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Winning, Joanne (2016) Afterword: the body and the senses. In: Whitehead, A. and Woods, A. (eds.) *The Edinburgh Companion to the Critical Medical Humanities*. Edinburgh, UK: Edinburgh University Press, pp. 325-335. ISBN 978147440004.

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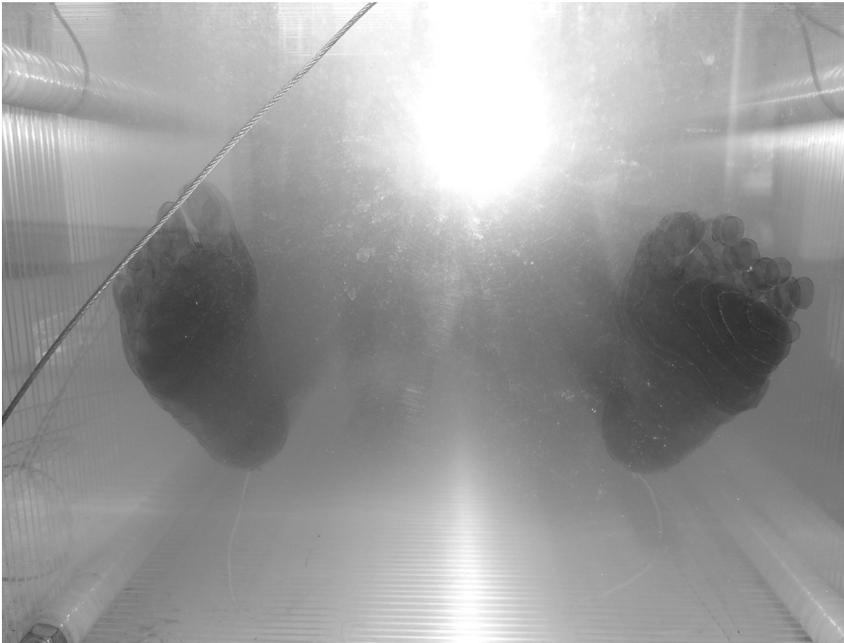
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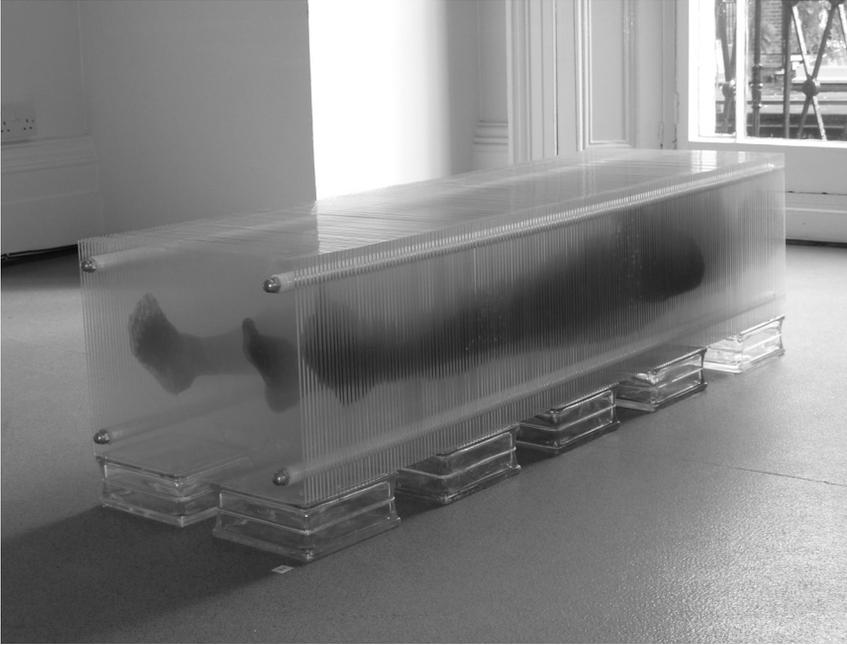
AFTERWORD: THE BODY AND THE SENSES

Jo Winning

WHAT IS A BODY? What are its boundaries and its contours? Can we ever really know the body in its entirety, or only ever in its parts? How do we come to know the body through the senses? And what does it mean to *be* a body and to encounter the body of the Other? Such questions resonate across the divide between the domains of philosophical and critical thought and clinical medicine, as likely to be asked by a doctor as by a humanities scholar. Yet the answers either might give would be spoken in radically different locations, utilise separate vocabularies and registers, and draw on distinct paradigms and histories, suggesting that there is no way to talk across these different domains. It is one of the key tasks of the critical medical humanities to establish a transdisciplinary dialogue across this divide, offering clinical medicine new terms and concepts to strengthen its ongoing dealings with the human body.

An initial entry point into the drama and complexity of the questions posed above can be found in the confrontative sculpture by Welsh artist Andrew Cooper, titled *Between a Rock and a Hard Place* (Figures 18.1 and 18.2).





Figures 18.1 and 18.2 Andrew Cooper, *Between a Rock and a Hard Place*, 2006. Fibreglass/acrylic/fabric/CAT scans/metal¹ exhibited in 'This is My Body', Birkbeck and Irish Museum of Contemporary Art, July 2011. Author's photographs, reproduced with permission of the artist.

On 5 August 1993, Death Row inmate, Joseph Paul Jernigan, was killed by lethal injection in the state of Texas, for the alleged murder of a 75-year-old man whose house he had broken into and entered.² As a last act, Jernigan donated his body for scientific research at the urging of the prison chaplain. Jernigan's cadaver was frozen in a mixture of gelatin and water, and then 'cut' into 2,500 axial sections, which were then recorded via computer tomography (CAT). This endeavour, run by the US National Library of Medicine (NLM), sought to produce a definitive data set of images of the male human body (they undertook the same process with a female cadaver at a later date), in order to 'correct' received anatomical knowledge and to provide, once and for all, an accurate record of human anatomy. The project, for which planning had begun in 1986, was compellingly titled the 'Visible Human Project' and, overall, produced 15 gigabytes of data.³

Cooper, a sculptor and multimedia artist whose work deals extensively with the body, mortality and representation, obtained a licence to utilise 250 of the 2,500 CAT scan images made of Jernigan's body. These CAT scans are encased in acrylic sheets, which are held together by metal rods with small gaps between each sheet. The sheets are arranged in the natural sequence of the body, recreating the shadowy sense of a

body caught in transparent casing. In this sculpture, the body cannot be apprehended as a whole but only in glimpses, traces, via oblique angles and sideways positioning of the viewer's body. It is an object that is implied but never fully grasped by the human eye. Moreover, it has the strange effect of reminding the viewer of her own body. As she bends, kneels and peers in an attempt to see between the acrylic sheets, her curiosity is enmeshed with her own embodiment (Figures 18.3 and 18.4). Such spectatorial practice reminds us of the primal human urge to see *inside* the human body, and of, as Rachael Allen describes it in her chapter in this section, 'our cultural curiosity with interiority'.⁴

The complexity of our encounter with the piece reminds us that the act of looking is not enough to comprehend the whole. As Cooper himself writes of *Between a Rock and a Hard Place*:

The inference is that although both interior and exterior of the human can be seen simultaneously from a number of perspectives, there is something else necessary for a more complete understanding of humanity, something that lies beyond rationality or physical and temporal notions of existence.⁵

Inasmuch as the artwork reminds us that this more holistic knowledge of the human body lies beyond the remit of 'rational' epistemological frameworks, it also draws our attention to the propulsive strength of biomedical science, the ongoing drive towards





Figures 18.3 and 18.4 Attempting to *see* the body in *Between a Rock and a Hard Place*, exhibited in ‘This is My Body’, Birkbeck and Irish Museum of Contemporary Art, July 2011. Author’s photographs, reproduced with permission of the artist.

ever more fine-grained knowledge of the human body and the ways in which the body is always-already mediated by biomedical culture, its technologies, its paradigms and its practices. Moreover, the NLM’s chosen title – the ‘Visible Human Project’ – also demonstrates exactly which of the five human senses predominates in this thrust for knowledge, which is to say the sense of sight. Biomedical culture is pre-eminently a visual culture, structured by what Jennifer Richards and Richard Wistreich call its ‘sight-dominance’.⁶

As attempts to challenge, undermine, reframe and understand biomedical culture, as well as our dominant cultural ideologies around the human body in the West, the collected chapters of this section, ‘The Body and the Senses’, remind the reader of the invocation issued by Michel Serres: ‘If a revolt is to come, it will have to come from the five senses!’⁷ Each in its own way, these chapters offer profound challenges to our existing paradigms of the body and the senses, evidencing most importantly the rich potential of *all* our physiological capacities for perception. Both conceptually and historically, the work of these chapters reinstates the senses of touch, hearing, smell and taste. Even where they examine sight, they problematise a monolithic, unitary notion of what it means to look. Both Rachael Allen, from the important perspective of creative practice, and Suzannah Biernoff, from the critically engaged

and self-reflexive stance of art history practice, remind us that there are different ways of *looking*. Moreover, even where the look is mediated by technology, Lindsey Andrews and Jonathan Metzl show that the technologies of medical imaging are far from neutral and are often placed in service of other cultural concerns, such as ideologies around race and racial difference. Together, these chapters foreground crucial questions: What do we know of the body? How do we conceptualise it? And then there are the implications for medicine itself: How do we heal the body? What are the tools at our disposal? These questions are central to the work of the critical medical humanities, as are the transdisciplinary approaches that are utilised by these chapters. As the historical chapters in this section suggest, our models and our tools have changed over time, and as the contemporary chapters show, even our current tools are limited by discursive and conceptual restrictions. Bethan Evans and Charlotte Cooper's examination of the construction of fatness as pathology points to the contestations around what size and shape the female body in particular should be, whilst Luna Dolezal's exploration of the elective surgeries and body modifications of the performance artists ORLAN and Stelarc puts under pressure our received ideas about exactly what kind of physical and/or organic boundaries the human body should have.

If one of the compelling questions that emerges from these collected chapters is what is to be done about the predominance of the visual in medical culture and clinical practice, it would seem timely to ask how we transform biomedicine back into a sensately fluent discipline. Indeed, we might say this is one of the most pressing requirements of the critical medical humanities: to find a way to create a productive interface between critical theory and clinical practice in order to restore biomedicine to a more holistic sense of the human body. As Jane Macnaughton and Havi Carel's chapter on breath and breathlessness shows, transdisciplinary explorations across the domains of culture and clinic begin to show ways in which new sensate and sensitive vocabularies might be brought into clinical practice and enhance biomedical knowledge.

Reading across the historical periods and different cultural and clinical domains represented in this section, we might characterise the body addressed in these chapters as one rendered docile, in a Foucauldian sense, by discourse. In his discussion of the body of the soldier, as constructed by military ideology and practice, Foucault describes the processes by which docility, a state of capitulation and internalisation of ways of being and feeling, is instilled: 'A body is docile that may be subjected, used, transformed and improved.'⁸ We might extrapolate from this concept and ask to what extent biomedicine insists upon the docility of the body in the clinical encounter. The roles of 'doctor' and 'patient' require apparently clear-cut bodily behaviours and locations, most often reinforced by the material space – ward, clinic, surgery, operating theatre – in which the encounter takes place. Moreover, biomedical discourse, as these chapters demonstrate in multiple ways, has already defined and situated the body as a site of signs and symptoms that can be read and treated. A docile body in this context might be said to be one that has lost full use of its sensory organs. From the patient's perspective, however, we can see that states of pain and illness might be said

to activate the senses. In her 1930 essay *On Being Ill*, now much quoted in medical humanities literature, Virginia Woolf describes illness as an embodied state remarkable for its heightening of our senses, one in which we become almost preternaturally sensate, acutely attuned to the fine nuances of even language itself: 'In health meaning has encroached upon sound. Our intelligence domineers over our senses. But in illness . . . words give out their scent and distill their flavour.'⁹ Further, it is important to remember that the clinical encounter involves (at least) *two* bodies: that of the patient for sure, but also that of the clinician. Perhaps the more radical suggestion here, in the context of a critical medical humanities inquiry, is that a clinician's body might similarly be made docile and have lost its ability to utilise all of its sensorium. As Heather Tilley and Jan Eric Olsén show in relation to notions and practices around visual impairment and sensory compensation in the nineteenth century, and Cynthia Klestinec compellingly demonstrates in relation to early modern medical practice, the sense of touch has played a crucial role in diagnosis and treatment in clinical practice in previous historical periods.

In his 2011 TED talk titled 'The Doctor's Touch', Abraham Verghese, Professor of Medicine at Stanford University, laments the onward march of biomedical technology and the loss of physical examination as the first port of call in the clinical encounter; he notes that 'the most important innovation in medicine to come in the next ten years . . . is the power of the human hand, to touch, to comfort, to diagnose and to bring about treatment'.¹⁰ It is partly the work of the critical medical humanities to identify why this loss of haptic perception has come about. One way to understand it is to consider the roots of biomedicine transculturally, in contrast to the development of other clinical traditions outside the West. In his book, *The Expressiveness of the Body and the Divergence of Greek and Chinese Medicine*, the Japanese scholar Shigehisa Kuriyama explores the pivotal role of dissection in the trajectory of Western medicine as it develops from its Greek origins, and the way in which the practice of dissection as a mode of acquiring anatomical knowledge creates 'a crystallization of a particular way of peering into the body, the birth of a certain visual style'.¹¹ This stands in direct contrast to the trajectory of Chinese medicine with its focus on touch as the primary sense in diagnosis. At the time Western medicine is developing its knowledge base out of the dissection of cadavers, 'Chinese writings [testify] that the eyes were wrong.'¹² What Kuriyama terms the particular 'visual style' of Western medicine comes to foreground the visual sense as a mode of 'reading' the signs of and in the body but it also comes at the cost of dulling the haptic sense in the clinician. To exemplify the pre-eminence of touch in the Chinese tradition, Kuriyama considers the clinical practice of taking the pulse.

What do we feel when we place our fingers on the wrist, and palpate the movements there? We say: the pulsing artery. What else could there be? Chinese doctors performing the same gesture, however, grasped a more complex reality. . . . There were thus six pulses under the index, middle, and ring fingers, and twelve pulses on the two wrists combined.¹³

The difference here is not just about the sensitivity or sophistication of the touch, or the amount or terms of the clinical detail obtained. The profound difference is about fundamentally differing models of the human body. The structural model acquired through centuries of anatomical dissection – and as the ‘Visible Human Project’ demonstrates, this knowledge base is ever needing to be refined – presents the body as an interior that must be made visible, must be seen. A model of the body such as that understood in Chinese medicine (here, of course, I acknowledge that Chinese medicine has many different strands) conceptualises the interior as not so distant or impenetrable that it cannot be read, and diagnosed, through touch.¹⁴ In their examination of the anatomisation of the voice in the Renaissance period, Jennifer Richards and Richard Wistreich identify a rich counter-discourse to the dominant tracts of dissection and anatomical knowledge in the work of the English physician Helkiah Crooke. Crooke’s ‘philosophical speculation on voice and hearing’ reveals to Richards and Wistreich a kind of dialectical thinking that moves beyond the binary opposition of ‘mind’ and ‘body’, and which demonstrates what they call ‘embodied thinking’, which is to say a way of approaching the human body, and understanding it, which folds in both rational thought and sensory information at the same time. It is, I would argue, a useful term for considering what we require of clinicians in the contemporary context of biomedicine.

In his book *Listening*, Jean-Luc Nancy asks, ‘Is listening something of which philosophy is capable?’ The question is a challenge to the discipline, a throwing down of the gauntlet to a mode of thought that has become bound in its own omnipotence. Nancy asks further, ‘hasn’t philosophy superimposed upon listening, beforehand and of necessity, or else substituted for listening, something else that might be more on the order of *understanding*?’¹⁵ The philosopher, according to Nancy, is someone who *hears*, rather than *listens*: indeed, is the subject who *cannot listen*. Why this splitting in this account of the aural sense of the philosopher? The problem, for Nancy, turns on the difference between the two French verbs *écouter* and *entendre*. In the first instance, *écouter* translates as listening, a deployment of the aural sense that suspends pre-judgement or understanding, which encounters sound rather than predeterminedly imposing meaning upon it. By contrast, as Nancy notes, ‘*entendre* “to hear” also means *comprendre* “to understand”’ and as such denotes a process in which the listener has already presupposed the meaning of the sound she encounters. Following Nancy’s evocation of the problems of a philosophy that forecloses its investigations through a state of omnipotence, I want to pose the following question: ‘Is medicine capable of listening?’ Nancy notes that ‘to be listening is always to be on the edge of meaning, or in an edgy meaning of extremity, as if the sound were precisely nothing else than this edge, this fringe, this margin.’¹⁶ The act of listening here might seem to suggest a radical state of unknowing that would appear to be untenable in clinical practice. Yet I am not arguing that biomedicine must quit its will to knowledge of the body by eschewing the primary sense of sight; rather, trying to suggest a way to crack open the ‘alliance’ identified by Foucault between ‘words and things’ – the fusing of biomedical discourse with bodily experience – which allows the clinician ‘to see

and *to say*'.¹⁷ As Foucault reminds us, the clinician's gaze is a very wordy one: in his terms, 'loquacious'.¹⁸ So loquacious, in fact, that it often silences the patient's voice and imposes its interpretation and knowledge on to the body and clinical evidence.¹⁹ Here, critical medical humanities might find ways to help medicine move from *entendre* to *ecouter*, to couple verbs beyond the Foucauldian dyad, which is to say, *to see* and *to listen*. As Macnaughton and Carel radically argue in this first exploration of their cross-cultural/clinical project on breath and breathlessness, 'biomedicine cannot wholly explain how illness may be expressed physiologically.'²⁰ To begin from a place of uncertainty and recognition that biomedical discourse is not the *only* knowledge base is concomitantly to propose a new kind of listening, an opening up to sound and language in the clinical encounter and deployment of the aural sense.

This is a kind of listening demonstrated in the clinical practice of the psychiatrist Alexis Brook. Brook's clinical practice drew on both his psychiatric and his psychoanalytic training. His published and unpublished papers on disorders of the gut and eye demonstrate a uniquely careful attunement to the complex relationship between psyche and soma, as well as the insightful recording of the bodily metaphors and symbols that permeate his patients' narratives. In 1995, Brook published a clinical paper on the psychological aspects of disorders of the eye, based on work he had undertaken as a psychoanalytic psychotherapist in the Eye Department of Queen Alexandra Hospital in Portsmouth and the Well Street GP Practice in Hackney, East London. Brook set out to study 'psychological aspects of disorders of the eye', using a methodology that, whilst relatively simple, pushed into territory beyond the remit of the ordinary clinical encounter. He undertook 'semi-structured interviews of an hour each' with the patients, not 'to establish a psychiatric diagnosis', but rather to 'try and understand whether any intra- or interpersonal conflicts' may have contributed to the eye disorders experienced by these patients. The eye, for Brook, is a crucial organ for the human subject, one that is central in the subject's relationship with external reality. As he argues, 'the eye is not just an organ of vision but is one of the most significant organs through which an individual makes contact with the world.'²¹ Brook identifies the intimate relationship between the eye and the mind in both his clinical cases and in his analysis of the symbols and metaphors of what he calls our 'everyday language':

Everyday language indicates that it is inherently recognised that the eye and the mind are very much equated. *I see* means 'I understand.' We visualise a problem. *To have one's eyes open* is to be emotionally and intellectually aware of what is going on. But if there is something we do not want to acknowledge, because it may be unacceptable, we *turn a blind eye*. The eye can reflect aspects of one's personality. We can *look with love* but we can *look with hate*. We can go in to a *blinding rage* and *looks can kill*. To make *eye contact* means making a relationship, and seeing *eye to eye* means experiencing mutual understanding. *Giving insight* means giving internal sight with the eyes to the mind.²²

The clinical cases in Brook's paper convey the way in which his attunement to the metaphors and symbols used in his patients' language allows him to access the psychic

content that is embedded within the somatic. In one clinical example, Brook recounts the following history:

A very worried-looking 50-year old single man, with a six months history of progressive visual loss, leading to an inability to read, had had many investigations, including a brain scan, all of which were normal. It emerged that his mother, on whom he had been deeply dependent, had died six months previously at the age of 85. 'I am trying,' he said, 'to blot it out.' His eye symptoms cleared after one interview.²³

Here, the patient's use of metaphor links tellingly to his somatic symptom of progressive visual loss. One interview is enough. *Telling* – putting the trauma and loss into words, into language – *someone* – having that language listened to – allows the body to heal. As the mouth speaks – 'I am trying to blot it out', so the body speaks through the symptom of progressive visual loss. In one sense, this is no news at all to psychoanalysis. We might say that what Brook offers here is a kind of miniaturised version of the 'talking cure'.²⁴ What is important here, though, is the way in which it is brought into the realm of clinical practice and biomedical research, with a recognition that the affective and the somatic combine and meet in the place of linguistic signification. It is Brook's ability to *listen* as a psychoanalytic psychotherapist, as well as a psychiatrist, that allows him to hear the way in which psyche and soma are correlated. In his concluding remarks, Brook notes that 'it was the patients who valued the experience of being understood who were more likely to respond to even a few interviews.'²⁵ In particular, one of his patients tells him: 'I think it's because I'm beginning to look at my problems; you have opened my eyes.'²⁶ There is a complex enmeshment of sensory metaphor here in this seemingly simple everyday statement. Brook's *listening*, his use of his aural sense, allows the patient to *see* – have insight – into his problems. Unsurprisingly, such insight means both he and Brook can gain purchase on his refractory eye disorder. Yet here too, we might say, there is something of a more sensately fluent clinical practice at work. Brook has eschewed the use of his visual sense as a clinician, his *eye*, in favour of the deployment of his aural sense. In his listening, Brook utilises his *I*, it is an act of selfhood or 'embodied thinking' that allows for a space of intersubjectivity to emerge between himself and his patient. There is a small but deeply significant revolution that takes place here, in which more senses, if not all five, are placed in the service of treating the human body. The future of a more sensate biomedicine will lie in such small revolutions between bodies and minds, in the clinic, the teaching room and the laboratory. It is our task, in the critical medical humanities, to help to provide the conceptual tools for this future.

Notes

1. *Between a Rock and a Hard Place*, exhibited in 'This is My Body', Birkbeck and Irish Museum of Contemporary Art, July 2011. Author's photographs, reproduced with permission of the artist.

2. For an exploration of medicine and state execution, see Lisa Guenther, 'On Pain of Death: The "Grotesque Sovereignty" of the US Death Penalty', in this volume, pp. 395–410.
3. For more detail on the 'Visible Human Project', see http://www.nlm.nih.gov/research/visible/visible_human.html (accessed 31 May 2015).
4. Rachael Allen, 'The Body Beyond the Anatomy Lab: (Re)addressing Arts Methodologies for the Critical Medical Humanities', in this volume, p. 191.
5. Andrew Cooper, Artist's Statement <<http://www.andrew-cooper.org/about/>> (accessed 11 August 2015).
6. Jennifer Richards and Richard Wistreich, 'The Anatomy of the Renaissance Voice', in this volume, p. 279
7. Michel Serres, *Angels: A Modern Myth* (Paris and New York: Flammarion, 1995), p. 71.
8. Michel Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Vintage, 1995), p. 136.
9. Virginia Woolf, *On Being Ill* (Ashfield, MA: Paris Press, 2002), p. 21.
10. Abraham Verghese, 'A Doctor's Touch', TED talk, July 2011. Verghese's talk is a moving invocation to recapture the clinical art of touch; see the talk in its entirety at <http://www.ted.com/talks/abraham_verghese_a_doctor_s_touch?language=en#t-136627> (accessed 4 September 2015).
11. Shigehisa Kuriyama, *The Expressiveness of the Body and the Divergence of Greek and Chinese Medicine* (New York: Zone Books, 2002), p. 120.
12. *Ibid.*, p. 22.
13. *Ibid.*, p. 25.
14. For a more extensive discussion of Chinese medicine and its complex intersections with biomedicine, see Volker Scheid's chapter in this volume.
15. Jean-Luc Nancy, *Listening* (New York: Fordham Press, 2007), p. 1.
16. *Ibid.*, p. 7.
17. Michel Foucault, *The Birth of the Clinic* (London: Routledge, 2007), p. xiii.
18. *Ibid.*, p. xii.
19. Of note here, Richards and Wistreich's chapter in this volume points to the complex constitution of the voice, a human faculty not simply restricted to the anatomical apparatus that produces sound, but also made up of breath and tone, which open up different modalities of meaning.
20. Jane Macnaughton and Havi Carel, 'Breathing and Breathlessness in Clinic and Culture: Using Critical Medical Humanities to Bridge an Epistemic Gap', in this volume, p. 294.
21. Alexis Brook, 'The Eye and I: Psychological Aspects of Disorders of the Eye', *Journal of the Balint Society* 23 (1995), p. 13.
22. *Ibid.*, p. 13.
23. *Ibid.*, p. 15.
24. Brook utilises this model of listening in other medical disciplines. In his work in the Department of Gastroenterology at St Mark's Hospital, he continues to listen closely to the language of his patients. In his 1991 paper, 'Bowel Distress and Emotional Conflict' (*Journal of the Royal Society of Medicine* 84.1, pp. 39–42), Brook examines case histories of patients presenting with gastrointestinal disorders, again listening for the affective content in patients' accounts of their illness. In an undated and unpublished paper titled 'Gut Language of Somatizing Patients', Brook collects quotations from gastroenterology patients: 'My whole gut is in rebellion,' says one woman; 'my abdomen is screaming and

complaining,' says another. A third says 'Fighting is going on in my abdomen, like there are a whole lot of people fighting. My whole system is rebelling, my gut is boiling up.' 'Gut language' suggests that the gut – that corporeal entity – has its own language and in these three clinical examples, gut language is characterised by conflict, violence and militaristic symbols. Thus Brook, the sensitised clinician, listens to the metaphors of his patients.

25. Brook, 'The Eye and I', p. 15.
26. *Ibid.*, p. 15.