Introduction

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'People Bleed Stories': Illness, Medicine and Poetry

Verse is for healthy arty-farties. The dying and surgeons use prose.

(Peter Reading, from *C*, 1984)

In this poem, a haiku, Peter Reading raises the age-old division between art and science. 'Verse' stands here for imagination, creativity, art and poetry, while 'prose' stands for fact, rationality, empiricism and medicine. There are at least two opposing ways to read these three simple lines. One way is to take it at face value: when health scares and serious illness stop daily life in its tracks, verse becomes a luxury that is quickly superseded by the certainty of forthright and factual prose. When confronted with disease and debility, we often seek assurance from the language of analysis, machines, medications and operations. Scientific prose seems to penetrate the body's surface, uncovering the unseen sources of disorders and promising cures. Poetry can do nothing of the kind.

Yet we can understand Reading's poem another way: we may assume that his tongue is set firmly in his cheek. Verse *is* the language of the sick and dying; *in extremis,* we reach for a literary form that is particularly able to express the silences and eruptions of emotion attendant upon trauma, anger and fear. The spare language and restrained form of the haiku offer a different kind of assurance in the face of uncertainty. When a body goes wrong, the mind can gather strength from reflection. We may consider the successes and failures of our lives, the states of our relationships or the beauty of the natural world – subjects particularly suited to poetic expression. Faced with his impending death from ocular cancer, the neurologist and writer Oliver Sacks describes how he suddenly found himself caring very little about the daily political affairs that had always interested him. Instead his thoughts had shifted to focus on the 'enormous privilege and adventure' of having 'been a sentient being, a thinking animal, on this beautiful planet' (2015: A25). Our experience as reflective, expressive beings, living in an endlessly intriguing and evolving world – this is the very stuff of poetry.

[1]With Andy Brown.

Perhaps Peter Reading's poem makes yet another claim: that there is much more coherence between medical prose and poetic language than we may commonly assume. The sociologist Arthur Frank identifies a similar type of overlap. He points out that we tend to think of *disease* as biochemistry, and thus expressed in medical prose; at the same time, we think of *illness* as personal, and thus expressed through autobiographical genres (2014: 14). In reality however, the relationships between disease and illness, prose and poetry, and the professional objectivity of the physician and the personal experiences of the patient, are much more muddled. For pathographies (or illness autobiographies) are informed by hard science, and the human experience of illness unquestionably feeds back into medical knowledge and treatment. Even if we examine the experience of disease and illness from the perspective of the patient alone, we notice that 'by the time disease is imagined, it has already become illness' (Frank 2014: 14). The mind and body exist symbiotically, and so disease and illness are always 'conjoined', as Frank notes; in fact, they could only be separated if the mind could miraculously locate 'itself outside the body' (2014: 15). How patients manage their recoveries, their bodies and their lives in the face of hard medical facts is informed by a range of emotions – among them anxiety, anger, denial, resignation, hope and sometimes hopelessness.

I THE TWO CULTURES REVISITED (AGAIN)

The dichotomies – or false dichotomies, as the case may be – that we have identified here between medical prose and 'arty-farty' poetry is underpinned by a more foundational opposition, between medicine and the humanities. Taken at face value, Peter Reading's verse encapsulates (and perhaps targets) a general attitude, famously voiced by the scientist and novelist C. P. Snow, in his 1959 Rede lecture at Cambridge. Snow's theme, on the irreconcilable differences between the humanities and the sciences, has spawned numerous newspaper articles and books on this topic.[2] An in-depth engagement with this still provoking argument is beyond the remit of this introduction, and others have taken up its challenge admirably.[3] We only want to re-raise Snow's spectre here in the hopes of contributing in some small way to healing the remaining rift. This anthology, and further sections of this introduction, should show clearly that poetry and medicine have not always been so historically divided, and that even in the wake of Snow's challenge there has been considerable collaboration between the two cultures.

In the supposed contest between the humanities and science, Snow came down firmly on the side of science. The Western world had entered a new political and

[2]*The Times Literary Supplement* included the subsequent publication of Snow's lecture, *The Two Cultures and the Scientific Revolution,* among the 100 post-Second World War books that have most influenced Western public discourse. [3]See Stefan Collini's essay on this contest (2013) and his two introductions to recent editions of Snow (2012) and Leavis (2013). Also, see individual essays in *From Two Cultures to No Culture: C P Snow's 'Two Cultures' Lecture Fifty Years On* (Whelan 2009).

scientific era and he worried that 'the rate of change' had 'increased so much that our imagination can't keep up' ([1959] 2012: 42–3). Science and the humanities responded to the demands of a speedily shifting world in markedly different ways. The scientists had 'the future in their bones,' he claimed, but 'traditional culture', by which he meant the humanities and the arts, wished 'the future did not exist' ([1959] 2012: 10–11). According to Snow, nostalgic arty-farties only hid their heads in the sand, while scientists, medics and researchers got on with the progressive stuff that would pull Britain ahead in the global race for intellectual, technological and political might.

Literary don F. R. Leavis was utterly incensed. In 1962, he responded to Snow and his claims with an almost equally famous, and rather scathing counter-attack. Leavis accused Snow of being a hack – 'as a novelist he doesn't exist; he doesn't begin to exist. He can't be said to know what a novel is' – as well as a fairly poor scientist who put on 'a show of knowledgeableness' ([1962] 2013: 57, 59). Fighting words these may be, but in many ways they ring true. On the count that Snow was a failed novelist, most literary critics would agree, for his novels are widely acknowledged to be pedestrian, with stilted dialogue, formulaic plots and flat characters. On the second count, that Snow was a second-rate scientist, Leavis may have been ungentlemanly, but again there is support for his opinion. Snow spoke as science's great defender, but his own contributions could be described as less than stellar. At any rate, the strident tone and personal nature of Leavis's attack should not overshadow his most important point, that the culture of capital had created a society where image trumped substance, and indiscriminate self-promotion was the name of the game. Privileging neither the sciences nor the arts, Leavis called for a thinking public, properly educated in a system where profit did not determine policy and economics did not drive education ([1962] 2013: 84–5; 108–18).[4]

Since Leavis's call for a balanced approach to the disciplines, others have pointed out the historical inaccuracy of Snow's description of the humanities as traditional, nostalgic, anti-rational and both 'unscientific' and 'anti-scientific' (2012: 11). Even a perfunctory understanding of history teaches us quite the opposite lesson, for as Roger Kimball puts it, 'there's not much anti-scientific aroma emanating' from a Western intellectual tradition in the humanities that includes the work of Aristotle, Galileo, Descartes, Newton, Locke and Kant (2009: 37). In addition, Snow's claim that scientists had 'the future in their bones', while artists, writers and philosophers were 'natural Luddites', ignores or misses an extraordinarily long and varied tradition of dissent ([1959] 2012: 10–11; 22–30). Throughout history, and across the globe, artists and poets have challenged authority, dogma, injustice, superstition, and false, unethical beliefs. Those same poet-philosophers and artist- anatomists, among history's most forward-looking and inventive individuals, would not recognize our concept of the two cultures. Arguably, until the beginnings of

[4]It is worth remembering that the Snow-Leavis conflict is a product of specific mid-century political, social and educational crises – among them, the first phase of the Cold War, economic austerity and the creation of the post-war welfare state.

 a divide began to show in the nineteenth century, generations of thinkers worked

within a *one*-culture model of knowledge.[5]

II CONSILIENT CULTURES

At the beginning of the nineteenth century, the scientist, inventor, poet, painter and one-time president of the Royal Society, Sir Humphry Davy saw commonality between art and science, and identified continuities between history and the present. In an 1805 essay on the 'Parallels between Art and Science', he wrote:

The perception of truth is almost as simple a feeling as the perception of beauty; and the genius of Newton, of Shakespeare, of Michael Angelo, and of Handel, are not very remote in character from each other. Imagination, as well as reason, is necessary to perfection in the philosophical mind. A rapidity of combination, a power of perceiving analogies, and of comparing them by facts, is the creative source of discovery ([1805] 1840: 308).

Davy celebrates artists like Michelangelo and scientists like Newton who were receptive, imaginative and dared to follow the counter-intuitive path. They shared an ability to innovate by recognizing significant correspondences between things, where at first none was obvious. In other words, they were consilient thinkers.

Consilience is a belief in the unity of knowledge: the methods of chemistry and medicine, history and literature, should produce analogous and equally valuable results.[6] A consilient thinker himself, Davy collaborated not just with fellow scientists, such as the surgeon (and poet) Thomas Beddoes, the naturalist Sir Joseph Banks, and the chemist Michael Faraday, but also with the inventor and engineer James Watt and the Romantic poets Samuel Taylor Coleridge and Robert Southey. The consilient, investigative mind is not confined to a specific discipline: Coleridge, who commented that Davy could have been a great poet, attended Davy's scientific lectures in order to pick up new metaphors, while Beddoes studied 'historical criticism', at the same time that he experimented with gases and developed novel bovine treatments for tuberculosis. (Although it must be said that Beddoes was rather less successful in these experiments than Edward Jenner was with his cowpox vaccination against smallpox.)

A particularly salutary example of a career characterized by consilient thinking is that of the Victorian doctor and early anaesthetist John Snow, celebrated today for his

identification of the source of cholera. During the 1854 cholera epidemic, Snow set out to identify the local origin of the disease in the hard-hit neighbourhood of Soho, London. The dominant medical paradigm of the day, miasma theory, conceived of

[5]In another Rede Lecture, in 1882, the critic Matthew Arnold considered whether a classical education was still relevant in an age of great scientific and technological advance. In his lecture on 'Literature and Science', Arnold responded to an earlier lecture by the writer and scientist T. H. Huxley, who argued that science offered as rigorous an intellectual training as the (then privileged) study of the classics (Arnold [1882] 1974).

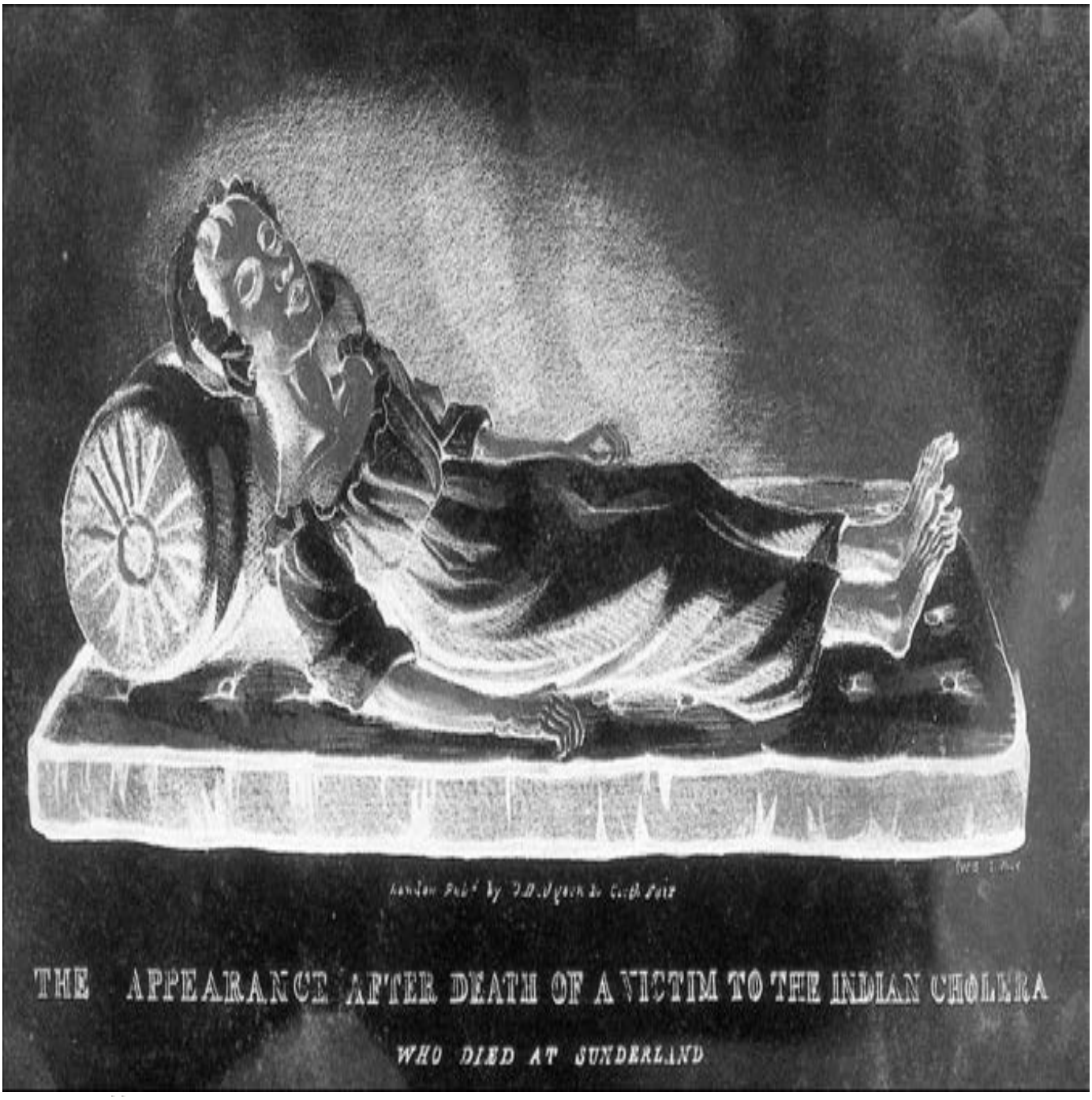
[6]For more on consilience see Slingerland and Collard (2012) and Wilson (1998).

disease as originating in filth, damp and decay, and then spreading via contaminated air. But Snow rejected this airborne paradigm, based upon evidence, which he had gathered from listening to people, observing their habits and understanding their relationships. In addition, Snow collaborated with the local cleric of St Luke's Church in Soho, Henry Whitehead, to construct a demographic picture of the cholera-hit neighbourhood, and to trace the outbreak to contaminated drinking water. His findings were then plotted on his famous map (see Figure 2, p. 231), which gives a bird's-eye view of where cholera occurred. The unmistakable black bars, their thicknesses indicating numbers of deaths, clearly ring the Broad Street Pump, and taper off as the eye moves away from this locus. The map confronts viewers with truths made visible, which they otherwise could not, or would not see. It shows us the *where* and *who* of disease, and thus also indicates something of the all-important *how*. So, despite the technological limitations in microscopy at the time, which meant that he could not see and therefore prove the existence of the bacterium *Vibrio cholerae*, Snow deduced correctly, through sociological methods, that cholera was waterborne.

We raise this particular historical anecdote in order to underscore the importance of consilient thinking. Snow was a working physician, a medical researcher and one of the founders of epidemiology, but he was also a sociologist, an anthropologist and a geographer. This anthology shows that contrary to popular misconception, in the past 300 years, poets and doctors did not speak diametrically opposed languages. Throughout history, knowledge about the functioning of the body, new methods of diagnoses, innovative treatments and changing ideas about the prevention of disease migrated between medicine and literature. In fact, scientific writing and poetry very often shared a common language. In the eighteenth century, there existed a medico-poetic discourse quite simply because many doctors were poets. In the age of

FIGURE 1: 'I. W. G.', *A Victim of Cholera at Sunderland*, c. 1832. Courtesy Wellcome Library,

London.



Enlightenment, a well-respected medical man was very often a man of letters. This was the case with, for example, Erasmus Darwin (1731–1802); Oliver Goldsmith (1728–74);

Edward Jenner (1749–1823) and Friedrich von Schiller (1759–1805). In addition, some eighteenth-century doctors, such as John Armstrong (1709–79), composed full medical treatises in verse. Almost invariably, of course, this is an all- male realm, but there are some quite wonderful exceptions, such as Jane Barker's 1688 poetic musings on anatomy or Lady Mary Wortley Montagu's prose writing on smallpox inoculation (see them in this anthology).

At the turn of the nineteenth century, the priorities of the professionalizing medical establishment sometimes meshed less seamlessly with literary ones. This is the case, for instance, with the Romantic poet-physician John Keats (1795–1821), who turned away from the triumphs of progressive medicine to resurrect in poetry the classical and medieval worlds he associated with humanistic virtues – virtues he feared were under threat in modern society. Yet, Keats had a continuing interest in medicine and a unified understanding of the natural world and human culture, as he expresses in one May 1818 letter. 'Every department of knowledge we see excellent and calculated towards a great whole,' he wrote, 'I am so convinced of this, that I am glad at not having given away my medical Books, which I shall again look over to keep alive the little I know' (1958: 277). Other writers used poetry as a means of entering more directly into medical debates on issues surrounding madness, hospitals, evolution and genetics. The American federal judge and writer Francis Hopkinson, for instance, promotes anatomical dissection in a poem written about a dispute between a professor of anatomy and a lecturer in Philadelphia in 1789. And, the Victorian philosopher of science Constance Woodhill Naden combined Darwinian theories of evolution and natural selection with the private intimacies of everyday life in her poetry.[7]

At the dawn of the twentieth century, poet-physicians such as Sir Oliver Wendell Holmes (1809–94), Sir Ronald Ross (1857–1932), Havelock Ellis (1859–1939) and Gottfried Benn (1886–1956) lauded the importance of humanistic values, sometimes as a counter to the demands of rationality, empiricism and professional objectivity. The Canadian bibliophile, writer and 'Father of Modern Medicine', William Osler used the past to bring about what has been termed a 'rehumanisation of medicine'.[8] A founder of Johns Hopkins Hospital, Osler contributed to reinstate the model of the gentleman-physician, for whom a liberal arts education was as vital as practical medicine. Today, we continue to grapple with the problems that Osler identified and responded to, including overspecialization, commercialization and apathy.

In spite of the predominance of the two-culture model in the twentieth century, many poet-physicians seemed as comfortable in the 'white coat' as the 'purple coat', to use Dannie Abse's distinctions.[9] Besides Abse (1923–2014), were William Carlos

[7]Selections by Hopkinson and Naden are included in this anthology, see pp. 307–11 and 400–02. [8]As early as 1889, professor of medical history at Vienna, Theodor Puschmann agitated for a rehumanization of the physician in an age of science, and Osler would pick up this torch. See Warner, 'Humanizing', 322–32. [9]Abse titled his 1989 poetry collection 'White Coat, Purple Coat'.

Williams (1883–1963), Miroslav Holub (1923–98), Gael Turnbull (1928–2004), John Stone (1936–2008), Raymond Tallis (b.1946) and Rafael Campo (b. 1964). Twentieth- and twenty-first-century medical poetry often contends with competing demands, and expresses a wide-ranging approach to the body and its care. Abse captures this by imagining how a doctor and a poet would respond to the fall of Icarus. The doctor would attempt to help; the poet would write a poem; but a poet-doctor 'must do both'.[10] This collection celebrates those who recognize the importance of both fixing and creating, healing and crafting, and it honours those who refuse to sacrifice a comprehensive view of the medical arts in the face of specialization. We should 'be impatient' with the 'two cultures', the biographer Richard Holmes urges, and like Beddoes and his curious, speculating friends, we should embrace a 'wider, more generous, more imaginative perspective' (2010: 469). We hope this book will encourage just that.

III THE EMERGENCE AND EVOLUTION OF MEDICAL HUMANITIES

The growing field of medical humanities – made up of contributing disciplines and sub-disciplines including sociology, cultural studies, history, art history, human geography, fine art, music and drama – has been notoriously difficult to define. We have no intention of attempting definitions here, both because we appreciate the indeterminacy of a field that continues to shape itself as it responds to issues in medicine, health and well-being, and also because this is a task others have ably taken on.[11] Here, we wish only to give the briefest overview of the history of this field. The term 'medical humanities', coined by George Sarton in 1947, referred at that time mainly to efforts in the United States and the United Kingdom to use art as medical therapy and to 'humanize' medical curricula. Former director of the Institute for the Medical Humanities at the University of Texas, Ronald A. Carson, identifies the consumerist – but also reactively anti-authoritarian and anti-capitalist – decade of the 1960s as a time when medical professionals turned to the humanities for input into medical training and patient care (2007: 322). Director of a similar program at Colorado's Center for Bioethics and Humanities, Therese Jones points to the 1970s as a decade when organ transplantation and in vitro fertilization raised new ethical issues that required contributions from philosophers, historians and social scientists (2014: 29). In subsequent decades, literature, history, philosophy, as well as the social sciences, have all contributed to developing innovative methods of care.

More recently, there has been a move to use the descriptor 'health humanities' rather than medical humanities, so as to better capture the wide, inclusive and

[10]Qtd. in 'Dannie Abse - Obituary,' *The Telegraph*, 24 August 2015. [11]Scholars have wrangled over whether to call medical or health humanities a 'multidiscipline', 'interdiscipline', 'transdiscipline', 'circumdiscipline' or 'field'. Those interested in this discussion should see, for instance, Bates, Bleakley and Goodman (2014); Evans and Mcnaughton (2000) and Jones, Wear and Friedman (2014).

interdisciplinary nature of this field. Daniel Goldberg, for instance, suggests that efforts 'should be directed to health and human flourishing rather than to the delivery of medical care' even though both aims are clearly 'of great worth' (2012). Whichever term we choose to use, we agree with Victoria Bates and Sam Goodman's recent plea that the medical humanities be inclusive, broad and reciprocal (2014: 5). This inclusivity and reciprocity is captured in the Wellcome Trust's definition of medical humanities as 'a variety of disciplines that explore the social, historical and cultural dimensions of scientific knowledge, clinical practice and healthcare policy' (web).[12] Inclusivity demands that we recognize the consilient value and utility of disciplinary backgrounds that are not our own and that we consider the significant ways that history and culture have shaped, and continue to shape, medicine.

Over the years, researchers and teachers in humanities disciplines have been challenged to defend what they do. More specifically, those in medical humanities have been asked: What can historians, artists, and literary critics add to public understanding of medical issues, to care of the ailing, or to the training, ethical decision-making and daily practices of doctors, nurses, surgeons, medical researchers and therapists?[13] Clearly, this is another huge, multi-sided debate, and one which we cannot possibly do justice to here. We only wish to situate this anthology as part of the exciting, still emerging and perennially evolving field, by outlining its main areas of activity.

1 Narrative Medicine

One argument, posed early on by Joanne Trautmann Banks, the first literary scholar hired by a medical school (in 1972) and Rita Charon, the founder and executive director of the program in Narrative Medicine at Columbia University, is that there is clinical utility in the study of novels, plays and poetry.[14] Such literary training teaches healthcare professionals how to interpret ambiguities in language and to understand the social contexts behind the personal narratives of their patients. Importantly, narrative competence is not inherent; we are not born with it. Just as would-be engineers and architects must train to obtain a set of specific skills, so too must one learn how to gain narrative competence, which 'requires a combination of textual skills (identifying a story's structure, adopting its multiple perspectives, recognizing metaphors and allusions), creative skills (imagining many interpretations, building curiosity, inventing

multiple endings), and affective skills (tolerating uncertainty as a story unfolds, entering the story's mood)' (Charon 2004: 862). These literary competencies are not frills, added on to 'real' medical training; the skills Charon outlines are fundamental to the business of diagnosis.

In *How Doctors Think*, Jerome Groopman makes the point that medicine is an uncertain business, and the majority of diagnostic errors are the result of settling on a particular diagnosis and/or treatment too soon (2007). Accurate narrative interpretation is what medical professionals are required to do, whether that is

[12]See the Wellcome Trust website http://www.wellcome.ac.uk/Funding/Humanities-and-social-science/index.htm [13]See for instance, Jones, Wear and Friedman (2014). [14]See Charon (2006), Charon and Montello (2002) and Charon (2003).

diagnosing symptoms, unravelling patient case histories or deciphering X-rays, scans and MRIs. Learning how to read a character's psychology, motivation and desire are skills that transfer directly to understanding those patient histories and symptoms. The writer and paediatrician Mark Vonnegut may seem to overstate things when he claims that 'the arts are about as extra' to medicine 'as breathing', but in light of the fact that 'Huck Finn, Lady Chatterley, Willy Loman, and Ophelia ... will all come to see you disguised as patients,' literary study would seem to fit the bill (2014: ix). Undoubtedly, it is one way of making an uncertain business less so.

As in literary and historical studies more generally, the best kind of narrative medical approach also considers larger, overarching issues – public health and social justice, for example – at the same time that it pays heed to individual, interpersonal experiences. Narration of personal experience of illness, treatments and clinics 'reaches beyond the individual', as Arthur Frank puts it, and enters 'into the consciousness of the community' (1997: 63–4). Likewise important research in the humanities not only pays close attention to the nuances of texts (whether they are poems, eyewitness accounts or court documents), but also raises big questions from them and draws larger conclusions about the structure and function of society, politics, science and culture.

2 The Ethical Approach: Compassion, Humanitarianism and Medical Training

The focus on narrative competence is allied to the view that literary study fulfils a distinctly humanistic or ethical role in the training of medical professionals. For advocates of this approach, training in the humanities is a positive counterbalance to clinical training in objectivity and professional distance. According to Rita Charon,

acquiring skills in narrative interpretation and evaluation also trains our emotions, increases our capacity for compassion, and encourages us to be 'moved by the stories of illness' (2008: vii).[15] Others working in this area have suggested that an arts-based curriculum encourages medical students to feel empathy and to recognize their own prejudices.[16]

This is deeply contested terrain, and a variety of criticisms and cautions have been levied against casting the humanities as a humanizing force. In a 1998 *Lancet* article, 'More Than a Green Placebo', Dannie Abse contended that

in an attempt to justify one's trade as a poet, it is no longer possible to resort to arguing the moral nature of poetry. Those 19th century claims that 'Poetry strengthens the faculty which is the organ of the moral nature of man in the same manner as exercise strengthens a limb' ('A Defence of Poetry', P. B. Shelley) seem hollow now post Auschwitz and Hiroshima. Even T. S. Eliot's 'poetry refines the dialect of the tribe' seems in all its ambiguities to be a grandiose assertion, if not a dubious one (362).

[15]See also Charon (2001) and DasGupta and Charon (2004). [16]See for instance Stokes (1980); Downie, Hendry and Macnaughton (1997); Rees (2010) and Perry, Maffulli and Willson (2011).

Abse looks back on Romantic and modernist defences of poetry through a sceptical lens, in the twilight of the twentieth century. World wars and many other political, ideological and religious conflicts have made moderns less sanguine than their ancestors about the civilizing effects of the arts. Even art's greatest advocates hesitate to make claims about how paintings and poetry can contribute to the creation and maintenance of a just, equitable and liberal society.

Literary critics have also expressed doubts about the idea that engaging with literature can lead to empathic feeling and compassionate action. In a playfully insightful article, renowned critic Geoffrey Hartman expresses strong doubts about the ability of literature, or more specifically, storytelling and illness narratives, to mobilize real human emotion. In light of the prevailing faith in neuroscience and the penchant for prescribing drugs to cure what ails, he poses an apposite and timely set of questions. Apart from 'a chemical intervention', he asks, how can people be made 'to feel for other people'? 'Short of pharmaceutical treatment ... can there be empathy management, as we now have pain management?' (2004: 339).[17] Speaking more widely of the disciplines, the literary theorist Jonathan Culler rejects the 'traditional strategy of justification', which links humanities with '*humanistic* thinking and even *humane* behaviour' (2005: 38). This view accords with that of Anne Hudson Jones who, some decades ago, argued that there was

no ‘guarantee’ that literature or art would necessarily inspire empathy, fairness or understanding, nor should this be the ‘burden’ or sole purview of the humanities (1984: 32). The point is that many thoughtful, caring surgeons and lab technologists did not get that way through the study of literature. Moreover, there have been some rather hard-hearted poets and artists who, in spite of their proximity to great literature and fine art, have held reprehensible political views. Of course, the hope is that a humanities education *will* inspire empathy and fairness; it is only that a love of classical music, the poems of Emily Dickinson or the paintings of Vincent Van Gogh will not guarantee it.

This emphasis on humanizing often leads to instrumental justifications for the inclusion of humanities subjects in both medical education and in considerations of patient care. The danger is that in the effort to make ‘physicians more understanding people’ and thus ‘more effective physicians’, the medical humanities becomes increasingly ‘product oriented’ (Gillis 2008: 7). With this orientation comes a pressure to produce measureable outcomes, thereby forcing the humanities to conform to a market model. In addition, there have been concerns that this model relegates the humanities to a nonthreatening, supplementary position, a tool of medicine, rather than an equally weighted and independent voice (Macneill 2011; Greaves and Evans 2000; Bishop 2008). Johanna Shapiro calls what is described here ‘a model of acquiescence’, and she uses the terms ‘instrumental’ and ‘ornamental’ to encapsulate the view of the medical humanities as a softening and humanizing force that equips medical students and physicians to better perform their stressful, demanding jobs (Shapiro 2012: 3; also Greaves 2001). Again, some of these aims and outcomes are tremendously positive, yet the arts and humanities

[17]Also on the question of literary studies specifically, see Suzanne Keen (2007).

should not simply be made functional or reduced to an instrument of market forces.

3 Therapy and/or Aesthetics?

Yet another approach, related to the two described above, shifts focus from the education of medical professionals to the care of the patient. Charon’s work in narrative competence also emphasizes this therapeutic component, which is clearly illustrated by one of her case studies, worth reproducing here:

A 36-year-old Dominican man with a chief symptom of back pain comes to see me for the first time. As his new internist, I tell him, I have to learn as much as I can about his health. Could he tell me whatever he thinks I should know about his situation? And then I do my best not to say a word, not to write in his chart, but to absorb all that he emits

about his life and his health. I listen not only for the content of his narrative, but for its form – its temporal course, its images, its associated subplots, its silences, where he chooses to begin in telling of himself, how he sequences symptoms with other life events. I pay attention to the narrative's performance – the patient's gestures, expressions, body positions, tones of voice. After a few minutes, he stops talking and begins to weep. I ask him why he cries. He says, 'No one has ever let me do this before' (2004: 862).

Charon's anecdote captures how important it is for the practitioner to listen for information about symptoms that would not otherwise be forthcoming. Charon is trained to process subtle signposting about lived experiences that may have triggered illness, yet these same skills and techniques can also lead to therapeutic benefits for the patient. Diagnosis is 'encoded in the narratives patients tell of symptoms'; at the same time, listening attentively and critically provides 'deep and therapeutically consequential understandings of the persons who bear symptoms' (2004: 862). Moreover, these benefits also go beyond the clinical encounter, when mobilized in practical forms of healing, including drama, music and writing therapies.

Creative arts therapies for patients with, for instance, dementia, aphasia or a terminal prognosis, would seem to be anything but objectionable; yet there are issues too, about the instrumentalization of the arts. Angela Wood rightly cautions against viewing art therapies 'as an expert-therapeutic-pedagogic "service" provided to the client-patient-student with the goal of enhancing individual wellbeing' (2014: 1). Surveying current writing in this area, she observes that 'too often, treatises on the merits of the medical humanities' that emphasize practical therapies can 'appear either oddly evangelical or cagey, anxious and defensive in tone' (2014: 1). In some respects, this is due to the fact that, as Jane Macnaughton et al. point out, the arts in health movement began life as 'small, local and poorly resourced' (2005: 337). Yet even as this movement has become more supported, diverse and well- connected, it has produced rather less successful research and writing in which, as Woods observes, 'rigorous reflexivity is bracketed in favour of reflections on the humanisation of healthcare' (2015: 1). It seems to us that this is often the case

when defences of art, music and writing therapy are not underpinned by, or at the very least informed by historical research or theoretical models. It is worth mentioning again that the use of arts in healing and well-being is a very good thing, but insisting that the arts perform to an agenda, or casting the arts as solely an instrument of therapy limits what writing, painting, music and performance can do. One group that has addressed these problems in commendable ways is the Centre for Research into Reading, Literature

and Society (CRILS) at the University of Liverpool. Led by literary scholar Philip Davis, the Centre has developed literature-based programs for older people living with dementia, and other vulnerable groups. For them, shared reading has intrinsic value, in that it stimulates the patient's mental involvement and cognitive processes as well as fostering feelings of community. Importantly, they suggest that shared reading might be 'therapeutic for not being therapy' and 'useful precisely by not being instrumental' (39).[18] The point is that the arts and humanities should fully participate, in a variety of ways, in debates about wellness, public health and the intersection of social issues and medicine. (We will examine this issue more closely in a later section.)

Even accomplished or 'professional' medical poetry has not always ranked highly aesthetically. When the editor of a 1945 anthology of medical poetry, Mary Lou McDonagh surveyed her own collection, she admitted that medical poetry was often seen as 'poetry in quotation marks and much of it . . . feeble stuff ', but she defended her collection on the grounds that it reflected 'the spirit of helpfulness which gives to the medical profession its value to humanity.'[19] More recently, the poet-physician Jack Coulehan echoed McDonagh's verdict about the low aesthetic standards of medical poetry. On the NYU School of Medicine's *Literature, Arts, and Medicine Database* he describes McDonagh's anthology as a collection of poems that mostly 'have no enduring literary value'. In light of the fact that Coulehan refers to work by professional, published poet-physicians (some of whom are also included in his anthology), what shall we say about the poetry of the untrained and uninitiated? It can be difficult to reconcile the whole enterprise of critical judgment with the heartfelt, good-intentioned, even necessitous poetry of illness, which may also be, if we are honest, simply not very good.

Difficult, but not impossible. The writer and literary critic Anatole Broyard, who wrote about his experiences with prostate cancer, sought to square the tension between aesthetics and healing. It is not enough for illness to be a story, he argues, it must be a *good* story, and constructing a good story requires the knowledge and skills that come from reading, writing and practice in evaluation and analysis, as are taught in humanities subjects (1992: 45). Picking up from Broyard's argument, Arthur Frank underscores the importance of these skills for the wounded storyteller: 'The humanities have extraordinary resources', he argues, 'that can help ill people first

[18]Quoted in 'Cultural Value: Assessing the intrinsic value of The Reader Organisation's Shared Reading Scheme,' A Report from the Centre for Research into Reading, Literature and Society (CRILS), University of Liverpool. [19]McDonagh gives no reference for this quote, but it is from Dr William Osler's *Medical Incunabula*, quoted in Harvey Cushing's 1940 *The Life of Sir William Osler*, vol. 2 (Hamburg: Severus Verlag) rpt. 2013, p. 1081.

to tell good stories and then in the telling to *become* good stories'; moreover, these extraordinary resources become 'necessary resources' for sick people who 'try to live illness as more than bare disease' (Frank 2014: 14). Reading and writing can open new imaginative worlds for a patient, thereby expanding 'what illness has contracted' (2014: 17).[20] For Broyard, writing fills the silence that otherwise surrounds diagnosis and treatment. Illness causes the patient 'to bleed stories' but those 'stories are antibodies against illness and pain' (1992: 21, 20).

Part of this sense of expansion and imaginative engagement can come through process, rather than product; in other words, the actual process of learning how to be a properly good writer, to pursue excellence, can be incredibly therapeutic. Communicating new imaginative worlds in effective and engaging ways requires that writers learn the differences between hackneyed, clichéd poetry and innovative, insistent poems. For illness to be a good story it should challenge readers in some way; it should demand something from them, whether that be emotion, introspection, action, a change of opinion, greater understanding or something else. Very good writing about the body is often difficult and full of discord; like the poems of Emily Dickinson, they can be fragmented; like the poems of Robert Graves, there can be semantic confusion. But the disquiet we get from these poems – their refusal to assure us – can be another form of therapy. It is worth mentioning, too, that one learns how to be a good writer through the practice of reading. The selections in this anthology, perhaps some more aesthetically sophisticated than others, provide access to a wide variety of human encounters with illness and communicate diverse experiences of living in a body. We hope that readers, whether professionals or patients, scholars or practitioners, healthy or otherwise, will find these poems pleasurable, reassuring and/or challenging.

4 History and Debate

Another school of thought insists that humanities subjects are not simply supplementary to the real business of medicine, but actively contribute to debates about the body and its treatment. A previous editor of the *British Medical Journal*, Richard Smith terms the former the 'additive view', which sees the humanities as softening the hard edges of medicine, and the latter as the 'integrated view' which more ambitiously shapes the 'nature, goals and knowledge base' of medicine (1999: 319, 0a).[21] Historians in particular have taken up the integrated view, although other humanities disciplines have as well; in fact, medical historians David S. Jones, Jeremy A. Greene, Jacalyn Duffin and John Harley Warner recently produced a manifesto of sorts, in which they argue that among other things, history in medical education offers 'essential insights about the causes of disease' and demonstrates 'the contingency of medical knowledge and practice amid the social, economic, and

[20]Frank expands here on a William James's 1906 lecture, in which he argued that humans failed to live up to their potential, that they lived 'contracted' lives. This is especially the case, Frank proposes, when living with a demoralizing illness. [21]See also, in the same issue, Evans and Greaves (1999), Evans and

Mcnaughton (2000).

political contexts of medicine' (17). History should be considered, they suggest, as legitimate a part of medical school curricula as anatomy or pathophysiology. This group of historians are keen to carve out a distinct role for their discipline and to make a particular case for it as 'an essential component of medical knowledge, reasoning, and practice' (2014: 1). As such, they resist identifying themselves under the medical humanities umbrella, choosing not to affiliate with humanities scholars who aim to foster medical professionalism (2014: 1).

These medical historians makes a strong case for their discipline; however almost the same strong case could be made for literary studies – after all, poems, paintings, novels and films are historical artefacts. They reveal as much about how we have approached the body in the past as the more obvious historical documents like medical treatises and court documents. More to the point, as art historian Ludmilla Jordanova succinctly puts it, 'medicine may productively be considered as a form of culture' (2014: 43). This has been demonstrated and recognized time and again: 'The truth is', Oliver Wendell Holmes stated unequivocally in 1860, 'that medicine, professedly founded on observation, is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to the changes of atmospheric density'.[22] This refrain has since received widespread agreement – and literature is an important part of the cultural milieu that informs and is informed by medicine. Literature not only reveals how culturally specific anxieties and priorities influenced medical practices that often claim objective, value-free status; it also engages in debates with medicine about its priorities and values.

Jordanova has made a convincing case, along these lines, for visual culture specifically. She outlines 'a hefty agenda for the medical humanities', which includes exploration of such topics as:

the medicalization of selfhood, the visualization of medicine, the somatization of sexuality, the rebellion against conventions surrounding the body, the sensational display of bodily phenomena and the commercialization of suffering (2014: 61).

This ambitious, expansive agenda is not confined to visual art, for what she describes – the medicalization of selfhood, the rebellion against conventions – is also the stuff of literature. These themes are equally present in 'misery memoirs' or disability literature. The visualization of medicine or the sensational display of bodily phenomena occurs in genres that combine text and visual representation, such as graphic pathographies (autobiographical comics about illness), neuroscientific/theatrical collaborations, or the

huge realm of performance art that uses the body as a text.

5 History, Debate and *Literature*

This anthology is informed by an inclusive approach to the medical humanities, which is why medical writing – historical documents proper – is included alongside poems. The poems should be approached as legitimate historical texts, as well as

[22]See page 367 of this anthology.

aesthetic objects and as forms of engagement and protest (but more about that later). The poems and medical texts in this anthology, which span from the Enlightenment to the present day, reveal significant moments of historical and aesthetic change, as well as surprising continuities. Religious beliefs, political events and prevailing cultural attitudes affect the aetiology, classification, diagnosis and treatment of disease (and what even counts as disease). Certain cultural influences on medical science reach down through generations, sometimes even in spite of radical alterations to definitions and treatments of disease. At the same time, new medical knowledge can bring about profound transformations in culture – instigating changes in religious belief or social attitudes toward addictions, sex, reproduction or contagion, for instance.

A chronological survey of any of the chapters reveals how the medical themes of the poems change over time – as do the diseases and conditions that plague human communities. In the eighteenth century, poems and medical treatises recount the horrors of syphilis and quack treatments; in the same century, poems about smallpox recount not only the deadly effects of a virus that claimed lives and left others blinded or permanently debilitated, but also the aftermath of living permanently with facial scars. The cholera that arrived in England in the autumn of 1831, as part of the second great pandemic, and then in 1848–49, 1853–54 and 1866, generated a body of poetry replete with images of dampness, fog, mildew and poisoned air. That cholera had bubbled up from the mangrove swamps of the Sunderbans on the Bay of Bengal, then wound itself along trade routes, across oceans, and down the Thames to infect the heart of the capital, produced a whole realm of anxieties. As the sample of Victorian poetry on cholera included here reveals, those anxieties gave rise to a considerable number of poetic tropes about foreign invasion and the dark side of imperialism.

Cholera was the most frequently mapped disease of the nineteenth century – the same century in which medical mapping emerged as an important tool for understanding both the global and local relations between disease, people and place. So, for instance,

American poets and physicians wrote about yellow fever, or in the vernacular of the South, 'Yellow Jack', at roughly the same time that British writers were fixating on 'King Cholera'. Lady Mary Wortley Montagu's writing on smallpox inoculation is a case in point about the global circulation of medical ideas. In 1717, she spent two years in the Ottoman Empire with her husband, the British ambassador to Istanbul. There she observed the Turkish women practice 'engrafting', that is, introducing pus from a smallpox lesion into an incision on the arm of a healthy person. It was believed that this inoculation against smallpox – also called 'variolation' – would then render that person immune to the disease. Montagu had her son inoculated in Turkey, and on her return to London, promoted the practice to friends, as well as to an unyielding medical establishment who would not support a foreign, Eastern practice. Montagu's poetry and prose, like that on the topic of cholera, give us a sense of medico-geographical differences, and the medical changes that are brought about through inter-cultural contact. We are reminded of the long- standing relationship between health and space, and the unevenness of the medical terrain, geographically and chronologically. Clearly, this anthology contains mostly

British and American writing, reflecting the lively transatlantic exchange of ideas and styles. We do not have the room or the expertise to include many selections from around the world, but we would urge interested readers to seek specialist collections for poetry from farther afield.

The frameworks for understanding illness are also constantly evolving. In the nineteenth century, for instance, the contamination model of disease posited that morbid matter was transmitted between individuals. Doctor-poets such as John Armstrong wrote of how, particularly in cities, contaminated lungs breathed out 'contagious matter' that was inhaled by other sets of lungs. This model of disease posited an 'invisible threat' and placed responsibility for the health of the wider community with individuals, which led to disciplinary measures against those who were seen as unhygienic or polluted by poverty, alcohol or immoral sexual habits (Wagner 2013: 143). The poems and medical writing on cholera are also informed by the prevailing belief in miasma theory in the long nineteenth century, which conceived of disease as originating in bad air or vapours filled with particles of decomposed matter (miasmata). The miasma framework was replaced by the germ theory of disease in the second half of the nineteenth century, following the epidemiological studies of John Snow, Louis Pasteur, Robert Koch and others. This change in medical understanding elicited new literary paradigms: microscopic vision, metaphors of infection and updated plague narratives with active, dangerously intelligent microbes as the new enemy.

The idea of evolving and shifting paradigms structures the work of French theorist Michel Foucault, who has shown us that facts, knowledge and even physical realities like disease are deeply embedded in culture, and vice versa. Through his genealogical method, he investigated cultural assumptions surrounding sexuality, madness and disease, and in the process demonstrated that phenomena which appear natural or 'without history' actually have very complicated cultural histories (139–40). Foucault has influenced the work of many literary and cultural historians who have addressed 'the role of the literary imagination in the cultural framing of disease', to use David Shuttleton's phrase (2012: 3). This is not to deny the material reality of illness or to suggest that culture invented disease: one need only read Fanny Burney's account of experiencing a mastectomy before the days of anaesthetic, X-ray and germ theory to realize how misguided that would be (see pp. 292–99). Nevertheless cultural assumptions, discourses and beliefs affect the way illnesses are imagined, treated, written about, visually represented and known – by medical professionals and the general public. As Shuttleton points out, it was once thought that smallpox could be contracted by fear, and since women were thought to be naturally nervous, it was believed they were more susceptible to infection. In *The Adventures of David Simple* (1753), the eighteenth-century novelist Sarah Fielding satirized this belief through her portrayal of the manipulative, socially aspirational character, Mrs. Ratcliffe, who fakes a fear of becoming infected through the upsetting words of a letter. As Shuttleton points out, 'this satirical depiction relied for its reach upon the reader's own morally freighted associations between the imagination, femininity and the risk of contagion by conceit' (2012: 39). This example reminds us that medical knowledge is historically contingent, and shaped by prevailing beliefs about race, ethnicity, class, gender and sexuality.

There are many similar examples of evolving beliefs and attitudes in *Body of Work*, but as things change, so they stay the same. The gender biases of previous centuries that are so obvious in the bawdy poems of the popular eighteenth-century sex handbook *Aristotle's Masterpiece,* or John Marten's anti-masturbation treatise *Onania* (1723) are very different from the gendered perceptions expressed in Fleur Adcock's 1971 pro-masturbation poem 'Against Coupling' or Haki R. Madhubuti's 1997 poem 'Abortion'. At the same time, however, some of the gender biases that seem so apparent in *Aristotle's* bawdy poems are also more subtly expressed in the professional, supposedly objective medical findings of Havelock Ellis's 1905 *Sexual Selection in Man*. In fact, readers will also notice how aims, attitudes and anxieties about the body often remain surprisingly consistent. The ambiguity and anguish that inform Anne Finch's 1701 poem 'The Spleen' also informs Edward Thomas's 1915 poem 'Melancholy', two hundred years later. Despondency also crosses gender and racial divides, appearing in Anne Sexton's 1960

‘Noon Walk on the Asylum Lawn’ and Michael S. Harper’s 1973 ‘Maalox Bland Diet Prescribed’. For all the differences between these poems, there are connections to be made between modern struggles to represent depression as a legitimate illness and the defensiveness of the eighteenth-century narrator of Anne Finch’s poem, who is unfairly accused of ‘pretended Fits.’ The perennial sense of uncertainty surrounding a condition that has been known variously as ‘spleen’, ‘depressed spirits’, ‘melancholy’ or ‘depression’, also crosses disciplinary borders. Many of the feelings, fears and ideas expressed in poetry can be detected in medical and psychological treatises such as Robert Whyte’s 1765 work on hysteria and nervous disorders, George Miller Beard’s *American Nervousness: Its Causes and Consequences* (1881) and Sigmund Freud’s *Mourning and Melancholia* (1917).

We could do this same exercise – mapping changes and continuities – with terms such as ‘contagion’, ‘cancer’ or ‘pain’. We could also trace how tenacious certain conditions and discourses are, as well as how unstable are others. What changes and what remains the same, for example, between British poet John Greenleaf Whittier’s ‘The Fat Man’ of 1832 and the Ghana-born, Jamaica-raised Kwame Dawes’s ‘Fat Man’ of 2003? How have our attitudes toward body size or ‘excess’ evolved? Or, what are the differences between poetic and medical representation of addiction? What is at stake when ‘monstrosity’ becomes replaced with the word ‘curiosity’, later jettisoned in favour of ‘handicap’, and then for very good reasons, replaced with ‘disability’?

In addition, this collection reveals how aesthetic traditions have both endured through centuries but have also developed in new directions. In the opening to his long peripatetic essay of 1821, ‘Confessions of an English Opium-Eater’, Thomas De Quincey writes that there is nothing ‘more revolting to English feelings, than the spectacle of a human being obtruding on our notice his moral ulcers or scars’. Part of the golden age of English essay writing, De Quincey recognized that although the eighteenth-century novel of sensibility had introduced readers to character interiority, they was a reticence about committing to paper one’s nightmarish experiences ‘chasing the dragon.’ There were successors to De Quincey’s *Confession*: in his own *Confessions* (1782), Jean Jacques Rousseau told of his homoerotic encounters with monks, his desire to be spanked, and his urge to flash unsuspecting women. But

unlike De Quincey’s text, Rousseau’s confessions rationalize his transgressions and excuse his sometimes repugnant behaviour. Samuel Taylor Coleridge’s opium dream of Xanadu, ‘Kubla Khan’, was written under the drug’s effect, but not about his personal experiences of it, and while Coleridge’s ‘The Pains of Sleep’ represents withdrawal,

addiction and nightmares that bleed into waking hours, it is nothing like De Quincey's frank, gritty urban prose. De Quincey was the new modern flaneur, who meshed personal confessions about addiction with rational, incisive observations about nineteenth-century society.

Almost a century and a half later, D. J. Enright's poem 'Confessions of an English Opium Smoker' (1962), is haunted by the spectres of Coleridge and De Quincy.

I offer to recall those images: Damsel, dome and dulcimer, Portentous pageants, alien altars, Foul unimaginable imagined monster, Façades of fanfares, Lord's Prayer Tattooed backwards on a Manchu fingernail, Enigma, or a dread too well aware,

Swirling curtains, almond eyes or smell?

De Quincey's 'unutterable monsters' become Enright's 'Foul unimaginable imagined monster', here in a twentieth-century version of Romantic English-Orientalist visions of Chinese, Indian, Turkish apparitions. De Quincey's experiences of being solitary and invisible in the midst of the nineteenth-century urban multitude are resurrected in Enright's description of being 'rocked by the modern traffic of the town'. But, the abrupt juxtaposition of English and Orientalist scenes reflects a contracted world – Enright lived and worked in Egypt, Japan, Thailand and Singapore – in which the foreign and the local were in closer proximity. His images of common English people, common English objects and common English streets portray a degenerating society; demoralized people living in grubby shacks signal the long slow decline of Empire and Britain's downgraded status on the world stage. This is a poem informed by the past, but its poetic form and its take on contemporary events indicate a cultural, geographical, medical and historical specificity.

6 Activism and Protest

Crucially, literary texts are more than artefacts that provide evidence of the preoccupations and prevailing ideologies of a people. A poem is an aesthetic object that can also shape and, more to the point, *challenge* those ideologies. Walt Whitman's 'Wound-dresser' (1881–82), one of his civil war poems, is an articulation of his experience conveying and attending the wounded, from the battlefields to Washington hospitals. Yet more than a personal account, 'Wound-dresser' is a declaration against the bloody waste of war and a condemnation of politicians who weigh up the cost of goods and land but not individual life. Whitman's poem is as much a form of protest

as a strongly worded polemic, but does so through poetic language and by creating striking images of crushed heads and death-glazed eyes.

On a completely different subject, if we again think of the poems and medical writing about sex that were addressed in the previous section, we see how poets can write against the weight of history. Fleur Adcock's poem 'Against Coupling' (1971) could be read as something of a declaration against contemporary sexual hang-ups that have their foundation in the beliefs of earlier centuries (as expressed, for instance, in John Marten's 1723 treatise *Onania*). Adcock's poem challenges the powerful legacy of the medical designations *normal*, *deviant* or *perverse*; it also protests the way religion has influenced medical knowledge in problematic ways.

Some decades ago, the early historian of medicine Henry Sigerist claimed that the study of history would equip doctors to combine health care with social action. 'If we want to act consciously and intelligently', he argued, we must be able to trace the historical origins of contemporary 'developments and trends' (1939: 659). Since then, medical historians making similar claims have produced work that examines social injustice, uncovers the mechanisms and processes of oppression, and integrates protest with institutional politics. Yet, this is not the purview of medical historians only. Seventy-five years on, Therese Jones echoes Sigerist's sentiments, but rather than singling out any particular discipline, she highlights the radical potential and democratizing energies of the humanities as a *whole*. As a body of thinkers, we are renowned, she writes, for our 'fearless questioning of representations', our willingness to confront 'abuses of authority' and our 'steadfast refusal' to acknowledge the division that medicine has traditionally set 'between biology and culture' (2014a: 28–9). Ultimately, these are precisely the qualities that link the various disciplines in the arts and humanities. These are also the qualities that make literary critics, historians, philosophers and artists so important as key players – and protesters – in debates about the relationship between biology and culture.

Investigations of the ways discourses determine how we deal with material reality have been particularly fruitful. In *Illness as Metaphor* (1978) and *AIDS as Metaphor* (1989), Susan Sontag interrogates the mythologies that attach to illness. The frightening physical reality of cholera in the nineteenth century – which very quickly turned people into shrunken, dehydrated, blue skinned figures – has left its trace in today's language. In French, the phrase for overpowering fear is *une peur bleue* ([1989] 2002: 121). Sontag explores how historically, the most feared diseases, such as leprosy, syphilis and cholera, have been those that 'transform the body into something alienating' ([1989] 2002: 131). These diseases, she argues, have been understood in the cultural imagination as forms of biblical plagues, as retributive epidemics visited on an errant populace. The moral language surrounding plague in the early modern period (which Daniel Defoe captures in his 1722 *Journal of the Plague Year*) is remarkably similar to the discourse surrounding AIDS in the 1980s and 1990s.

Sontag identifies discourses, borrowed from other domains, which become frameworks for understanding and dealing with a disease like cancer. She draws a trajectory from the militaristic language of late-nineteenth-century bacteriology

and the discourse surrounding cancer in the late twentieth century. In the 1880s, when disease-causing bacteria were discovered, they were said to 'invade' or 'infiltrate', and a hundred years later, we are using a similarly literal and authoritative language to describe cancer as 'the enemy on which society wages war' ([1978] 2002: 67). The cancer patient's body is under 'siege': its weakened 'defenses' are bombarded by 'invasive' and colonizing cells ([1978] 2002: 66–8). And so our researchers, health authorities and governments have declared 'a war on cancer' ([1978] 2002: 67). This is more than an exploration of the ways society describes disease and disease sufferers – although that is a major undertaking in itself. Sontag uncovers how deeply the past influences both public and professional reactions to disease, in order to encourage readers to change the way they speak about and conceive of disease, and the way they treat sufferers. Sontag's work has had its detractors, including those who argue that metaphors are a necessary way to make meaningful sense of illness.[23] Nevertheless, Sontag's synthesis of discourse analysis and literary and medical history is an important protest against the damaging consequences of the way we use metaphor to make sense of the things we fear or can't understand. She condemns, perhaps most pointedly, the way metaphors have been used to conflate the patient with the disease. To describe syphilis as 'pollution', to see leprosy as a hideous 'emblem of decay', to see AIDS as 'contamination' is to stigmatize and ostracize ([1978] 2002: 36, 55; [1989]: 109, 149–50). Metaphors may help us make sense of frightening things, but they also cause further harm to those who are already harmed.

III POETRY: WHAT IS IT GOOD FOR?

Since poetry is at the centre of this anthology, it is fitting in this final section to adapt the question posed above – 'what can the medical humanities offer?' – to ask specifically what poetry can do. The easiest answer is that even the simplest of poetic forms can communicate things in ways that prose forms cannot. Consider, for example, this poem:

Sir Humphry Davy Abominated gravy. He lived in the odium Of having discovered sodium.

As children, our first introduction to Davy may have been through this clerihew (a whimsical, rhyming 4-line poem invented in 1905 by Edmund Clerihew Bentley). But, the comical juxtaposition of words – 'odium/sodium' and 'abominated gravy' – does

more than make us remember an elementary science lesson. This is also a parody of the tradition of panegyric, a form typically associated with an uncritical celebration of authority.

[23]For instance, see Clow (2001).

Clerihews can encourage us to wonder what lies beneath the simplicity and light humour, as in this one about the philosopher René Descartes and his famous maxim 'Cogito ergo sum', or 'I think, therefore I am':

Did Descartes Depart With the thought 'Therefore I'm not'?

Even the lightest of poems can take on the weightiest of theories. Is Bentley's poem about Descartes a statement about the triumph of materialism – the belief that matter is the fundamental substance of human life? Is this a negation of the belief in an eternal, immaterial, intangible human soul, which exists separately from the material body? Is this the early twentieth-century writing back to the seventeenth to say, we no longer believe in the human as divinely made? That modern medical science has shown us that the human is a sum of his or her biological parts? This clever reversal of Descartes' dictum 'I think therefore I am', suggests that once the heart stops pumping and the lungs stop respiring, the 'I' simply ceases to exist – in any form. Perhaps the suggestion is that in his last moments even the great dualist Descartes had a crisis of faith, and thought, 'is this it?'

Of course, in terms of form and content, the selections in this anthology go well beyond the humble clerihew. There are lyric poems that communicate the realities of experiencing disease, aging, recovery, death and loss. There are confessional poems that ask for non-judgmental compassion as they communicate personal experiences with addiction, sexual dysfunction or abortion. There are humorous odes that provide perspective in anxious times and reveal the resilience of the human spirit. Readers will find that parody and satire once mediated our experiences with quacks in the eighteenth century, and continues to do so with respect to bureaucracy, machines and pills in the twenty-first. Free verse that is patterned on the rhythms of regular speech encourages dialogue about difficult subjects where there might otherwise be silence. The prose poem, which is a blend of two forms, mimics the experience of hovering between life and death, hope and despair, even comedy and tragedy. Their fragmentary quality can mirror the sense of disconnection from everyday life that illness, trauma and psycho- logical disturbance can bring. Sometimes, the fragment is all that can be expressed.

Poetic language, which is typically distilled, concentrated and more spare than regular prose, encourages the reader to focus closely on the meanings that inhere in single words. Through the lens of personal lived experience, or imagined experiences, poetry reveals how the perceptions and practices associated with freighted words like *natural* and *normal* or *unnatural* and *abnormal* inscribe the bodies and psyches of individuals. Kwame Dawes's 'Fat Man' is a political poem, but it also describes being physically weighed down by extra weight: medical discourses warning of premature death colour the experience of living with short breath and an awkward waddle. The narrator's search for poetic words and phrases – 'plump existentialism' – is intended to put distance between himself and the word that weighs heaviest: fat. Robert Lowell redefines the word 'life' as 'both the fire and the fuel', but for

William Earnest Henley, 'life' is 'a blunder and a shame'. Death shambles by in Arthur Stringer's poem, but reveals itself to W. H. Auden as 'right and splendid', while Will Carleton's 'Country Doctor' learns that 'Death is master both of Science and of Art'. These are examples of how, in poetry, the single word is brought sharply into focus; poetry distills, redefines and makes words confrontational.

It may be obvious to say that of the literary forms, the rhythm and beat of poetry makes it closest to music, but less obvious is the way this association with sound makes poetry suited to the rhythms of the body. Poetry can mimic the energetic or lethargic pulses of the blood; the rhythmic or the ragged breathing of the lungs. Imagine, too, what happens when verse translates the professional prose of medical experts; the objective prose of textbooks; the sympathetic prose of well-wishers; the plaintive, bewildered, resigned or angry prose of the dying into rhythm, rhyme, meter and line. Poetry then becomes the music of bodies in pain; bodies in recovery; bodies in mourning; and perhaps most importantly, bodies with good stories. This then, is the poetry of '*holding one's own* in the face of the multiple threats that are the occasion of suffering', to use Arthur Frank's words (2014: 23).

Finally, if all else fails, and skeptics and non-believers will still insist that 'verse is only for the healthy arty-farties' or that the utility of the arts and humanities is limited *or* that poetry doesn't *do* anything, we are content to leave the final words to the physician and poet Dannie Abse:

Some may argue that poetry is a useless thing, an activity that can rival the counting of the cats of Zanzibar. But whatever else poems do, or do not do, at the very least they profoundly alter the man or woman who wrote them (1998: 364).

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