they have become 'perfect' objects and so 'it is not possible for the infant to begin to develop a capacity to experience a relationship to external reality' (*Playing* 14). The implications of this are telling, because, being signified as abject, the mother is shown to be ingesting, incorporating, consuming what are bad, harmful, poisonous, toxic, unwanted elements into her being. The paradigm of an orthodox medical dichotomy between sickness and wellness is

---

<sup>79</sup> Evidence suggests that self-esteem and a coherent sense-of-self (what Ross has routinely expressed as an ontological narrative order) should be considered as potential targets of intervention in an effort to aid quality of life and avoid the potentially destructive consequences of internalizing such stigma (Świtaj et al.).

maintained and her construction as the sick medical object that she must gift to herself and ‘that seemed to have been with her always’ continues.

In return, the small child, as it grew, loved the mother more than all other things in the world put together. If it had had the capacity to speak of itself truly somehow, the child would have said that it felt itself to be a very wicked, loathsome child who through some undeserved stroke of good fortune got to have the very best, most loving and patient and beautiful mother in the whole world (“SSP” 243).

Furthermore, ‘in return’ invites us to consider the potential duality of meaning in the titular “[...] Present” – it describes Bullmore’s recursive, circular relationship of two elements in a totalizing, interrelated system by which each node of the system is distinguishable but integral; each is a co-creator of the products of the system. Not only is the relationship between mother and child built upon a series of undesirable presents gifted between them, but there is the sense in which Wallace is using ‘present’ to mean ‘existing’ or ‘occurring now’ and so the child experiences the same feelings of self-loathing suffered by the mother after all, as though the emotion is somehow genetic, or innate between them. In this aspect Wallace is asking us to take another turn: a re-turn to the idea that the mother and child’s shared self-loathing – its magical omnipresence – confirms its homogeneity and is not a product of Bataille’s ideal, heterogeneously-constructed self.<sup>80</sup> Wallace encourages this reading by marking the similarities between mother and child. This mother’s self-loathing, for example, is ‘compounded by the fact that there existed only a very tiny and indistinct separation in the mother’s mind between her own identity and that of her small child’ (“SSP” 242). So the twin positions of mother and child are somewhat hallucinatory, the hallucination being an excess produced by the homogeneity of her self-loathing in the first place. In the same manner that the patient’s attempts to communicate her mental anguish outward in “The Depressed Person” ultimately reified her isolation, her subjective experience of the pain, so here the fact the mother’s abject traits have been gifted back to her by the actions and attitude of her child mean – once again – that there is no escape from the self. The hallucination compounds the isolation; it is paradoxical to the extent that the child is of a separate, or different material being, but which, because it suffers in the same present, disorders that narrative and serves only to reinforce the sameness of their material being. In this story, even the capacity to expend the accursed share outwards, into the realm of another being, their being separate only in a ‘tiny and indistinct’ way denies the mother access to the essential, transitional space between inner and outer psychic reality where her accursed share can be expelled or destructed. In this then Bataille and Winnicott offer a communion of the transitional space because were the mother able to access it, see the objects of her mental

---

<sup>80</sup> The evidence of Ross’ previous medical encounters appears to confirm this absolute split between the ideal cases of instituted medical scientism and the individual cases theorized in medical humanism;



anguish retain some element external to her being, she would be able to confirm the existence of a world beyond the prison of her torments and see the material and mutable qualities of her pain. She could play with them as way out of her 'unending psychic shit'.

So it went, throughout his childhood and adolescence, such that, by the time the child was old enough to apply for various licenses and permits, the mother was almost entirely filled, deep inside, with loathing: loathing for herself, for the delinquent and unhappy child, for a world of impossible expectations and merciless judgment. She could not, of course, express any of this. And so the son—desperate, as are all children, to repay the perfect love we may expect only of mothers—expressed it all for her ("SSP" 244).

And so, to conclude, I return to Wallace's depiction of suicide, albeit the specter of one in an event that haunts the story but is never explicitly represented. Instead, we are left to diagnose that the son's 'express[ing] it all for her' is the act of his suicide and that his suicide is itself a "Present" to the mother. His gift to her is to take his own life and so expend the wealth of self-loathing and abjection that has accrued between them. His gift to her is to destroy the excesses of a their lifetime's mental anguish, the 'tears and self-recriminations ... and impossible expectations and merciless judgment and unending psychic shit' ("SSP" 244) that until his death they were bound by and which returned to her time and again, and which imprisoned them in a sickly homogeneous existence, that inescapable place of solitude where the useless excess threatened them from within and denied them community beyond themselves because they could not be accepted as part of the narrative of a healthy social order. Whether we consider the son's last act rational or irrational is no matter, it was all either could hope for to end the feeling so what matters is that it represents a Bataillean expenditure, without utility or profit; it is the catastrophic destruction of the accursed share, and in this way, his suicide is a gift, sort of.

If every suicide is a tragedy and every single life lost to suicide one too many, then we have to find a way to educate people of the mental excess and homogeneity of the depressed and suicidal self, which operates only in a recursive loop to confirm there is no space to externalize the self-hatred and desire to self-annihilate, and transition out of yourself; that there is no object beyond yourself but just yourself, in trapped, subjective isolation and pain, no community of recognition of the feeling beyond yourself but just yourself and the feeling... Unless

To conclude this analysis, I would like to propose that Wallace's suicidal narrative in "Present" disorders the instituted orthodoxy to depict it as an act of empowered agency; a productive act of empathy that has medical value. This reading takes us to the material and mutable aspect of Wallace's text as an artwork; in the first he presents to us the material object of a story that is a "case study" presentation of the actually-instituted medical orthodoxy of diagnoses of depression and its suicidal factors, and which the reader can readily diagnose. But, so the story goes, in the act

of listening to the material text as it presents to us, we transition from the materiality of this narrative as the object produced by the reader, or “diagnostician”, to narrative as the object produced by the storyteller; the text itself, or “patient”. Our material understanding has been made anew at the point of transition between the intersubjective exchange of the author and the reader and so the mutable factuality of the story is made clear, which – in the case of depression and suicide, is precisely what medical orthodoxy needs to reconstruct itself in accord with, because only that case attends to the whole person; the individual story of the person who is suffering.

The pertinent response to this problem – as I have alluded to throughout these past sections – is the medically humanist discipline of narrative medicine, which praxis reifies the patient’s story and establishes the critical need to attend to their narrative of their medical experience. It asks that medical practitioners operate in respect of the ‘patient as a text’, calling on the skills and practices of literary analysis to validate the patient’s story of their medical encounter. However, as Mayes’s discourse on Foucault addressed, if the physician must embark on a hermeneutics in the medical encounter and assume the role of ‘storyteller’ (Verghese), we risk reverting to its finding that the medical gaze is a totalizing one, allowing for no other interpretations of the body; we risk reaffirming medicine as an ‘always clinical’ community (A. Nussbaum). As such narrative medicine’s artful effort is not necessarily the solution to the problem of medicine’s so-called scientific inhumanity. In fact, the very existence of a dichotomy between medical science and medical art is part of the problem and draws out the consternation of many medically humanist scholars because it maintains the polarized positions that imperil the field. What emerges from the discordant voices is the call to dismantle the paradigm. Its proposals identify the need for a truly intersubjective praxis, a praxis that destructs the subject-object divide and operates from a democratic space of exchange – not in opposition but in mutual relation and co-creation; a realm in which the distinctions between the practitioner and the patient are not constructed in abjection, or denial, or exclusion, but are rather accepted, integrated and respected. I contend that the discipline of narrative medicine *is* in accord with this paradigmatic shift as its efforts are attendant to an individualized medical ontology. By reifying the efficacy of subjectivity in the medical encounter, narrative medicine creates a democratic space for the subject in pain whose whole person may be tended to.

Verghese and Nussbaum are marginally opposed in this regard and it is the latter’s concern about an ‘always clinical’ community that reformulates the position of practitioner-storyteller as a clinical need invested with the problematic manner by which doctors have been called upon to ‘read the right texts’ in order to restore the humanity to their practice. The contention is that that this practice risks reifying the medical gaze as the totalizing, privileged node of power in the medical encounter. Nussbaum identifies three concerns in the proposition of doctors as storytellers, which reside in the

responsibilities inherent to the practitioner-patient exchange and what the practitioner and patient are not responsible for in that exchange. The first is evident from the Foucauldian issue of the medical gaze; if the doctor is the storyteller – the author – of the “patient-as-text” then they assume authority for the truth of the patient’s material being. This has its corollary in the second concern, which is that the doctor, as the sole reader of the patient, thus assumes the power to impart the sole meaning of the patient’s life. The third position we can trace to the “gallows humor” of the ‘Staffers’ in *Infinite Jest*, which is that the lack of ‘therapeutic distance’ between doctor and patient that is the consequence of this position of ‘full responsibility’, is likely to result in alienating the doctor from their patients because its demands are unsustainable from the position of self-care (A. Nussbaum 390). Nussbaum’s proposal is that doctors assume a role akin to that of a ship’s captain:

[F]errying people through the seas of illness and depositing them on the other shore either to continue their lives or reconcile themselves to death. In this possibility, a physician maintains therapeutic distance—an awareness of the limits of medicine and of what physicians and communities outside of medicine can and cannot do when a person is ill—and avoids becoming the sole reader, interpreter, and teller of his patients’ stories (390).

The ‘physician-as-captain’ offers a medical, interpretive space, in which patients maintain authorial power as the narrator of their own experiences and in each telling the possibility of the (heterogenous) mutable case remains because the exchange with the physician is intersubjective, so long as the doctor does not assume the position of the storyteller. If the power of ownership for the narration of their story remains with the patient, both practitioner and patient retain independence from the ‘full responsibility’ of authority for the medical truth of the exchange and so instead operate as twin mediators of truth. In short: Winnicottian co-creators in interrelational play; playing ‘a role in someone else’s story’ but not, after all, ‘responsible for pulling the story together and giving the story its meaning’ (399).

*“My mum attends to people in grief; she deals with bereavement daily and witnesses the effects of trauma in the care of families and friends whose loved ones are dying or have died. I am in awe of people that are able to maintain care for other people for a living, for a lifetime. I feel barely able to do it for myself, today. I have also wondered on the toll it takes. How do you do it, day after day? But then maybe it doesn’t take such an exacting toll – maybe that’s part of the myth of the thing... But it seems to, from my viewpoint, from far away from the meat of it. I know I couldn’t do it; that much I know. I couldn’t live with how it feels and affects me; it’s too much; too much pain; too much feeling; I know I couldn’t provide the support to people in need, day-in, day-out. I couldn’t provide the giving it takes. It empties me and I haven’t yet learned to save something back for myself, without shutting*

*myself off completely, rather I just run until I am depleted and have an excuse to evade and avoid. I am not a professional caregiver.*

*As I sit here reflecting on it, I realize now that they may be part of the problem.*

*I wonder if the necessity to safeguard the people that care for us, who help heal us and whom we need to protect from the weight of full responsibility for anything beyond the medical encounter under its medical gaze – is another factor, or function, of the orthodoxy medical humanism provokes to challenge. If the practice and language of care was a more common proclivity in Western societies, was part of the mix of daily living, part of the mix such that death, for example, or mental health, or suicide, was more readily discussed and educated for, and the experience more localized; rather than outsourced to the homogeneous spaces of the institution, far removed from the heterogenous communal spaces between our family and friends and... life. Well then might there be less of a burden of responsibility on the caregiver? I envision a medicine in which the daily traumas of our medical encounters – for practitioner and patient both – is shared and expressed outside of the confines of Institutions of care; that it is more akin to a common responsibility, that it is part of a story we can all attend to and are in play with; a process of simple empathic and personal interrelation and not one limited by the constraints of a professional relationship.”*

Nussbaum concludes with the suggestion that captaining patients through the medical encounter could constitute a true renewal of medicine, as it would offer a route beyond the enclosed and intense exchanges of the medical encounter, to communities, where lived stories and accounts of what it means to be in sickness and in health are expressed, because it is ‘communities, not just physicians, [that] help author our bodies and lives’ (399).

But then again: what professional or community can the patient who has been made abject by their very being turn to, to tell their story? If the world beyond them does not recognize them, or does not provide the space into which they might transition out of abjection, but in abjection refuses to countenance the possibility of their acceptance and merely affirms their exclusion from the world; well then they have no access to a shared story, no point of communion in the world. They would have no means but their own to explain or express what it means to be in sickness and in health. They would have to make a story of themselves; to chart the choppy waters with no captain to ferry them and take what they could from the world of shared signs and material things and make them their own; to tell a new story; a punk story; a pirate’s story.

*“From what I recall and what I’ve been told, I was a precocious reader when I was a child.<sup>81</sup> I gained an enormous amount of comfort reading stories; I found relief in them, often, and often it was as though I was somewhere else when I read, some place beyond myself, or outside of myself – outside and away from my suicidal thoughts – as if filling my thoughts with new stories was a way of feeling differently about my own. I was an avid listener too, to songs and stories and people, audiobooks especially, which I would listen to during the night, not sleeping, or making up stories of my own, with my teddies and toys. *The Giraffe and the Pelly and Me*, as read the author, remains my favorite of those audiobooks and contains my favorite closing lines of any book, ever:*

*All you do is to look  
At a page in this book  
Because that’s where we always will be.  
No book ever ends  
When it’s full of your friends  
The Giraffe and the Pelly and me.<sup>82</sup>*

*I cannot say exactly what magic happened when I heard that story and in particular those last lines, but the combination of those words and Roald Dahl’s wondrous voice was the start of it all; it was a marvelous medicine indeed. Those lines gave me something that has informed everything I love about story-telling and the sounds of words at play to this day, something very important about words and sounds that I take for granted as a fact of life: that they are materially affecting, which is to say that they can create, induce, inspire or provoke effects in me, real effects; physiological effects; psychological effects. They have power and substance in the world. I have always assumed that the same is true for everyone, whatever their language or capacity with words and however differently they may be able to communicate. Whether you think of their substance in the world as the soundwaves of the physical production of air through the material objects of the larynx and our oral and nasal cavities, or as the substance of emergent signs of meaning in the world and its methods of record, it is clinically and critically understood that the speaking of a thing is an act of agency and empowerment, of self-expression and realization; that words can hurt and heal; that naming a thing gives us a power over it, whether for goodwill or ill.*

*To my mind, among the most eloquent espousals of this truth, universally acknowledged, is that of Tony Award winning playwright, performer, and activist, V [formerly Eve Ensler], in a spoken essay for the radio program “This I Believe” on the NPR network and edited for the collection, *This I Believe: The Personal Philosophies of Remarkable Men and Women* (2006). I will cite just its opening, here:*

---

<sup>81</sup> I concur; Ross did read a lot when he was young. I recall his being given the freedom to read during lesson times when he’d finished the tasks at hand, at both infant’s and junior school, and at the end of some of school days he was allowed to read to the class from the books in the classroom library. He also read a lot of horrific pulp fiction, literally horrific that is.

<sup>82</sup> I know this one, it is by Roald Dahl (32).

*I believe in the power and mystery of naming things. Language has the capacity to transform our cells, rearrange our learned patterns of behavior and redirect our thinking. I believe in naming what's right in front of us because that is often what is most invisible.*<sup>83</sup>

## A Clinical Intervention in Visible Women

As Luce Irigaray made plain in *Speculum of the Other Woman* (1987 [1974]), the position of the female subject ‘remains in unrealized potentiality’ (165), which is to say that theories of ‘the subject’ and subjectivity are always theories of the heteronormative masculine. This point was taken on in Linda Hutcheon’s address of ‘the subject’ in *A Poetics of Postmodernism* (chap.10), which affirms and extends Irigaray’s site of orthodoxical order to include ‘theories of bourgeois, white, individual, western “Man”’ (159), thereby interpolating within the dichotomy of ‘subject-object’ a paradigm by which it is understood as ‘male-female’ or ‘masculine-feminine’. If we consider this a point of order in the narrative of feminism and transposition to the fictional cases I have considered so far, we can see affirmation of that order from my forays into *Infinite Jest* and the stories in *Brief* thus far, which focused exclusively on women as the subjects objectified and constructed in accordance with medical gaze. However, what I have not yet addressed explicitly, and what cannot be overlooked in this discussion, is the specific situation of “gender” in the medical encounter because gender differentiation has a significant impact on instituted readings of mental health and suicide, and, more vitally, the imposition of identity and subjectivity.

First though is to establish exactly what manner of tumor we are dealing with, to ensure the precision of the surgical incision into it. This means establishing the site of masculine-feminine orthodoxy and the narrative orders instituted therefrom. In countermanding the orthodoxy I will draw from a wealth of gender and feminist scholarship to clarify the position of ‘the female’ as the abjected term in the masculine-feminine formulation and, transposed to the medical encounter, illustrate how medical orthodoxy maintains that orthodoxy and – in some instances – establishes it from the beginning [*ab origine*]. To continue in the disorderly methods of “Sick Literature”, I will extend the orthodoxical remit of the medical space in sympathy with congruent orthodoxies in the institutions of the academe, literary canons, and critical studies. Beyond the medical space then, this effort will outline how the canon of “Sick Literature” is – most of all – a case-by-case literature, an appellation that recognizes its potential efficacy as a model for intersubjective praxis in line with medical humanism’s ambition to treat the individual, not the ideal. I will argue that each text or “case” attends to a sickness that is materially instituted in accord with a homogeneous derivation of ‘sickness’ according to some order of narrative. But the sickness extends beyond the material case,

---

<sup>83</sup> An audio record of the essay is available in its entirety from NPR’s website, [npr.org](http://npr.org). See: Ensler.

disordering it in recognition that materially instituted constructions provide the measure against which the play can begin, and by playing reifies each individual subject on its own merits, according to its own narrative.

Our first experience in the medical encounter exposed the subject-object divide through Wallace's presentation of Kate Gompert and – fittingly – we read about a woman whose subjectivity is denied by institutional orthodoxy. It would have been remiss to assess the significance of gender in Wallace's presentation there however, because Wallace is writing from the position of 'an academic brat' (Katovsky 6) steeped in heteronormative masculine orthodoxy, but given this thesis is offered as an exercise in narrative medicine and asks that attention is paid to the storyteller, it would be hypocritical of me not to honor that ambition in stories other than my own. So, knowing full well that there is a whole history of criticism invested in the discourse of authorial intention and its role in works of fiction, I will *start* from the premise of good faith in Wallace's own words on the matter and try and listen to what he has to say. In "The Salon Interview" Wallace suggests that the *Infinite Jest* is an attempt at writing what it is like to live in Millennial America:

[S]omething that doesn't have very much to do with physical circumstances, or the economy, or any of the stuff that gets talked about in the news. It's more like a stomach-level sadness. I see it in myself and my friends in different ways. It manifests itself as a kind of lostness. Whether it's unique to my generation I really don't know (Miller and Wallace 59).

And for Wallace, America towards the turn of the millennium was sick. The consensus in the scholarship is that this 'sickness' is the recursive danger of the empty language of much postmodern fiction, with *Infinite Jest* positioned as the restorative to its 'dead end [...], a dead end that has been reached because of postmodernism's detachment from the social world and immersion in a world of nonreferential language' (McLaughlin 55). The first stirrings of this disorderly mode emerge from the essay "E Unibus Pluram: Television and U.S. Fiction", which was published alongside an interview with Larry McCaffrey in the summer issue of *The Review of Contemporary Fiction* (1993). This engagement formed the so-called 'essay-interview nexus' (Burn 21) and this nexus, in conjunction with the short story "Westward the Course of Empire Takes its Way"<sup>84</sup>, is often cited as the foundation for Wallace's 'artistic manifesto' (McCaffrey and Wallace). In the McCaffrey interview Wallace states:

In most other cultures, if you hurt, if you have a symptom that's causing you to suffer, they view this as basically healthy and natural, a sign that your nervous system knows something's wrong. For these cultures, getting rid of the pain without addressing the deeper cause would be like shutting off a fire alarm while the fire's still going. But if you just look at the number of ways that we try like hell to alleviate mere symptoms in this

---

<sup>84</sup> Hereafter referred to in-text as "Westward".

country—from fast-fast-fast relief antacids to the popularity of lighthearted musicals during the Depression—you can see an almost compulsive tendency to regard pain itself as the problem. And so pleasure becomes a value, a teleological end in itself (McCaffery and Wallace 23).

If we take this statement alone, we can establish that Wallace is troubled by a function in American society that organizes itself against pain, that the pain-experience is to be avoided at all costs.

Wallace clearly identifies with cultures that regard this abnegation as ‘unhealthy’ because it ignores the potential utility and value in pain-experiences; it ignores that pain can be productive and beyond ‘pain’ alone; that disease, illness, sickness – all can have value. Wallace’s response to his contemporary moment is driven by the impetus to antagonize the ‘complete suppression of narrative consciousness’ that he found endemic to American culture and which, in literature, he hoped to bring back into play:

I guess a big part of serious fiction’s purpose is to give the reader, who like all of us is sort of marooned in her own skull, to give her imaginative access to other selves. Since an ineluctable part of being a human self is suffering, part of what we humans come to art for is an experience of suffering, necessarily a vicarious experience, more like a sort of generalization of suffering (McCaffery and Wallace 21-23).

Timothy Jacobs holds that the novel establishes ‘an aesthetic that combines order with originality’ to create an ‘new space’ in American fiction in response to postmodern suffering and its bequest that – according to Wallace – has muted literature’s capacity to provide real community between humans. Jacobs frames this as a consequence of an aporia between writer and reader that is the result of postmodern literature’s aesthetic abandon but which Wallace revives in ‘the mimetic tradition of realism’ in accordance with a canon of literary conventions and adherence to past aesthetic rules (215–16). More than simple adherence however, this ‘new space’ reflects what Wallace scholarship refers to as ‘New Sincerity’, which, in Adam Kelly’s reading (cf. Konstantinou), urges the relinquishing of the self, such that ‘the fiction of the New Sincerity is thus structured and informed by this dialogic appeal to the reader’s attestation and judgment’ (145) – a position that is regularly lionized in reference to Wallace’s proclamation that ‘fiction’s about what it is to be a fucking *human* being’ (McCaffery and Wallace 26 {Italics in original}). Christopher Bartlett acknowledges a dialogic appeal in Wallace’s movement away from postmodernism, championing the novel’s ‘conversation-like’ structure for asking the reader to ‘actively participate’ in its reading:

[F]irst, it breaks the cycle of passive consumption of entertainment (common in television and, as Wallace states, revived Realist literature); second, it allows Wallace to engage an audience and to present grand narratives and themes, as well as clichés, without fear of the “eye rolling” and cynicism that had characterized postmodernism (374).

Timothy Aubry situates the cognitive challenge of Wallace’s intentional game between postmodern irony and a new sincerity that revolves around ‘a reductive polarity’, a framework analogous with



the interrelational, dialogic, circular phenomena I have traced through Bataille, Bullmore, and Winnicott, here divided between 'drug abuse, irony, excessive self-obsession, mass-culture entertainment, hedonistic pursuit of pleasure' and the oppositional elements of 'AA-sponsored sobriety, sincerity, empathy, difficult art and authentic feeling' (213). Relatedly, Petrus Van Ewijk identifies a solution to the addictive, totalizing reflexivity of postmodernism solipsism and an escape from homogeneous self-realization in the articles of Alcoholics Anonymous, which language games are a central tenet of the novel's exploration of earnestness (Ewijk 132). AA's 'meetings' represent the hermeneutic crux of the novel, in which Wallace confronts the paradox of the 'double-bind' (Curtis 39) and which here describes a figuration 'for self-imprisonment and transformation' that encapsulates a narrative of decline and fall, recovery and re-integration (39–42) – an interrogation by which Wallace contends with the paradox of the divided self on the level of individual addiction (44) and collective addiction (45).<sup>85</sup>

According to his biographer, D.T. Max, Wallace chafed at the clichés of AA, the "Attitude of Platitude" (Jest 706), and the "cheesy 1930s adman vocabulary" of the Big Book (Max 139), while David Letzler conjectures that there is the potential for an empathic, engaged response from readers to Wallace in these episodes, a positive reaction because the 'empty, easy clichés' of AA and Ennet House provide 'relief from the near-unreadable manic overload in the novel's other sections' (Letzler 143). It was exactly this attitude towards readerly engagement that leant Max to claim '*Infinite Jest* [...] didn't just diagnose a malaise. It proposed a treatment' (214). So whilst Wallace's 'new sincerity' was not necessarily the solution to the complex relationship between the text and the world, nor a comment on his generation exactly – much of the scholarship problematizes Wallace's positioning as antagonistic to his literary forebears and contemporaries (Roberts and Jackson) – it presents as a warning to future generations of the risks at play if 'certain [narrative] cycles are not broken and replaced with salubrious, conducive alternatives' (Bartlett 375). Similarly, the four interviews that comprise the homonymous pieces of *Brief* seek to interrogate the therapeutic process and expose the hideous nature of the misogynistic men at their center, which Wallace proposed as "'a parody (a feminist parody) of feminism'" (Max 247) that 'add up to a comically unappealing and disconcertingly vivid portrait of the American male and his view of women' (Merritt). Simon de Bourcier allies to the novel's vivid portrait as a 'mimetic polyphony' that conjures up individual persons through distinctive argots, idioms and patters of speech but all of whom contend with the

---

<sup>85</sup> Here 'the divided self' is taken from R.D. Laing's work of that name (1960). Foundational to Laing's work was the belief that it was impossible to be objective towards a person in the medical encounter without dehumanizing them, a deformation of the person into an object or thing, i.e.: 'To see "signs" of "disease" is not to see neutrally' (31). For a survey of the book's reception and impact in the fields of psychoanalysis and psychiatry in the years since its publication, see: Smith; Itten and Young.

issues of 'recursion, self-consciousness, and whether being consciously aware of a bind and/or radically honest about it even lets one out of the bind' (15).

In all of this then is the trace of the medical encounter as a common motif within Wallace's works and within commentary and scholarship of the novels more generally; all stemming from the wealth of critical work devoted to his post-irony; post-metafiction; "New Sincerity" cure. It is this latter, culturally curative vein, into which I would like to inject some disorderly mix of stimulant that addresses the treatment of "New Sincerity", in critiques of elements of Wallace's "Sick Literature" that have ill effects and which articulations do not accord with the homogenizing consensus, or narrative order of things.

This disorder begins from the perspective that that Wallace the author is in the position of instituted power in relation to a much more pervasive, persistent and insidious medical orthodoxy: *Infinite Jest* presents a narrative 'geared exclusively towards the novel's white male characters' (Roberts and Jackson); for many Wallace is seen as the 'lingua franca of a certain subset of overeducated, usually wealthy, extremely serious (mostly) men' (Shephard). Likewise, while Stephanie Lambert recognizes the narrative that "Westward", in conjunction with the aforementioned 'essay-interview nexus', is Wallace's manifesto and affirms its pursuit of the reality beneath postmodernism's inauthentic presentations within the broader cultural reaction of 'New Sincerity', she critiques the narrative from a position of disorder to claim that the orthodoxy actually reproduces the 'cultural logic of neoliberalism' (395). Her skepticism is pursuant to an diagnosis that reads Wallace in a misogynistic frame of mind and exposes the misogyny 'that underlies the quest for sincerity and foregrounds the specifically gendered consequences of the forms of value extraction inaugurated by neoliberal capital' (396).<sup>86</sup> So the positive appraisals and affirmations of Wallace's consciousness of the 'bind' of *Brief's* feminist parody of feminism is problematized by probing Wallace's presentation of the bind in the physical construction of the text. It is a materially constituted fact that the female interviewer of the novel's four male subjects is omitted from the text, her questions are silenced. The positive view would reify this as Wallace's parodic excision or figuration of the abjection of women – or 'the female' – but it is also a literal excision that Wallace held power over, and the reader is left to observe the presence of 'the female' only from what can be inferred from the male orthodoxy – literally and figuratively. In an interview for *Publisher's Weekly* (1999)<sup>87</sup>, Wallace himself suggests that the female interviewer is the book's protagonist and that "Something bad happens to

---

<sup>86</sup> Wallace's "celebrity" has been the subject of increasing criticism in recent years, and his reputation diminished significantly in light of revelations of his violent behavior and abuse of a former partner, poet and memoirist Mary Karr, in addition to a number of new allegations emerging from the #MeToo moment (Garber; Taranto).

<sup>87</sup> Taken here from the edited collection from Stephen Burns, *Conversations with David Foster Wallace* (2012).

her over the course of the book [...] like something *really* bad” (Stein 90). His response to questions on the book’s probity is disarmingly frank but equally telling:

“I had no idea quite how upsetting the book was going to be, or that friends would see it as reflecting things that were going on with me – which, if that’s true, then I’m the literary equivalent of the person who writes ‘Help me’ on the mirror without knowing it” (Stein 90)

It is the admission that the book reflects aspects of Wallace himself that drives Lambert’s examination of the ‘spectacularly tortured embodiment’ in his early texts as a means of restoring referentiality to the abjected subjects within them, and the readers without them, but which also signals the ‘impossibility of referentiality’ that emerges as a consequence of the mediated authorial position (Lambert 407). This invites us to consider how trustworthy such an obviously mediated stance is. As such, *Brief*’s overt parodic stance risks Wallace’s having his cake and eating it, by presenting its misogyny from the inculcated position of misogyny in its textual objectification and abjection of women. This is a concern following a reading by Mary K. Holland, who counters that *Brief* is rather a parody of chauvinism. It is a common parody ‘that so often finds a way to cloak itself with’ feminism and sees Wallace exert his own masculinist orientation and a sense of complicity in the objectification of women in some of the stories (Holland 74). The simultaneous critique/complicity that defines Wallace’s oeuvre, in *Brief* incites Holland to consider the ‘fairly male’ field of Wallace studies as a whole, its paucity of female voices, concluding:

One wonders how many other readings and lenses distort themselves in order not to see the implications of gender and power dynamics that Wallace so consistently puts before us. This denial of all sorts of gender issues constitutes a blindness at the heart of the considerable insight thus far gained from Wallace studies (75).<sup>88</sup>

If we consider *Infinite Jest* in this light, in addition to Kate Gompert there is Joelle van Dyne whose meticulously planned, ‘most deliberate’ (*IJ* 236) suicidal attempt occurs at a social gathering in a performative act that speaks to its spectacle and suggestion that she wants witnesses to her pain, rather than an end to it as such. A critical engagement with Katrina Jaworski reveals the novel’s presentation of acts of suicide and the specifically ‘failed’ acts of attempted suicide, reinforce notions of gender as the privilege of masculine and masculinist social structures in Western society. Jaworski argues that medical orthodoxy assumes it is operating from the perspective that the body in the morgue is an ‘autonomous, stable and visually mappable tableau for displaying suicidal intent’ (49). This clearly alludes to Foucault’s construction in *The Birth of the Clinic*, with Jaworski’s argument attacking the orthodoxy by exposing the influence of the medical institution, its language and gaze, as constitutive of the medicalized body and thus, any position on the dead body’s

---

<sup>88</sup> For additional readings that problematize the milieu of Wallace’s critical and complicit presentments, see: (Himmelheber; Hayes-Brady).

neutrality 'cannot exist outside social and cultural norms that condition how knowledge about suicide is constructed' (49), cultural norms that are detailed expansively in Brown's survey of its history in *The Art of Suicide* and which confirm the supposition of suicide's gendering (e.g. R. Brown 135–37, 146–48). As another example of the epistemic failures of the medical institution, to recognize and reflect upon the limitations of its extant orthodoxies and what is excluded by their construction, the likelihood is that suicide will persist as a predominantly 'male act' that the medical space produces and reproduces, denying, ignoring, and overlooking the possibility that 'female acts of self-harm are "true" suicides' (Jaworski 59).

Jaworski states that it is in the autopsy room where the inscription of gender determinations most obviously manifests, because it is 'post-mortem examination [that] is crucial to verifying whether what appears as lethal is an actual cause of death' (p.49). We saw from Foucault that the clinic provided the means by which medical truths were exhumed to be mapped on the visible surfaces of the body, and so too we can see the truth of it by returning to the suicidal act at the end of *Present*. The revelation that the death of the son occurs outside of the material text of the story, which requires that we read the act of suicide after the fact; the act exists outside of the subjectivity of the suicidal son and is introjected instead by the reader. This neatly correlates with Jaworski's contention that there is a 'gendering of suicide via the autopsy, which means that it fails to sustain self-destruction as ontologically secure' (49). In other words, the presumed ontological security exhibited by a self with subjective self-awareness, after the act of suicide, is unsustainable – obviously in the sense that the self is literally no longer, but also because it falls upon the medical gaze to construct the narrative of the suicide and in so doing the narrative of the preceding life, which must be ordered – recalibrated or reconfigured – to secure the reading of the suicidal act as the culmination of that life as it was lived. This is not the position of Nussbaum's 'practitioner-captain' then, but more like Verghese in the guise of practitioner-storyteller, clearly at risk of supplanting the meaning of the life that was lived by the suicide. In some sense the autopsy space best exemplifies the extant power of the medical gaze, because it cannot offer a narrative medicine, but become a narrative interrogation, 'an interrogation room, where deceased bodies are framed as yielding their secrets to determine whether what appears is indeed self-inflicted' (Jaworski 53).

## “Sick Literature” as Figurative Disorder, Literally Speaking

So far, I have demonstrated how aspects of David Foster Wallace’s *Infinite Jest* and *Brief Interviews with Hideous Men* reflect the extant orthodoxies of institutional medicine by their presentations of medical subjects-made-objects under the oppressions of the medical space and medical gaze. This attends to the extant ‘additive’ view of medical humanism that maintains the narrative order privileging ‘scientism’ over ‘humanism’ by framing the value of the arts according to what they may contribute, solely on the authority of what has been predetermined by ‘scientism’ as valuable. The next part of my story addresses the concept of “Sick Literature” according to its provision of the ‘integrated’ concept of medical humanism. In this it contributes to the need for a model that deconstructs and democratizes the parameters by which medicine institutes its orthodoxies and constructs its patients as medical objects and is in service of an intersubjective medical theory that attends to the individual subject of the medical encounter as a whole person. I will begin by outlining how a foundational element in “Sick Literature” is its construction of “disorderly” narratives.

Let me first acknowledge that there is no consensus on narrative; it is applied across disciplines with each definition attending to those discipline’s specific predilections and contexts. If we accept the conceit that narratives are “constructions that privilege an arrangement imposed upon a particular set of events, over a particular period of time” then a consensus can be reached about what constitutes “narrative order” according to the orthodoxies of any historical moment, or culture that describes the status quo. Therefore, I will present narrative within works of ‘Sick Literature’ as a “disordering” of the status quo such that the terms ‘order’ and ‘disorder’ be taken as oppositional nodes in the by-now familiar model of dichotomies; in this sense ‘order’ and ‘disorder’ are analogous with ‘conventional’ and ‘unconventional’, ‘orthodox’ and ‘unorthodox’ etc.

In literary theory, for example, the concepts of the “literary canon” and “literary genre” operate as metonyms for texts that adhere to a ‘narrative order’ according to their constitutions within such. To extend the example further, we might take an historiographical approach to our literary scholarship and institute a ‘narrative order’ in the consensus that marks the twentieth century turn from the discourses of modernism to postmodernism to post-postmodernism. In short, the approach here is attuned to the broadly dualistic conceits identified elsewhere in Ross’ thesis that posit entities in opposition to their inverse or other. However, the term ‘disorder’ suggests an obvious medical context and in this sense its suitability as a descriptor of ‘Sick Literature’ requires a little more parsing. There is still little consensus on what constitutes a medical disorder in the Western medical tradition, but in 1978, ahead of publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, a working-group was called upon by the American Psychiatric

Association's Task Force on Nomenclature and Statistics to provide a definition. It serves my purposes well. The proposed definition reads:

A medical disorder is a relatively distinct condition resulting from an organismic dysfunction which in its fully developed or extreme form is directly and intrinsically associated with distress, disability, or certain other types of disadvantage. The disadvantage may be of a physical, perceptual, sexual, or interpersonal nature. Implicitly there is a call for action on the part of the person who has the condition, the medical or its allied professions, and society (Spitzer et al.)

So, taking this piece by piece: the matter of "Sick Literature's" organismic dysfunction is evident in its material objects – the physical matter of the texts and their structuring or form of narrative. In their fully developed and extreme forms, this dysfunction extends to the content of the novels, or what the narratives say for themselves. In this sense we can posit the novel's 'organism' as the composite of its form and content, or a symbiosis of those terms in the material object of a text. These texts' dysfunction – i.e. sickness – is as objects that disorder the functional – i.e. healthy – narratives that may be taken as constituted by order of institutionalized measures of orthodoxy. So just as our medical institutions constitute concepts of 'health' and 'sickness' with a 'narrative order' of our "living a healthy life", so our my sense of 'narrative disorder' reflects the disease, illness, sickness, trauma... that disrupts that life. For example: let us say the academe institutes a concept of 'structuralism' as the 'narrative order' out of which 'poststructuralism' emerges as its 'disordering' response, but then also 'poststructuralism' might be instituted as a 'narrative order' to which 'post-poststructuralism' is its disorderly other etc., etc. – Anything may be taken as the narrative order in these terms and thus any discourse taken as a dysfunction of narrative order. It all depends upon the contextual matter – or to return to our medical argot – the patient history of any given case. It all depends on whose story we are attending to and what is at play.

So, of crucial importance to this broad definition is that "Sick Literature" is an appellation to the efforts of narrative medicine and its attendant praxis of intersubjectivity; that 'sickness' *qua* 'ill health' is dependent on the context of the individual patient; it is a case-by-case conceit, a case-by-case literature. Here is where the 'call for action' emerges as it accentuates the agency implicit in the pursuit of 'wellness' or 'health'. We might say that 'sickness' is contingent upon relational exchange, such that when you are 'sick' there is a dysfunction in your subjective experience of being and you are no longer able to maintain a narrative order of 'wellness' or 'health'. In life, so as in art [and vice-versa]; we have interrogated Wallace's spaces long enough and have seen something of this circular relationship before, in the seemingly oppositional terms of a system operating beyond their distinctions as mutually reinforcing co-constituents modelled in a mode of interrelational exchange. The conclusion is that if narrative medicine is about attending to the stories of its patients, I would do well to transition away from Wallace's own orthodoxal, patriarchal presentations of 'the

female' and attend to a more cogent exploration of the specifically gendered and sexualized expressions of subjectivity experienced by women in the medical encounter. I would better be listening to women themselves. For this, I turn to the punk and playful fictions of Kathy Acker.<sup>89</sup>

Margaret Henderson offers the best, most extensive interrogation of Kathy Acker's punk identity, providing a series of critical inquiries into Acker's fiction, interviews, profiles and reviews to propose a 'unique suturing of the identities and ideologies of the punk and the feminist' ('Kathy Is a Punk Writer' 536) in the body of her work. A survey of definitions of the punk ethos brings Henderson to the conclusion that is 'a movement of (sexual) outsiders, of the abject, the lowly, and the stupid, as well as something – even in, if not because of, its decaying state – volatile and forceful' (537). What is more crucial to Henderson's analysis though, is the intersection between authorial self, the actual self, the publishing industry and the public intellectual spheres of reception and representation for which Kathy Acker was the nexus and her work the conduit ('From Counterculture to Punk Culture'; 'Kathy Acker's Punk Feminism'). In this sense what Acker explores is the self-same heterogeneity that Bataille suggests is the source of identity; that it is impossible to conceive of a subject created in homogeneity. The subject stuck in homogeneity, as I explained from our *Brief* excursions, is the subject in mental anguish, abjected from a community that would recognize them and provide for them a space in the world.

What is missing from the subject in mental anguish; where might they find a space to escape from the recursive pain of their self-sustaining, homogeneously self-actualizing psychic torment?

---

<sup>89</sup> Finally.

## Bodily Material

The Western attitude towards the body in the twentieth century has to do with the act that when reality (or the meanings associated with reality) is up for grabs – which is one of the central problems ever since the end of the nineteenth century – then the body becomes the only thing you can return to. You can talk about sexuality as a social phenomenon, so that it's up for grabs; and you can talk about any intellectual thought and it will be "up for grabs" in the sense that anything can mean anything else and hence be completely perverted. You get to Baudrillard's black hole. But when you get to something called the actual *act* of sexuality, or that actual act of disease, there is a kind of undeniable materiality which *isn't* up for grabs. It's in the body finally which [*sic*] we can't be touched by all our skepticism and ambiguous systems of belief. The body is the only place where any basis for real values exists anymore.

- Kathy Acker (McCaffrey, 93)

Kathy Acker constructs traumatic texts. Her novels have an almost 'obsessive deliberation' in their approaches to matters of bodily pain and present an almost 'ruthless search for a potential free of the strictures of conscribed identity' (Redding 283). In treatments of traumas ranging through incest, mutilation masochism, sexual abuse and rape, her contextual and formal ludic aesthetic and the textual material of the novels embodies prevalent medical understanding about trauma and the effect that trauma can have on one's subjectivity, in sympathy with an illuminating reading by Carolyn Zaikowski (2010), which states:

In their various modes of linguistic and syntactic constriction, hyperarousal, and intrusion, these bodies of narrative go beyond a traditionally coherent telling of events, by using their physical existence as texts to mirror and enact the unspeakable experience of traumatized bodies in the world (203).

Informed by the findings of psychiatrist and trauma researcher Bessel van der Kolk and his seminal text, *The Body Keeps the Score* (2015), this encounter will demonstrate the presence of a vital material feminism in certain of Kathy Acker's novels to emphasize how figurations of female identity and subjectivity are constructed within Western medical orthodoxy. I will argue that Acker's works contribute to the canon of "Sick Literature" by disordering the institutional orthodoxies that order 'female' subjectivity at the site of their traumatic abjection – in which I follow from theories of the abject developed by Julia Kristeva and which follow the concept addressed earlier [above], as defined by Georges Bataille (*Accursed (II-III)*). From out of this abjected position Acker transitions through orthodoxical spaces and the literal objects of her texts to return to the matter of the 'female' body, creating the material for a new subject; a female subject; her subject.<sup>90</sup> My framing of

---

<sup>90</sup> Ross uses the term 'female' here in accordance with the term as it is used vis-à-vis the binary of male/female in the texts in play; it is not an attempt to affirm that binary. In effect, it operates as a modal shorthand in this regard; it is representative more of the convenience of the shorthand in order to observe the dominance of the patriarchy as the prism of CIS-gendered heteronormative men and masculinity. As such the term 'female'



Acker's work in this way provides insight into the correlation between mind and body as integrated, co-creative phenomena of the whole human organism, continuing this thesis' creative-destruction of mind-body dualism and its return to matters of the whole person. In this sense Acker's novels offer an articulation of trauma for people who have suffered similarly, that is: they offer case studies in trauma's effects, but which, in Acker's transitional spaces of play, instruct a material mimesis that reifies the interrelational exchange between the author and the reader to provide a medical, medicinal space into which the effects of a traumatic 'accursed share' can be expressed. This suffusion of Winnicottian and Bataillean philosophy reinforces this thesis' effort to instantiate playfulness as an intersubjective medical praxis and medicine.

Julia Kristeva's landmark essay, *Powers of Horror* (1982), recognizes that 'the plane of abjection is that of the *subject/object*' (64 [Italics in original]), which follows from Bataille in whom the concept of exclusion presents from the domain of things, not human beings. Kristeva's critical intervention was to disorder the objective model of Bataille's assertion and impart the subject at its heart, by instantiating the abject as the "other" without a name:

[T]he *confrontation with the feminine* and the way in which societies code themselves in order to accompany as far as possible the speaking subject on that journey. Abjection or the journey to the end of the night (58 [Italics in original]).

Drawing from Kristeva's understanding of abjection as that 'which lies outside, beyond the set, and does not seem to agree to the [superego's] rules of the game' (2) it is evident that the female characters in Kathy Acker's fiction are abjected entities. In *Don Quixote* (1986)<sup>91</sup> the opening paragraph describes a 'crazy [...] insane' (9) woman, soon to undergo an abortion and whose insanity is caused by a desire to love. She is an abjected figure, medically unorthodox or 'misfitting' (Garland-Thomson) in relation to her mental health, her sexual-physical or material health, and also framed as abject in her subjective self, whereby the very quest to love is 'insane'.

'How can a woman love?' (*DQ* 9) she asks, and which pursuit stands as the conceit that launches the novel into the quest the as-yet unnamed 'her' will undergo. The playful introduction, framed as the "thesis" to Acker's sick text, situates 'her' in a world in which orthodoxies of love, gender, and female subjectivity are introduced and made abject. Acker's proposition informs her readers of the orthodoxy that desire for love is sane because, after all, "doesn't everybody want to be loved?" Distinct from the reader however, 'her' subjectivity stands in a space of dislocation; 'her' desire for love is 'crazy'; her subjectivity made abject in relation to the 'world' because, as a woman, her sexual

---

may be taken as the analogue of "they who are abjected; they who are objectified; they whose subjectivity has been denied them".

<sup>91</sup> Hereafter referred to in-citation as '*DQ*'.

identity and gender has been constructed by 'the dynamics of identification and language' imposed upon her (Ragland-Sullivan, 'Jacques Lacan' 6).

Acker disorders these patriarchal and masculine structures, which disfigure women as abjected entities, by embarking on her own 'quest', a quest for a female subjectivity established without phallogocentric paradigms and which deconstructs the traditional Oedipal narrative by subverting its conventions from within, creating a new, transitional narrative, from which a distinct subjectivity emerges. A female subject. Setting out Acker's interrogation of boundaries of institutional influence in the medical encounter in sympathy with my analyses of Wallace's *Infinite Jest* and *Brief*, the novel's opening section is titled 'Don Quixote's Abortion' and begins:

When she was finally crazy because she was about to have an abortion, she conceived of the most insane idea that any woman can think of. Which is to love. How can a woman love? (9).

While this reifies the same conventions marked in Wallace, it also addresses the specifically 'female' position of abjection that Wallace overlooks, or cannot see. It presents an environment in which women are dehumanized and abused by the practices of medicine and their subjectivity negated by their construction as the abjected 'other' entity of medical procedure. We can see this interpolation at play throughout the novel, but which is instituted from an explicit exploration of the position of women in the medical encounter. Addressing this directly in an interview with Larry McCaffery, Acker stated:

What I was trying to do at that time was to talk about trying to make a text that was an "environment" rather than a centralized, meaningful narrative. I guess what I wanted was to have a narrative that was a kind of "de-narrative" (McCaffery and Acker 89).

As the central conceit of the novel then, '[h]ow can a woman love?' represents the quest the as-yet unnamed 'she' will undergo and informs us of how Acker's 'de-narrative' involves disordering the Oedipal quest, which – in taking its title from Cervantes – at first appears to preserve the masculine, orthodoxal construct but swiftly reveals itself to be a narrative of unorthodox interrogations.<sup>92</sup> This is a position that Terry Brown asserts by conflating 'she' with the authorial self 'Kathy Acker', a rebel overturning convention in pursuit of a feminine voice, identity, and narrative structure. Teresa de Lauretis argues that women must 'work with and against narrative, in order to represent not just the power of female desire but its duplicity and ambivalence' (156), but which cannot be achieved by partaking of another normative narrative 'wrapped around the thematics of liberation' (156). T. Brown thus presents Acker as the feminist artist de Lauretis demands, who 'enacts in her fiction

---

<sup>92</sup> De Lauretis suggests that the traditional Oedipal narrative adheres to certain dictates; it demands that a protagonist completes a quest, defeats a foe, gains information, or conquers an element. All of which is at play in Acker's work.

what feminist theorists [...] have articulated as the crisis of female desire and subjectivity, that is: woman's 'otherness' and her exclusion from narratives of masculine desire, such as the nostalgic story' (T. Brown 171). The text 'follows the structure of the conventional nostalgic narrative, but ultimately resists that narrative'; it is then, a disorderly tale, a work of "Sick Literature" that 'represents the psychic pain that comes from the realization of the impossibility of return' and so instead of a quest that returns to a 'nostalgic dream', 'she' is in a 'nightmare' and there can be no return home (T. Brown 167). That this is impossible is because there is no space for women to return to, a symptom of "Sick Literature" we can diagnose through this thesis' case histories and examine in Wallace's depiction of Kate Gompert's observing the male M.D., who has access to both the external and internal spaces of the psych-ward and can pass between them, through the doorway, whilst Kate could only look beyond, seeing nothing, and without access. There can be no exchange: if the environments of life attend only to the narrative orders of men, the masculine, and the institutions that exert those orders there can be no transition from one to the other, there is only the 'stable', homogeneous world of the institutes of men.

In this 'rough' world Don Quixote's quest in pursuit of love involves suffering physical and metaphysical traumas whilst navigating the orthodoxies and oppressions of institutional spaces, linguistic conventions, and sociocultural constructs. This sees Acker posit a subjective position of abjection in which women are excluded from accessing even the homogeneous realm of the social, symbolic order (Lacan) as the lesser of the binary opposition: male-female and which informs construction of the patriarchal spaces of the text; as Ragland-Sullivan maintains, reading Lacan, the female clings to 'her suffering order to assure the Other of its predominance' (Ragland-Sullivan, 'Discontented Discourses' 214). Marjorie Worthington meanwhile defines Acker's work as a 'genre unto itself' (394), full of 'grim whorehouses, slimy pirate ships, and dark vaginal caves' (389). Identifying Acker as her nominal 'pirate', Worthington parses Acker's aesthetic juxtapositions as textual representations that display the 'cyclical, non-linear time that folds back upon itself and repeats, where events from vastly differing temporal moments are presented simultaneously and often more than once' (394); they are dynamic texts that appear to shift as you read them; living texts that draw attention to Acker's authorial presence as she navigates through the disparate, episodic encounters and draws agency from the reader as they work between passages and paragraphs, illustrations and endnotes; almost tidal or [in Wallace] like a game of tennis, the ebb and flow is central to the texts' disorderly narratives. Thus, Worthington conceives of 'pirate spaces' to explain the material qualities of Acker's aesthetics. This affirms that Acker's ludic textual constructions, her metatextual, asynchronous and dislocated narrative strategies so conceived are thus an exacting but exact model of the traumatic effects described by the pioneering work of Bessel

van der Kolk, whose treatment of psychic and somatic traumas recognizes how trauma ‘inhibits integration of new experience – life continues ‘as if the trauma were still going on’ (53). Much has been written already about how Kathy Acker’s formal luddism – her autobiographical narratives, narrative techniques, meta-textual interruptions and overt plagiarism – all is part of her punk aesthetic and operates to subvert subjective norms through the deconstruction of orders of patriarchal and institutional narrative orthodoxy (N. Jacobs; Brooke; Finck). By formally projecting these constructions and orders of orthodoxy within the material, she is able to disorder them in a mode of destruction in relation with her readers to propose and create new narratives of female subjectivity.

In concurrence with de Lauretis, Worthington similarly contends that the binary model imposed by patriarchal institutions is replicated by orthodoxies extant in cultural and literary theory – the models by which meaning is made. Acker’s narrative spaces are therefore ‘reminiscent of the many demonstrations of how our most pervasive binary structures connect fundamentally to that one hierarchical binary of male-female’ (Worthington 392). These traumatic spaces demand that the reader infer an authorial, ‘material’ truth in the face of relentless deconstruction, so as Acker [and Wallace] promote perpetual deconstruction in form, they defy Barthes their deaths, and instead reveal themselves and speak to their readers *as authors*, on each page. Almost Brechtian but not quite, rather than disappearing behind their novels’ stories, they stand beside them, in conversation with their readers, demanding of them not simply to interpret but more importantly to co-create the story at the point of mutable intersubjectivity and be heard. In Acker, for example, Worthington recognizes:

Stories or sections of her novels will be repeated – often verbatim – eliciting both confusion and a different sort of narrative expectation in the reader. Indeed, readers are often at loss to determine what Acker’s novels are actually “about” in the usual sense ... Kathy Acker’s fictional spaces are not realistic portrayals of places in the world; rather, they seem otherworldly, timeless, mythical, and symbolically significant (389).

From van der Kolk we can model how ‘a sudden and passively endured trauma is relived repeatedly, until a person learns to remember simultaneously the affect and cognition associated with the trauma through access to language’ (van der Kolk and Ducey 271). This provision of a symbolically significant language is the reaffirmation of the subjective position that operates from an abjected literary or narrative space in which ‘the female’ is denied access to the symbolic order (Lacan) as the lesser of the binary opposition ‘male-female’ and which dichotomy informs the orthodoxies that construct the patriarchal spaces of the text. As Ragland-Sullivan maintains, the female clings to ‘her suffering order to assure the Other of its predominance’ (Ragland-Sullivan, ‘Discontented Discourses’ 214). This is how Acker begins her ludic feat: instantiating a subjective point of view or creating a

new point of view – ‘her’ point of view – that sits at an intersubjective distance from the reader, but also – as I shall demonstrate – at a disjunction from the textual material of the work itself. In short: the text operates from a transitional space but also embodies the transitional object, which, through play, creatively destructs orthodoxies of gender and narrative.

The presence of a female protagonist constructed in abject sickness is not unique to *Don Quixote*, however. *In Memoriam to Identity* (1990)<sup>93</sup> begins as many of Acker’s novels do, with birth; she presents a literal and figurative beginning that conforms to an homogeneous order of gender identities and so establishes the novel’s narrative structure along heteronormative lines. Acker is explicit here, confirming this orthodoxy with ‘heterosexual fucking gives women pain’ (*IMI* 3). But immediately here the choice of ‘gives’ rather than ‘is painful to’ ruptures linguistic orthodoxy to better signal what will I present as the playful unorthodoxy in Acker’s modes of expression. It promotes ambiguity here, a lexical misfitting which very act creates the transitional space between the author/text and its reader, wherein mutual play or creative-destruction emerges.

Within this transitional space Acker’s expression contains the reading that heterosexual fucking gives women literal pain (which we might frame in conjunction with the narrative orders, or tropes, stories about “losing one’s virginity” *qua* “it’s my first time” for example) – that the sexual act of intercourse can be painful. In a figurative reading it contains the theocratic orthodoxy of Eve’s transgression in Eden and the punishment of pain in childbirth as what was given by God as the consequence of heterosexual fucking. More significant to this thesis though is that Acker utilizes heteronormative orthodoxy to create correlative associations of sex and menstrual pain and in so doing uses these literal and figurative readings to return to the materiality of women’s bodies and the pain inflicted by a society constructed along heteronormative, and patriarchal orthodoxies.

At first then, Acker offers a position that reifies a traditional narrative of heteronormative orthodoxy: sex is painful for women. However she creates the transitional space of play through the heterogeneous mode of expression found in ‘gives’, which destructs the homogeneity of the syntactical order and so begins disordering the orthodoxy from within by conflating the material of women’s bodies with the materiality of text – that each is constructed object and constructed in traumatic pain by the orthodoxies of the prevailing heterosexual and patriarchal structures by which these objects are constructed. In short, Acker presents us with the conceit that women are modelled as the sick objects and that her text itself is a sick object. She marks out the textual artefact as constructed by the creative-destruction of play by establishing a transitional space in which the

---

<sup>93</sup> Hereafter referred to in-citation as ‘*IMI*’.

reader works to diagnose exactly *how* Acker interrogates the construct 'woman' in the interplay between author and reader and the material of the text and its content.

The confluence of identities that comprise the typical Acker protagonist, which resist coherent characterization, or resist realistic, consistent characterization reveal a disinterest in what Worthington calls the 'metaphoric' elements of linear narratives – 'that one event succeeds another, building tension until an eventual climax of temporal significance is reached' (401) – instead Acker's protagonists are interchangeable and exist simultaneously in the pirate spaces of her novels. How much like our medicine is this disinterest in individual characterization; what I have taken throughout as the medicine of the whole person; of individuals rather than ideals. In theory it is desirable, but in practice it the law of averages and best-treatment; anonymous double-blind testing and economies of scale that have more sway in the construction of medical protocol. As Bataille reminds, medicine necessarily demands a reductionist approach to individual identity because it operates according to the homogenized orders of scientific assimilation where – among other things – market forces determine who has access to which medicines based upon ethics and efficacious decisions that ensure the best bang for your buck.

Paul Patton's reading of Foucault expresses this position well, his expository of the latter's position on autonomy providing the framework to understand Acker's punk position: those subjected to relations of domination can exert autonomy in acts of resistance and will inevitably be led to oppose the dominant structures imposed upon them:

For bodies with the complexity and specific powers of human beings, power is the capacity for various kinds of *action* upon oneself and others. The kinds of action of which a human body is capable will depend in part upon its physical constitution, in part upon the enduring social and institutional relations within which it lives, but also upon the frameworks of moral interpretation which define its acts (74).

Patton thus presents the capacity to act on oneself and on others as an instance of negotiating ethics and politics, respectively. In this context the abortion scene of the novel's opening presents its environment – and attendant medical encounter – as evidence of Acker's pursuit of a position of subjective female agency wrought from the desire to resist the ethical and political impositions of that environment; a desire she attests to in the interview McCaffrey, and which is evident throughout her corpus of works. Tellingly, she identifies the punk movement and a meeting with Sylvere Lotringer for providing her with the framework to explain the 'de-narratives' she produces, Lotringer having introduced her to the works of Deleuze, Guattari and Foucault. In Deleuze and Guattari especially, but '(somewhat) Foucault' she found 'a language for what [she] was doing' (McCaffery and Acker 89). She states:

I suddenly had a theory for what I was doing. Even more importantly, it was a theory that made sense to me because it wasn't just abstract theoretical garbage. It was grounded very much in the political and social world I saw around me. It explained my own anger, which was very much an anger against the centralization of the Phallus (90).

In her protagonist's taking – not adopting – but 'taking' the name 'Don Quixote' for example, Acker yokes together the dominance of patriarchal privilege inherent to the subject-object dichotomy of medically instituted masculinist orthodoxy but extends its sphere of influence to that of its academic, scholastic or literary equivalent – framing her work in relation to the classical canon; it makes clear that it is not just the orthodoxies of the medical institution that are a site of female trauma, but literary ones as well.

Knox provides a comprehensive dissection of this nexus of medical encounter, narrative order and subjectivity at play in the novel, which, tied together in relation to the character's gender becomes the quest or pursuit of a community exterior to the 'sane' community that has coerced her into abortion and determined her 'crazy' (DQ 9). Knox argues that the novel's narrative is Don Quixote's quest to construct a community for herself, but one that may – necessarily – only be possible outside of the 'real' community for whom she is a delusional, psychotic presence (24–25). Her community must be an imagined one, or at least in line with Irigaray in its 'unrealized potentiality' because at the outset she has been excluded by the dominant, medically instituted narrative order. Acker's female protagonist is not a subject in that order; she has no subjectivity and must 'take a name herself' (DQ 9), and so too assumes the guise of a man, 'Don Quixote', throwing-off certain pre-scripted identifiers of womanhood in search of a narrative identity of her own, a disordered identity, unbound from the impositions of institutional determination. As Don Quixote so names herself, because '[s]he needed a new life. She had to be named' (DQ 10), she recognizes its performative function and an active constitution of herself in otherness, or abjection, because all the while she is not a man, she is instituted – or governed – as a form of anti-human, exterior too humanity. 'By taking on such a name which, being long, is male, she would be able to become a female-male or a night-knight (DQ 10) – the conjunction here of 'night-knight' drawing an explicit connection to the journey of abjection described by Kristeva. And so, the quest narrative of the novel becomes a punk act of disordering such that Acker may write herself anew. It is of course paramount that this begins in a medical encounter, with the marking of the medical space's power to order gender from birth. In the abortion scene, which, with the surgical procedure a literal incision anointing her as 'nothing' by killing the life inside her, Acker confirms that it is 'women' – the

space for women; the space for a female subject – that is killed in this procedure: ‘they had never aborted a *woman* like this one’ (*DQ* 13 [my italics]).<sup>94</sup>

As postmodern feminism continues to reveal the structures by which Western societies are organized along the masculine-feminine binary, the efforts of postmodern feminists have seen the urge to shift debate away from the transitions between one side of the binary divide to the other and instead deconstruct the dichotomy itself (Alaimo and Hekman). The effort is sympathetic with several fields addressed in this thesis and can be framed as the reconstitution of those apparent binaries so that they might be better understood, not as oppositional terms but as reciprocal or integrated terms whose presumed or apparent differences exist because of their construction in the first instance. Bataille illustrates the mechanism by which this move occurs in relation to his concept of ‘sovereignty’ – a process by which thought and calculation is suspended (Bataille, *Accursed (II-III)* 197). According to Bataille, the state of sovereignty, which we might represent more conventionally as the phenomenological experience of “being present” or “in the moment” is the only state through which truth unfolds because in the Bataillean dichotomy constructed between humankind and nature (*Essential* 15), it represents freedom from the immaterial or metaphysical and a return to the material or physical.

In short: Bataille conceived of sovereignty in opposition to the ‘project’ – which is the human imperative to order the world as though by design, or, as expressed previously [above], to create a teleological narrative that structures lived experience as purposeful or utilitarian and towards a projected goal. The ‘project’ emerges from the attempt to construct an ordering of lived experience according to a perceived truth, what Acker in the excerpt from her interview with Larry McCaffrey [above] states as ‘systems of belief’ in the tradition of philosophical anthropology (Olafson).<sup>95</sup> Where Acker turns to Baudrillard she invokes the long history of Cartesian dualism that I have touched on throughout and which privileges ‘mind’ over ‘body’ because the mind is the locus of ‘objects of thought’ – as distinct from ‘objects of perception’ [perception is taken to be a process outside of the body, which, through the sense organs, constructs a facsimile of the phenomenological process (or object) within the body]. Therefore: humankind’s capacity to think beyond perception is what is privileged as a mark of its distinction from nature and which in turn distinguishes each human subject from another.

---

<sup>94</sup> One could also consider the work of Laurie Foos in this regard, her novel *Ex Utero* offering a similar quest narrative which – as Susan Squier identifies in her reading of Jorlmon [1995, p336] – plays with traditional assumptions of self/body integrity by interrogating the economies of the uterus, which has ‘long rivalled the brain as a site of core selfhood’ for women (Squier 67).

<sup>95</sup> This a contested field informed by an orthodoxy of scientific materialism that determines facts according to their common level[s] of physical process.



So, Acker's 'systems of belief' represent knowledge produced by phenomena that exist outside of one's mind, but which have a 'mental' or 'meta-physical' location and are 'up for grabs' to be played with as objects of thought. In *Don Quixote* we see this orthodoxy of Western philosophy framed by what emerges as the titular character's project:

She decided that since she was setting out on the greatest adventure any person can take, that of the Holy Grail, she ought to have a name (identity). She had to name herself. When a doctor sticks a steel catheter into you while you're lying on your back and you do exactly what he and the nurses tell you to; finally, blessedly, you let go of your mind. Letting go of your mind is dying. She needed a new life. She had to be named (*DQ* 9-10).

Here Acker marks the 'Holy Grail' as the greatest adventure any person can take, but whether we interpret this as a literal or figurative invocation of the Holy Grail quest, what Acker makes irrefutable is the extant cultural capital or canonical orthodoxy of 'quest' narratives such that it assumes significance as the 'greatest' of them. What emerges from this communion between Acker and Bataille is that these belief systems be understood as abstractions of what is materially real, and which takes form in Acker as a return to the material of female body. They are abstractions precisely because they are constructed, homogeneous 'truths' that emerge from agreement within human experience alone and for Bataille, this is what marked the 'project' (and therefore humanity) in opposition to nature:

Man appears to be the only animal to be *ashamed* of that nature whence it comes, and from which he does not cease to have departed. This is a sore point for us. We have fashioned this humanised world in our image by obliterating the very traces of nature; above all, we have removed from it everything that might recall the way we came out of it (Bataille, *Essential* 16).

He argues that humankind's projects represent an intercession into nature's essence, transforming it into a realm of the artificial. To Bataille therefore, all of humankind's truths could be framed as convolutions of the first abstractions of nature that humankind created to order the world and through which emerges 'the erroneous belief that humanity is an elevation from base animals' (15). We might better conceptualize this move by analogy with the entropic process such that the more we pursue the projects that order our perception of what is real, the more chaotic and complicated and removed from nature's essence the truths those projects establish must be. Take, for example, the human construct of 'disease'; the organism of a disease has no 'project' in a Bataillean sense, it only *is*. As such, it is free from the human effort to bring order to the world and define it. Only humankind attempts to define or construct 'disease' to suit a perceived future benefit, or in relation to narratives of health and wellbeing, and for Bataille this act of projection masks us to the truths that unfold only by achieving a state of sovereignty; by "being present" (Bataille, *Essential* 1–2). We can say then that the issue of disease is not a discourse because it has no project but that Bataille's

concept of the human 'project' necessarily positions all human endeavor at the point of discourse. In short: a discourse between what is materially real (e.g. the "organism" of the disease) and what is not, can be framed in human experience as *only* the abstraction constructed by humankind's projects and which are therefore subject to discourse and therefore, always relational – or mutable. Acker is better at this than I am though and so parses it pretty simply in the quotation above, with reference to sexuality as natural, 'material' phenomena but which, through the mediations of the human organism, becomes a mutable social phenomenon that is always 'up for grabs' because it is at the point of discourse and 'anything can mean anything else and hence be completely perverted'.

To return to Alaimo and Hekman's assessment of these epistemological formulations, they assert that modernism, for example, is grounded in objective access to a real or natural world, whereas postmodernists present the real and material as entirely constituted by language and what we call 'the real' is a product of language and has its reality only in language (Alaimo and Hekman 2). In turn, the discursive becomes the exclusive source of the constitution of culture, nature, society, reality:

Even though many social constructionist theories grant the existence of material reality, that reality is often posited as a realm entirely separate from that of language, discourse, and culture. This presumption of separation has meant, in practice, that feminist theory and cultural studies have focused almost entirely on the textual, linguistic, and discursive (Alaimo and Hekman 2-3).

Here we can trace the stirrings of a postmodern configuration of the world in which everything can be deconstructed by discursive investigation and is therefore: discourse.<sup>96</sup> As discourse human existence must necessarily embrace notions of paradox, which, as was noted by Bataille's concept of the 'paradoxical science' of heterology, paradoxes are 'the condition of human existence' (*Essential* 2). To reiterate: what Bataille means is that our understanding of the world is constructed by the interrelationship between truth and falsehood.<sup>97</sup> We can access what is true about the world only by seeing what is there and what is absent – it is truth represented by an integrated or reciprocal totality of what it *is* and *is not*. Paradoxes then can be framed as emerging from the consequence of human knowledge, but which knowledge is an abstraction of what is real (or material, if you prefer). That is the nature of paradoxes – they emerge as representations of truth but in confluence with the fact of the heterogeneous tenets of that truth appear contradictory, or opposed, or apparent impossibilities.<sup>98</sup>

[You might think of each such theoretical gambit in this thesis as the attempt to disclose and then disorder an understanding based on the predominance of the oppositional, dualistic or dichotomous

---

<sup>96</sup> I have been having some existential thoughts about this, conceited as I am. I think I am beginning to realize that I have been spending too much time in Ross' head...

<sup>97</sup> ... I do not think I am cut-out for this work.... I think I am losing my edge...

<sup>98</sup> ... I can't be in two places at once.

bent of much Western philosophy; instead it promotes an understanding based on the interrelationship of what is privileged and what is abjected; to disorder what is orthodox and what is therefore constructed in opposition as the *de facto* unorthodox. Although it is important to address the concerns of Alaimo and Hekman, and resist retreating further into discursive deconstruction when the imperative is to reify the materiality of the textual object as a prominent component of both Acker's texts].

That Alaimo and Hekman stake a claim for a return to materiality rests on a concern that postmodern theory increasingly privileges the discursive methods of its practice. The reverence of the linguistic at the remove of the material suggests that emerging work about the female body and female identity 'in the last 20 years [1988-2008]' (3) has almost always been confined to discourses *about* the body, so nearly always constituted to foreclose lived, material bodies and 'evolving corporeal practices' (3). So – the argument goes – we need to find a way to talk about the materiality of the body as an active, sometimes recalcitrant force:

Pain, pleasure, diseases, medical interventions... These things must be talked about without focusing exclusively on representations, ideology, and discourses that necessarily exclude lived experience, corporeal practice and biological substance (Alaimo and Hekman 4).

Kathy Acker's fiction presents from just such a position; she presents a panoply of 'misfitting' women in her works following Rosemarie Garland-Thomson's coining of the term as a concept within 'feminist material disability theory'. [In this concept, the term 'misfit' replaces 'disabled' to better extract sociocultural and temporal/spatial understandings from more traditional or earlier theoretical models - modes of discourse that focus on disability in linguistic terms.] According to Garland-Thomson this mode helps develop 'accounts of embodied aspects of disability such as pain and functional limitation without giving up the claim to disability as a social phenomenon' (592). [I hope it is obvious that the linguistic application of the word misfit in relation to the medical institution carries significant capital if we consider the term 'fit' to represent "being in good health"]. In short: the medical institution frames patients as objects that are either fit (well) or unfit (unwell). This dichotomy extends to mean that any patient suffering with illness can be designated a misfit, and one whose sense of fitting-in is interrupted by sickness. This interruption represents the destruction of conventions that frame life in accordance with the sense of its teleological narrative – which is perhaps linear, orderly, and orthodox. Within the medical institution then, illness can be taken to represent nonlinearity, the disorderly and the unorthodox; it is constructed as an abjected element of lived experience and which demands the intervention of medical professionals to ensure the patient's return to a sense of fitting. But how to answer the call to return to the materiality of the body, lived experience, corporeal practice, and biological substance? Where does Acker's text

interrogate the material experience of a woman in the medical encounter, and more broadly: where does Acker situate the materiality of female identity in the context of Western society overall?

As a woman/as women can we read Acker's own position materially – as a misfit who simultaneously orchestrates the journey[-ies] of a misfitting femininity or female gender? Her disorderly enterprise and ludic aesthetic are equally misfitting in this sense, the gender fluidity of her protagonists similarly so, and the results are that Acker stands as a female writer exposing narrative orthodoxy as a patriarchal imposition by adopting its tenets and destroying them from within. This ludic process is best addressed with a return to Garland-Thomson and an elucidation of her concept of misfits:

*Fitting and misfitting denote an encounter in which two things come together in either harmony or disjunction. When the shape and substance of these two things correspond in their union, they fit. A misfit, conversely, describes an incongruent relationship between two things: a square peg in a round hole. The problem with a misfit, then, inheres not in either of the two things but rather in their juxtaposition, the awkward attempt to fit them together (592-593).*

It should appear evident here then that Garland-Thomson is aligned to the sense of Bataille's heterogeneity. She does not propose a homogenous enterprise in coining the term misfit, rather she emphasizes context over essence, relation over isolation, mediation over origination: '[m]isfits are inherently unstable rather than fixed, yet they are very real because they are material rather than linguistic constructions' (593).

*I think this brilliantly elucidates the artistic method of play I have been promoting throughout this thesis; this is exactly how playfulness operates. As an example, if we consider 'biomedicine' [which we are using a representation of the scientific method], then we can say it provides an abstraction of reality by setting the body against what can be measured – a measurement is necessarily an abstraction because it requires the transposition of 'that-which-is-measured' into ulterior terms. These ulterior terms are the expressions of the scientific method, they are its product. And with these products truths about the body can be held as material facts (until proven otherwise). In addition, given a capacity to learn the language(s) of science [mathematics for example, Ross?], then these fundamental facts are – potentially – available to all and everyone with the capacity to read them, or hear them, and [following proper, scientific procedure of course] repeatable ad infinitum with predictable, [that is: "given"] results. This is the homogeneous world of scientific assimilation according to Bataille.*

I would propose that Kathy Acker is – perhaps – a 'proactive' misfit; she is assuming an intended position or apparent pedagogy. Her novels, however, are representative of the subjugation of the female binary because of inherent sociocultural patriarchy – in effect, a 'passive' misfitting. Her

characters' search for agency and identity can thus be problematized in line with Bataille's position on the essentialism of heterogeneity as *the* determiner of identity. In short: in their content the novels reveal women to be misfits as the result of their abjection by traditional sociocultural structures [i.e. orthodoxy]. To assert an identity and agency freed from these sociocultural structures, women [i.e. Acker the author – I think I'm really following this now, Ross!] must voluntarily assume the position of misfit to rupture the structures from within. In this way Acker's works demonstrably adhere to Winnicott's concept of transitional phenomena and corollary notion of creative-destruction [play] whilst supporting my contention that these ludic works – both in content and form – are representative of a sick [i.e. misfitting, or disorderly] literature. The author-reader dialectic operates through the book and each in relation to the book, and thus we can extract from this a similarly problematic understanding of the relationship between health (fit) and ill-health (misfit), where the extant medical orthodoxy of good health (fit) constitutes and subjugates ill health as anti-orthodox and misfitting.

So then the reader of Acker is similarly configured as a misfit, requiring a 'dynamic encounter [via the text] between flesh and world' (Garland-Thomson 593). As noted however, If the patient is similarly misfitting in the medical encounter, how is it that Acker's work 'confers agency and value on disordered subjects at risk of social devaluation by highlighting adaptability, and subjugated knowledge as potential effects of misfitting' (Garland-Thomson 592)? Given the medical gaze's inherent presumption of the 'stable' body, Acker's stories are immediately antagonistic. The playful and violently punk aesthetic she utilizes in one sense reifies this sense of 'stability' but more pointedly acts to destabilize the body – specifically the female body:

How do you feel about yourself when every human being you hear and see and smell every day of your being thinks you're worse than garbage? Your conception of who you are has always, at least partially, depended on how the people around you behave towards you' (Acker, *Blood* 67)

There is no game here; this is Acker playing it straight. What I would like to consider is the relationship between mapping the body and the mind; how orthodoxy has written-in this separation between such, and by which – one might argue – the map of patient is necessarily inaccurate. In the spaces Acker creates – her pirate spaces – a new map emerges, one that redraws the connections between brain and body in the fashion seen [repeatedly by now] in Bullmore. She creates a new map of the relationship between the body in pain and its linguistic report or – from the readers' perspective – what we would recognize, or read, as the psychological states of her characters. In this sense what Acker presents is more in line with holistic, non-Western medicine, where the mapping of the body is understood to correlate with the psychological or emotional state of the patient; practices such as acupuncture and

reflexology attend to the body directly, mapping the body in a praxis that treats mind and body as one; as interrelational. As much as Western medicine clearly recognizes the fact of this correlation, *its* praxis is driven by the privileging of scientific orthodoxy and the political impositions a capitalist medical system necessitates.

Turning to a book like *Cure: A Journey into the Science of Mind over Body* (2017), we can see the effect of this system on outlying fields of medicine, which, because private enterprise has yet to find profit in it, remains significantly underfunded (Marchant). The evidence from these areas of research is limited and in its early stages, but the evidence is surfacing – that the organism of our symbiotic mind and body is irrefutable and more prominent research emerges to confirm this correlation day-by-day. The consequence of this burgeoning research amid a broader reappraisal of the epistemological limits of our institutional medical orthodoxies, the stronger the case becomes that Western medicine's clinical gaze sees a map ordered by quantifiable variables and limitations. This map has proved invaluable but now is time to redraw it and Kathy Acker's ludic texts provide the pirate spaces in which to do so. Her creative deconstruction, her playfulness, perhaps offers us a Pirate's Map for a Pirate Space – not a map of either the character's psychological state, nor their physical state; not either a map of sociocultural or theoretical states, nor the physical spaces of the worlds of her novels, but a map in which both metaphysical and physical can be charted in sympathy with one other; a map that creates a new understanding of identity whilst deconstructing the space, orthodoxies and understanding from which it emerged. Her sick literature redraws the map of bodies to show the sickness at the heart of our medical epistemologies – what happens to the body emerges in the brain; what happens in the brain is written in the body, and the body keeps the Score.

I propose Worthington's pirate space can thus be seen in correspondence with, or as an analogue of, Winnicott's transitional spaces; the texts, as transitional objects, play with the mediating presence of their authors to instantiate the subjective standpoints of both author and reader. The reflexive processes inculcated by this intersubjective exchange remind us that Acker, and likewise Wallace, have invited us to partake in a game to which only they themselves know the rules, but which, marked as points of traumatic, narrative disorder, disrupt materially constructed orders of lexical, structural and formal homogeneity and invite their readers into a disruptive co-created textual heterogeneity. Reading the novels invites us to unearth and imprint upon them what we imagine the rules of text might be, and this is play; this is the creative-destruction at the heart of Winnicott's transitional phenomena. The text-as-transitional-space/object demonstrates that 'play' creates these pirate spaces in a manner that institutional spaces typically do not or cannot.

I began this encounter with reference to the scene of Don Quixote's abortion, and I will now return to the body of that text in which Acker describes a surgical gown of 'pale or puke green paper. This was her armor,' and yet it 'would tear as soon as the abortion began' (DQ 9). For women then, the medical space is a battleground; it is a space of war that the patient is ill-equipped to survive. Acker is telling us of the discontinuity between design and practice in the medical encounter when you are woman. Totems of the medical institution: the triage, pre-op procedural practices and patients' clothing – all is idealized 'armor' intended to provide protection, order and a sense of narrative coherence, the same teleological orthodoxy we have seen previously in the "return to wellness". But we know from T. Brown that this 'return' is a nightmare, that Acker's narrative is disorderly and so, as she makes clear: 'this's no world for idealism' (DQ 9). Under the surgeon's knife the world is ruptured from its narrative ideals and instead Acker presents us with the reality: a knight, without her 'armor' hanging around 'with the other bums. That is, women who're having abortions' (DQ 9). So how can a woman love?

By loving someone other than herself [...] By loving another person she would right every manner of political, social, and individual wrong: she would put herself in those situations so perilous the glory of her name would resound (DQ 9).

If this is a new narrative, should we take the notion of 'female subjectivity' that emerges from Acker as a representation or order of the story of all women? I tend to think not, otherwise we risk replacing the homogeneous reality of medicine's masculinist privilege with one that simply inverts the homogeneity in favor of the feminine term. Whilst this would at least be a move in the right direction as it would recognize the formerly abjected node of female subjectivity and work to its reconfiguration as the dominant order of the institution, the homogeneous state of play would not have been destructed but simply reinstated under the formerly abject term, replete with the extant problems that we are attempting to create anew. Conversely then, to reach a state of intersubjective and heterogeneous co-creation, we need simply to countenance the position of 'female subjectivity' according to Acker's terms. This is her story, and we need to accept it as such, which, in short, can be said to present from any position of unorthodoxy by which the heterogeneity of the subject is made abject as a consequence of the homogenizing aspects of the social order and the world at large. This is why *Don Quixote* so perfectly represents the canon of "Sick Literature", it is a case-by-case literature and sickness affects us all, 'conditions are so rough for *any* single person, even a rich person, that person has to make do with what she can find' (DQ 9 [My italics]).

## Concluding His Story

*“Before I turned 36, every day waking with that familiar inclination to kill myself was an exercise in the ‘narrative order’ of my life; that ‘the feeling’ was in my make-up; brain and body. I was built to feel this way – I thought – and as such, in many respects the familiarity of it – my closeness to that feeling – become the tether by which I managed those feelings. For the most part I learned to live in that feeling, that it was futile fighting against it and instead I should simply let the feeling be, to be mindful of it, as many might say today. Living with the feeling meant that whenever I woke up to its absence I was overwhelmed with relief and excitement. And hope. Maybe it had at last passed; maybe I cracked it; maybe it was possible to live without wanting to die, after all.*

*Without my tether it was as though all my feelings were convoluted aspects of some mental or intellectual capacity located outside of my body but inside my head; whether in isolation or in company; it often felt like I wasn’t there in the room. The best analogue I can think of is the feeling one might have at the dentist, when your mouth has been anaesthetized during a tooth extraction; you can feel the pressure and the imprint of activity in your mouth, but it’s not exactly sensory; there’s no quality to the feeling.*

*And then but the sickness creeps back in, in the hope; the hope that it might be different this time... The same is true of my addictions; each time to slip back into the habit you think ‘maybe this time’; you have hope that this time you can sustain the relief you find in the chemical effects; you hope you can control your clamor for the relief, your desperate hope that know you’ve found a way out of the psychic pains in your brain by negating it and flourishing in the physiological sensations flooding through your body – where the pain isn’t. But then even if there is pain there too, you hope to hold onto it because it’s not the feeling you live with every day in the want to die...*

*Until I was 36, I thought my suicidal ideation was innate. I was wrong. Now I have been in therapy for almost two and half years and since its beginning, I have begun to understand that there are likely very, very good reasons for my having felt this way my whole life, and in fact, my suicidal ideation may not be innate but partly the product of a lifetime’s disassociation from traumatic memories and experiences from my childhood, teens and twenties, and which, until therapy, I couldn’t access. I didn’t know they existed.*

*It all began with a medical encounter, when I was eighteen months old, I underwent the surgeon’s knife. It turns out that I have an atypical reaction to anesthetic and so, whilst immobile, and unresponsive, and to all manner of measurement ‘unconscious’ during the procedure.*

*I was awake.*



*I was locked in my body.*

*And I felt the cut to my core.*

*To cope I disassociated.*

*But the body keeps the score.”*

This thesis presented a dialectic exploration of the transitional spaces and objects of play in the material and mutable, ludic novels of Kathy Acker and David Foster Wallace. It was presented by a patient of Western medicine, whose medical encounters and experience of medical institutions did not serve his whole person; without meaning to cause him any harm, they excised from him his human being and made of him a medical object of the mind, abjected from himself in a dislocated space from his body because it was not a material concern in the game.

I have shown that Western medicine cannot but reproduce its orthodoxies because its patients' whole experience of being must be reduced by transposition into what can and cannot be measured; what is and is not medically relevant. That it must privilege the material measure of things through the methods and practices of science – the realm of 'scientism' – is because its institutions, the academy, the hospital, the clinic, the psych-ward – all are necessarily constructed by the impositions of scientism in accordance with an ethics that instantiates empirical orthodoxies as the only 'acceptable' form of institutionalized medicine. In so doing I have contributed to the argument that holds the result of this institutionalism as the exclusion of praxes that cannot adhere to the metrics of the scientific method and are therefore preconfigured as unorthodox and must be 'abjected.'

My answer to this conjecture, was to propose a canon of works of that disorder the foundational narratives that instantiate such orthodoxies and bring them back into play. My introduction set out the genealogy of this canon under the rubric of 'Cold War studies' and which texts provide ample scope to begin a more extensive evaluation. Extending the remit of their disorderly functions and the multiple factors at play, I proposed a new canon of "Sick Literature" exemplified by the works of Kathy Acker and David Foster Wallace. In these works, I presented a series of critical and theoretical engagements with the medical encounter to attest to the fact of medicine's need to afford more care to its artful practices, and utilize art's products – its artifacts, its artworks – to create a better, more democratic medicine. At the forefront of this thesis then, was the field of medical humanities, a discipline that explicitly addresses the reification of the arts in medical practice. My contribution to this field was a concept of 'playfulness', in which I demonstrated a sympathy with Eugene Fink's formalizing playfulness as an inherently irrational quality of universal human understanding and – in accordance with D.W. Winnicott – expressed a method of this playfulness through the transitional phenomena of spaces and objects of play, as exemplified by the ludic texts of "Sick Literature".

I positioned “Sick Literature” in consensus with the material aspects of the medical encounter by reproducing case-studies that accord with the narrative order of medically instituted diagnoses and practices. But, crucially, having affirmed the material facts of things, demonstrated how “Sick Literature” transitions beyond representation and disorders its narratives to become a mutable literature with medical and medicinal utility. I showed that the disorder is made manifest in the literal sickness of the material objects of the texts themselves, which become objects by which a praxis of intersubjective, relational exchange between the mediating subjects of the author and reader can be realized, and mutual co-creation occurs. In this intersubjective act of co-creation is a model with utility in the medical encounter because it reflects an ambition of medical humanism; to imagine medicine that affords more care to – and an account of – the “individual” patient, not an “ideally” constructed patient who is the marker of Western medicine’s institutional orthodoxy in its current guise.

As a patient I told you, my story; I told you what my understanding of that story is. I know there is so much work I can do to understand more. I can do all the work in the world to learn more about why I feel and think the way I do. As it happens, I did do a lot of that work for myself; it was vital that I did so, “vital” being the operative word. But my understanding of my story was no more a record of its truth than might be the interpretation of my story by another, someone skeptical about my version of events. Why might they be skeptical? If they were a scientifically minded medical professional, it might be because there is no cohesive, universal measure of my sicknesses that stands-up to empirical standards of scientific experimentation; the presentation of my symptoms might differ, day-to-day – even the textbook on the matter accedes that there is no reliable measure of those symptoms in the first place. If they were more medically humanist in their approach my reader might simply be skeptical of my story’s narrative facts. Still, given their expertise in the arena of literary analysis, I can hope they might read the text of it and discern enough to confirm a diagnosis.

As we saw from Mayes however, this latter effort might simply reinstitute the orthodoxy of expertise in the personage of my reader, in whose skills I trust and to whom I submit in full knowledge that only they have the vision to see some hidden symptom of my story and unearth a sickness I am blind to. Mayes’ warning also pointed to the possibility that even addressing the hierarchy of power in the practitioner-patient exchange could simply inverse the hierarchy and institute the power in a different subject – which, applied to this thesis, would maintain my supremacy in the matter. I mean it is *my* thesis after all. But I do not want to privilege my version of events and – let me be clear – beyond a degree of dramatic license and some mastery of English I am

not [yet] institutionally recognized, nor medically trained. I am not a doctor.<sup>99</sup> My position is that of the lay person, doing what they can with the materials available to them. All I can do is proffer the best understanding of the narrative as it presents to me and explain the case as I see it. And all that occurred [t]herein. I certainly do not want to denigrate the multitude of incredible works that medical science has provided, not least for the fact that if I had continued to ignore the possibility of escaping the homogenous, reflexive cycle of suicidal depressive sickness I lived with for 36 years, and continued to deny myself access to the heterogeneous expertise in the external world beyond me, it is likely I would find myself as the characters in “The Depressed Person” and “Suicide as a Sort of Present” find themselves; contemplating, once again, a final ‘inevitable explosion’ because of my accursed share of negative, self-sustaining mental excess. I would find myself sat on my bed, staring at stockpiled pills and knowing nowhere else to escape it.

*“I sometimes think that life in axiomatic terms might be the plurality of interrelational systems that instantiate its material and mutable aspects, and to me I find that most obviously abundant in our artistic expressions and the objects of art; perhaps less so in science, even despite the latter’s elemental mottoes, “to the best of our knowledge; until we learn otherwise; we cannot say; we do not know”. I think the artistic method that makes the world is explicit in its play, because it makes mutable evaluations of its products or objects implicit, wherein the materiality of those artworks can be disordered with each and every new encounter with them and because we seem intrinsically to accept the subjective imposition of the observer’s point of view and their reading of matter. I think the scientific method that makes the world is necessarily less explicit than that; that the opposite is true, because the materiality or factuality is the implicit product of its method, and the mutability less so. Without some method to determine the rules of the game, the game cannot even begin.*

*“The world is round”. Fact. Or rather, it is a globe. Fact. Or rather, it is an oblate spheroid... Facetiousness aside, all these statements may be taken as fact according to context, because within those contexts they signify a homogeneous, unified system of understanding. But as facts they are still susceptible to creative-destruction and in accord with a proposal of difference from those instantiated facts. So yes: the world is round and a globe and an oblate spheroid from the perspective of the observer from far, far away, but from a different perspective, according to the fact of a heterogenous set of systemic impositions; it is also topologically different at the surface and from every distant point from its center. “The world is round” is then a material and mutable statement – context, framing systems, paradigms... Ludic literature, according to my thesis, begins from this understanding; what can be assumed as known, what is explicitly or implicitly suggested, what the*

---

<sup>99</sup> It is official, 8 October 2021.

*author writes on the page; the narrative order of things – all of these elements are ‘playful’ or ‘in play’ and so being, transition from material to mutable; from orthodoxy to unorthodoxy; from order to disorder in the spaces and objects of playful difference. I have a habit of playing with language; it is my favorite method of creative play and of playful deconstruction. I think the most destructive thing about my being is a tendency to see the world in words and revel in deconstructing them. In that way all ends up destroyed, even me. I am somewhere in the rubble with nothing left and everything turned to nothing. But out of nothing, everything began; out of all this indistinct matter, the whole universe was constructed; constructed in a big bang of creative-destruction; constructed in interrelational play.*

*I think ludic literature does reify the life and subject of the author and not their death because it presents with symptoms that state: “this is the game I’m playing. And you can play too if you recognize the rules I am playing with”. In so doing the text is ours both, and so an understanding between us both occurs. The text is a mutuality incarnate; the text is ours and not either yours or mine alone. By all means play with it at your leisure; feel free to make your own game of the material I give you; it’s of no matter to me – the material never changes; it will remain the same text today as tomorrow, only you will change, and you can read in it what you will. As you wish.”<sup>100</sup>*

---

<sup>100</sup> “As you wish.”

## Bibliography

- Abram, Jan, and Robert D. Hinshelwood. *The Clinical Paradigms of Melanie Klein and Donald Winnicott: Comparisons and Dialogues*. Routledge, 2018.
- Acker, Kathy. "Against Ordinary Language: The Language of the Body." *The Last Sex*. Edited by Arthur Kroker and Marilouise Kroker, Macmillan Education UK, 1993, pp. 20–28. *Crossref*, [https://doi.org/10.1007/978-1-349-22944-4\\_2](https://doi.org/10.1007/978-1-349-22944-4_2).
- . *Blood and Guts in High School: Plus Two*. Picador, 1984.
- . *Bodies of Work: Essays*. Serpent's Tail, 2006.
- . *Don Quixote*. Grafton Books, 1986.
- . *Empire of the Senseless*. Reprint., Grove Press, 2005.
- . *In Memoriam to Identity*. Pandora Pr, 1990.
- Adler, Jonathan M., Jennifer Lodi-Smith, et al. 'The Incremental Validity of Narrative Identity in Predicting Well-Being: A Review of the Field and Recommendations for the Future'. *Personality and Social Psychology Review*, vol. 20, no. 2, SAGE Publications, May 2016, pp. 142–75. *SAGE Journals*, <https://doi.org/10.1177/1088868315585068>.
- Adler, Jonathan M., Theodore E. A. Waters, et al. 'The Nature of Narrative Coherence: An Empirical Approach'. *Journal of Research in Personality*, vol. 74, June 2018, pp. 30–34. *ScienceDirect*, <https://doi.org/10.1016/j.jrp.2018.01.001>.
- Agrawal, Manish, and Ezekiel J. Emanuel. 'Death and Dignity: Dogma Disputed'. *The Lancet*, vol. 360, no. 9350, Dec. 2002, pp. 1997–98. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(02\)12031-9](https://doi.org/10.1016/S0140-6736(02)12031-9).
- Alaimo, Stacy, and Susan J. Hekman, editors. *Material Feminisms*. Indiana University Press, 2008.
- Althusser, Louis. 'Ideology and Ideological State Apparatuses'. *Lenin and Philosophy, and Other Essays*. Translated by Ben Brewster, Monthly Review Press, 2001.
- Althusser, Louis, and Étienne Balibar. *Reading Capital*. Translated by Ben Brewster, 2nd ed., NLB, 1977.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 5th ed., American Psychiatric Association, 2013.

Androutsopoulou, Athena. 'Fiction as an Aid to Therapy: A Narrative and Family Rationale for Practice'. *Journal of Family Therapy*, vol. 23, no. 3, Aug. 2001, pp. 278–95. *Wiley Online Library*, <https://doi.org/10.1111/1467-6427.00184>.

Antypa, Niki, et al. 'Clinical and Genetic Factors Associated with Suicide in Mood Disorder Patients'. *European Archives of Psychiatry and Clinical Neuroscience*, vol. 266, no. 2, Mar. 2016, pp. 181–93. *link-springer-com.ezproxy.sussex.ac.uk*, <https://doi.org/10.1007/s00406-015-0658-1>.

Anyaeqbunam J. A., et al. 'Five Voices, One Story'. *JAMA*, vol. 310, no. 24, Dec. 2013, pp. 2615–16. *Silverchair*, <https://doi.org/10.1001/jama.2013.283712>.

Apple, Rima D., editor. *Women, Health, and Medicine in America: A Historical Handbook*. Garland Pub, 1990.

Arbib, Michael A. 'Mirror System Activity for Action and Language Is Embedded in the Integration of Dorsal and Ventral Pathways'. *Brain and Language*, vol. 112, no. 1, Jan. 2010, pp. 12–24. *PubMed*, <https://doi.org/10.1016/j.bandl.2009.10.001>.

Arnott, R. 'The University of Birmingham Medical School and the History of Medicine'. *Medical Humanities*, vol. 28, no. 1, Jan. 2002, pp. 33–34. *mh.bmj.com*, <https://doi.org/10.1136/mh.28.1.33>.

Arnott, Robert, et al. 'Proposal for an Academic Association for Medical Humanities'. *Medical Humanities*, vol. 27, no. 2, Jan. 2001, pp. 104–05. *mh.bmj.com*, <https://doi.org/10.1136/mh.27.2.104>.

Arntfield, Shannon L., et al. 'Narrative Medicine as a Means of Training Medical Students Toward Residency Competencies'. *Patient Education and Counseling*, vol. 91, no. 3, June 2013, pp. 280–86. *ScienceDirect*, <https://doi.org/10.1016/j.pec.2013.01.014>.

- Atkinson, Paul. 'Narrative Turn or Blind Alley?' *Qualitative Health Research*, vol. 7, no. 3, SAGE Publications, Aug. 1997, pp. 325–44. *SAGE Journals*, <https://doi.org/10.1177/104973239700700302>.
- Aubry, Timothy. 'Selfless Cravings: Addiction and Recovery in David Foster Wallace's Infinite Jest'. *American Fiction of the 1990s: Reflections of History and Culture*. Edited by Jay Prosser, Routledge, 2008.
- Auerbach, Erich. *Mimesis: The Representation of Reality in Western Literature*. Translated by Willard R. Trask, 1st Princeton Classics ed., 50th anniversary ed., Princeton University Press, 2013.
- Aylesworth, Gary. 'Postmodernism'. *The Stanford Encyclopedia of Philosophy*. Edited by Edward N. Zalta. Spring 2015, Metaphysics Research Lab, Stanford University, 2015. *Stanford Encyclopedia of Philosophy*, <https://plato.stanford.edu/archives/spr2015/entries/postmodernism/>.
- Baimel, Adam, et al. 'Enhancing "Theory of Mind" Through Behavioral Synchrony'. *Frontiers in Psychology*, vol. 6, Frontiers, 2015. *Frontiers*, <https://doi.org/10.3389/fpsyg.2015.00870>.
- Baker, Charley, et al. *Madness in Post-1945 British and American Fiction*. Palgrave Macmillan, 2010.
- Ballantyne, Jane C., and Mark D. Sullivan. 'Intensity of Chronic Pain — The Wrong Metric?' *New England Journal of Medicine*, vol. 373, no. 22, Nov. 2015, pp. 2098–99. *CrossRef*, <https://doi.org/10.1056/NEJMp1507136>.
- Bartlett, Christopher. "'An Exercise in Telemachry": David Foster Wallace's Infinite Jest and Intergenerational Conversation'. *Critique: Studies in Contemporary Fiction*, vol. 57, no. 4, Aug. 2016, pp. 374–89. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/00111619.2015.1113921>.
- Bataille, Georges. 'Definition of Heterology'. *Theory, Culture & Society*, vol. 35, no. 4–5, SAGE Publications, Sep. 2018, pp. 29–40. *SAGE Journals*, <https://doi.org/10.1177/0263276418790349>.
- . *Georges Bataille: Essential Writings*. Edited by Michael Richardson, SAGE Publications, 1998.

- . *Inner Experience*. Translated by Leslie Anne Boldt, State University of New York Press, 1988.
- . *More & Less*. Edited by Sylvère Lotringer and Chris Kraus, Fine Arts Graduate Studies Program and the Theory, Criticism and Curatorial Studies and Practice Graduate Programs, Art Center College of Design; Distribution, MIT Press, 2006.
- . *The Accursed Share: An Essay on General Economy*. Translated by Robert Hurley, vol. 1, Zone Books, 1988.
- . *The Accursed Share: An Essay on General Economy*. Translated by Robert Hurley, vol. 2–3, Zone Books, 1991.
- . *Visions of Excess: Selected Writings, 1927-1939*. Edited by Allan Stoekl. Translated by Allan Stoekl et al., University of Minnesota Press, 1985.
- Bates, Don. 'Knowledge and the Scholarly Medical Traditions'. *Cambridge Core*, Nov. 1995, <https://doi.org/10.1017/CBO9780511621666>.
- . 'Scholarly Ways of Knowing: An Introduction'. *Knowledge and the Scholarly Medical Traditions*. Edited by Don Bates, Cambridge University Press, 1995, pp. 1–22. *CrossRef*, <https://doi.org/10.1017/CBO9780511621666.001>.
- Beck, A. H. 'The Flexner Report and the Standardization of American Medical Education'. *JAMA*, vol. 291, no. 17, May 2004, pp. 2139–40. *Silverchair*, <https://doi.org/10.1001/jama.291.17.2139>.
- Benjamin, Walter. 'The Work of Art in the Age of Mechanical Reproduction'. *Illuminations*. Edited by Hannah Arendt. Translated by Harry Zorn, Pimlico, Pimlico, 1999, pp. 211–44.
- Ben-Zeev, Dror, et al. 'DSM-V and the Stigma of Mental Illness'. *Journal of Mental Health*, vol. 19, no. 4, Aug. 2010, pp. 318–27. *Taylor and Francis+NEJM*, <https://doi.org/10.3109/09638237.2010.492484>.
- Berger, John, *Ways of Seeing*. Reprint, British Broadcasting Corporation and Penguin Books, 1990.
- 'Biden Defends Obamacare as Top Court Hears Case'. *BBC News*, 10 Nov. 2020. [www.bbc.co.uk](http://www.bbc.co.uk), <https://www.bbc.co.uk/news/world-us-canada-54896663>.



- Bishop, Jeffrey P. 'Foucauldian Diagnostics: Space, Time, and the Metaphysics of Medicine'. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, vol. 34, no. 4, Aug. 2009, pp. 328–49. *academic-oup-com.ezproxy.sussex.ac.uk*, <https://doi.org/10.1093/jmp/jhp027>.
- . 'Rejecting Medical Humanism: Medical Humanities and the Metaphysics of Medicine'. *Journal of Medical Humanities*, vol. 29, no. 1, Dec. 2007, pp. 15–25. *link.springer.com*, <https://doi.org/10.1007/s10912-007-9048-7>.
- . *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*. University of Notre Dame Press, 2011.
- Bjørkløf, Guro Hanevold, et al. 'Being Stuck in a Vice: The Process of Coping with Severe Depression in Late Life'. *International Journal of Qualitative Studies on Health and Well-Being*, vol. 10, no. 1, Jan. 2015, p. 27187. *Taylor and Francis+NEJM*, <https://doi.org/10.3402/qhw.v10.27187>.
- Bleakley, Alan. *Medical Humanities and Medical Education: How the Medical Humanities Can Shape Better Doctors*. Routledge, 2015.
- Bleakley, Alan, and John Bligh. 'Students Learning from Patients: Let's Get Real in Medical Education'. *Advances in Health Sciences Education*, vol. 13, no. 1, Oct. 2006, pp. 89–107. *link.springer.com*, <https://doi.org/10.1007/s10459-006-9028-0>.
- Bleakley, Alan, and Robert Marshall. 'Can the Science of Communication Inform the Art of the Medical Humanities?' *Medical Education*, vol. 47, no. 2, Feb. 2013, pp. 126–33. *Wiley Online Library*, <https://doi.org/10.1111/medu.12056>.
- Bliss, Michael. *William Osler: A Life in Medicine*. Oxford University Press, 1999.
- Bochner, Arthur P. 'Narrative's Virtues'. *Qualitative Inquiry*, vol. 7, no. 2, Jan. 2001, pp. 131–57. *qix.sagepub.com*, <https://doi.org/10.1177/107780040100700201>.

- . 'Perspectives on Inquiry II: Theories and Stories'. *Handbook of Interpersonal Communication*, 2nd ed, SAGE Publications, 1994. *works.bepress.com*,  
[https://works.bepress.com/art\\_bochner/1/](https://works.bepress.com/art_bochner/1/).
- . 'Resisting the Mystification of Narrative Inquiry: Unmasking the Real Conflict Between Story Analysts and Storytellers'. *Sociology of Health & Illness*, vol. 32, no. 4, May 2010, pp. 662–65. *Wiley Online Library*, [https://doi.org/10.1111/j.1467-9566.2010.01240\\_2.x](https://doi.org/10.1111/j.1467-9566.2010.01240_2.x).
- Bochner, Arthur P., and Carolyn Ellis. *Evocative Autoethnography: Writing Lives and Telling Stories*. Left Coast Press, 2016.
- Bolton, Derek. 'Overdiagnosis Problems in the DSM-IV and the New DSM-5: Can They Be Resolved by the Distress-Impairment Criterion?' *The Canadian Journal of Psychiatry*, vol. 58, no. 11, SAGE Publications, Nov. 2013, pp. 612–17. *SAGE Journals*,  
<https://doi.org/10.1177/070674371305801106>.
- Bolton, Gillie. 'Medicine and Literature: Writing and Reading'. *Journal of Evaluation in Clinical Practice*, vol. 11, no. 2, Apr. 2005, pp. 171–79. *Wiley Online Library*,  
<https://doi.org/10.1111/j.1365-2753.2005.00521.x>.
- . 'Medicine, the Arts, and the Humanities'. *The Lancet*, vol. 362, no. 9378, July 2003, pp. 93–94. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(03\)13894-9](https://doi.org/10.1016/S0140-6736(03)13894-9).
- Boudreau, J. Donald, and Abraham Fuks. 'The Humanities in Medical Education: Ways of Knowing, Doing and Being'. *Journal of Medical Humanities*, vol. 36, no. 4, Apr. 2014, pp. 321–36. *link.springer.com*, <https://doi.org/10.1007/s10912-014-9285-5>.
- Bourcier, Simon de. "'They All Sound Like David Foster Wallace": Syntax and Narrative in Infinite Jest, Brief Interviews with Hideous Men, Oblivion and The Pale King'. *Orbit: A Journal of American Literature*, vol. 5, no. 1, 1, Open Library of Humanities, Mar. 2017. *orbit.openlibhums.org*,  
<https://doi.org/10.16995/orbit.207>.
- Bourdieu, Pierre. *Outline of a Theory of Practice*. Translated by Richard Nice. Reprint, Cambridge University Press, 2010.

---. *The Logic of Practice*. Translated by Richard Nice. Reprint, Stanford University Press, 2008.

Boyd, J. Wesley. 'Narrative Aspects of a Doctor-Patient Encounter'. *Journal of Medical Humanities*, vol. 17, no. 1, 1996, pp. 5–15. [link.springer.com](http://link.springer.com), <https://doi.org/10.1007/BF02276310>.

Breen, Gerome, et al. 'A Genome-Wide Significant Linkage for Severe Depression on Chromosome 3: The Depression Network Study'. *The American Journal of Psychiatry*, vol. 168, no. 8, Aug. 2011, pp. 840–47. *PubMed*, <https://doi.org/10.1176/appi.ajp.2011.10091342>.

British Centre for Durkheimian Studies. *Durkheim's Suicide a Century of Research and Debate*. Edited by W. S. F Pickering and Geoffrey Walford. Routledge, 2000.

Brockmeier, Jens, and Donal Carbaugh. *Narrative and Identity: Studies in Autobiography, Self and Culture*. John Benjamins, 2001. *ProQuest Ebook Central*, <http://ebookcentral.proquest.com/lib/suss/detail.action?docID=622888>.

Brockmeier, Jens, and Hanna Meretoja. 'Understanding Narrative Hermeneutics'. *StoryWorlds: A Journal of Narrative Studies*, vol. 6, no. 2, 2014, pp. 1–27.

Brody, Howard. 'Defining the Medical Humanities: Three Conceptions and Three Narratives'. *Journal of Medical Humanities*, vol. 32, no. 1, Mar. 2011, pp. 1–7. *Springer Link*, <https://doi.org/10.1007/s10912-009-9094-4>.

Brooke, Patricia. *Subversive Mimesis and Fierce Play: The Revisionary Subjects of Christine Brooke-Rose, Angela Carter, and Kathy Acker*. Texas A&M University, 1999. *ProQuest*, <http://search.proquest.com/docview/304560996/abstract/F4E965831E104DC0PQ/1>.

Brown, Brian, et al. 'Interaction, Language and the "Narrative Turn" in Psychotherapy and Psychiatry'. *Social Science & Medicine*, vol. 43, no. 11, Dec. 1996, pp. 1569–78. *ScienceDirect*, [https://doi.org/10.1016/S0277-9536\(96\)00053-6](https://doi.org/10.1016/S0277-9536(96)00053-6).

Brown, Ron. *The Art of Suicide*. Reaktion, 2001.

Brown, Terry. 'Longing to Long: Kathy Acker and the Politics of Pain'. *Lit: Literature Interpretation Theory*, vol. 2, no. 3, Feb. 1991, pp. 167–77. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/10436929108580054>.

Bruner, Jerome S. *Acts of Meaning*. Harvard University Press, 2002.

---. *Actual Minds, Possible Worlds*. Harvard University Press, 1986.

Bruzina, Ronald. *Edmund Husserl and Eugen Fink: Beginnings and Ends in Phenomenology, 1928-1938*. Yale University Press, 2004.

---. 'Eugen Fink and Maurice Merleau-Ponty: The Philosophical Lineage in Phenomenology'. *Merleau-Ponty's Reading of Husserl*. Edited by Ted Toadvine and Lester Embree, Springer Netherlands, 2002, pp. 173–200. *Springer Link*, [https://doi.org/10.1007/978-94-015-9944-3\\_9](https://doi.org/10.1007/978-94-015-9944-3_9).

---. 'The Transcendental Theory of Method in Phenomenology; the Meontic and Deconstruction'. *Husserl Studies*, vol. 14, no. 2, May 1997, pp. 75–94. *Springer Link*, <https://doi.org/10.1023/A:1005991502516>.

Bullmore, Edward. *The Inflamed Mind: A Radical New Approach to Depression*. Short Books, 2018.

Bynum, W. F. *The History of Medicine: A Very Short Introduction*. Oxford University Press, 2008.

---. *The Western Medical Tradition: 1800-2000*. Cambridge University Press, 2006.

Bynum, William F., and Roy Porter. *Companion Encyclopedia of the History of Medicine*. 1st pbk ed., Routledge, 1997.

Caillois, Roger. *Man and the Sacred*. Translated by Meyer Barash. University of Illinois Press, 2001.

---. *Man, Play, and Games*. Translated by Meyer Barash. University of Illinois Press, 2001.

Callahan, Jay. 'The Ethics of Assisted Suicide'. *Health & Social Work*, vol. 19, no. 4, Jan. 1994, pp. 237–44. *hsw.oxfordjournals.org*, <https://doi.org/10.1093/hsw/19.4.237>.

Calman, Kenneth C. 'The Arts and Humanities in Health and Medicine'. *Public Health*, vol. 119, no. 11, Nov. 2005, pp. 958–59. *ScienceDirect*, <https://doi.org/10.1016/j.puhe.2005.08.006>.

Caracciolo, Marco. 'Narrative, Meaning, Interpretation: An Enactivist Approach'. *Phenomenology and the Cognitive Sciences*, vol. 11, no. 3, Aug. 2011, pp. 367–84. *link.springer.com*, <https://doi.org/10.1007/s11097-011-9216-0>.

Carel, Havi. *Illness: The Cry of the Flesh*. 2013. *Open WorldCat*, <http://site.ebrary.com/id/10831976>.

Casey, Edward S. 'The Place of Space in The Birth of the Clinic'. *Journal of Medicine and Philosophy*, vol. 12, no. 4, Jan. 1987, pp. 351–56. [jmp.oxfordjournals.org](http://jmp.oxfordjournals.org),  
<https://doi.org/10.1093/jmp/12.4.351>.

Cassedy, James H. *Medicine in America: A Short History*. Johns Hopkins University Press, 1991.

Cenci, Cristina, and Oriano Mecarelli. 'Digital Narrative Medicine for the Personalization of Epilepsy Care Pathways'. *Epilepsy & Behavior*, vol. 111, Oct. 2020, p. 107143. *ScienceDirect*,  
<https://doi.org/10.1016/j.yebeh.2020.107143>.

Charon, Rita. 'At the Membranes of Care: Stories in Narrative Medicine'. *Academic Medicine*, vol. 87, no. 3, Mar. 2012, pp. 342–47. *CrossRef*, <https://doi.org/10.1097/ACM.0b013e3182446fbb>.

---. 'Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust'. *JAMA*, vol. 286, no. 15, Oct. 2001, pp. 1897–902. *Silverchair*, <https://doi.org/10.1001/jama.286.15.1897>.

---. *Narrative Medicine: Honoring the Stories of Illness*. 1st pbk ed., Oxford University Press, 2008.

---. 'Narrative Reciprocity'. *Hastings Center Report*, vol. 44, no. s1, Jan. 2014, pp. S21–24. *Wiley Online Library*, <https://doi.org/10.1002/hast.264>.

---. *The Principles and Practice of Narrative Medicine*. Oxford University Press, 2017.

Chiapperino, Luca, and Giovanni Boniolo. 'Rethinking Medical Humanities'. *Journal of Medical Humanities*, vol. 35, no. 4, Jan. 2014, pp. 377–87. [link.springer.com](http://link.springer.com),  
<https://doi.org/10.1007/s10912-014-9269-5>.

Chiavaroli, Neville, and Constance Ellwood. 'The Medical Humanities and the Perils of Curricular Integration'. *Journal of Medical Humanities*, vol. 33, no. 4, Aug. 2012, pp. 245–54.  
[link.springer.com](http://link.springer.com), <https://doi.org/10.1007/s10912-012-9183-7>.

Cholbi, Michael. 'What Is Wrong with "What Is Wrong with Rational Suicide"'. *Philosophia*, vol. 40, no. 2, June 2012, pp. 285–93. *Springer Link*, <https://doi.org/10.1007/s11406-011-9326-5>.

Clarke, D. M. 'Autonomy, Rationality and the Wish to Die'. *Journal of Medical Ethics*, vol. 25, no. 6, Jan. 1999, pp. 457–62. [jme.bmj.com](http://jme.bmj.com), <https://doi.org/10.1136/jme.25.6.457>.

- Connolly, Angela. 'To Speak in Tongues: Language, Diversity and Psychoanalysis'. *Journal of Analytical Psychology*, vol. 47, no. 3, 2002, pp. 359–82. *Wiley Online Library*, <https://doi.org/10.1111/1465-5922.00325>.
- Conrad, Lawrence I. 'Scholarship and Social Context: A Medical Case from the Eleventh-Century Near East'. *Knowledge and the Scholarly Medical Traditions*. Edited by Don Bates. Cambridge University Press, 1995, pp. 84–100. *CrossRef*, <https://doi.org/10.1017/CBO9780511621666.005>.
- Cooke, Molly, et al. 'American Medical Education 100 Years after the Flexner Report'. *New England Journal of Medicine*, vol. 355, no. 13, Sep. 2006, pp. 1339–44. *Taylor and Francis+NEJM*, <https://doi.org/10.1056/NEJMra055445>.
- Corry, Dagmar A. S., et al. 'Harnessing the Mental Health Benefits of the Creativity–Spirituality Construct: Introducing the Theory of Transformative Coping'. *Journal of Spirituality in Mental Health*, vol. 16, no. 2, Apr. 2014, pp. 89–110. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/19349637.2014.896854>.
- Coulter, Angela, et al. *Education for Partnership: Developments in Medical Education*. Picker Institute Europe, 2006.
- . *Engaging Patients in Their Healthcare: How Is the UK Doing Relative to Other Countries?* Picker Institute Europe, 2006.
- Coulter, Angela, and Nick Richards. *Is the NHS Becoming More Patient-Centred?: Trends from the National Surveys of NHS Patients in England 2002-07*. Picker Institute Europe, 2007.
- Cowie, Martin R. 'Person-Centred Care: More Than Just Improving Patient Satisfaction?' *European Heart Journal*, vol. 33, no. 9, May 2012, pp. 1037–39. [eurheartj.oxfordjournals.org](http://eurheartj.oxfordjournals.org), <https://doi.org/10.1093/eurheartj/ehr354>.
- Crawford, Paul, Brian Brown, Charley Baker, et al. *Health Humanities*. Palgrave, 2015.

- Crawford, Paul, Brian Brown, Victoria Tischler, et al. 'Health Humanities: The Future of Medical Humanities?' *Mental Health Review Journal*, vol. 15, no. 3, Emerald Group Publishing Limited, Jan. 2010, pp. 4–10. *Emerald Insight*, <https://doi.org/10.5042/mhrj.2010.0654>.
- Crawford, Paul, Peter Nolan, et al. 'Linguistic Entrapment: Medico-nursing Biographies as Fictions'. *Journal of Advanced Nursing*, vol. 22, Dec. 1995, pp. 1141–48. *ResearchGate*, <https://doi.org/10.1111/j.1365-2648.1995.tb03116.x>.
- Crawford, Paul, Charley Baker, et al. 'Madness and Literature'. *Mental Health Review Journal*, vol. 16, no. 3, Emerald Group Publishing Limited, Jan. 2011. *Emerald Insight*, <https://doi.org/10.1108/mhrj.2011.55816caa.001>.
- Crawford, Paul, Alison May, et al. 'The Language of Mental Health Nursing Reports: Firing Paper Bullets?' *Journal of Advanced Nursing*, vol. 29, Feb. 1999, pp. 331–40. *ResearchGate*, <https://doi.org/10.1046/j.1365-2648.1999.00893.x>.
- Crawford, Paul, B. J. Brown, et al., editors. *The Routledge Companion to Health Humanities*. Routledge, 2020.
- Crawshaw, R. 'Humanism in Medicine - The Rudimentary Process'. *New England Journal of Medicine*, vol. 293, no. 25, Dec. 1975, pp. 1320–22. *Taylor and Francis+NEJM*, <https://doi.org/10.1056/NEJM197512182932513>.
- . 'The Contemporary Use of Medical Oaths'. *Journal of Chronic Diseases*, vol. 23, no. 3, Sep. 1970, pp. 145–50. *ScienceDirect*, [https://doi.org/10.1016/0021-9681\(70\)90091-3](https://doi.org/10.1016/0021-9681(70)90091-3).
- . 'The Hippocratic Oath Is Alive and Well in North America'. *BMJ : British Medical Journal*, vol. 309, no. 6959, Oct. 1994, p. 952.
- Criado-Perez, Caroline. *Invisible Women: Exposing Data Bias in a World Designed for Men*. Vintage, 2019.
- Critchley, Simon, and David Hume. *Notes on Suicide*. Fitzcarraldo Editions, 2015.

- Curtis, Paul M. “‘Yo Man so What’s Your Story’: The Double Bind and Addiction in David Foster Wallace’s ‘Infinite Jest’”. *Mosaic: An Interdisciplinary Critical Journal*, vol. 49, no. 4, 2016, pp. 37–52. JSTOR.
- Dahl, Roald. *The Giraffe and the Pelly and Me*. Penguin Books, Limited, 2016.
- Davin, Solange. ‘Healthy Viewing: The Reception of Medical Narratives’. *Sociology of Health & Illness*, vol. 25, no. 6, Sep. 2003, pp. 662–79. *Wiley Online Library*, <https://doi.org/10.1111/1467-9566.00364>.
- Davis, Madeleine, and David Wallbridge. *Boundary and Space: An Introduction to the Work of D.W. Winnicott*. Reprint, Karnac, 1991.
- De Lauretis, Teresa. *Alice Doesn’t: Feminism, Semiotics, Cinema*. Indiana University Press, 1984.
- Dean-Jones, Lesley. ‘Autopsia, Historia and What Women Know: The Authority of Women in Hippocratic Gynaecology’. *Knowledge and the Scholarly Medical Traditions*. Edited by Don Bates, Cambridge University Press, 1995, pp. 41–59. *CrossRef*, <https://doi.org/10.1017/CBO9780511621666.003>.
- Dempsey, Noel. ‘Arts Funding: Statistics’. *House of Commons Library*, Apr. 2016. [commonslibrary.parliament.uk/research-briefings/cbp-7655/](https://commonslibrary.parliament.uk/research-briefings/cbp-7655/).
- Dennett, Daniel C. ‘Why Everyone Is a Novelist’. *The Times Literary Supplement*, no. 4459, Sep. 1988, pp. 1016–. The Times Literary Supplement Historical Archive.
- Depraz, Natalie. ‘What About the Praxis of Reduction? Between Husserl and Merleau-Ponty’. *Merleau-Ponty’s Reading of Husserl*. Edited by Ted Toadvine and Lester Embree, 2002.
- Dinstein, Ilan, et al. ‘A Mirror up to Nature’. *Current Biology : CB*, vol. 18, no. 1, Jan. 2008, pp. R13–18. *PubMed Central*, <https://doi.org/10.1016/j.cub.2007.11.004>.
- Dittrich, L. ‘The Humanities and Medicine: Reports of 41 US, Canadian and International Programs’. *Academic Medicine*, vol. 78, 2003, pp. 951–52.
- Donohue-Smith, Maureen. ‘Telling the Whole Story: A Conceptual Model for Analysing the Mental Illness Memoir’. *Mental Health Review Journal*, vol. 16, no. 3, Emerald Group Publishing



- Limited, Jan. 2011, pp. 138–46. *Emerald Insight*,  
<https://doi.org/10.1108/13619321111178096>.
- Douglas, Guy. 'Why Pains Are Not Mental Objects'. *Philosophical Studies*, vol. 91, no. 2, Aug. 1998, pp. 127–48. *Springer Link*, <https://doi.org/10.1023/A:1004280711849>.
- Dreyfus, Hubert L., et al. *Michel Foucault, Beyond Structuralism and Hermeneutics*. 2nd ed., University of Chicago Press, 1983.
- Durkheim, Émile. *Suicide: A Study in Sociology*. Edited by George Simpson. Translated by George Simpson and John A. Spaulding. Routledge, 2002.
- Durkheim, Emile. *The Elementary Forms of Religious Life*. Translated by Karen E. Fields. Free Press, 1995.
- Earle, William James. 'DSM-5'. *The Philosophical Forum*, vol. 45, no. 2, May 2014, pp. 179–96.  
*onlinelibrary-wiley-com.ezproxy.sussex.ac.uk (Atypon)*, <https://doi.org/10.1111/phil.12034>.
- Egnew, Thomas R. 'Suffering, Meaning, and Healing: Challenges of Contemporary Medicine'. *Annals of Family Medicine*, vol. 7, no. 2, Mar. 2009, pp. 170–75. *PubMed Central*,  
<https://doi.org/10.1370/afm.943>.
- Ellis, Carolyn, et al. 'Autoethnography: An Overview'. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, vol. 12, no. 1, 1, 2011. [www.qualitative-research.net](http://www.qualitative-research.net),  
<https://doi.org/10.17169/fqs-12.1.1589>.
- Ellis, Carolyn, and Arthur Bochner. 'Autoethnography, Personal Narrative, Reflexivity: Researcher as Subject'. *Handbook of Qualitative Research*, Jan. 2000.
- Emanuel, Ezekiel J., et al. 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe'. *JAMA*, vol. 316, no. 1, American Medical Association, July 2016, pp. 79–90. *jamanetwork.com*, <https://doi.org/10.1001/jama.2016.8499>.
- . 'Euthanasia: Where The Netherlands Leads Will The World Follow? No. Legalisation Is A Diversion From Improving Care For The Dying'. *BMJ: British Medical Journal*, vol. 322, no. 7299, BMJ, 2001, pp. 1376–77.

- . 'What Is the Great Benefit of Legalizing Euthanasia or Physician-Assisted Suicide?' *Ethics*, vol. 109, no. 3, The University of Chicago Press, 1999, pp. 629–42. *JSTOR*, <https://doi.org/10.1086/233925>.
- Engelbrechtsen, Eivind, et al. 'Towards a Translational Medical Humanities: Introducing the Cultural Crossings of Care'. *Medical Humanities*, vol. 46, no. 2, Institute of Medical Ethics, June 2020, pp. e2–e2. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2019-011751>.
- Ensler, Eve. 'The Power and Mystery of Naming Things'. *NPR.Org*, <https://www.npr.org/templates/story/story.php?storyId=5285531>. Accessed 23 Oct. 2020.
- Evans, Martyn. 'Reflections on the Humanities in Medical Education'. *Medical Education*, vol. 36, no. 6, June 2002, pp. 508–13. *Wiley Online Library*, <https://doi.org/10.1046/j.1365-2923.2002.01225.x>.
- Evans, Martyn, and Ilora G. Finlay, editors. *Medical Humanities*. BMJ, 2001.
- Evans, Martyn, and David Greaves. "'Developing the Medical Humanities" – Report of a Research Colloquium, and Collected Abstracts of Papers'. *Medical Humanities*, vol. 27, no. 2, Jan. 2001, pp. 93–98. *mh.bmj.com*, <https://doi.org/10.1136/mh.27.2.93>.
- . 'Exploring the Medical Humanities'. *BMJ*, vol. 319, no. 7219, Nov. 1999, pp. 1216–1216. *www.bmj.com*, <https://doi.org/10.1136/bmj.319.7219.1216>.
- . 'Ten Years of Medical Humanities: A Decade in the Life of a Journal and a Discipline'. *Medical Humanities*, vol. 36, no. 2, Jan. 2010, pp. 66–68. *mh.bmj.com*, <https://doi.org/10.1136/jmh.2010.005603>.
- Ewijk, Petrus Van. "'I" and the "Other": The Relevance of Wittgenstein, Buber and Levinas for an Understanding of AA's Recovery Program in David Foster Wallace's Infinite Jest'. *English Text Construction*, vol. 2, no. 1, John Benjamins, Jan. 2009, pp. 132–45. *www.jbe-platform.com*, <https://doi.org/10.1075/etc.2.1.08ewy>.

- Finck, Shannon. *Rough Text: Women's Experiments in Undoing the Autobiographical Subject*. Georgia State University, 2014. ProQuest,  
<http://search.proquest.com/lion/docview/1617962002/abstract/3328C91734D047E2PQ/1>.
- Fink, Eugen. *Play as Symbol of the World and Other Writings*. Translated by Ian Alexander Moore and Christopher Turner. Indiana University Press, 2016.
- . 'What Does the Phenomenology of Edmund Husserl Want to Accomplish? (The Phenomenological Idea of Laying-a-Ground)'. *Research in Phenomenology*. Translated by Arthur Grugan, vol. 2, no. 1, Jan. 1972, pp. 5–27. *brill-com.ezproxy.sussex.ac.uk*,  
<https://doi.org/10.1163/156916472X00018>.
- Fink, Eugen, and Edmund Husserl. *Sixth Cartesian Meditation: The Idea of a Transcendental Theory of Method*. Translated by Ronald Bruzina. Indiana University Press, 1995.
- 'Foreword, n.' *OED Online*, Oxford University Press. *Oxford English Dictionary*,  
<https://www.oed.com/view/Entry/73263>. Accessed 1 Sep. 2020.
- Fornaro, Michele, et al. 'Medicine and Psychiatry in Western Culture: Ancient Greek Myths and Modern Prejudices'. *Annals of General Psychiatry*, vol. 8, Oct. 2009, p. 21. *BioMed Central*,  
<https://doi.org/10.1186/1744-859X-8-21>.
- Foucault, Michel. *The Birth of the Clinic: An Archaeology of Medical Perception*. Translated by A. M. Sheridan. Reprint, Routledge, 2003.
- . *The Order of Things: An Archaeology of the Human Sciences*. Reprint, Routledge, 2007.
- . *The Will to Knowledge*. Translated by Robert Hurley. Reprint, vol. 1, Penguin Books, 1998.
- Frank, Arthur W. 'Asking the Right Question about Pain: Narrative and Phronesis'. *Literature and Medicine*, vol. 23, no. 2, 2004, pp. 209–25. *muse.jhu.edu*,  
<https://doi.org/10.1353/lm.2005.0003>.
- . 'Reclaiming an Orphan Genre: The First-Person Narrative of Illness'. *Literature and Medicine*, vol. 13, no. 1, 1994, pp. 1–21. *Project MUSE*, <https://doi.org/10.1353/lm.2011.0180>.

---. 'The Standpoint of Storyteller'. *Qualitative Health Research*, vol. 10, no. 3, Jan. 2000, pp. 354–65.

*qhr.sagepub.com*, <https://doi.org/10.1177/104973200129118499>.

French, R. K., and A. Wear, editors. *British Medicine in an Age of Reform*. Routledge, 1991.

Freud, Sigmund. *Beyond the Pleasure Principle and Other Writings*. Translated by John Reddick.

Penguin Books, 2003. *Open WorldCat*, <https://www.overdrive.com/search?q=94511F13-AC51-43EB-86B9-A3AE0DC913DC>.

Galen. *On the Constitution of the Art of Medicine: The Art of Medicine, a Method of Medicine to*

*Glaucon*. Edited by Ian Johnston. 1st ed., Harvard University Press, 2016.

Gallagher, Shaun. 'Prenoetic Constraints on Perception and Action'. *How the Body Shapes the Mind*,

Oxford University Press, 2005. *oxford.universitypressscholarship.com*,

<https://oxford.universitypressscholarship.com/view/10.1093/0199271941.001.0001/acprof-9780199271948-chapter-7>.

---. 'The Earliest Senses of Self and Others'. *How the Body Shapes the Mind*, Oxford University Press,

2005. *oxford.universitypressscholarship.com*,

<https://oxford.universitypressscholarship.com/view/10.1093/0199271941.001.0001/acprof-9780199271948-chapter-4>.

Gallagher, Shaun, and Andrew N. Meltzoff. 'The Earliest Sense of Self and Others: Merleau-Ponty and

Recent Developmental Studies'. *Philosophical Psychology*, vol. 9, no. 2, Mar. 1996. *PubMed*, <https://doi.org/10.1080/09515089608573181>.

Garber, Megan. 'David Foster Wallace and the Dangerous Romance of Male Genius'. *The Atlantic*,

May 2018. *The Atlantic*, <https://www.theatlantic.com/entertainment/archive/2018/05/the-world-still-spins-around-male-genius/559925/>.

García-Ballester, Luis. 'Artifex Factivus Sanitatis: Health and Medical Care in Medieval Latin

Galenism'. *Knowledge and the Scholarly Medical Traditions*. Edited by Don Bates. Cambridge University Press, 1995, pp. 127–50. *CrossRef*,

<https://doi.org/10.1017/CBO9780511621666.007>.

- Garden, Rebecca. 'Disability and Narrative: New Directions for Medicine and the Medical Humanities'. *Medical Humanities*, vol. 36, no. 2, Jan. 2010, pp. 70–74. *mh.bmj.com*, <https://doi.org/10.1136/jmh.2010.004143>.
- . 'Telling Stories about Illness and Disability: The Limits and Lessons of Narrative'. *Perspectives in Biology and Medicine*, vol. 53, no. 1, 2010, pp. 121–35. *Project MUSE*, <https://doi.org/10.1353/pbm.0.0135>.
- Garista, Patrizia, et al. 'The Mouse Gave Life to the Mountain: Gramsci and Health Promotion'. *Health Promotion International*, vol. 30, no. 3, Sep. 2015, pp. 746–55. *academic-oup-com.ezproxy.sussex.ac.uk*, <https://doi.org/10.1093/heapro/dau002>.
- Garland-Thomson, Rosemarie. 'Misfits: A Feminist Materialist Disability Concept'. *Hypatia*, vol. 26, no. 3, Aug. 2011, pp. 591–609. *Wiley Online Library*, <https://doi.org/10.1111/j.1527-2001.2011.01206.x>.
- Gay, Peter. *Reading Freud: Explorations & Entertainments*. Yale University Press, 1990.
- Gereau IV, Robert W., et al. 'A Pain Research Agenda for the 21st Century'. *The Journal of Pain*, vol. 15, no. 12, Dec. 2014, pp. 1203–14. *ScienceDirect*, <https://doi.org/10.1016/j.jpain.2014.09.004>.
- Grant, V. J. 'Making Room for Medical Humanities'. *Medical Humanities*, vol. 28, no. 1, Jan. 2002, pp. 45–48. *mh.bmj.com*, <https://doi.org/10.1136/mh.28.1.45>.
- Greaves, David, and Martyn Evans. 'Medical Humanities'. *Medical Humanities*, vol. 26, no. 1, Jan. 2000, pp. 1–2. *mh.bmj.com*, <https://doi.org/10.1136/mh.26.1.1>.
- . 'Medical Progress, Reason and the Imagination'. *Medical Humanities*, vol. 27, no. 2, Jan. 2001, pp. 57–57. *mh.bmj.com*, <https://doi.org/10.1136/mh.27.2.57>.
- Greenberg, Jay R., and Stephen A. Mitchell. *Object Relations in Psychoanalytic Theory*. Harvard University Press, 1983.
- Greenhalgh, Trisha, and Brian Hurwitz. 'Narrative Based Medicine: Why Study Narrative?' *BMJ: British Medical Journal*, vol. 318, no. 7175, 1999, pp. 48–50.

- Griffin, Fred L. 'The Fortunate Physician: Learning from Our Patients'. *Literature and Medicine*, vol. 23, no. 2, 2004, pp. 280–303. *Project MUSE*, <https://doi.org/10.1353/lm.2005.0005>.
- Halák, Jan. 'Beyond Things: The Ontological Importance of Play According to Eugen Fink'. *Journal of the Philosophy of Sport*, vol. 43, no. 2, May 2016, pp. 199–214. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/00948705.2015.1079133>.
- . 'Towards the World: Eugen Fink on the Cosmological Value of Play'. *Sport, Ethics and Philosophy*, vol. 9, no. 4, Oct. 2015, pp. 401–12. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/17511321.2015.1130740>.
- Hall, Alfred Rupert, and Marie Boas Hall. *A Brief History of Science*. Iowa State University Press, 1988.
- Halliwell, Martin. *Therapeutic Revolutions: Medicine, Psychiatry, and American Culture, 1945-1970*. Rutgers University Press, 2013.
- Halperin, Edward C. 'Preserving the Humanities in Medical Education'. *Medical Teacher*, vol. 32, no. 1, Jan. 2010, pp. 76–79. *PubMed*, <https://doi.org/10.3109/01421590903390585>.
- Hampson, Lindsay A., and Ezekiel J. Emanuel. 'The Prognosis for Changes in End-of-Life Care After the Schiavo Case.' *Health Affairs (Project Hope)*, vol. 24, no. 4, Aug. 2005, pp. 972–75.
- Hankinson, Robert, James. 'The Growth of Medical Empiricism'. *Knowledge and the Scholarly Medical Traditions*. Edited by Don Bates. Cambridge University Press, 2018, pp. 60–83.
- Haraway, Donna. 'Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective'. *Feminist Studies*, vol. 14, no. 3, 1988, pp. 575–99. *JSTOR*, *JSTOR*, <https://doi.org/10.2307/3178066>.
- Harding, Sandra. 'After the Neutrality Ideal: Science, Politics, and "Strong Objectivity"'. *Social Research*, vol. 59, no. 3, Fall 1992, pp. 567–87.
- . 'European Expansion and the Organization of Modern Science: Isolated or Linked Historical Processes?' *Organization*, vol. 3, no. 4, Nov. 1996, pp. 497–509. *SAGE Journals*, <https://doi.org/10.1177/135050849634007>.

- . 'Feminism and Theories of Scientific Knowledge'. *Women: A Cultural Review*, vol. 1, no. 1, Apr. 1990, pp. 87–98. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/09574049008578026>.
- . 'Gender, Development, and Post-Enlightenment Philosophies of Science'. *Hypatia*, vol. 13, no. 3, 1998, pp. 146–67. JSTOR.
- . 'Rethinking Standpoint Epistemology: What Is "Strong Objectivity?"' *The Centennial Review*, vol. 36, no. 3, 1992, pp. 437–70.
- , editor. *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies*. Routledge, 2004.
- Hayes-Brady, Clare. *The Unspeakable Failures of David Foster Wallace: Language, Identity, and Resistance*. Bloomsbury, 2017.
- Hecht, Jennifer Michael. *Stay: A History of Suicide and the Philosophies Against It*. Yale University Press, 2013.
- Heidegger, Martin, and Eugen Fink. *Heraclitus Seminar*. Translated by Charles H. Seibert. Northwestern University Press, 1993.
- Henderson, Margaret. 'From Counterculture to Punk Culture: The Emergence of Kathy Acker's Punk Poetics'. *Lit: Literature Interpretation Theory*, vol. 26, no. 4, Oct. 2015, pp. 276–97. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/10436928.2015.1092347>.
- . 'Kathy Acker's Punk Feminism: A Feminism of Cruelty and Excess in More Liberated and Liberal Times'. *Contemporary Women's Writing*, vol. 11, no. 2, July 2017, pp. 201–20. *academic.oup.com*, <https://doi.org/10.1093/cww/vpw037>.
- . 'Kathy Is a Punk Writer: When the Underground Goes Overground'. *Critique: Studies in Contemporary Fiction*, vol. 55, no. 5, Oct. 2014, pp. 536–50. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/00111619.2013.793169>.
- Hewitt, Jeanette. 'Why Are People with Mental Illness Excluded from the Rational Suicide Debate?' *International Journal of Law and Psychiatry*, vol. 36, no. 5–6, Sep. 2013, pp. 358–65. *ScienceDirect*, <https://doi.org/10.1016/j.ijlp.2013.06.006>.

- Hiatt, Mark D., and Christopher G. Stockton. *The Impact of the Flexner Report on the Fate of Medical Schools in North America After 1909*. 2004.
- Hickmore, Harry. 'Cuts Mean Arts Education Is Being Outsourced To The Culture Sector – And It's Not Working'. *HuffPost UK*, 16 Apr. 2019, [https://www.huffingtonpost.co.uk/entry/the-government-is-outsourcing-education-arts-education\\_uk\\_5ca0eaaae4b0e4e4834dacb1](https://www.huffingtonpost.co.uk/entry/the-government-is-outsourcing-education-arts-education_uk_5ca0eaaae4b0e4e4834dacb1).
- Hill, Liz. 'EXCLUSIVE: Arts in Schools Plummets, New Figures Show'. *ArtsProfessional*, 21 June 2016, <https://www.artsprofessional.co.uk/news/exclusive-arts-schools-plummets-new-figures-show>.
- Himmelheber, Rachel Haley. "'I Believed She Could Save Me": Rape Culture in David Foster Wallace's "Brief Interviews with Hideous Men #20"'. *Critique: Studies in Contemporary Fiction*, vol. 55, no. 5, Oct. 2014, pp. 522–35. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/00111619.2013.829798>.
- Ho, Ming-Chou, et al. "'Cool" and "Hot" Executive Functions in Suicide Attempters with Major Depressive Disorder'. *Journal of Affective Disorders*, vol. 235, Aug. 2018, pp. 332–40. *ScienceDirect*, <https://doi.org/10.1016/j.jad.2018.04.057>.
- Hodgkin, Robin A. 'Cognitive Objects'. *Oxford Review of Education*, vol. 14, no. 3, Taylor & Francis, Ltd., 1988, pp. 353–62.
- Holland, Mary K. "'By Hirsute Author": Gender and Communication in the Work and Study of David Foster Wallace'. *Critique: Studies in Contemporary Fiction*, vol. 58, no. 1, Routledge, Jan. 2017, pp. 64–77. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/00111619.2016.1149798>.
- Holman Jones, Stacy, et al. *Handbook of Autoethnography*. Left Coast Press, 2013.
- Holpuch, Amanda. 'Conservative US Supreme Court Justices Suggest Obamacare Will Be Upheld'. *The Guardian*, 10 Nov. 2020. [www.theguardian.com](http://www.theguardian.com), <https://www.theguardian.com/us-news/2020/nov/10/obamacare-supreme-court-hearing-trump-lawyers-argue-to-end>.



- Holt, Terence E. 'Narrative Medicine and Negative Capability'. *Literature and Medicine*, vol. 23, no. 2, Johns Hopkins University Press, 2004, pp. 318–33. *Project MUSE*, <https://doi.org/10.1353/lm.2005.0008>.
- Homan, Catherine. 'The Play of Ethics in Eugen Fink'. *The Journal of Speculative Philosophy*, vol. 27, no. 3, Aug. 2013, pp. 287–96.
- Hooker, Claire. 'Understanding Empathy: Why Phenomenology and Hermeneutics Can Help Medical Education and Practice'. *Medicine, Health Care and Philosophy*, vol. 18, no. 4, Mar. 2015, pp. 541–52. *link.springer.com*, <https://doi.org/10.1007/s11019-015-9631-z>.
- Hooker, Claire, and Estelle Noonan. 'Medical Humanities as Expressive of Western Culture'. *Medical Humanities*, vol. 37, no. 2, Institute of Medical Ethics, Dec. 2011, pp. 79–84. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2011-010120>.
- Hughes, Judith M. *Reshaping the Psychoanalytic Domain: The Work of Melanie Klein, W.R.B. Fairbairn, and D.W. Winnicott*. University of California Press, 1990.
- Hughes, Julian C., et al. 'Types of Centredness in Health Care: Themes and Concepts'. *Medicine, Health Care and Philosophy*, vol. 11, no. 4, Apr. 2008, pp. 455–63. *link.springer.com*, <https://doi.org/10.1007/s11019-008-9131-5>.
- Huizinga, Johan. *Homo Ludens; A Study of the Play-Element in Culture*. Routledge and Kegan Paul, 1998.
- Hunter, Kathryn Montgomery, et al. 'The Study of Literature in Medical Education'. *Academic Medicine*, vol. 70, no. 9, Sep. 1995, pp. 787–94.
- Hurwitz, Brian, and Rita Charon. 'A Narrative Future for Health Care'. *The Lancet*, vol. 381, no. 9881, June 2013, pp. 1886–87. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(13\)61129-0](https://doi.org/10.1016/S0140-6736(13)61129-0).
- Hutcheon, Linda. *A Poetics of Postmodernism: History, Theory, Fiction*. Routledge, 1988.
- Iniesta, I. 'Neurología y Literatura 2'. *Neurología*, vol. 29, no. 4, May 2014, pp. 242–48. *ScienceDirect*, <https://doi.org/10.1016/j.nrl.2011.02.007>.

- Irigaray, Luce. *Speculum of the Other Woman*. Translated by Gillian C. Gill. Cornell University Press, 1985.
- Itten, Theodor, and Courtenay Young, editors. *R.D. Laing: 50 Years Since 'The Divided Self'*. Footprint Books, 2012.
- Jackson, Mark. 'Medical Humanities in Medical Education'. *Medical Education*, vol. 30, no. 6, Nov. 1996, pp. 395–96. *Wiley Online Library*, <https://doi.org/10.1111/j.1365-2923.1996.tb00856.x>.
- Jacobs, Michael. *D.W. Winnicott*. SAGE Publications, 1995.
- Jacobs, Naomi. 'Kathy Acker and the Plagiarized Self'. *Review of Contemporary Fiction*, vol. 9, no. 3, 1989, p. 50.
- Jacobs, Timothy. 'American Touchstone: The Idea of Order in Gerard Manley Hopkins and David Foster Wallace'. *Comparative Literature Studies*, vol. 38, no. 3, 2001, pp. 215–31.
- Jameson, Fredric. *Postmodernism, or, The Cultural Logic of Late Capitalism*. Reprint, Verso, 2008.
- Jaworski, Katrina. 'The Gender-Ing of Suicide'. *Australian Feminist Studies*, vol. 25, no. 63, Mar. 2010, pp. 47–61. *Crossref*, <https://doi.org/10.1080/08164640903499752>.
- Johnson, Sara S., et al. 'The Art of Health Promotion: Linking Research to Practice'. *American Journal of Health Promotion*, vol. 34, no. 2, SAGE Publications, Feb. 2020, pp. 206–26. *SAGE Journals*, <https://doi.org/10.1177/0890117119896122>.
- Jones, Anne Hudson. 'Literature and Medicine: An Evolving Canon'. *The Lancet*, vol. 348, no. 9038, Nov. 1996, pp. 1360–62. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(96\)09219-7](https://doi.org/10.1016/S0140-6736(96)09219-7).
- . 'Literature and Medicine: Narrative Ethics'. *The Lancet*, vol. 349, no. 9060, Apr. 1997, pp. 1243–46. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(97\)03395-3](https://doi.org/10.1016/S0140-6736(97)03395-3).
- . 'Literature and Medicine: Narratives of Mental Illness'. *The Lancet*, vol. 350, no. 9074, Aug. 1997, pp. 359–61. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(97\)07123-7](https://doi.org/10.1016/S0140-6736(97)07123-7).
- . 'Narrative in Medical Ethics'. *BMJ : British Medical Journal*, vol. 318, no. 7178, Jan. 1999, pp. 253–56.

- . 'Why Teach Literature and Medicine? Answers from Three Decades'. *Journal of Medical Humanities*, vol. 34, no. 4, Sep. 2013, pp. 415–28. [link.springer.com](http://link.springer.com), <https://doi.org/10.1007/s10912-013-9241-9>.
- Jones, Therese, et al., editors. *Health Humanities Reader*. Rutgers University Press, 2014.
- Josselson, Ruthellen, and Amia Lieblich, editors. *The Narrative Study of Lives*. SAGE Publications, 1996.
- Kalanithi, Paul. *When Breath Becomes Air*. Bodley Head, 2016.
- Katovsky, William R. 'David Foster Wallace: A Profile'. *Conversations with David Foster Wallace*. Edited by Stephen J. Burn. University Press of Mississippi, 2012, pp. 3–7. JSTOR, *JSTOR*, <https://doi.org/10.2307/j.ctt24hzc6.5>.
- Keller, Evelyn Fox. 'Making Gender Visible in the Pursuit of Nature's Secrets'. *Feminist Studies/Critical Studies*. Edited by Teresa de Lauretis. Palgrave Macmillan UK, 1986, pp. 67–77. *Springer Link*, [https://doi.org/10.1007/978-1-349-18997-7\\_5](https://doi.org/10.1007/978-1-349-18997-7_5).
- Keller, Kurt Dauer. 'The Corporeal Order of Things: The Spiel of Usability'. *Human Studies*, vol. 28, no. 2, Springer, 2005, pp. 173–204.
- Kelly, Adam. 'David Foster Wallace and the New Sincerity in American Fiction'. *Consider David Foster Wallace: Critical Essays*. Edited by David Hering. Sideshow Media Group Press, 2010.
- Kenny, Nuala P., and Brenda L. Beagan. 'The Patient as Text: A Challenge for Problem-Based Learning'. *Medical Education*, vol. 38, no. 10, Oct. 2004, pp. 1071–79. *Wiley Online Library*, <https://doi.org/10.1111/j.1365-2929.2004.01956.x>.
- Kingsland, James. *Presidential Election Results May Impact Voters' Mental Health*. 5 Nov. 2020, <https://www.medicalnewstoday.com/articles/presidential-election-results-may-impact-voters-mental-health>.
- Kirkland, Kathryn B., and Sienna R. Craig. 'Exploring the Surgical Gaze Through Literature and Art'. *JAMA*, vol. 319, no. 15, Apr. 2018, pp. 1532–34. [jamanetwork-com.ezproxy.sussex.ac.uk](http://jamanetwork-com.ezproxy.sussex.ac.uk), <https://doi.org/10.1001/jama.2018.0396>.

Kirklin, Deborah. 'Humanities in Medical Training and Education'. *Clinical Medicine*, vol. 1, no. 1, 2001, pp. 25–27.

---. 'The Centre for Medical Humanities, Royal Free and University College Medical School, London, England'. *Academic Medicine: Journal of the Association of American Medical Colleges*, vol. 78, no. 10, Oct. 2003, pp. 1048–53.

Kirklin, Deborah, and Ruth Richardson, editors. *Medical Humanities: A Practical Introduction*. Royal College of Physicians of London, 2001.

Kisch, Jeremy, et al. 'Aspects of Suicidal Behavior, Depression, and Treatment in College Students: Results from the Spring 2000 National College Health Assessment Survey'. *Suicide and Life-Threatening Behavior*, vol. 35, no. 1, Feb. 2005, pp. 3–13. *Wiley Online Library*, <https://doi.org/10.1521/suli.35.1.3.59263>.

Klein, Melanie. *Love, Guilt, and Reparation and Other Works 1921-1945*. Vintage, 1998.

---. *Narrative of Child Analysis: The Conduct of the Psycho-Analysis of Children as Seen in the Treatment of a Ten Year Old Boy*. Vintage, 1998.

---. *The Psycho-Analysis of Children*. Translated by Alix Strachey. Vintage, 1997.

Kleinman, Arthur. *The Illness Narratives: Suffering, Healing, and the Human Condition*. Basic Books, 1988. *ProQuest*, <https://search-proquest-com.ezproxy.sussex.ac.uk/docview/617478070/54BE4419EEEA4891PQ/18>.

Knox, Paul D. *Where Do We Go From Here? Conclusions and Community in the Postmodern American Novel*. University of Nevada, 2010. *ProQuest*, <http://search.proquest.com/lion/docview/527813105/abstract/598DB7FD5BB4469APQ/1>.

Konstantinou, Lee. 'The World of David Foster Wallace'. *Boundary 2*, vol. 40, no. 3, Aug. 2013, pp. 59–86. *read-dukeupress-edu.ezproxy.sussex.ac.uk*, <https://doi.org/10.1215/01903659-2367040>.

Kosalka, David L. R. *Bataille and the Notion of Gift*. Dec. 1999, p. 10.

- Krell, David Farrell. 'Towards an Ontology of Play: Eugen Fink's Notion of Spiel'. *Research in Phenomenology*, vol. 2, no. 1, Jan. 1972, pp. 63–93. *brill-com.ezproxy.sussex.ac.uk*, <https://doi.org/10.1163/156916472X00045>.
- Kristeva, Julia, et al. 'Cultural Crossings of Care: An Appeal to the Medical Humanities'. *Medical Humanities*, vol. 44, no. 1, Institute of Medical Ethics, Mar. 2018, pp. 55–58. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2017-011263>.
- . *Powers of Horror: An Essay on Abjection*. Translated by Leon S. Roudiez. Columbia University Press, 1982.
- Kumagai, Arno K. 'A Conceptual Framework for the Use of Illness Narratives in Medical Education': *Academic Medicine*, vol. 83, no. 7, July 2008, pp. 653–58. *CrossRef*, <https://doi.org/10.1097/ACM.0b013e3181782e17>.
- Kuspit, Donald. 'Disintegrated History'. *C (Archive: 1987-1992); Toronto*, no. 23, C the Visual Arts Foundation, Sep. 1989, pp. 17–19.
- . 'The Contemporary and the Historical'. *Artnet*, 2005, <http://www.artnet.com/magazine/features/kuspit/kuspit4-14-05.asp>.
- Lacan, Jacques. *Écrits: A Selection*. Translated by Alan Sheridan. Routledge, 2001.
- Laing, R. D. *The Divided Self*. Viking, 1991.
- Lambert, Stephanie. "'The Real Dark Side, Baby": New Sincerity and Neoliberal Aesthetics in David Foster Wallace and Jennifer Egan'. *Critique: Studies in Contemporary Fiction*, vol. 61, no. 4, Routledge, Aug. 2020, pp. 394–411. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/00111619.2020.1727831>.
- Lamprell, Klay, and Jeffrey Braithwaite. 'Patients as Story-Tellers of Healthcare Journeys'. *Medical Humanities*, Apr. 2016, p. medhum-2016-010885. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2016-010885>.
- Lawrence, Christopher. 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914'. *Journal of Contemporary History*, vol. 20, no. 4, 1985, pp. 503–20.

- Leggett, J. M. 'Medical Scientism: Good Practice or Fatal Error?' *Journal of the Royal Society of Medicine*, vol. 90, no. 2, Feb. 1997, pp. 97–101.
- Lenormand, Marie. 'Winnicott's Theory of Playing: A Reconsideration'. *The International Journal of Psychoanalysis*, vol. 99, no. 1, Routledge, Jan. 2018, pp. 82–102. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/00207578.2017.1399068>.
- Lester, David. 'Can Suicide Be a Good Death?' *Death Studies*, vol. 30, no. 6, July 2006, pp. 511–27. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/07481180600742509>.
- Letzler, David. 'Encyclopedic Novels and the Craft of Fiction: Infinite Jest's Endnotes'. *David Foster Wallace and 'The Long Thing': New Essays on the Novels*. Edited by Marshall Boswell. 1st ed., Bloomsbury, 2014, pp. 127–48.
- Lloyd, G. E. R. 'Epistemological Arguments in Early Greek Medicine in Comparativist Perspective'. *Knowledge and the Scholarly Medical Traditions*. Edited by Don Bates. Cambridge University Press, 1995, pp. 25–40. *CrossRef*, <https://doi.org/10.1017/CBO9780511621666.002>.
- Loewald, Hans W. *Sublimation: Inquiries into Theoretical Psychoanalysis*. Yale University Press, 1988.
- Lokhandwala, Tasneem M., and John S. Westefeld. 'Rational Suicide and the Crisis of Terminal Illness'. *Journal of Personal and Interpersonal Loss*, vol. 3, no. 2, Apr. 1998, pp. 143–59. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/10811449808414437>.
- Lokugamage, Amali U., et al. 'Decolonising Ideas of Healing in Medical Education'. *Journal of Medical Ethics*, vol. 46, no. 4, Institute of Medical Ethics, Apr. 2020, pp. 265–72. *jme.bmj.com*, <https://doi.org/10.1136/medethics-2019-105866>.
- Loudon, I. 'The Hippocratic Oath'. *BMJ*, vol. 309, no. 6951, Aug. 1994, p. 414. *www.bmj.com*, <https://doi.org/10.1136/bmj.309.6951.414a>.
- Loughlin, Michael, et al. 'Science, Practice and Mythology: A Definition and Examination of the Implications of Scientism in Medicine'. *Health Care Analysis: HCA: Journal of Health Philosophy and Policy*, vol. 21, no. 2, June 2013, pp. 130–45. *PubMed*, <https://doi.org/10.1007/s10728-012-0211-6>.

- Louis-Courvoisier, M., and A. Wenger. 'How to Make the Most of History and Literature in the Teaching of Medical Humanities: The Experience of the University of Geneva'. *Medical Humanities*, vol. 31, no. 1, Jan. 2005, pp. 51–54. *mh.bmj.com*, <https://doi.org/10.1136/jmh.2004.000206>.
- Louw, Jakobus M., et al. 'Patient- or Person-Centred Practice in Medicine? – A Review of Concepts'. *African Journal of Primary Health Care & Family Medicine*, vol. 9, no. 1, Oct. 2017. *PubMed Central*, <https://doi.org/10.4102/phcfm.v9i1.1455>.
- Ludwig, Birgit, et al. 'The Life Span Model of Suicide and Its Neurobiological Foundation'. *Frontiers in Neuroscience*, vol. 11, 2017. *Frontiers*, <https://doi.org/10.3389/fnins.2017.00074>.
- Lund, Crick. 'Reflections on the Next Ten Years of Research, Policy and Implementation in Global Mental Health'. *Epidemiology and Psychiatric Sciences*, vol. 29, Cambridge University Press, ed 2020. *Cambridge University Press*, <https://doi.org/10.1017/S204579601900074X>.
- Lyotard, Jean-François. *The Postmodern Condition: A Report on Knowledge*. Reprint, Manchester University Press, 2005.
- Machado, Roberto. 'Foucault, Philosophy, and Literature'. *Contemporary French and Francophone Studies*, vol. 16, no. 2, Mar. 2012, pp. 227–34. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/17409292.2012.668814>.
- Macnaughton, Jane. 'The Dangerous Practice of Empathy'. *Lancet*, vol. 373, no. 9679, June 2009, pp. 1940–41.
- . 'The Humanities in Medical Education: Context, Outcomes and Structures'. *Medical Humanities*, vol. 26, no. 1, Jan. 2000, pp. 23–30. *mh.bmj.com*, <https://doi.org/10.1136/mh.26.1.23>.
- Macneill, Paul Ulhas. 'The Arts and Medicine: A Challenging Relationship'. *Medical Humanities*, vol. 37, no. 2, Jan. 2011, pp. 85–90. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2011-010044>.
- Magner, Lois N. *A History of Medicine*. 2nd ed., Taylor & Francis, 2005.

- Mallinson, Sara, and Jennie Popay. 'Describing Depression: Ethnicity and the Use of Somatic Imagery in Accounts of Mental Distress'. *Sociology of Health & Illness*, vol. 29, no. 6, Sep. 2007, pp. 857–71. *Wiley Online Library*, <https://doi.org/10.1111/j.1467-9566.2007.01048.x>.
- Marchant, Jo. *Cure: A Journey into the Science of Mind over Body*. Canongate, 2017.
- Marraffa, Massimo, and Cristina Meini. 'Forms of Vitality Revisited: The Construction of an Affective Bodily Self'. *Theory & Psychology*, vol. 29, no. 1, Feb. 2019, pp. 27–45. *SAGE Journals*, <https://doi.org/10.1177/0959354318822175>.
- Marsh, Ian. 'The Uses of History in the Unmaking of Modern Suicide'. *Journal of Social History*, vol. 46, no. 3, Mar. 2013, pp. 744–56.
- Marsh, Sarah, and Amelia Hill. 'Figures Lay Bare Toll of Pandemic on UK Children's Mental Health'. *The Guardian*, 21 Oct. 2020, <http://www.theguardian.com/society/2020/oct/21/figures-lay-bare-toll-of-pandemic-on-uk-childrens-mental-health>.
- Maruthappu, Mahiben, et al. 'The NHS Five Year Forward View: Transforming Care'. *The British Journal of General Practice*, vol. 64, no. 629, Dec. 2014, p. 635. *PubMed Central*, <https://doi.org/10.3399/bjgp14X682897>.
- Max, Daniel T. *Every Love Story Is a Ghost Story: A Life of David Foster Wallace*. Granta, 2013.
- Mayes, Christopher. 'Pastoral Power and the Confessing Subject in Patient-Centred Communication'. *Journal of Bioethical Inquiry*, vol. 6, no. 4, Oct. 2009, p. 483. *link.springer.com*, <https://doi.org/10.1007/s11673-009-9195-9>.
- Mayo, David J. 'Rational Suicide?' *Journal of Personal and Interpersonal Loss*, vol. 3, no. 2, Apr. 1998, pp. 193–203. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/10811449808414441>.
- McCaffery, Larry, and Kathy Acker. 'An Interview with Kathy Acker'. *Mississippi Review*, vol. 20, no. 1/2, 1991, pp. 83–97.
- McCaffery, Larry, and David Foster Wallace. 'An Expanded Interview with David Foster Wallace'. *Conversations with David Foster Wallace*. Edited by Stephen J. Burn. University Press of Mississippi, 2012, pp. 21–52. *JSTOR, JSTOR*, <https://doi.org/10.2307/j.ctt24hzc6.8>.



- McDonald, Peter. *Oxford Dictionary of Medical Quotations*. Oxford University Press, 2004.
- McGuffin, P., et al. 'The Genetics of Affective Disorder and Suicide'. *European Psychiatry*, vol. 25, no. 5, June 2010, pp. 275–77. *ScienceDirect*, <https://doi.org/10.1016/j.eurpsy.2009.12.012>.
- McHale, Brian. *Postmodernist Fiction*. Reprint, Routledge, 2004.
- McHugh, Hugh Marshall, and Simon Thomas Walker. "'Personal Knowledge" in Medicine and the Epistemic Shortcomings of Scientism'. *Journal of Bioethical Inquiry*, vol. 12, no. 4, Dec. 2015, pp. 577–85. *PubMed*, <https://doi.org/10.1007/s11673-015-9661-5>.
- McLaughlin, Robert L. 'Post-Postmodern Discontent: Contemporary Fiction and the Social World'. *Symplokē*, vol. 12, no. 1/2, 2004, pp. 53–68. JSTOR.
- McLellan, M. Faith. 'Literature and Medicine: Narratives of Physical Illness'. *The Lancet*, vol. 349, no. 9065, May 1997, pp. 1618–20. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(97\)04429-2](https://doi.org/10.1016/S0140-6736(97)04429-2).
- McLellan, M. Faith, and Anne Hudson Jones. 'Why Literature and Medicine?' *The Lancet*, vol. 348, no. 9020, July 1996, pp. 109–11. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(96\)03521-0](https://doi.org/10.1016/S0140-6736(96)03521-0).
- McManus, I. C. 'Humanity and the Medical Humanities'. *The Lancet*, vol. 346, no. 8983, Oct. 1995, pp. 1143–45. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(95\)91806-X](https://doi.org/10.1016/S0140-6736(95)91806-X).
- Mead, Nicola, et al. 'The Impact of General Practitioners' Patient-Centredness on Patients' Post-Consultation Satisfaction and Enablement'. *Social Science & Medicine*, vol. 55, no. 2, July 2002, pp. 283–99. *ScienceDirect*, [https://doi.org/10.1016/S0277-9536\(01\)00171-X](https://doi.org/10.1016/S0277-9536(01)00171-X).
- Mead, Nicola, and Peter Bower. 'Measuring Patient-Centredness: An Assessment of the Reliability and Validity of Three Different Consultation-Based Measures'. *Patient Education and Counseling*, vol. 34, May 1998, p. S27. *ScienceDirect*, [https://doi.org/10.1016/S0738-3991\(98\)90058-1](https://doi.org/10.1016/S0738-3991(98)90058-1).

- . 'Patient Enablement: The Relationship Between Doctor-Patient Communication and a New Patient Outcome Measure for GP Consultations'. *Patient Education and Counseling*, vol. 34, May 1998, pp. 577–78. *ScienceDirect*, [https://doi.org/10.1016/S0738-3991\(98\)90191-4](https://doi.org/10.1016/S0738-3991(98)90191-4).
- . 'Patient-Centred Consultations and Outcomes in Primary Care: A Review of the Literature'. *Patient Education and Counseling*, vol. 48, no. 1, Sep. 2002, pp. 51–61. *ScienceDirect*, [https://doi.org/10.1016/S0738-3991\(02\)00099-X](https://doi.org/10.1016/S0738-3991(02)00099-X).
- Meakin, R. 'Medical Humanities in Undergraduate Medical Education - Moving On'. *Medical Humanities*, vol. 28, no. 1, Jan. 2002, pp. 32–32. *mh.bmj.com*, <https://doi.org/10.1136/mh.28.1.32>.
- 'Medicine, n.1'. *OED Online*, Oxford University Press. *Oxford English Dictionary*, <https://www.oed.com/view/Entry/115715>. Accessed 29 Sep. 2020.
- Meline, Caroline W. *The Creative Dimension of Subjectivity in Lacan, Freud, and Winnicott*. Temple University, 2004. *ProQuest*, <http://search.proquest.com/docview/305131681/abstract/6F35D0F83F344BC7PQ/1>.
- Merleau-Ponty, Maurice. *Phenomenology of Perception: An Introduction*. Translated by Colin Smith. Routledge, 2002.
- Merritt, Stephanie. 'Review: Brief Interviews with Hideous Men by David Foster Wallace'. *The Guardian*, 28 Jan. 2001, <http://www.theguardian.com/books/2001/jan/28/fiction.reviews2>.
- Meza, James P., and Daniel S. Passerman. *Integrating Narrative Medicine and Evidence-Based Medicine: The Everyday Social Practice of Healing*. Radcliffe Pub, 2011.
- Miles, Andrew. 'On a Medicine of the Whole Person: Away from Scientistic Reductionism and Towards the Embrace of the Complex in Clinical Practice\*'. *Journal of Evaluation in Clinical Practice*, vol. 15, no. 6, Dec. 2009, pp. 941–49. *Wiley Online Library*, <https://doi.org/10.1111/j.1365-2753.2009.01354.x>.

- Miller, Laura, and David Foster Wallace. 'The Salon Interview: David Foster Wallace'. *Conversations with David Foster Wallace*. Edited by Stephen J. Burn. University Press of Mississippi, 2012, pp. 58–65. JSTOR, *JSTOR*, <https://doi.org/10.2307/j.ctt24hzc6.10>.
- 'Mimesis, n.' *OED Online*, Oxford University Press. *Oxford English Dictionary*, <https://www.oed.com/view/Entry/118640>. Accessed 6 Oct. 2020.
- Mirkovic, Bojan, et al. 'Genetic Association Studies of Suicidal Behavior: A Review of the Past 10 Years, Progress, Limitations, and Future Directions'. *Frontiers in Psychiatry*, vol. 7, 2016. *Frontiers*, <https://doi.org/10.3389/fpsyt.2016.00158>.
- 'Mission Statement'. *Association of Medical Humanities*, [http://amh.ac.uk/?page\\_id=428](http://amh.ac.uk/?page_id=428). Accessed 5 May 2016.
- Montgomery, Kathryn. *How Doctors Think: Clinical Judgment and the Practice of Medicine*. Oxford University Press, 2006.
- Moran, Stephen T. 'Autopathography and Depression: Describing the "Despair Beyond Despair"'. *Journal of Medical Humanities*, vol. 27, no. 2, June 2006, pp. 79–91. *link-springer-com.ezproxy.sussex.ac.uk*, <https://doi.org/10.1007/s10912-006-9007-8>.
- Morantz-Sanchez, Regina. *Sympathy and Science: Women Physicians in American Medicine*. Reprint, University of North Carolina Press, 2000.
- Mullangi, Samyukta. 'Presenting the Case for the Medical Humanities'. *AMA Journal of Ethics*, vol. 16, no. 8, American Medical Association, Aug. 2014, pp. 592–94. *journalofethics.ama-assn.org*, <https://doi.org/10.1001/virtualmentor.2014.16.8.fred1-1408>.
- Nagel, Thomas. *The View from Nowhere*. Oxford University Press, 1986.
- Naples, Nancy A. 'Strong Objectivity'. *The Blackwell Encyclopedia of Sociology*, American Cancer Society, 2017, pp. 1–2. *Wiley Online Library*, <https://doi.org/10.1002/9781405165518.wbeoss286.pub2>.

- NHS England. 'The NHS Five Year Forward View – Executive Summary'. *NHS England*, 23 Oct. 2014, <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/>.
- Nock, Matthew K., et al. 'Measuring the Suicidal Mind: Implicit Cognition Predicts Suicidal Behavior'. *Psychological Science*, vol. 21, no. 4, 2010, pp. 511–17.
- Nowaczyk, Małgorzata J. M. 'Narrative Medicine in Clinical Genetics Practice'. *American Journal of Medical Genetics Part A*, vol. 158A, no. 8, 2012, pp. 1941–47. *Wiley Online Library*, <https://doi.org/10.1002/ajmg.a.35482>.
- Nussbaum, Abraham M. "'I Am the Author and Must Take Full Responsibility": Abraham Verghese, Physicians as the Storytellers of the Body, and the Renewal of Medicine'. *Journal of Medical Humanities*, Oct. 2014, pp. 1–11. [link.springer.com](http://link.springer.com), <https://doi.org/10.1007/s10912-014-9312-6>.
- Nussbaum, Martha Craven. *Not for Profit: Why Democracy Needs the Humanities*. 1st pbk ed., Princeton University Press, 2012.
- Olafson, Frederick A. 'Philosophical Anthropology'. *Encyclopedia Britannica*, <https://www.britannica.com/topic/philosophical-anthropology>. Accessed 22 Feb. 2019.
- Oliver, David. 'David Oliver: Covid-19 Should Increase Our Commitment to Publicly Funded and Provided Healthcare'. *BMJ*, vol. 370, British Medical Journal Publishing Group, July 2020. [www.bmj.com](http://www.bmj.com), <https://doi.org/10.1136/bmj.m2667>.
- Olivier, Abraham. 'When Pains Are Mental Objects'. *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition*, vol. 115, no. 1, 2003, pp. 33–53.
- Oquendo, María A., et al. 'Issues for DSM-V: Suicidal Behavior as a Separate Diagnosis on a Separate Axis'. *American Journal of Psychiatry*, vol. 165, no. 11, American Psychiatric Publishing, Nov. 2008, pp. 1383–84. [ajp.psychiatryonline.org](http://ajp.psychiatryonline.org) (Atypon), <https://doi.org/10.1176/appi.ajp.2008.08020281>.

- Orr, R. D., et al. 'Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993'. *The Journal of Clinical Ethics*, vol. 8, no. 4, 1997, pp. 377–88.
- Ousager, Jakob, and Helle Johannessen. 'Humanities in Undergraduate Medical Education: A Literature Review': *Academic Medicine*, vol. 85, no. 6, June 2010, pp. 988–98. *CrossRef*, <https://doi.org/10.1097/ACM.0b013e3181dd226b>.
- Panda, S. C. 'Medicine: Science or Art?' *Mens Sana Monographs*, vol. 4, no. 1, 2006, pp. 127–38. *PubMed Central*, <https://doi.org/10.4103/0973-1229.27610>.
- Patton, Paul. 'Foucault's Subject of Power'. *The Later Foucault: Politics and Philosophy*. Edited by Jeremy Moss. SAGE Publications, 1998, pp. 64–77.
- Pefanis, Julian. *Heterology and the Postmodern: Bataille, Baudrillard, and Lyotard*. Duke University Press, 1991.
- Petersen, Alan, et al. 'The Medical Humanities Today: Humane Health Care or Tool of Governance?' *Journal of Medical Humanities*, vol. 29, no. 1, Dec. 2007, pp. 1–4. [link.springer.com](http://link.springer.com), <https://doi.org/10.1007/s10912-007-9044-y>.
- Petrov, Kristian. 'The Art of Dying as an Art of Living: Historical Contemplations on the Paradoxes of Suicide and the Possibilities of Reflexive Suicide Prevention'. *Journal of Medical Humanities*, vol. 34, no. 3, Sep. 2013, pp. 347–68. [link.springer.com](http://link.springer.com), <https://doi.org/10.1007/s10912-013-9235-7>.
- Philo, Chris. 'The Birth of the Clinic: An Unknown Work of Medical Geography'. *Area*, vol. 32, no. 1, Mar. 2000, pp. 11–19. *Wiley Online Library*, <https://doi.org/10.1111/j.1475-4762.2000.tb00110.x>.
- Pilpel, Avital, and Lawrence Amsel. 'What Is Wrong with Rational Suicide'. *Philosophia*, vol. 39, no. 1, Mar. 2011, pp. 111–23. [link.springer.com](http://link.springer.com), <https://doi.org/10.1007/s11406-010-9253-x>.

- Plotka, Witold. 'Reduction and the Question of Beginnings in Husserl, Fink and Patočka'. *Human Studies*, vol. 41, no. 4, Dec. 2018, pp. 603–21. *Springer Link*, <https://doi.org/10.1007/s10746-018-09482-3>.
- Polianski, Igor J., and Heiner Fangerau. 'Toward "Harder" Medical Humanities: Moving Beyond the "Two Cultures" Dichotomy'. *Academic Medicine: Journal of the Association of American Medical Colleges*, vol. 87, no. 1, Jan. 2012, pp. 121–26. *PubMed*, <https://doi.org/10.1097/ACM.0b013e31823ad204>.
- Porter, Roy, editor. *The Cambridge History of Medicine*. Cambridge University Press, 2006.
- 'Post-Debate Briefing: The EBacc and Creative, Artistic and Technical Subjects'. *D&T: The Design and Technology Association*, <https://www.data.org.uk/news/post-debate-briefing-the-ebacc-and-creative-artistic-and-technical-subjects/>. Accessed 11 Nov. 2020.
- Ragland-Sullivan, Ellie. 'Dora and the Name-of-the-Father: The Structure of Hysteria'. *Discontented Discourses: Feminism/Textual Intervention/Psychoanalysis*. Edited by Marleen S. Barr and Richard Feldstein. University of Illinois Press, 1989, p. 250.
- . 'Jacques Lacan: Feminism and the Problem of Gender Identity'. *SubStance*, vol. 11, no. 3, 1982, pp. 6–20. *JSTOR*, *JSTOR*, <https://doi.org/10.2307/3684310>.
- Rancière, Jacques. *Aisthesis: Scenes from the Aesthetic Regime of Art*. Translated by Zakir Paul. 1st English ed., Verso Books, 2013.
- . *Dissensus: On Politics and Aesthetics*. Translated by Steve Corcoran. Continuum, 2011.
- . *The Politics of Aesthetics: The Distribution of the Sensible*. Translated by Gabriel Rockhill. Reprint, Continuum, 2009.
- Range, Lillian M. 'Reply to Lokhandwala and Westefeld'. *Journal of Personal and Interpersonal Loss*, vol. 3, no. 2, Apr. 1998, pp. 161–65. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/10811449808414438>.
- Reardon, Sara. 'Brain Study Seeks Roots of Suicide'. *Nature News*, vol. 528, no. 7580, Dec. 2015, p. 19. [www.nature.com.ezproxy.sussex.ac.uk](http://www.nature.com.ezproxy.sussex.ac.uk), <https://doi.org/10.1038/nature.2015.18870>.

- Redding, Arthur F. 'Bruises, Roses: Masochism and the Writing of Kathy Acker'. *Contemporary Literature*, vol. 35, no. 2, 1994, pp. 281–304. *JSTOR*, <https://doi.org/10.2307/1208840>.
- Richman, J. 'A Rational Approach to Rational Suicide'. *Suicide & Life-Threatening Behavior*, vol. 22, no. 1, 1992, pp. 130–41.
- Richman, Joseph. 'The Case Against Rational Suicide'. *Suicide and Life-Threatening Behavior*, vol. 18, no. 3, Sep. 1988, pp. 285–89. *Wiley Online Library*, <https://doi.org/10.1111/j.1943-278X.1988.tb00165.x>.
- Rizzolatti, Giacomo, and Laila Craighero. 'The Mirror-Neuron System'. *Annual Review of Neuroscience*, vol. 27, 2004, pp. 169–92. *PubMed*, <https://doi.org/10.1146/annurev.neuro.27.070203.144230>.
- Roberts, Joel, and Edward Jackson. 'White Guys: Questioning Infinite Jest's New Sincerity'. *Orbit: A Journal of American Literature*, vol. 5, no. 1, 1, Open Library of Humanities, Mar. 2017. [orbit.openlibhums.org](https://doi.org/10.16995/orbit.182), <https://doi.org/10.16995/orbit.182>.
- Rollo, Dolores, and Francesco Sulla. 'Maternal Talk in Cognitive Development: Relations between Psychological Lexicon, Semantic Development, Empathy, and Temperament'. *Frontiers in Psychology*, vol. 7, Frontiers, 2016. *Frontiers*, <https://doi.org/10.3389/fpsyg.2016.00394>.
- Rose, Gillian. *Love's Work: A Reckoning with Life*. 1st American ed., Schocken Books, 1995.
- Saavedra, Javier, et al. 'Incomprehensibility in the Narratives of Individuals With a Diagnosis of Schizophrenia'. *Qualitative Health Research*, vol. 19, no. 11, SAGE Publications, Nov. 2009, pp. 1548–58. *SAGE Journals*, <https://doi.org/10.1177/1049732309351110>.
- Salter, Brian. 'Who Rules? The New Politics of Medical Regulation'. *Social Science & Medicine*, vol. 52, no. 6, Mar. 2001, pp. 871–83. *ScienceDirect*, [https://doi.org/10.1016/S0277-9536\(00\)00190-8](https://doi.org/10.1016/S0277-9536(00)00190-8).
- Saunders, John. 'The Practice of Clinical Medicine as an Art and as a Science'. *Medical Humanities*, vol. 26, no. 1, Jan. 2000, pp. 18–22. *mh.bmj.com*, <https://doi.org/10.1136/mh.26.1.18>.

- Saxena, Shekhar, et al., editors. *Preventing Suicide: A Global Imperative*. World Health Organization, 2014.
- Scarry, Elaine. *The Body in Pain: The Making and Unmaking of the World*. Oxford University Press, 1985.
- Schiff, Brian. 'The Promise (and Challenge) of an Innovative Narrative Psychology'. *Narrative Inquiry*, vol. 16, no. 1, John Benjamins, 2006, pp. 19–27. *APA PsycNET*, <https://doi.org/10.1075/ni.16.1.05sch>.
- Schillace, Brandy. 'Border Crossings: Joining a Multidisciplinary Conversation about Medical Humanities'. *Medical Humanities*, vol. 44, no. 1, Institute of Medical Ethics, Mar. 2018, pp. 1–1. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2018-011442>.
- Scott, Charles E. 'The Power of Medicine, the Power of Ethics'. *Journal of Medicine and Philosophy*, vol. 12, no. 4, Jan. 1987, pp. 335–50. *jmp.oxfordjournals.org*, <https://doi.org/10.1093/jmp/12.4.335>.
- Scott-Fordsmand, Helene. 'Reversing the Medical Humanities'. *Medical Humanities*, Institute of Medical Ethics, Aug. 2020. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2019-011745>.
- Seligman, Stephen. 'Illusion as a Basic Psychic Principle: Winnicott, Freud, Oedipus, and Trump'. *Journal of the American Psychoanalytic Association*, vol. 66, no. 2, Apr. 2018, pp. 263–88. *SAGE Journals*, <https://doi.org/10.1177/0003065118769908>.
- Shapiro, Johanna, Jack Coulehan, et al. 'Medical Humanities and Their Discontents: Definitions, Critiques, and Implications'. *Academic Medicine*, vol. 84, no. 2, Feb. 2009, pp. 192–98. *CrossRef*, <https://doi.org/10.1097/ACM.0b013e3181938bca>.
- Shapiro, Johanna, Marni Friedman, et al. 'The Resident as Teacher of Medical Humanities'. *Medical Education*, vol. 36, no. 11, 2002, pp. 1099–100. *Wiley Online Library*, <https://doi.org/10.1046/j.1365-2923.2002.136318.x>.
- Sheldon, Helen, et al. *The Patient Voice in Revalidation: A Discourse Analysis*. Picker Institute Europe, 2011.



- Shephard, Alex. 'Neil Gorsuch Will Be Our First Lit Bro Supreme Court Justice.' *The New Republic*, Mar. 2017. *The New Republic*, <https://newrepublic.com/minutes/141498/neil-gorsuch-will-first-lit-bro-supreme-court-justice>.
- Skelton, JR, et al. 'Teaching Literature and Medicine to Medical Students, Part I: The Beginning'. *The Lancet*, vol. 356, no. 9245, Dec. 2000, pp. 1920–22. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(00\)03270-0](https://doi.org/10.1016/S0140-6736(00)03270-0).
- . 'Teaching Literature and Medicine to Medical Students, Part II: Why Literature and Medicine?' *The Lancet*, vol. 356, no. 9246, Dec. 2000, pp. 2001–03. *ScienceDirect*, [https://doi.org/10.1016/S0140-6736\(00\)03318-3](https://doi.org/10.1016/S0140-6736(00)03318-3).
- Slattery, Patrick, and Nancy Langerock. 'Blurring Art and Science: Synthetical Moments on the Borders'. *Curriculum Inquiry*, vol. 32, no. 3, 2002, pp. 349–56.
- Slutsman, Julia, et al. 'Managing End-of-Life Care: Comparing the Experiences of Terminally Ill Patients in Managed Care and Fee for Service'. *Journal of the American Geriatrics Society*, vol. 50, no. 12, 2002, pp. 2077–83. *Wiley Online Library*, <https://doi.org/10.1046/j.1532-5415.2002.50622.x>.
- Smith, Andrew C. 'R. D. Laing: The Divided Self'. *The British Journal of Psychiatry*, vol. 140, no. 6, Cambridge University Press, June 1982, pp. 637–42. *Cambridge University Press*, <https://doi.org/10.1017/S000712500011222X>.
- Smith, B. H., and R. J. Taylor. 'Medicine - a Healing or a Dying Art?' *The British Journal of General Practice*, vol. 46, no. 405, Apr. 1996, pp. 249–51.
- Smith, David Woodruff. 'Phenomenology'. *The Stanford Encyclopedia of Philosophy*. Edited by Edward N. Zalta. Summer 2018, Metaphysics Research Lab, Stanford University, 2018. *Stanford Encyclopedia of Philosophy*, <https://plato.stanford.edu/archives/sum2018/entries/phenomenology/>.

- Smyth, Bryan. 'The Meontic and the Militant: On Merleau-Ponty's Relation to Fink\*'. *International Journal of Philosophical Studies*, vol. 19, no. 5, Dec. 2011, pp. 669–99. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/09672559.2011.600771>.
- Smyth, Rosalind L. 'Regulation and Governance of Clinical Research in the UK: New Report Aims to Remove Unnecessary Burdens and Bureaucracy'. *BMJ: British Medical Journal*, vol. 342, no. 7790, 2011, pp. 180–81.
- Solomon, Andrew. *The Noonday Demon: An Anatomy of Depression*. Vintage, 2016.
- Spariosu, Mihai. *Literature, Mimesis, and Play: Essays in Literary Theory*. G. Narr, 1982.
- Spelman, Margaret Boyle. *The Evolution of Winnicott's Thinking: Examining the Growth of Psychoanalytic Thought over Three Generations*. Karnac, 2013.
- Spitzer, Robert L., et al. 'Medical and Mental Disorder: Proposed Definition and Criteria'. *Annales Médico-Psychologiques, Revue Psychiatrique*, vol. 176, no. 7, Sep. 2018, pp. 656–65. *ScienceDirect*, <https://doi.org/10.1016/j.amp.2018.07.004>.
- Squier, Susan. 'Fetishism and Hysteria: The Economies of Feminism Ex Utero'. *Journal of Medical Humanities*, vol. 21, no. 2, June 2000, pp. 59–69. [link.springer.com](http://link.springer.com), <https://doi.org/10.1023/A:1009054712964>.
- Stein, Lorin. 'David Foster Wallace: In the Company of Creeps'. *Conversations with David Foster Wallace*. Edited by Stephen J. Burn. University Press of Mississippi, 2012, pp. 89–93. JSTOR, <https://doi.org/10.2307/j.ctt24hzc6.16>.
- Stewart, Moira, et al. *Patient-Centered Medicine: Transforming the Clinical Method*. 3rd ed., 2013. *Open WorldCat*, <https://www.taylorfrancis.com/books/9781909368040>.
- Strawson, Galen. 'Against Narrativity'. *Ratio*, vol. 17, no. 4, Dec. 2004, pp. 428–52. *Wiley Online Library*, <https://doi.org/10.1111/j.1467-9329.2004.00264.x>.
- 'Suicide'. *WHO*, <http://www.who.int/mediacentre/factsheets/fs398/en/>. Accessed 21 Mar. 2017.
- Świtaj, Piotr, et al. 'The Relationship Between Internalized Stigma and Quality of Life Among People with Mental Illness: Are Self-Esteem and Sense of Coherence Sequential Mediators?' *Quality*

- of Life Research*, vol. 26, no. 9, Sep. 2017, pp. 2471–78. *link-springer-com.ezproxy.sussex.ac.uk*, <https://doi.org/10.1007/s11136-017-1596-3>.
- Tannenbaum, Rebecca J. *Health and Wellness in Colonial America*. Greenwood, 2012.
- Taranto, Julius. 'On Outgrowing David Foster Wallace'. *Los Angeles Review of Books*, Sep. 2018, <https://lareviewofbooks.org/article/on-outgrowing-david-foster-wallace/>.
- Taylor, Steve. *Durkheim and the Study of Suicide*. St. Martin's Press, 1982.
- Tekin, Şerife. 'Self-Concept Through the Diagnostic Looking Glass: Narratives and Mental Disorder'. *Philosophical Psychology*, vol. 24, no. 3, June 2011, pp. 357–80. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/09515089.2011.559622>.
- Thomas, Carol. 'Negotiating the Contested Terrain of Narrative Methods in Illness Contexts'. *Sociology of Health & Illness*, vol. 32, no. 4, May 2010, pp. 647–60. *Wiley Online Library*, <https://doi.org/10.1111/j.1467-9566.2010.01239.x>.
- Thomas, Eric A. "'Psychotic Depression" and Suicide in David Foster Wallace's Infinite Jest'. *Critique: Studies in Contemporary Fiction*, vol. 54, no. 3, July 2013, pp. 276–91. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/00111619.2011.587476>.
- Toadvine, Ted, and Lester Embree, editors. *Merleau-Ponty's Reading of Husserl*. Springer Netherlands, 2002. *Open WorldCat*, <https://doi.org/10.1007/978-94-015-9944-3>.
- Tyler, Imogen. 'The Wretched of the Earth'. *Social Abjection*, 11 July 2013, <https://socialabjection.wordpress.com/2013/07/11/the-wretched-of-the-earth/>.
- Uchtenhagen, Ambros. 'New and Remaining Problems with DSM-V'. *Addiction*, vol. 106, no. 5, 2011, pp. 888–89. *Wiley Online Library*, <https://doi.org/10.1111/j.1360-0443.2010.03328.x>.
- Van der Kolk, Bessel. *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma*. Penguin Books, 2015.
- Varga, Somogy. 'Winnicott, Symbolic Play, and Other Minds'. *Philosophical Psychology*, vol. 24, no. 5, Oct. 2011, pp. 625–37. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/09515089.2011.559621>.

- Verghese, Abraham. 'The Physician as Storyteller'. *Annals of Internal Medicine*, vol. 135, no. 11, Dec. 2001, pp. 1012–17, <https://doi.org/10.7326/0003-4819-135-11-200112040-00028>.
- Walker, Mary Jean. 'Neuroscience, Self-Understanding, and Narrative Truth'. *AJOB Neuroscience*, vol. 3, no. 4, Oct. 2012, pp. 63–74. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/21507740.2012.712603>.
- Wallace, David Foster. *Brief Interviews with Hideous Men*. Reprint, Abacus, 2009.
- . *Infinite Jest*. Back Bay 10th anniversary pbk. ed, Back Bay Books, 2006.
- Wallis, Faith. 'The Experience of the Book: Manuscripts, Texts, and the Role of Epistemology in Early Medieval Medicine'. *Knowledge and the Scholarly Medical Traditions*. Edited by Don Bates. Cambridge University Press, 1995, pp. 101–26. *CrossRef*, <https://doi.org/10.1017/CBO9780511621666.006>.
- Walton, Kendall L. *Mimesis as Make-Believe: On the Foundations of the Representational Arts*. Harvard University Press, 1990.
- Warden, John. 'UK Changes Law for Medical Regulation'. *BMJ: British Medical Journal*, vol. 317, no. 7173, 1998, pp. 1615–1615.
- Warner, John Harley. 'The Humanizing Power of Medical History: Responses to Biomedicine in the 20th Century United States'. *Medical Humanities*, vol. 37, no. 2, Jan. 2011, pp. 91–96. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2011-010034>.
- Warner, John Harley, and Janet A. Tighe, editors. *Major Problems in the History of American Medicine and Public Health: Documents and Essays*. Houghton Mifflin, 2001.
- Wasson, Sara. 'Before Narrative: Episodic Reading and Representations of Chronic Pain'. *Medical Humanities*, vol. 44, no. 2, June 2018, pp. 106–12. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2017-011223>.
- Waters, Theodore E. A., and Robyn Fivush. 'Relations Between Narrative Coherence, Identity, and Psychological Well-Being in Emerging Adulthood'. *Journal of Personality*, vol. 83, no. 4, 2015, pp. 441–51. *Wiley Online Library*, <https://doi.org/10.1111/jopy.12120>.

- Wear, Andrew. 'Epistemology and Learned Medicine in Early Modern England'. *Knowledge and the Scholarly Medical Traditions*. Edited by Don Bates. Cambridge University Press, 1995, pp. 151–74. *CrossRef*, <https://doi.org/10.1017/CBO9780511621666.008>.
- Wear, Delese. 'The Medical Humanities: Toward a Renewed Praxis'. *Journal of Medical Humanities*, vol. 30, no. 4, Sep. 2009, pp. 209–20. *link.springer.com*, <https://doi.org/10.1007/s10912-009-9091-7>.
- . 'Toward Negative Capability: Literature in the Medical Curriculum'. *Curriculum Inquiry*, vol. 34, no. 2, 2004, pp. 169–84.
- Wentzer, Helle S., and Ann Bygholm. 'Narratives of Empowerment and Compliance: Studies of Communication in Online Patient Support Groups'. *International Journal of Medical Informatics*, vol. 82, no. 12, Dec. 2013, pp. e386–94. *ScienceDirect*, <https://doi.org/10.1016/j.ijmedinf.2013.01.008>.
- Werth Jr., James L. 'An Attempt to Clarify the Concept of Rational Suicide: A Commentary on Lokhandwala and Westefeld'. *Journal of Personal and Interpersonal Loss*, vol. 3, no. 2, Apr. 1998, pp. 167–76. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/10811449808414439>.
- . 'Can Shneidman's "Ten Commonalities of Suicide" Accommodate Rational Suicide?' *Suicide and Life-Threatening Behavior*, vol. 26, no. 3, Sep. 1996, pp. 292–99. *Wiley Online Library*, <https://doi.org/10.1111/j.1943-278X.1996.tb00614.x>.
- . *Rational Suicide?: Implications for Mental Health Professionals*. Taylor & Francis, 2016.
- . 'Using Rational Suicide as an Intervention to Prevent Irrational Suicide'. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, vol. 19, no. 4, 1998, pp. 185–92. *ProQuest*, <http://dx.doi.org/10.1027/0227-5910.19.4.185>.
- Werth Jr., James L., and Daniel J. Holdwick. 'A Primer on Rational Suicide and Other Forms of Hastened Death'. *The Counseling Psychologist*, vol. 28, no. 4, July 2000, pp. 511–39. *SAGE Journals*, <https://doi.org/10.1177/0011000000284003>.

- Whatley, Shawn D. 'Borrowed Philosophy: Bedside Physicalism and the Need for a Sui Generis Metaphysic of Medicine'. *Journal of Evaluation in Clinical Practice*, vol. 20, no. 6, Dec. 2014, pp. 961–64. *PubMed*, <https://doi.org/10.1111/jep.12214>.
- Whitehead, Anne, et al., editors. *The Edinburgh Companion to the Critical Medical Humanities*. Edinburgh University Press, 2016.
- Winnicott, D.W. *Human Nature*. Free Ass. Books, 1988.
- . *Playing and Reality*. Reprint, Routledge, 2010.
- Winnicott, D. W. *Psycho-Analytic Explorations*. Edited by Clare Winnicott et al. Karnac Books, 2010.
- Wittgenstein, Ludwig. *Philosophical Investigations*. Translated by G. E. M. Anscombe. 2nd ed., Reprint, Blackwell, 1989.
- Wittwer, Héctor. 'The Problem of the Possible Rationality of Suicide and the Ethics of Physician-Assisted Suicide'. *International Journal of Law and Psychiatry*, vol. 36, no. 5–6, Sep. 2013, pp. 419–26. *ScienceDirect*, <https://doi.org/10.1016/j.ijlp.2013.06.009>.
- Woods, Angela. 'The Limits of Narrative: Provocations for the Medical Humanities'. *Medical Humanities*, vol. 37, no. 2, Dec. 2011, pp. 73–78. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2011-010045>.
- Worthington, Marjorie. "'The Territory Named Women's Bodies': The Public and Pirate Spaces of Kathy Acker". *Lit: Literature Interpretation Theory*, vol. 15, no. 4, Oct. 2004, pp. 389–408. *Taylor and Francis+NEJM*, <https://doi.org/10.1080/10436920490534406>.
- Wright, Jeremy. 'Jeremy Wright's Value of Culture Speech'. *GOV.UK*, 18 Jan. 2019, <https://www.gov.uk/government/speeches/jeremy-wrights-value-of-culture-speech>.
- Xie, Weizhen, et al. 'Anhedonia and Pain Avoidance in the Suicidal Mind: Behavioral Evidence for Motivational Manifestations of Suicidal Ideation in Patients With Major Depressive Disorder'. *Journal of Clinical Psychology*, vol. 70, no. 7, July 2014, pp. 681–92. *Wiley Online Library*, <https://doi.org/10.1002/jclp.22055>.
- Young-Bruehl, Elisabeth. *Anna Freud: A Biography*. 2nd ed., Yale University Press, 2008.

Zai, Clement C., Vincenzo de Luca, et al. 'Genetic Factors and Suicidal Behavior'. *The Neurobiological Basis of Suicide*. Edited by Yogesh Dwivedi, CRC Press/Taylor & Francis, 2012. *PubMed*, <http://www.ncbi.nlm.nih.gov/books/NBK107191/>.

Zai, Clement C., Mirko Manchia, et al. 'The Brain-Derived Neurotrophic Factor Gene in Suicidal Behaviour: A Meta-Analysis'. *International Journal of Neuropsychopharmacology*, vol. 15, no. 8, Sep. 2012, pp. 1037–42. *academic-oup-com.ezproxy.sussex.ac.uk*, <https://doi.org/10.1017/S1461145711001313>.

Zaikowski, Carolyn. 'Reading Traumatized Bodies of Text: Kathy Acker's Blood and Guts in High School and Selah Saterstrom's The Pink Institution'. *Nebula*, vol. 7.1/7.2, Jun. 2010, pp. 199–219.

Zazulak, Joyce, et al. 'The Art of Medicine: Arts-Based Training in Observation and Mindfulness for Fostering the Empathic Response in Medical Residents'. *Medical Humanities*, vol. 43, no. 3, Institute of Medical Ethics, Sep. 2017, pp. 192–98. *mh.bmj.com*, <https://doi.org/10.1136/medhum-2016-011180>.

Zhang, Jie, and Ziyao Li. 'The Association Between Depression and Suicide When Hopelessness is Controlled For'. *Comprehensive Psychiatry*, vol. 54, no. 7, Oct. 2013, pp. 790–96. *ScienceDirect*, <https://doi.org/10.1016/j.comppsy.2013.03.004>.