

# Representing Health and Illness: Thoughts for the Twenty-First Century

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In their critical paper on images in the health sciences, Roger Cooter and Claudia Stein pointed out the limits of visualisation and representation in the existing literature in the public representation of health and illness.<sup>1</sup> They focus on the complex and multilayered field of medical representations as the site where levels of epistemic, philosophical and political presuppositions provide insight into the interpreter's historical position. From a close focus on medical (or even public health) representations as a reflection of a partial worldview, to the historical embeddedness that they suggest is the key to understanding the limitations of all visual hermeneutics in the sphere of health and illness:

[H]istorians seeking to use visual materials need to be aware that any instruction as to their use is *a priori* discourse laden. The coming into focus of health posters in the 1990s and visual culture in general as something of seemingly great importance, something for serious critical engagement, is but a perception of one particular sociocultural moment (precisely that which we have sought to outline in this paper). It is a discursive regime, not a universal truth. Historians of medicine should by all means be encouraged to pursue the abundant visual objects in their field, and treat such objects in terms appropriate to the context of their production. A multiplicity of approaches is also to be encouraged. But they should do so with awareness of, and open candour towards the historicity of the discourses around the visual from which their approaches derive; that is, they should be attentive to how their mindedness to the visual has been informed.<sup>2</sup>

But the response to such a warning in a moment now given to the empirical, the material, the 'real' in the study of the history and culture of medicine, is to disqualify the study of representations as 'merely' the interest of a subjective and therefore not transcendental history. Tom Mitchell had supported the view espoused by Cooter and Stein in the mid-1990s observing that 'representation (in memory, in verbal descriptions, in images) not only "mediates" our knowledge (of slavery and of many other things), but obstructs, fragments, and negates that knowledge.'<sup>3</sup> For him, representations are *not* merely 'objects representing' but an index (in the sense of C.S. Peirce) of the means by which representations are produced and received. Today's new functionalism seems to

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<sup>1</sup> Roger Cooter and Claudia Stein, 'Coming into Focus: Posters, Power, and Visual Culture in the History of Medicine,' *Medizinhistorisches Journal*, 42 (2007), 180–209.

<sup>2</sup> *Ibid.*, 205.

<sup>3</sup> W.J.T. Mitchell, *Picture Theory* (Chicago: University of Chicago Press, 1994), 188.

have moved towards the 'real' in ways that question the very premises of theories of representation.

While the shift in claims of the history and culture of medicine have not been as radical as that in recent literary interpretation, with its discovery of the claimed objectivity of brain imaging and the neurosciences or evolutionary biology or psychology as the single pathway to a true understanding of the process of literary creation or reception, there is a false empiricism in medical history that has rejected the study of representations in its totality because of its 'merely' subjective nature. The new social history of medicine seems to have become a means of speaking about the reality that is 'merely' mirrored in representations, while the real questions to be asked by the history and culture of medicine are understood to lie within clinical reality, biological empiricism, or even within the absolute of social reality. Thus, the new study of childhood by the anthropologist Melvin Konner seeks the absolutes of development psychology (which he reads as a map for evolutionary psychology) to replace an environmental or historical model of childhood with a developmental / genetic model.<sup>4</sup> That childhood is also, and has long been understood as, an historical and cultural phenomenon, does not figure into his calculus. So much for the history of childhood; replaced by brain scans and genetic maps. Such a reductive and uncritical approach by a leading anthropologist is a model for the newest 'empirical' approaches of both the social sciences and the humanities.

As medical history has become a field within the new history of science that is more and more engaged with local, real, and material world aspects of health and illness, interest in representations has taken a back seat. In complex ways, we have returned to the negative attitudes of the first generation of medical historians in the late nineteenth century with regard to representations, as I documented in my book on *Health and Illness: Images of Difference* (1995).<sup>5</sup> Indeed, the dividing line between the history of medicine and the social study of medicine on the distinctions in the general field of the history of science and science studies seems to be on this fault line between interpretation and empiricism. Lorraine Daston recently commented on the distinctions in the general field of the history of science and science studies, or to put it into the language of the academy: the distinction between the 'soft' and the 'hard' disciplines.<sup>6</sup> She quotes the Harvard sociologist of technology 'Sheila Jasanoff, speaking *qua* president of the Society for the Social Studies of Science, [who] recently complained of a "somewhat one-sided love affair" with the history of science and a certain "jitteriness about being caught out in risqué company [that] marks the hiring practices of our major history of science departments.'" Social scientists interested in 'science' want the hard empiricism of history while, according to Daston, 'the discipline of history... in turn was in hot pursuit of cultural anthropology'.<sup>7</sup>

Is 'soft' the new 'hard' for history? Hardly. For the history of science, and Daston's own work is a good example of this, has moved towards the technology of representation and its material world history as central to this new, hard history of science. It is the

<sup>4</sup> Melvin Konner, *The Evolution of Childhood: Relationships, Emotion, Mind* (Cambridge, MA: Harvard University Press, 2010).

<sup>5</sup> Sander L. Gilman, *Health and Illness: Images of Difference* (London: Reaktion Books, 1995).

<sup>6</sup> Lorraine Daston 'Science Studies and the History of Science', *Critical Inquiry*, 35 (2009), 798–813.

<sup>7</sup> *Ibid.*, 798.

study of images that provides the core for a rethinking of the history of science. In Lorraine Daston and Peter Galison's *Objectivity* (2007), the history of the image is at the core. Using the history of the scientific image from anatomy to crystallography, from the Enlightenment to the twentieth century, they sketch a world in which the creation of images is the reflection of the creation of a self-understanding of science within the consciousness of the scientist. The scientist's goal is as much in the 'techniques of shaping the self, as well as of picturing nature'.<sup>8</sup> Yet the claims of this critique of representations still assumes some type of objective correlative, whether in the 'real' world or in the psyche of the 'scientist'. The critique of the former is clear: the absence of a theory of mind – even a socially based theory of mind – places the 'picturing of nature' as a reflex of the psyche of the scientist as a free-floating signifier.

'Picturing' is moved from being an individual act in an historical context, to that of the collective self-labelled as 'scientists' without much consideration to the mechanisms present. But present and universal they are. It is, as Peter Novick argued, decades ago, the creation of an academic notion of objectivity out of the subjectivity of the historical agent.<sup>9</sup> The scientific atlas thus is both the origin of and the creation of a scientific objectivity that defines the scope of evidence for the historian of science.

While this new history of science with its bent towards a material world (read: technological) orientation is as much of a construct, of course, as the biologisation of literary study through the application of evolutionary psychology or genetics, it is what is perceived as fashionable in 2011. This pursuit, driven by what Marjorie Garber has called 'discipline envy' has moved both fields in this direction.<sup>10</sup> Daston ends her account with the same problem that Cooter and Stein recognised in the field of medical representations; that the approaches of the history and the social study of science 'are contingent to a certain time and place yet valid for certain purposes'.<sup>11</sup> The history of medicine has moved in this direction; new models have appeared; old objects have been abandoned as they seem polluted by outmoded models of evidence and interpretation. The young Turks of the last generation have become the dons of this age; they must be swept away and their questions abandoned. Daston imagines a solution:

[A] new vision of what science is and how it works has yet to be synthesised from the rich but scattered and fragmented materials gathered by some twenty years of historicised history of science. The very practices that made that history possible militate against such a synthesis coming from the history of science itself. Science studies seem a still less likely candidate for the task. A new form of interdisciplinarity must be forged. Philosophy, anyone?<sup>12</sup>

Having just gone through the age of post-modern philosophical theory and the concomitant abandonment of Popperian philosophy of science, philosophy seems a remote possibility for the future of the history and culture of medicine.

In the same issue, Mario Biagioli noted that 'the disciplinary predicament of science studies offers a useful vantage point for reconsidering some of the recent debates on

<sup>8</sup> Lorraine Daston and Peter Galison, *Objectivity* (Cambridge: Zone Books, 2007), 363.

<sup>9</sup> Peter Novick, *That Noble Dream: The Objectivity Question and the American Historical Profession* (Cambridge: Cambridge University Press, 1988).

<sup>10</sup> Marjorie Garber, *Academic Instincts* (Princeton, NJ: Princeton University Press, 2001).

<sup>11</sup> Daston, *op. cit.* (note 6), 813.

<sup>12</sup> *Ibid.*, 813.

the crisis of the humanities and the university.<sup>13</sup> For him, the rupture is post-Kuhnian with the easy – his claim – political critique of science as seen from the position of post-modernism. At the conclusion of his essay, he presents a menu of what could be done to improve the interface between science and the humanities in the near future. He too, demands a rethinking of the function of the study of visual images in science departing from the study of medical images. His sixth item reads:

6. Science, visuality, imaging techniques, and so on. Such analyses should not be limited to the relationship between canonical art and canonical science (for example, Leonardo and anatomy) but expanded to encompass the study of the widespread production and role of all sorts of imaging techniques in science (both still and moving images). They could also venture in the direction of science-based art, like bio-art and tissue art.<sup>14</sup>

Is this the new aestheticism? Hard science now turned into the object of art galleries? In a real sense this simply echoes the new materialism: as it replicates without questioning the image and its relationship to the very claims of science. Not surprisingly, any critique of the division between the ‘soft’ and the ‘hard’ approaches to the interface between the humanities and the ‘real’ history of medicine looks at the image as the source for the study of the local, of the empirical, of technology and art; the cultural history of medical images, in this account, ‘merely’ studies representations with their global meaning without much attention to the context or the history of the specific. This is Cooter and Stein’s general point but is also echoed in Biagioli’s, as well as Daston’s – and Galison’s – critique. Yet this debate, which is inherent to the question of a new history of medicine, seems to be a recapitulation of what the study of images in the history and culture of medicine has been since the 1970s. Foucauldian globalism versus the detailed study of the specific; the analysis of the epistemic *vs* the concern with the detail; historical sociology or social study of science (whether Foucault or Latour) *vs* ‘real’ history. All centre on readings of representations as key to rather than illustrative of Mitchell’s problems of visual hermeneutics. Yet the very questions of the categories that Biagioli envisions are expanding the study of images points out the boundary question even more clearly. Where does the history of medical images end and the employment of such images in the world of ‘art’ or at least in the world of the art gallery begin? Must we not ask questions about the constitution, not of a rapprochement between ‘art’ and ‘science’, but the very selling of both? What does this employment of science in art and art as science tell us about ‘discipline envy’ in the arts and the sciences? Can we see a clear line between the furthering of such art by foundations such as the Wellcome Trust and the sudden interest in the visual aspect of science as imported into the arts?

There is a need for a radical rethink of the function of the study of representations in the history and culture of medicine. This does seem to demand our renewed attention given its priority in recent discussions. But what position is open to us as critics of entire systems of visual and cultural representation in terms of a new or renewed epistemic? Where can we stand in terms of analysing the reflection or distortion of the meanings

<sup>13</sup> Mario Biagioli, ‘Postdisciplinary Liaisons: Science Studies and the Humanities’, *Critical Inquiry*, 35 (2009), 816–32: 816.

<sup>14</sup> *Ibid.*, 832.

associated with health and illness in the present world? The role of the study of medical (in the broadest sense) representations, or perhaps better, images of health and illness and their attendant social and cultural settings needs to be addressed while acknowledging the new materialism and its claims about transcending its own cultural embeddedness. The function of representations (and those trained to study and analyse them) in the history of medicine is to knit the function of public and private representations with the continuities and discontinuities in attitudes and beliefs both within and beyond the health sciences. It is the frame for all empirical studies, as all such studies, whether epidemiological, genetic, developmental, social, or cultural, rely to one degree or the other on the analysis of representations. To study 'medical technology', without understanding how its generation of representations is the key to its understanding, is limited, as those working on NMRI and genetics have shown; to study the representations without understanding the technology and the knowledge it generates is equally one-sided. To then examine the appropriateness of such images in the visual arts as a simple reflex of the interest in medicine in the world is naïve beyond belief. Yet we must also understand the inherent limitations of our own positionality. We engage with the world of medical representations not to show their duplicity or truth but to reveal their function in their historical context; we too are subject to this rule. We need to find a means to examine such representations by engaging with the debates about the meanings attached to representations and narratives in any given context as a way of bridging these growing gaps in the history and culture of medicine. By studying the claims about representations, you will come much closer to their underlying epistemic value in any given system; and, of equal importance, you can begin to understand the individual variants in or to these values. The study of representations thus are a paramount means of examining both collective and personal responses to cultural notions of health and illness, disease and healing, as well as to institutions from the hospital to the advertising agencies engaged in these worlds.

There are practical policy issues that are reflected in the problems that I have outlined concerning the nature of representations of health and illness. These were important in the 1980s but seem to have vanished in the most recent debates. Recently, I have written about the continuities and ruptures in the image of the obese and obesity.<sup>15</sup> Yet such considerations seem to play little role in the debates about healthcare in the United States and the new healthcare bill [HR 4872]. Assuming that the bill remains basically the same between now and 2015–16, when it comes into effect, one of the real questions raised deals with whether the changes introduced will radically reduce costs and thus enable more people to get better healthcare. The claim was – and this is classic Adam Smith economics – the more people you have in a pool, the fewer, percentagewise, are going to get ill at any given time, and therefore the general costs will go down. Meaning, if you have healthy 18-year-olds in the pool, their contributions will help pay for older people with greater health problems.

Yet it is the image of the 'healthy 18-year-old' and the 'infirm elderly' that shapes such as argument. If the claims about increased obesity in children and teenagers are

<sup>15</sup> Sander L. Gilman, *Obesity: The Biography* (Oxford: Oxford University Press, 2010).

anywhere near accurate – I think they are more accurate than not – then we are going to experience an enormous number of younger people who will have major illnesses early on, as well as the sequelae from those illnesses. If you become diabetic when you are forty, you will have cardiovascular problems when you are sixty. If you become diabetic when you are ten, that means you are already going to be an ill 18-year-old and a sick and very expensive 30-year-old.

The disjuncture between idealised images of ‘normal and healthy man / woman’ (an odd version of what some economists call ‘rational man’ and the law has called ‘reasonable man’) that haunt such reckoning can be seen in today’s politics of obesity. Childhood obesity has been taken up by Michelle Obama as one of her primary interests as First Lady. Her view is that obesity is not a medical problem, even though it has health consequences, rather it is a social or even a moral problem. Obesity is the result of poverty or lack of desire to exercise and eat well. Such views stereotype all people who are obese as poor or lazy and stupid and unable to deal with problems that they themselves have some control over. But ever since, obesity has become a public health issue that has an ever-growing pot of money associated with it. Everybody is jockeying to get a part of that pie: the geneticists are making claims that it is all a question of genetic inheritance; the endocrinologists are arguing that this is mainly a problem of metabolic change; the infectious disease specialists point to increased obesity in those infected with specific viruses; the people interested in social medicine say if people only had better access to ‘organic or slow food’ there wouldn’t be any problem with obesity – all of which, in bits and pieces, is true. The moralisers argue that we should reintroduce physical labour – now in the form of compulsory exercise regimes in schools or a ‘fat tax’ on unhealthy food. If the First Lady is heard, then obesity will not be primarily a medical problem but a social one. Yet for some overweight people it is primarily a medical problem. They are not going to be helped by having access to better food and a better lifestyle. It is the image of the obese with all its history that frames these questions. Without an awareness of this, the debates and the solutions will always be partial, fragmentary, or contradictory. As an historian I am a great believer that what medicine does best is to think about multiple causes for complex outcomes; and much of what I’ve heard over the last couple of years, both in the medical science, sadly, and also in the political realm is exactly the opposite. It is simple answers and simple proposals based on incomplete command of the vocabulary of images employed. This is a typical policy problem that the study of images of health and illness may help address.