Writing Sickness, Writing Healing: Narratives of Illness and Identity

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CERTIFICATE

This is to certify that I, Neeraja S., have carried out the research embodied in the present thesis, “Writing Sickness, Writing Healing: Narratives of Illness and Identity”, for the full period prescribed under the PhD ordinances of the University of Hyderabad.

I declare to the best of my knowledge that no part of this thesis was earlier submitted for the award of a research degree of any other university.

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Contents

Section A: Illness, Healing and the Individual

Section B: Toward the Social

Section C: The Social

List of Illustrations

On Facing Page

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Chapter One

Introduction: Illness, Healing, Narrative

Chapter Plan

This dissertation focuses on patient, doctor and public health narratives in the late twentieth century in India. This study will argue that disease is performed *in* narrative, and may be read as organized around interventions in two key domains – the individual and the social (epidemics, however, are outside the scope of this study). The thesis moves from examining performances of illness and the healing process at the level of the individual to the performance at the level of the social/collective.

My dissertation argues that narrative "accounts" of illness in (i) doctor memoirs (ii) patient memoirs and (iii) the medical documentary, plot the emergence of "socialized" identities for the individuals whose alteration through disease and treatment they seek to represent. In doctor and patient memoirs this narrative ordering of illness experience and its treatment takes the form of a medical Bildungsroman, mapping the "growth" and social integration of an individual (doctor or patient) through the condition of illness and healing. The medical documentary makes explicit the presence of disease in the individual body and reimagines this body socially through a sentimental narrative that emphasizes a shared vulnerability to disease at the level of the individual, filial and social/communal.

This project will examine discourses of health, illness and medicine in contemporary public culture in India. Health and medicine are matters of public culture as well as popular culture. They encode power relations, questions of narrative method and stereotyping – and therefore might be profitably examined for language, discourse and narrative strategies in the Humanities. Since Humanities is defined as "all things that constitute the human", and medicine (with attendant conditions of health, sickness, cure) is central to the very idea of the human, it is necessary, I believe, to study discourses of health, illness and medicine to examine what forms of the "human" emerge, thus making health and medicine subjects for the "Humanities". Scholars of public culture are interested in the process through which shared meaning is negotiated among a diverse group of individuals. Arjun Appadurai and Carol A. Breckenridge argue that the term "public culture" allows us to hypothesize a zone of cultural debate. "This zone", they argue, "may be characterized as an arena where other types, forms and domains of culture are encountering, interrogating and contesting each other in new and unexpected ways" (6). Concepts of "disease", "illness", "sickness" and "health" need to be differentiated in order to make clear the varying roles of the individual, the medical practitioner and society. "Disease" can be differentiated from "illness", in that it lies within the domain of scientific medicine and the medical practitioner, while "illness" is understood as the individual's "experience". "Sickness" is what society attributes to an individual who perceives himself/herself as ill and who is identified as having a "disease" by a medical professional. Moreover, each of these terms, validates action in its respective spheres. The medical professional, therefore, is responsible for identification, discovery and treatment of disease. Individuals who are ill are required to narrate their experience of illness and seek care. The duties and rights of an ailing individual are a social responsibility ("Disease" 407). Narratives of disease, in other words, are a fit subject for a Humanities project, because these narratives construct subjects and subjectivities through languages of representation.

Every culture frames disease, health, illness and cure in certain ways. Thus, the biological experience of a condition is interpreted within a framework that is not only biological, but cultural. Thus "disease", as we in non-biomedical terms understand it, is the intersection of a physical-material condition and a discourse in which the meanings of this condition are interpreted. Bryan Turner (1997) and Paula Treichler (1998), for instance, have emphasized the discursive and material domains of disease, by combining the notions that disease is a language (Treichler for instance, defines AIDS as an "epidemic of signification" (11)), the body is a representation and medicine is a political practice. This cultural framework of interpretation requires representation or narrative. I argue in this dissertation that narratives of disease organize our perception of various aspects of the "reality" of disease. These "narratives" are informed by and inform a "cultural imaginary" framed around disease that governs our interpretation of the "illness experience". This cultural imaginary that "frames" definitions, perceptions and information about disease, is already in place via State authorized medical and public health discourse, fictions about disease and epidemics and reports on "scientific" research about disease in the popular domain. I will return to contemporary illustrations of the "cultural imaginary" surrounding disease in section IV of the Introduction. Doctor memoirs, patient memoirs and public health discourse, foreground the undeniable materiality of disease (in terms of pain, bodily decay, disruption) while simultaneously contributing to knowledge about the true "nature" of disease. Disease narratives thus convey the experience of illness or the "reality" of disease, through certain modes that in turn enable the construction of particular images of biomedicine, the body and the pathogen.

The "real" threat posed by the pathogen and the "experience" of illness, are interpreted within the frames of recoverability, science-as-cure, the possibility of building a "robust" immunity, the "heroic" individual battling an "invading" viral enemy that constitutes the cultural imaginary surrounding disease. This cultural imaginary thus enables a shared grammar or vocabulary, with which ideas of health, disease, medicine and the body can be articulated. An individual narrating an "experience" of illness, an institution that provides "educational information" about a disease or a doctor narrating "encounters" with viral agents, can thus deliver to the reader, the "reality" of the powerful, yet not entirely knowable idea of disease. This is communicated through familiar sites of interpretation and identification made possible by the cultural imaginary of disease. These "familiar" narrative modes, like the materiality of an illness (physical symptoms, pain, bodily decay, rigorous treatment regiments), combine with the "individual's" particularized reiteration of his/her actual "experience" to create the "truth" or "reality" of disease. A viral agent or pathogen is thus described as the "other" and the doctor and the medical institution are seen as "redemptive" for the individual, who is "expected" to "recover" normalcy, because the frame of interpretation for these narratives defines them similarly. The material and the discursive realms here combine to influence our "perception" of disease in these "texts", by bringing together an individual's "facts" about disease (defined within the frames of medical science in the form of lab tests, reports and scans, a definitive "test" to determine the presence of disease) and his/her experience of medical treatment (organized in the form of a "stoic", "resilient" patient committed to the cause of "recovering", or a doctor committed to the "improvement" of medical practice, yet bounded within the discursive realm of medical "care" and "cure").

This dissertation will study the modes of representing illness/disease manifest in popular, non-fictional narratives of/about disease/illness in the late twentieth century in India. To this end, I will examine patient memoirs and physician memoirs written by Indians (both residents and diaspora) and medical documentaries produced and disseminated by the Films Division, India. The doctor memoirs I will look at are Sandeep Jauhar's *Intern: A Doctor's Initiation* (2008), Atul Gawande's *Complications: Notes From the Life of a Young Surgeon* (2002), Abraham Verghese's *My Own Country* (1995)and Noshir H. Antia's *A Life of Change: The Autobiography of a Doctor* (2009), all of which are first-person accounts of the experience of medical education/training and the individualized *practice* of treating/healing. The patient memoirs I will study include Anup Kumar's *The Joy of Cancer* (2002) and *Smiles and Tears: A Salute to Cancer* (2003), Anita Jayadevan's *Malicious Medicine: My Experience with Fraud and Falsehood at Infertility Clinics* (2009), Lata Mani's *Interleaves: Ruminations on Illness and Spiritual Life* (2011), R. M. Lala's *Celebration of the Cells: Letters from a Cancer Survivor* (2011) and Yuvraj Singh's *The Test of My Life* (2013), which detail protagonists' intimate experience of illness, its treatment and at-home management. The medical documentaries under study include *AIDS* (1995), *Conquest of Cancer* (1980), *Controlling Leprosy* (1989), *Glaucoma – A Race to Blindness* (1990), *Sexually Transmitted Diseases* (1982), *There is Life for Selvi* (2004), *Your Enemy - TB* (1980) and *H1N1 Flu: Few Facts* (2010), among others. These documentaries are characterized by information and advisory about illness/disease, in addition to narrating individual "stories" about experiencing and diagnosing illness that serve as "instructive" examples. I am interested here in the social and cultural dimensions of these narrative accounts of disease/illness.

This study is organized into seven chapters. The first is the Introduction, comprising five main sections. I will return subsequently in the Introduction to a summary of the remaining chapters of the dissertation. The first section of the Introduction is dedicated to examining the conceptual and theoretical framework of this study. The second section will briefly survey the domains of Medical Humanities and Narrative Medicine, within which this project is largely located. The third section of the Introduction provides a brief summary of and outlines the relevant contexts for my primary texts. The fourth section will elaborate the rationale and scope of the project, while the fifth section details the organization of the thesis in addition to offering a brief summary of the ensuing chapters. Fictional representations of disease/illness and fiction written by doctors and patients however, are outside the purview of this dissertation.

Section I: Narrating Sickness and Healing

The act of recording an experience of sickness and healing participates in several genres and media. The following section will detail the various theoretical frames and concepts that underpin this study of an individual's ordering of an experience of illness. I will begin by focusing on theories surrounding various genres/modes of articulating a story of the "self", namely, the autobiography, memoir, *testimonio*, self-help literature, the *Bildungsroman* and the documentary. I will then move on to the theoretical frames that inform the representation of illness and disease manifest in the major modes under study in this dissertation: the medical *Bildungsroman* and the medical documentary. Subsequently, this section will examine theories of "narrating" or "storying" an experience of illness and healing. I will also detail theories of "voice" and "agency" that underpin the arguments made in this dissertation, about the concretizing of "agency" in the acquiring of a particular kind of "voice" by narrators in the medical *Bildungsroman*. Finally, this section will delineate theories of social and public "identity" formation that contextualize the "development/transformation", and eventual "socialization", performed by narrators in the medical *Bildungsroman* and visualized in the medical documentary.

(a) Genres/modes of Representing the "Self"

(i) Autobiography

Several of the texts studied in this dissertation are suggestively titled to indicate the "truth" inherent in the experiences/stories narrated therein. Some examples include the physician autobiographies – Sandeep Jauhar's *Intern: A Doctor's Initiation* and Noshir Antia's *A Life of Change: The Autobiography of a Doctor*, Anita Jayadevan's patient memoir titled *Malicious Medicine*: *My Experience with Fraud and Falsehood in Infertility Clinics* and the medical documentaries about Glaucoma, H1N1 Flu and Tuberculosis titled *Glaucoma – A Race to Blindness*, *H1N1 Flu*: *Few Facts* and *Your Enemy-TB*. These texts insinuate a certain "authoritative" experience and claim to clarify "facts", construct notions of "falsehood" (of medical science), "enmity" (against the pathogen) and the "actualization" of disease ("racing" towards blindness). They raise questions thus, about "truth telling" and "authority" that can be productively studied via theories of non-fictional forms, and their appeal to readers and authors as a mode of accessing the "truth" about a particular experience. As Sidonie Smith and Julia Watson have argued in their essay, "The Trouble With Autobiography: Cautionary Notes for Narrative Theorists", writers often subvert a fiction/non-fiction distinction to interrogate the dominant modes of truth-telling and self-representation (363).The narrators of patient-memoirs and doctor memoirs relate the story of their "heroic" battles against disease, empowered by the textual authority afforded by the autobiographical form.In addition, in his examination of medical autobiography in "Physician Autobiography: Narrative and the Social History of Medicine", Donald Pollock asserts that the life story of an individual is only worth recounting if it somehow deviates from the ordinary and commonplace (109). Pollock argues for a "professional conscience" that novice physicians give voice to in physicians training tales (123). Physician autobiographies, Pollock argues, sometimes offer a kind of "projective screen" that helps their authors cast uncertainties and anxieties regarding bureaucracy and medical science (124). In recounting their days of medical education/training as "novices", the doctor is able in his autobiography, to articulate a critique of medical practice and express uncertainties about the effectiveness and universality of medical science. The autobiography and other non-fictional forms also give rise to questions of cultural/professional authority, a point I will return to later in the section on "Voice and Agency". For now, we can move on to a discussion of the "pact of listening", or the conditional nature of reading/writing non-fictional forms and their engagement with the reader's "present", using the testimony and the memoir as illustrations.

(ii) Memoir and Testimony

As argued by Nancy Miller and Jason Tougaw in their*Extremities: Trauma, Testimony and Community*, a testimony cannot take place in isolation and is contingent on a "response" from the listener/reader. A testimony tries to bridge the gap between an individual's suffering and a community of listeners. This "contract of listening" involves an empathetic response on the part of the listener/reader, which is palliative for the witness/speaker (11). Working with ACT UP's slogan "Silence=Death", Jason Tougaw argues that the subjects of AIDS memoirs are in a state of "crisis" and write in order to survive and to put an end to the epidemic. The AIDS memoirist, however, rarely lives to see the effects of his/her literary act of writing, despite the promise of ACT UP's slogan, "Silence=Death".He/she thus generally tends to abandon the act of writing. Tougaw argues that memoirists' abandonment of writing does not take away the power of their memoir as a "speech act", as such an "act" speaks for a collective and endeavours to disseminate the “story” of this collective, to prevent the recurrence of the historical conditions that led to trauma for the collective. AIDS, however, occupies a unique position within the above formulation, as the conditions which led to the writing of the memoir continue to exist in the reader’s present. This has led to the reconfiguration of gay discourse and gay communities, as the memoir itself is a reminder of the grim conditions that led to its production (175).

The narrating “self” in several of the texts under studyare a reminder of the conditions that led to the literary production of these texts – doctor’s experiences with the “fallibility” of medical science and incurable diseases, patients’ experiences of chronic/incurable illness and its management at home and the medical documentary’s construction of a “vulnerable” individual whose immunity can easily be “compromised”. The “reality” of disease and the “difficulties” in the practice and execution of “healing” described in these texts, inhabits the “present” of readers and the conditions that led to its development are unresolved, thereby threatening the “self” created by the narrator.

It would also be useful at this juncture, to examine doctor and patient narratives in the light of a genre of literature that also makes powerful claims to “truth-telling”, the *testimonio*. John Beverly, in his “The Margin at the Centre: On *Testimonio* (Testimonial Narrative)”, defines the *testimonio* as “a novel or novella-length narrative in book or pamphlet form, told in the first person by a narrator who is also the real protagonist or witness to the events he/she recounts, and whose unit of narration is usually a “life” or significant life experience” (93). Unlike the novel, Beverly argues, a *testimonio* is distinguished by “sincerity” rather than literariness. Moreover, in the *testimonio,* narration is situated as involving “an urgency to communicate, a problem of repression, poverty, subalternity, imprisonment, struggle for survival, implicated in the act of narration itself" (94) The narrators of doctor and patient memoirs do not strive for "literariness", rather, they seek to communicate "problems" and "anxieties" about the nature of medical practice and articulate a struggle for survival (against illness, struggling to "become" experts in the practice of medicine) that is implied in their very act of narrating. Patients recounting their experience of illness and doctor's accounts of treating (as professional) and witnessing (as novice) treatment of illness, constitute a more depoliticized articulation of the *testimonio*. In such a case, as Beverly defines it, "*testimonio* gives voice in literature to a previously "voiceless", anonymous, collective popular-democratic subject, the *pueblo* or "people", but in such a way that the intellectual or professional, usually of bourgeois or petty bourgeois background, is interpellated as being part of, and dependent on, the "people" without at the same time losing his or her identity as an intellectual" (98). Doctor and patient memoirs thus, suggest an appropriate ethical and political response, while retaining their identity as "professional" or "ethical experts" in a society. These memoirs speak for a collective (patients usually place themselves, however briefly, within a "society of illness"), by recounting stories of other patients met at visits to the clinic or by explicitly situating the purpose of narration as one that is to "help" or stand as testimony to "others" who have suffered silently. Although doctors similarly explicitly place themselves within "the medical profession", speaking on behalf of an "imperfect science" as well as its powerless "subjects" (patients), their "authorial" function is not erased. Unlike the classic instances of the *testimonio* genre, which is a "fundamentally democratic and egalitarian form of narrative in the sense that it implies that any life so narrated can have a kind of representational value" (96), doctor and patient narratives foreground the "authorial" function by "setting apart" their narrators from "others" in the community. I will now move on to a discussion of the documentary, as another mode of "authoritatively" and "objectively" representing the "truth" about the prevalence of disease and the experience of illness.

(iii) Documentary

Writing about the etymology of "documentary" – it derives from "document" which means "teaching, instruction" – Catherine Belling in her "Reading *The Operation*: Television, Realism and the Possession of Medical Knowledge" argues that the documentary attempts to "teach" its viewer and towards this end, the medium assumes an inequality between the knowledge possessed by its (assumed) lay viewer and the knowledge that it (the documentary) represents (15). The Films Division documentaries under study in this dissertation, thus address a mass audience and attempt to "teach" them about the common threats to their health and the various avenues for treatment that are available to those infected through the advances of modern medicine. The documentary, however, I argue, is also effective on account of its ability to "narrativize" the "event" of illness through elements that are distinctly unscientific in their particularized and subjective rendering. As Michael Renov has argued, non-fiction films may contain numerous fictive elements and thus fictional and non-fictional forms of films are mutually constitutive. These are "moments", Renov argues, "at which a presumably objective representation of the world encounters the necessity of creative intervention" (2). In "teaching" their viewers "objectively" about the many dangers to their normal/healthy bodies and lives, however, these documentaries also have to inevitably "creatively" visualize and narrate for their audiences, what constitutes a "healthy" and consequently "normal" body and what conditions/factors lead to this "healthy" body's failing under siege by illness. I will return to questions of "narrativizing" or "storying" disease/illness subsequently in this section.

The documentary derives its “authority” to teach or instruct, from the popular associations built into the camera’s ability to “record” rather than “interpret” and the non-fiction film’s (as the documentary is sometimes studied) preferred focus or domain being the “real” as opposed to its “fictional” counterpart. As Brian Winston has argued in his “The Documentary Film as Scientific Inscription”, despite filmmakers’ denials of objectivity off-screen or even their assertions to presenting a subjective viewpoint onscreen, their work is both contained and contradicted by science’s powerful cultural contexts (41). Owing to popular belief in the camera’s scientifically precise ability to “record”, the documentary, Winston argues, cannot shake off the “evidential” and the “scientific” because such contexts are already inbuilt “in the cinematographic apparatus” (41). Just as the testimony requires a “response” from the reader/listener and cannot take place in isolation, the documentary too is contingent upon viewers’ “perceptions”. In his *Documentary,* Dave Saunders has argued that what partly makes a film a “documentary”, is the way it is watched by a spectator or viewer. “The way we look at, react to, and anticipate a film”, he argues, “crucially has a bearing on how “real” we perceive it to be” (14). Despite the “authority” invested in the narrators of non-fiction genres like the documentary, *testimonio*, memoir and autobiography, these “narratives” also expressly rely on the “accounts” of others to piece together the origins of their own “self”. A narrative recounting of an experience of illness thus relies on caregiver’s accounts of the period of illness, for “moments” that lie beyond the scope of memory and reconstruction. In addition, these narratives also rely on mainstream ideas about the experience of illness and “resilience” of the selfthat are informed by fictions about disease, state authorized medical discourse and popular media reportage. The next section will thus examine the genre of self-help literature and "relating narratives", to theoretically contextualize patients' and caregivers' accounts of illness.

(iv) Self-Help Literature and "Relating Narratives"

This dissertation studies patient memoirs or patients' accounts of an experience of illness that often take the form of self-help literature. These texts typically offer information and advisory for the reader, about various aspects of the particular illness detailed therein, in addition to "performing" an "improvement" of the ailing self. In her study of self-help literature in "All About Me, I Mean, You: The Trouble With Narrative Authority in Self-Help Literature", Louise Woodstock identifies the elision of the influence of social factors in the narration of an "individual" story of success (325). Authors of self-help books, Woodstock argues, whose narrative authority proceeds from their "articulation of similarity" with the reader, place considerable responsibility and power on the individual, while denying the influence of socially circulating narratives of positive thinking and progress (325).

Lisa Diedrich also suggests in her *Treatments: Language, Politics and the Culture of Illness,* via Barbara Ehrenreich's study of "brightsiding ideology" at work within "mainstream breast-cancer culture", that narrators working within this "mainstream culture", elide the structural and environmental influences on the acquisition of cancer and focus instead on individual responsibility, risk and management through early detection (51). "Brightsiding" involves a relentlessly positive attitude about cancer, where it is seen not as a dreadful disease that needs to be prevented but as an opportunity for creatively transforming the self (51). Treatment, in such narratives, is seen as the source of pain and suffering, rather than the disease itself. Patient-narrators similarly perform a selective process of affiliation, where only some qualities possessed by the narrator’s self are rendered “identifiable”, thereby “learning” to eliminate aspects of the self that do not qualify as worthy of “survival”. As Diedrich and Woodstock have argued, these narratives of “progress” and “improvement” possess an aspirational quality for their readers and as such attempt to “teach” the circumscribing of an experience of illness, through the lens of “progress” and “improvement” with an exclusive reliance on the self.

As argued earlier in this section, in addition to a concretizing of narrators’ “authority”, these non-fictional accounts of illness experience also rely on the accounts of others to recreate their “origins”. Anne Whitehead in her analysis of “care” and “caregiving” relations in “Writing With Care: Kazuo Ishiguro’s *Never Let Me Go*”, defines “relating narratives”, a term that she borrows from Adriana Cavarero, by emphasizing their origin in a desire we all have “to tell others who we are” (68). This “narrative of ourselves” Whitehead argues via Cavarero, is essentially a “relational” one since in order to narrate one’s story from the beginning, one needs to rely on the information others have about our origins or birth (68). Similarly, writing about “relating” acts of representation in his “Metamorphosis: Defending the Human”, Michael Rowe examines his role as caregiver during his son’s struggle with ulcerative colitis (a form of inflammatory bowel disease). Rowe underscores the importance of the caregiver, in representing the “prior” self of the patient transformed by illness. He argues that the “humanity” and “humane” treatment of the patient in the hospital bed, now reduced to someone other than himself on account of illness, is dependent upon the caregiver’s memory and representation of a past/normal/recognizable self of the patient in the space of treatment. Rowe, for instance, recalls how he and his wife individualize the space of the hospital room – they tape the “get well soon” messages that his son received from family members, along with pictures of him from a time prior to his hospitalization next to the medical charts that narrate the progress and state of his illness (276). Personal artefacts (the “get well soon” cards and photographs of a time of “normalcy” and “familiarity”) here serve to close the gap between the patient transformed by illness and the “person” he/she was and still is – linked to a network of family and friends and the world at large. Rowe is here drawing attention to the significance of the caregiver’s memory and the narrativizing of his/her role for the “humanity” and “personhood” of the patient.

The patient-narrator, I argue, empathetically reimagines his/period of dependency and the consequent burden on a caregiver. This empathetic reimagining of the caregiver’s “silent” suffering, is the only access the patient-narrator has to his/her period of transformation – a period of dependency, of feeling not quite like oneself – and thus is essential for his/her own recognizability as a “person”/ “individual”. The patient-narrator becomes recognizable and “familiar” for the reader, like Rowe’s son does at his hospital once his caregivers begin to represent his prior self for the doctors and nurses, through his/her empathetic reconstruction of the time when he/she was cared for, represented, in turn made “familiar” for others. I will now move on to a discussion of the *Bildungsroman* or the coming-of-age novel, of central importance to the texts under study in this dissertation. While the *Bildungsroman* is traditionally a fictional mode, it has a *functional* significance for the narrators studied here, with respect to *enabling* the articulation of an “emerging” self and its progress towards socialization through a condition of illness and/or healing. This next section will detail Franco Moretti’s (1987) examination of the *Bildungsroman* as a novelistic tradition in Europe and Joseph Slaughter’s (1997) reconfiguring of this genre, in terms of “narratability” and “human rights”. The next section will thus contextualize this study of doctor and patient memoirs as illustrations of the “medical *Bildungsroman*”, a cultural, non-fictional instance of the classical, primarily novelistic mode.

(v) The Bildungsroman

Franco Moretti emphasizes the significance of “youth” as a symbol in the *Bildungsroman* in his study of the genre, *The Way of the World: The Bildungsroman in European Culture*. Youth is chosen to represent modernity as its “essence” since modernity “perceives the experience piled up in tradition as a useless dead-weight, and therefore can no longer feel represented by maturity, and still less by old age” (5). Youth in the *Bildungsroman* thus functions as a specific material sign that is characterized by its ability to *accentuate* the instability and dynamism of modernity. However, this novelistic “symbolizing” of youth as similar to modernity in its formlessness, instability and “protean elusiveness”, could potentially destroy youth itself as a “form”. To survive successfully as a form therefore, youth in the *Bildungsroman* has to be endowed with a feature that is opposed to those characterizing modernity – it is thus circumscribed, perceived as having to “end”, as a period that does not last forever. Youth thus allows the establishment of a formal constraint on the depiction of modernity. Modernity is thus “humanized” and integrated into our intellectual and emotional system, rather than being seen as it usually is – a bombarding, hostile force that threatens with an “excess of stimuli”.

The doctor’s status as “professional” is thus “humanised” in the medical *Bildungsroman* and acquires meaning precisely through the circumscribing or elision of the “novice”, “filial” self. The “novice” self of the doctor, during the period of medical education, symbolizes “youth” that must be overcome/circumscribed to allow for the development of the “expert”/ “Professional” self. The doctor/narrator is socialized or integrated into a community, by transcending his/her “passively” acquired inheritance (in terms of knowledge acquired from the medical institution and family) to become a “professional”.As a “professional”, the doctor reflects this emergence, but also alters the scope and degree of transformation and socialization for the doctor protagonist in the *Bildungsroman* in new and unanticipated ways. The patient narrating an experience of illness similarly elides or circumscribes a self “prior” to the onset of illness, to construct a “stoic” resilient self who was always already *capable* of survival. The patient is socialized in the medical *Bildungsroman* through the performance of “ethical expertise”, where he/she is embedded in a social network of disease literacy and “learns” a new skill and temperament occasioned by illness. “Stoicism” and the “capacity” to survive mark the patient’s “growth” from the period of illness, seen as the “youthful” or passive state where the patient’s identity is equated with illness alone. As “ethical expert”, the patient is able to insinuate himself/herself into a community for whom he/she “speaks” and with whom he/she *shares* the experience and knowledge gained during illness. Joseph Slaughter suggests via Adenos Addis in his “A Question of Narration: The Voice in International Human Rights Law”that human rights can be productively reconceived in terms of narratability (412). He argues that in the modern *Bildungsroman*, any restriction to “liberty, property, security and resistance to oppression” tend to limit the individual’s ability to attain fixity for his/her “self”. This fixity of the modern hero in the *Bildungsroman* is dependent upon his/her ability to narrate his/her story (412). Through the articulation of a particular kind of voice that emphasizes the social and draws upon the textual and cultural authority of the author, doctors and patients in the medical *Bildungsroman*are able to narrate their “story” of heroic self-discovery to attain fixity for the “self” thus created. The *Bildungsroman* thus gives rise to questions of voice, narration and agency. The following section will examine the “narrativizing” or “storying” of illness experience and disease and I will return subsequently to questions of voice and agency.

(b) Narrating/ “Storying” Illness/Disease

This section will examine the theoretical frameworks that enable us to examine the “narration” or “plotting” of a “story” of experiencing/healing illness and disease.

In her *Narratology: An Introduction,* Susan Onega viaMieke Bal, identifies a “story” as that level of a narrative which functions as the “signified” of a narrative text. In its turn, Bal argues, a story signifies a fabula (6). Building on Bal’s formulation, Susan Onega argues that the “story” is thus a linguistic construct, a cognitive scheme of events that could, in turn, give rise to a number of texts (8). The “stories” negotiated by the narrators of patient and doctor memoirs, are crucial to the construction of their “social self”. Moreover, these narrators articulate their story in what can be seen as a “narrative society”. Building on Hayden White’s formulation of histories, events and lives being made to conform to story “types”, James Dawes in “Narrating Disease: AIDS, Consent, and the Ethics of Representation”, argues that the presentation of disease as a “story” similarly exploits linear narration and causality as a means of “restoring understanding and thereby alleviating the damage of confusion” (39). Disease as a story and therefore as a finished and complete event, serves the purpose of an apparently “unified” self that doctor-narrators construct in what Dawes terms a “narrative society” (38). The narrative society, for Dawes, conceptualizes itself and people as “stories” and as “narrative”, rather than through narrative. The doctor-narrator in the medical *Bildungsroman* emphasizes the importance of “story” with references to the therapeutic power of narrating and integrates several “stories”, most importantly those of patients, to present a unified, social “self” that is attentive to the ethical dimensions of the medical narrative. “Narrative” can thus be a productive means of conceptualizing individual and collective identities.

In a different context, writing about the ways in which members/participants in the online project Wikipedia construct and understand themselves as a “community”, Christian Penzold emphasizes the significance of studying the “symbolic”, rather than the “structural” constitution of communities (705). The doctor-narrator frames in his memoir, an *ethos community*, whose membership is governed by this narrator’s self-understanding and self-description. Pentzold has identified the ethos community as an instance of community formation through a shared negotiation of the “meaning” or “understanding” of community. In such a community, “communication” is of primary importance and actors/members of the group are themselves responsible for the production and sustenance of a commonality of structure, meaning and culture. The ethos community for Pentzold is defined as an “open body” which does not have any clearly demarcated boundaries and is a “group of concepts” linked around the understanding of the term “community”. The members of this community, Pentzold argues, are governed by a voluntary interest in participation but also the commitment to “a set of norms, behavioural standards and attitudes – by sharing its ethos” (712). The doctor-narrator’s ethos community is thus formed in his/her articulation of a particular set of norms and his/her designation of “productive” and “activist” patient stories as “ideal” responses to illness. I will return to issues of “normative”, “vulnerable” and “pathologized” identities constructed by disease/illness narratives in a subsequent section on social identity. For now, we can move on to questions about the centrality of narrating an experience of illness/healing and its link to the “difficulty” or “impossibility” of visualizing disease and bodily interiors.

The centrality of “narrating” or “storying” an experience of illness is related to its ability to “unify” the narrating subject’s “self”, seen to be threatened/disrupted by the onset of illness. Michael Bury in his “Chronic illness as biographical disruption” has made a case for illness constituting “biographical disruption”. In my study of the medical *Bildungsroman* however, I am interested in how patients construct a “social” identity that is not defined by illness alone. The “disruption” brought on by illness is seen not as a “break” or “rupture” in the individual’s biography, but as an occasion for the articulation of a “new” identity. This “new” identity in the patient memoir is seen to have origins in the person’s “self” prior to the onset of illness. “Interruption” by illness is thereby elided and the ill-self is refigured as being always already characterized by strength and resilience, typified by the “new” identity articulated in the patient memoir. “Narrating” an experience of illness also assumes centrality on account of the difficulty inherent in representing/remembering the body at a moment of extreme suffering. As Arthur Frank has noted in his “The Rhetoric of Self-Change: Illness Experience as Narrative Author”, the authority and appeal of the illness narrative lies in the belief that “truth” is what is produced when a body is at the extremes of suffering (48). Illness narratives, argues Frank, are an important means of studying how illness is socially constructed as a rhetorically bounded and discursively formulated phenomenon (“The Rhetoric of Self-Change” 41). “Narrating” or “storying” an experience of illness is however also significant, on account of the difficulty or impossibility inherent in directly apprehending bodily interiors and accurately “visualizing” disease and its onset.

Not only do illness narratives present an "extreme test case", in the words of Rimmon-Kenan, because of "the embodied nature of both continuity and disruption in them" ("What Can Narrative Theory Learn from Illness Narratives?" 244), but they also seek to articulate and interpret the visceral body. The visceral body is only known to the patient-narrator via biomedical tools of visualization, argues Belling in her "Narrating Oncogenesis: The Problem of Telling When Cancer Begins", a study of the "difficulty" in ascertaining the precise "onset" of cancer. The visceral body, Belling states, is not "human". In order to narrate this visceral body, she argues, "we must first imagine and humanize them, constructing the subjective habitation that marks the material of the body as place" (233).Examining scientific narratives about the origin of cancer, Belling argues that such narratives rely on "the complete effacement of the human and the partial anthropomorphosis of the renegade cell" (237). Patients thus creatively reimagine their bodily interiors and the progress of illness/treatment in their memoirs. In his study of the "culture of dissection" in the Early-Modern period, *The Body Emblazoned,* Jonathan Sawday illustrates this "individuality" or the "subjectivity" of bodily interiors, through a detailing of "the experience of the body" historically. He argues that although the interior of the body may carry signs of its "individuality" these "interior" signs cannot be observed in ourselves and can only rarely be discerned in others' bodies. It is this impossibility of observing our "unique" bodily interiors, Sawday argues, that makes the "exploring" of other bodies so captivating. We explore and journey through other bodies in the hope/fear that these "others" will be like "us" (7-8). Despite the impossibility of "knowing" our bodily interior and directly experiencing it, this interior is nonetheless relentlessly interpreted via various means of representation – from the early anatomists' "maps" of the body and the creative engagement with bodily interiority in literary texts in the seventeenth century to modern day imaging technologies like the X-ray and the MRI. This relentless interpretation or “deducing” of the interior of the body, Sawday argues, is what gives rise to the drive to understand the body through “representation” (7). The “body” is thus simultaneously represented in a subjective rendering of an experience of illness/healing.

The body, as Rita Charon argues in her *Narrative Medicine: Honoring the Stories of Illness*, co-authors the story of the life that is being lived in it. The telling of a story of illness, Charon argues, is the telling of two tales simultaneously – the story of the “person” of the self and the story of the “body” of the self. The body, however, despite its materiality, communicates only through representation, which is in turn mediated by sensations and meanings that are ascribed to these sensations (87). While the body can only be “articulated” and “reimagined” via representation, illness/disease is also difficult to apprehend directly except through specific “tools” or “modes” of visualization. Kirsten Ostherr in her *Cinematic Prophylaxis*: *Globalization and Contagion in the Discourse of World Health*”,foregrounds the crisis and anxiety about “visibility” that affects public health discourse, on account of the difficulty in the cinematic medium in “visualizing” for audiences, predominantly “invisible” pathogens (180). This struggle to visualize “invisible” pathogens, Ostherr argues, is responsible for public health cinema’s reliance on indexical and artificial modes of representation. To dispel the fear of bodily and national invasion by invisible contagions, this threat is visualized as a racially and sexually marked body with temporally and spatially distant origins. Films Division documentaries often rely on indexical modes of representation like maps that mark areas of increasing and reduced “risk” of contagion/infection, in addition to artificial modes like an animated anatomically “correct” body on which the “deviance” or “corruption” induced by disease can be “marked” for the viewer. However, this “visualizing” or “representing” of disease in the medical documentary also gives rise to questions about the “marking” of threat on “deviant” or “pathologized” bodies, a subject I will return to in the section on social identity.

Finally, narrating a “story” of illness or healing also gives rise to questions of “agency” and “voice”. Patients and doctors writing about an experience of illness and its treatment, often articulate a critique of medical practice and exercise choice with regard to the nature of “constituting” a story of the self. As Michael Bury argues in his “Illness narratives: fact or fiction?”, illness narratives find a new voice in the face of rising scepticism against medical practices and the growing impact of degenerative and chronic illnesses (267). The “grand narrative” of biomedicine has thus given way to the patient’s right to speak, about his/her subjective experience of the “heterogeneous” character of chronic illness and its everyday management. In other words, grand narratives of biomedicine are increasingly countered, supported or even subverted by *petitehistoires*, or the personal stories, of the ill. As Arthur Frank has noted in his “Five Dramas of Illness”, the “drama” of a story is not only present in this story as a conflict of forces but is also enacted in the process of arriving at a story. This process includes “resisting or provisionally accepting and then rejecting other stories” (384). The medical *Bildungsroman* thus enacts a process of arriving at a “subjective” “story” of an experience of illness or healing. This “process” involves the exercise of agency in the “provisional acceptance” or “editorial selection” of aspects of illness and healing, to articulate a particular, “subjective” “voice” for the doctor or patient narrator. The medical *Bildungsroman* is thus characterized by a subjective rendering of personal stories that are made to *fit*, through the exercise of agency, already existing frames or models of narration.The next section will survey the theoretical frames underpinning the examination of voice and agency in doctor and patient memoirs.

(c) Voice and Agency

An agent, as Anthony Giddens has argued, can elaborate discursively on the reasons for his/her actions. "Mastery of "I", "me", "you" relations, as applied reflexively in discourse", Giddens argues, "is of key importance to the emerging competence of agents learning language" (*The Giddens Reader*, 94). In her *Narrative Fiction: Contemporary Poetics*, Rimmon-Kenon identifies a narrator, at a very minimal level, as the "agent which at the very least narrates or engages in some activity serving the needs of narration" (90). Narrators of doctor and patient memoirs are thus invested with a degree of agency in elaborating discursively about a subjective experience of illness/healing. These narrators also "creatively" transform the "self", through a reimagining of experiences of others, the inner recesses of the body and through a visualizing of their "potential" to change. Lois McNay, in her *Gender and Agency*, attempts a reconfiguring of agency in terms of creativity of action. She uncovers this "creative or imaginative substrate to action", to illuminate how action transcends its social, economic, cultural, corporeal and material context. "A creative dimension to action," McNay argues, "is the condition of possibility of certain types of autonomous agency understood as the ability to act in an unexpected fashion or to institute new and unanticipated modes of behavior" (22). Thus the patient, rather than revert to his/her "identity" prior to disruption by illness, articulates a "new" identity about a self that has been "transformed" by illness. Physician-narrators in the medical *Bildungsroman* are invested with the ability to "transform" or "change" over the course of the narrative, thereby transcending their cultural, corporeal and material contexts. The narrators of these texts are also engaged in carving out a space to "voice" a particular "story" of/response to illness and its treatment that draws upon and contributes to a certain "textual" and "cultural" authority. I return here to questions of "voice" and its engagement with/contribution to a particular textual and cultural/professional "authority" for the author/narrator.

Ananda Mitra in his "Voices of the Marginalized on the Internet: Examples from a Website for Women of South Asia", conceptualizes voice as the acquiring of agency through which a speaker can assume the position of the "speaking agent", in order to "produce a specific kind of voice for himself/herself" (493). In recounting their experiences of medical education (as novice practitioners of medicine during internship and residency) and subsequent, often imminent, transformation into "experts" (whose "education" now accrues independently, through "real-life" forays into treating illness and healing patients that often takes them outside their immediate "role" within the institution), the doctor-narrator in the medical *Bildungsroman* is able to carve out a space from which a story of heroic emergence, or a narrative account of the construction of a "social" self can be articulated. Mitra and Eric Watts suggest in their "Theorizing Cyberspace: The Idea of Voice Applied to the Internet Discourse", that rather than conceiving of voice as an "effect of the text" or as "the property of the autonomous subject", it can instead be viewed as a "dialogic event", seeing it as a "phenomenon constitutive of ethical and emotional dimensions" (483). Voice is thus "public", in that it always presumes an addressee/reader/listener and examining voice necessitates a consideration, of how rhetoric and specific acts of "public discourse" comprise the means through which a community reinvents and sustains itself (484). The doctor-narrator's agency in the medical *Bildungsroman,* I argue, is concretized in the voicing of *particular* narratives of patients. In their "Development of the Physician's Narrative Voice in the Medical Case History", David H. Flood and Rhonda L. Soricelli identify the importance of finding an "appropriate narrative voice" for the case history. The case history has been criticized by Suzanne Poirier in her "Voice in the Medical Narrative" for being ethically limited in its condensed form (52). Flood and Soricelli argue for the importance of a narrative voice for the physician in the case history that can fulfil the humanistic and technological demands placed on this particular document that possesses many characteristics of a narrative (67). The doctor-narrator in the medical *Bildungsroman*, I argue, through narrating his/her "story", attempts to find a narrative voice that unifies an otherwise fragmented experience of treating and rehabilitating illness and provides the ethical dimension otherwise missing from the medical case history. Moreover, the acquiring of agency through the articulation of a particular "voice" is also linked to questions of "authority".

Wayne Booth argues in *The Rhetoric of Fiction* that the author exercises effective control by making clear to the reader, the "nature of the dramatic object" (200). In the case of the medical *Bildungsroman,* the doctor-narrator, through various means, makes clear to the reader how his/her experience deviates from the ordinary. As Booth argues, the author, like the doctor-narrator, makes clear the dramatic object's nature, by giving the reader the "hard facts" and "by establishing a world of norms by relating particulars to these norms or by relating the story to general truths" (200). With respect to the realist medical narrative, Jan Marta has argued in his "Postmodernizing the Literature-and-Medicine Canon: Self-Conscious Narration, Unruly Texts, and the Viae Ruptae of Narrative Medicine", that the particular significance of the physician-author's narrative authority is to establish his/her authority over the "written medical truth". To this end, the narrative function of the patient-character is curtailed, to enforce the physician-narrator's authority over both the primary narrative as well as the "written medical truth". The doctor here voices in a heteroglossia and seeks to include the voices of patients as well. Heteroglossia, as Bakhtin has argued, "is another's speech in another's language, serving to express authorial intentions but in a refracted way. Such speech constitutes a special type of double-voiced discourse. It serves two speakers at the same time and expresses simultaneously two different intentions" (324). The doctor-narrator seeks to particularize and voice the patient's narrative, itself already entangled in "someone else's discourse about it" (Bakhtin 330), and renders in his own language, an individualized utterance of a patient's story.

The doctor-narrator here seeks to overcome, in his/her voicing of the patient's narrative, the inherent "otherness" of this narrative, to make it his own. The doctor-narrator in the medical *Bildungsroman* also seeks to ensure the viability of his/her role for the community/society, in articulating the story of a "growing" or "emerging" expertise. The "diagnostic agency" of the doctor-as-expert is seen to be declining and the doctor narrating a subjective experience of "learning" to practice medicine ethically and transcending his/her immediate professional/cultural role, seeks to restore this declining agency. Tom Rice has argued in his study of the politics of stethoscope ownership and display, "'The Hallmark of a Doctor': The Stethoscope and the Making of Medical Identity", that there exists a discourse surrounding what he identifies as "the death of the stethoscope". The stethoscope, Rice argues, iconic of the "ideal" doctor, who possesses a good "bedside manner", with humanistic qualities of concern and empathy and can make an effective diagnosis relying on listening skills and similar "perceptual sensitivities", is seen to be jeopardized by an increasing encroachment by modern technologies. The stethoscope, Rice suggests via Alfred Gell, is “seen to hold ‘agency’ in the various ways in which it enables doctors and medical students to project and perform their respective skills, experience and competence” (288). The real threat posed by the “death of the stethoscope” thus, is to the doctor’s diagnostic agency, since this becomes widely dispersed with the introduction of technologies like echocardiography, which rely on a wider network of technicians and machines rather than on a specialized auditory skill learned and practised by the doctor. “Where the doctor becomes simply a point for the collation of test results”, Rice argues, “the value of his or her role and that of the entire profession will fall” (300).

In a different context, writing about the differences between Latin American writer Alejo Carpentier’s travel account, “On the American marvelous real” and its other metropolitan, European counterparts, ML Pratt argues in her *Imperial Eyes: Travel Writing and Transculturation* that the “neocolonial difference” is primarily articulated as a difference of authority, “a difference in what one is entitled to claim to know about others” (227). For the traveller from the neocolony, she argues, without book knowledge he/she is not entitled to write. European travelogue conventions generally do not require claims of unease about a lack of book knowledge about a particular destination. Travellers from the neocolony, however, commonly express uneasiness about lacking book knowledge about the place travelled to and are at ease when they recognize, from novels, for instance, names of places they are seeing. Carpentier, Pratt describes, even when surrounded by a place familiar to him from novels, still deviates from the conventions of other metropolitan travellers. He records what he is seeing, that is the “known world of Western Europe”, in “experiences of recognition” rather than in “acts of representation" (228). Carpentier is not concerned with recreating what he saw in the mind of the reader. Rather, he records what he recognizes from sights already identified in earlier travels or from the "*antecendentes literarios*". Therefore, rather than claim the European cultural authority to depict, represent or recreate what he sees, Carpentier only claims authority to "express recognition of what he has learned or been taught to know is there" (228). The doctor-narrator similarly utilizes as raw material for his narrative, what is learned during formal education and what he/she recognizes as the narrativizable particulars of individual patient narratives. The literary antecedents for the doctor-narrator comprise what he/she learns of the progress of disease in the body, but also what he/she learns from the patients' individual, particular presentations of accounts of illness experience. Carpentier's traveler, Pratt argues, exhibits an "uneasy insistence" on book knowledge, because of the "cultural predicament" he faces as a "peripheral intellectual". For him, "'real' reality and 'real' history have been lived as somewhere else" and he is "a portrait of the neocolonial autodidact whose personal library is the basis for his claim to belonging in modernity" (228). The doctor-narrator, like Carpentier's traveler, enters the narrative of the patient's history of illness, after it has already traversed half or sometimes more of its course outside the narrative purview of the doctor-narrator. The "real" reality of the disease and its "real" history, are only accessible to the doctor-narrator in a general context, partly through his own personal library of universalized, general knowledge about the disease and in the case of the individual, particular patient, almost entirely through the patient's own retelling to the doctor of the "story" of the onset of illness in his/her particular case. The "real" reality and the "real" history of the disease, for a time, before the patient's entry into the hospital, have been lived somewhere else. The doctor-narrator's agency is concretized in voicing particular narratives of patients, in recording his “recognition” of particulars from literary “antecedents”that comprise patients’ own narratives of illness experience.

The particulars of patients’ “stories” in the medical *Bildungsroman* are rendered by the physician-narrator as “immutable” or “combinable” mobiles. The new doctor-body presented in the medical *Bildungsroman,* is interested in bringing to the centre of medical knowledge, those aspects of disease and ailing individuals that are not yet familiar, that are yet to be integrated into the corpus of information that constitutes the doctor-as-expert. The corpus of information collected through the network created by the new doctor-body generates what Bruno Latour defines as immutable and combinable mobiles. In his *Science in Action,* Latour defines knowledge not in opposition to “ignorance” or “belief” or even by describing the thing itself, but by regarding what he calls a whole “cycle of accumulation”. This “cycle of accumulation” for Latour, is a way of being “familiar” with “things, people and events, which are distant” (220). Once these “unfamiliar” elements that exist on the peripheries of medical knowledge are transformed in the doctor-narrator’s informational narrative, into mobile and combinable elements, they can be brought back to the centre of medical knowledge. From this centre, these peripheries, these elements that were anomalous-before-but-recognizable-now, can be dominated from afar. Latour identifies a paradox at the heart of the construction of centres – they require elements that have to be brought from far away, without bringing them in for good. This paradox is resolved, he argues, “by devising inscriptions that retain simultaneously as little and as much as possible by increasing either their mobility, stability or combinability. This paradox between presence and absence is often called information” (243). In narrativizing/bearing witness to a patient’s story of illness, the doctor-narrator engenders a cycle of accumulation that renders these “stories” stable, mobile and combinable, so they can be brought “home” to the centre (the medical institution).In this process (technologies of representation employed by the doctor-body’s informational labour like the case history, medical “reports”),the doctor’s “story” retains not the patients’ themselves, but as much informational representation as is required to make “familiar” the pathological/abnormal unfamiliarity of their bodies and to diminish the distance between them and the “expertise” accumulated via the doctor-body at the centre.

The doctor-narrator’s “authority” over rendering patients’ stories, is also validated via the “trappings” of medical education or the “body work” performed by this narrator. The “trappings” of medical knowledge include the as-yet-unintegrated information, practice and experience required for the “novice” doctor to attain “expertise”. These “trappings”, symbolized by the “intern’s coat” and various diagnostic tools that over time become “transferrable” to the doctor-as-expert, function as “boundary objects”. This “boundary object” validates “work” and “expertise” in social worlds outside the doctor-narrator’s immediate corporeal and material contexts and allows him/her to exercise agency in these contexts/worlds. “Boundary Objects”, as defined by Susan Leigh Star and James Greisemer in their “Institutional Ecology, “Translations” and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39”,are “objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites” (393). Star and Greisemer draw attention to the importance of “boundary objects” in maintaining and developing coherence across intersecting social worlds. Though these “boundary objects” may have different meanings in different social worlds, they nevertheless retain a structure that is common and recognizable enough in more than one of these social worlds, so as to render them easily *translatable*.

The creation and management of these "boundary objects" is informed by the "frames of interpretation" provided by medical discourse. The incorporation and circulation of these "boundary objects" in the doctor memoir is of crucial significance, since patients' "narratives" of disease/illness emerge as they do, across diverse social groups of actors. "Boundary objects" are crucial in the establishment of a "mutual modus operandi" between actors from different social worlds. More significantly, "boundary objects" enable the creation of "scientific authority" that is invested in the hands of "entrepreneurs" who enlist "participants" or "allies" from a range of locations and "re-interpret" their interests. In this manner, the concerns/interests of the non-scientist are translated into those of the scientist, who subsequently establishes himself/herself as the gatekeeper of the mode of articulating these interests. Chapter two of this dissertation on the doctor memoir will examine how the "trappings" of medical education are governed by the doctor-narrator's frames of interpretation as a "boundary object", in his/her subjective detailing of the process of transformation effected from "novice" to "expert". This chapter will examine the doctor's insinuating of an "editorial self" and his/her exercise of agency, in re-interpreting patients' "stories" of illness, originally "presented" by the patient in his/her own words.

Narrators of doctor and patient memoirs, as argued in the section on "Relating Narratives", routinely incorporate the stories of "others" in rendering their own subjective "story" of their origins. Like the doctor's incorporation of "stories" of patients and his/her exercise of agency in "re-interpreting" these "stories", patients also routinely incorporate stories of their "carers". Patients reconstruct caregivers' labours, performed during the course of illness and testify to their reorganization of the hospital space. They reconstruct carers' efforts in making the illness-transformed narrator more "recognizable" and "familiar", in an act of "parasitic" agency. Caregiving labour performed for an ailing other, is spatio-temporally linked to the time and space illness and thus gives rise to what I argue, is a "parasitic" mutuality of transformation. In a different context, arguing for the "global" space inhabited by the postcolonial novel, in his "The Transnational Indian Novel in English: Cultural Parasites and Postcolonial Praxis", Pramod K. Nayar likens the relationships, exchanges and intersections between the First and the Third World represented by the postcolonial writer, to an instance of the "parasite". Nayar suggests, via Michel Serres, that the figure of the parasite, rather than being "another" or different, in fact "plays at being the same" (forthcoming). The host, in this case, finds itself mimicking the parasite, just as the parasite in its turn changes in order to be accommodated by the host. The patient in his/her memoir instantiates a caregiver *Bildungsroman*, which is contingent upon the performance of a particular set of emotional attributes. This caregiver *Bildungsroman* is also dependent upon the acceptance of a "role" that requires a spatio-temporal inextricability with the patient-narrator's illness. The patient-narrator's transformations – the medical regimen, the transformation of the home and the everyday, managing the symptoms of illness – are also the caregiver's own. The parasite here plays at "being the same", altering itself along with the host to produce and bring to prominence only one story – that of the host. The patient-narrator in turn circumscribes the caregiver's labour, performed in "silence", the representation of which stands in for his/her period of transformation and dependency and renders it "familiar". The host here changes itself to accommodate the parasite, made paradoxically more "recognisable" with its presence. However, Nayar also signals to another crucial aspect of the parasite – that of agency and change. The parasite, Nayar argues, initiates change through the assertion of agency, consciously or unconsciously interrupting and reordering information (forthcoming). I argue that the caregiver's "presence" in the hospital and his/her representation of the patient-narrator's individual circumstances, filial and personal networks and multiple affiliations, aside from his/her illness-induced identity, is an act of parasitic agency. Through the reconstruction of the caregiver's ability to negotiate the space of the hospital, by carving out an individualized inhabiting of this space that is not limited to illness and its treatment alone, the patient-narrator testifies to the initiation of change through the exercise of agency.

The above sections have examined the modes in which a "story" of the ailing/healing "self" is articulated in the medical *Bildungsroman*, thereby concretizing a particular, subjective "voice" and "agency" for its narrator. Narratives accounts of illness/disease and healing, however, are also responsible for constituting particular "social" identities for their narrators, constructed in opposition to "other" pathologized or "deviant" identities. The next section will examine the centrality of the "body" and "materiality" in the formation of social identity, via theories that underpin "embodied" social identities, the various "roles" performed in the enactment of social identity and the significance of "work" and "labour" in the medical *Bildungsroman*.

(d) Social Identity

(i) Embodied Identities: Chris Shilling,in his *Body and Social Theory*, has theorized the individual's self-identity in the late modern age as an "embodied biography" (4). Bodies, Shilling posits, are seen as unfinished, in the process of becoming, as a project that is worked on by the individual as a part of his/her self-identity. The body is an unfinished

social and biological phenomenon and is “transformed” as a result of its entry into society. This is of particular significance to a patient “narrating” his/her experience of illness, since the moment of illness is also a moment of change or transformation in the person’s embodied biography. The physician and the patient’s body in the medical *Bildungsroman* are *performed*, as argued earlier, via various modes of representation. Patients creatively imagine their bodily interiors, while physicians apprehend the bodies of others through various scientific (medical imaging technologies) and non-scientific (narrativizing the particulars of patients’ stories) means of representation, as seen in the previous section. These “acts” of performing or representing the body, however,are significant in the formation of a social identity. As Suzanne Poirier has argued in her “Medical Education and the Embodied Physician”, the physician’s body and those of the patients he/she treats, is central to the work of medicine and thus, in the “preparation” of physicians, the role of the body is heightened in positioning oneself in the world (525). The physician’s “growth” into an “expert” and the circumscribing of his/her “filial” or “novice” self, is marked through a performance of “preparation”. This “preparation” is performed partly via the “trappings” of medical education as “boundary objects”, as discussed in the section on Voice and Agency. However, doctor-narrators also testify to the difficulty of *translating* medical knowledge, being an important aspect of the “preparation” to become an “expert”. Universalized medical knowledge, viewed as being gained passively by the “novice” self, needs to be applied to idiosyncratic, individual contexts during the *practice* of medicine, in order to attain “expertise”.

The physician-narrator embodies this inherent “tension” of medical practice, by “marking” the process of growth from the filial novice/trainee to the expert/professional as dramatized encounters between the physician’s body and the patient, the pathogen and the institution. Jonathan Sawday in his *The Body Emblazoned*, signals to the trope of "heroism" implicit in the "mapping" of the body by Early-Modern anatomists like Vesalius and his followers, who were guided at the time by the belief that the human body was a miniaturized imitation of the larger cosmos. The body during this period is understood as an unexplored territory, an as yet undiscovered country that demanded from the anatomist-explorer, the same "heroic" skills demonstrated by real-life voyagers to various parts of the terrestrial globe at the time. The "triumphant" discoveries made by the explorers, cartographers, navigators and early colonialists thus become equated with the physician/anatomist's "new" map of the body, giving rise to the "new figure" of the "scientist as heroic voyager and intrepid discoverer" (24). Like the anatomists who "come of age" during the seventeenth century, with a "new" map of the body and a "new" grammar of understanding its inner recesses, the doctor-narrator in the medical *Bildungsroman* is embodied through his/her reiteration of an individualized process of learning and practicing medicine during varying levels/stages of expertise. The doctor-narrator constructs a "heroic" identity, through a performing of his individualized process of "learning" and by "marking" or "embodying" this process as "expert". Anne Balsamo for instance, in her "Forms of Technological Embodiment: Reading the Body in Contemporary Culture", defines the body as a historical, cultural and social production, where production signifies both product and process. In addition to being the material embodiment of racial, ethnic and gender identities, as a product, the body is also a "staged performance of personal identity, of beauty, of health. As a process it is a way of knowing and marking the world, as well as a way of knowing and marking a self" (Balsamo 217). The doctor-narrator in the medical *Bildungsroman* is "marked", as a "product" that is the effect of a particularized learning process. However, as discussed in the earlier section on the *Bildungsroman*, to emerge as “expert”, the doctor-narrator has to perform an overcoming or circumscribing of the “filial” or “novice” self. The period of medical education functions as a period of “passivity” and is seen as lacking “agency”, in addition to being characterized by the difficulty of *translating* universal knowledge to fit particular contexts. The doctor-narrator thus performs, I argue, a kind of “cosmopolitanism”, through which he transcends the “filial” or the “novice” self to become an “expert” who can engage local and global contexts simultaneously. We can move on now to a discussion of cosmopolitanism in the medical *Bildungsroman.*

Tobias Boes has argued in his “Apprenticeship of the novel: The *Bildungsroman* and the Invention of History, ca. 1770–1820”, that the *Bildungsroman*’s process of translating historical time into a narratable and concrete pace, always contains a culturally specific component (278). I argue that the protagonist of the medical *Bildungsroman*, translates historical time via a territorialized vernacular cosmopolitanism, to circumscribe and transcend the “filial”. A cosmopolitan world view, Emily Johansen argues in her “Imagining the Global and the Rural: Rural Cosmopolitanism in Sharon Butala’s *The Garden of Eden* and Amitav Ghosh’s *The Hungry Tide*”, develops from the actual engagement with cultures and people that are different from us, rather than just an exposure to them. As Johansen defines it, “people who exhibit cosmopolitan world views see themselves as having ethical and moral responsibilities to the world and a specific local place—or even places” (3). She emphasizes the ethical and political dimensions of this definition as being characteristic of the “postcolonial-inflected vernacular cosmopolitanism” (3). Moreover, a cosmopolitan sensibility is constantly in “a state of becoming rather than being” (3). The “professional” doctor engages the global (the challenges and changing contours of medical science) and the local (the everyday practice of medicine on individual bodies that exist at multiple cultural locations).The doctor's intimate engagement with disease prevention and cure in plural and globalized cultural contexts, sets his "professional" self apart from the filial. The filial, understood as the doctor/narrator's "passive" state of "being", must attain narrative closure in the medical *Bildungsroman*, to allow for the representation of the "professional" cosmopolitan "state of becoming". Like a person's "embodied" life biography, the doctor's "cosmopolitan" state is constantly "worked" on and is in a state of "becoming". The narrators of the medical *Bildungsroman*, in the case of doctors and patients, thus constantly *perform* for the reader, the "work" or "labour" inherent in the processes of "knowing" and "marking" a self. This is cultural "work" or work that is not only performed in a professional capacity. The "formation" of the self in the medical *Bildungsroman* is thus not only determined by professional "work", like the classical novelistic variant where, as Moretti has illustrated, "formation-socialization" takes place outside the "world of work" (*The Way of the World* 25). The next section will examine the theoretical contexts surrounding this "cultural work" performed by the narrators of the medical *Bildungsroman*.

(ii) Work, Technology and Social "Roles": Chris Shilling in *The Body in Culture, Technology and Society*, defines "body work" as those set of unofficial tasks performed by an individual to maintain the viability of his/her embodied self within the waged labour environment (73). Work is the primary marker of identity in the medical *Bildungsroman*, where youth (experiences narrated from the medical residency) is circumscribed by the physical rigor of professional "work", presented in the narrative as the labouring, cosmopolitan body that the physician/narrator strives to fashion. The physician's individual, cosmopolitan labouring body is often set apart from others' in the

narrative, to promote a greater degree of identification for the professionally "marked" body. Chris Shilling defines "cultural body work", as those forms of presentation developed by a group that allow individual members to recognize "safe" and "familiar" others or "strangers" who pose a threat to their existence and lifestyle (*The Body in Culture*77). As Shilling has argued, the body often functions as a location for communal norms and this helps determine how an individual intervenes in his/her environment (*The Body in Culture*76). The physician's labouring cosmopolitan self is embodied in its interactions with other bodies that are similarly marked. Work, as Shilling argues, is in the process of becoming a "project" – something that is "to be pieced together in increasingly contingent and creative ways" (*The Body in Culture*85).The doctor-body presented in the medical *Bildungsroman*, also seeks to reinstate the status and relevance of "expertise" that the novice journeys towards, threatened as it is, by the pace of technological advancement and the ineffectuality of current medical practice against disease and illness. As argued in the previous section, the doctor-narrator performs "informational" labour through the incorporation of "immutable" or "combinable" mobiles in the form of particular narratives of patients. Also, as demonstrated earlier, this is significant in the doctor-narrator's acquiring of "diagnostic agency", seen to be in a state of decline in the face of technological diagnostic procedures that are wielded by a diverse and diffuse group of actors.

Technology is thus recruited by the doctor-narrator into a social role – it is made into a prosthesis for the doctor-body, who integrates stories about/of his/her patients with institutional records to improvise a new role. As Shilling has argued, a "prosthetic identity" does not refer to *any* mechanistic device that supplements the body, but has historically denoted artificial body parts that possess a *restorative* function (*The Body in*

*Culture*175). A prosthetic device or prosthetic technologies thus, *restore* rather than extend a person's capacities. The doctor-body in the medical *Bildungsroman*, restores the viability of the doctor's role by eliding the technological (the institutional apparatuses that made compiling information possible) and offers in its place, an "expert" doctor-body as the point at which the institutional and social contexts of the individual come to bear on the diagnosis of illness.

Writing about the transcendence of bodily boundaries sought by humans through technological mediation, Shilling argues that these boundaries are neither arbitrary nor limitless. Instead, he suggests, "there tends to be a certain homology between people's existing bodily capacities and projects, and the types of physical development planned and achieved by humans" (*The Body in Culture*177). Shilling suggests that technology cannot be viewed as being imposed upon a body externally, without any regard for the "realities" of that bodily being. Instead, technology must be viewed as being "integrally related to people's plans, purposes and capacities. The body in short, remains an important source of technological development" (*The Body in Culture*177). Like the doctor-narrator's "social role", achieved through the addition of an "ethical" aspect to the patient's narrative case history as seen earlier and through the deployment of technology in a socially viable manner, the patient or the ailing body is also seen to aspire to a particular "role". These "roles" are significant for the "socializing" of identities constructed by narrators in the medical *Bildungsroman*.

Writing about the practice of "caring" for or "cultivating" the self in Greek culture in his *The Care of the Self*, Michel Foucault emphasizes the increased correlation of this tradition with medical practice and thought (54). This correlation drew from the belief at the time that afflictions of the body could have an impact on the soul and similarly, a lack of attention to the “bad habits” of the soul could result in physical misery. Foucault notes the increasing medical coloration of the practice of “improving” or cultivating the soul that the Greeks sought in Philosophy, where even the Philosophers’ School espoused the interconnectedness of education and caring for oneself (55). The patient memoir is an instantiation of such an interconnected education – where caring for the self, also entails *learning* or *educating* oneself about aspects of or “roles” required to be assumed by the patient’s ill-self. Foucault emphasizes in his examination of evolution of the practices of caring for the self, the recognition of dependency and needing assistance. He stresses therefore the importance of recognizing the self as “one who suffers from certain ills and who needs to have them treated, either by oneself or someone who has the necessary competence”, rather than simply constructing an image of one who is imperfect and ignorant and therefore requires improvement, correction and training (57). Self-knowledge, or recognizing the need for assistance (medical and filial), is thus of paramount importance in the practice of caring for or cultivating the self.

The performance of illness in the patient memoir is also about laying claim to the socially sanctioned “role” of being ill. Talcott Parsons in *The Social System* identifies illness as being one of the sanctioned or “conditionally” legitimized modes of “deviance” in a society. The sick individual’s claim to be cared for is made subject to the admission by this individual, that “it would be a good thing to get well as expeditiously as possible” (291). It is “institutionally” mandated that a person who is sick seek treatment from a trained medical professional and be discharged from the duties of his daily life (depending upon the severity and length of his illness), only on the condition that he/she will take on the “sick role”. The implication within the sanction for such “deviance”, is that a certain level of disability and the obligation to get well be accepted by the person granted this role. The “deviance” of ailment, is thus controlled through an institutionalized definition of the steps to be taken in the case of illness – seeking professional medical help, being in a state that requires the help of others and accepting that a speedy recovery from illness is necessary. While the patient’s status as such is sanctioned socially and institutionally, he/she is bound by the “moral imperative” to return to a state of health and activity.

Talcott Parsons describes illness as being predominantly a withdrawal into a “dependent relation”, where the person who is ill uses the disability brought on by illness as a basis for legitimizing his/her claim to be “taken care of” (285). Moreover, when a conditional legitimacy is offered to a “deviant” pattern like illness, it automatically shifts, he argues, from an individual to a collective phenomenon. The conditionally sanctioned legitimacy to be “ill” is reciprocally legitimized by the medical professional – who is authorized to provide counsel, treatment and seek payment for the restitution of the ill. Together, thus, the “patient” and medical professional constitute a collectivity that forms a sub-system within the social system. Parsons also identifies the significance of family for the “sick role”, in serving as the structure of support. The partial legitimation of the condition of being sick situates the sick individual in a relationship of dependence with other non-sick individuals, like his family and the medical practitioner and his personal circle, rather than with other similarly “deviant” sick individuals (312). The condition of being ill and its treatment thus gives rise to questions of particular “social roles” not only for the individual, but for the collective. These “institutionally” sanctioned “roles” are also significant in constituting ideas of “normalcy” and “deviance”. The next section will examine theories surrounding the construction of “ideal” and “pathologized” identities in narratives of illness and disease and their contribution to the "normalizing" or "pathologizing" of the individual in the public sphere.

(iii) The "Spectacle" of the Diseased Body and Pathologized Identities: In her critique of Habermas's universalized formulation of the "Public Sphere", Nancy Fraser argues in her "Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy", that a public sphere is not only an arena for the formation of discursive opinion but is an arena meant for the enactment and formation of social identities (68). In addition, public spheres also comprise culturally specific institutions that frame and set the tone of discursive formulation, through the application of specific rhetorical lenses and the filtering and altering of the accommodated utterances. The public sphere may thus accommodate certain expressive modes but exclude some others (69). Moreover, as Ann Travers has argued in her "Parallel Subaltern Feminist Counterpublics in Cyberspace", the apparent "universality" of the public sphere is characterized by the representation of the subjectivity of an elite group as *the* "objective category of normalcy" (229). In their visualization of the social "roles" of individuals in the public sphere, the documentaries produced by the Films Division India designate certain categories of "normalcy" and "deviance" through a "gendered" lens. In her *How to Have Theory in an Epidemic*, for instance, Treichler points to the gendered construction of individuals in AIDS discourse through a representation of the woman as a "passive" or "ineffective" carrier of the virus. This is contingent upon an understanding of the woman as possessing a "rugged" uterus or vagina that is not as easily penetrable or affected by the virus as the "fragile" anus of the man (17). Women are thus viewed as passive recipients of "infection" in the home and embody the "vulnerability" of the home. Similarly, writing about the socially sanctified role of the husband in her *Contagious*,

Priscilla Wald argues that the “infected man” who brings a disease into the family causes disruption to the “natural (biological) metamorphosis of social roles”, by preventing his daughter/wife from becoming a mother and thus corrupts the institution of marriage (87). The natural/biological roles embodied by the man and woman in the space of the family are thus socially sanctified and are seen to be disrupted via the entry of disease. Moreover, through a designation of the space of the home/family as the socially sanctioned location of reproductive and sexual roles in the medical documentary, the biological and social roles of the female members are conflated and individual rights are replaced or superseded by the rights of the future members of the family.

In her study of foetal photography and pro-life debates in the late twentieth century in America, Carol Stabile argues in her “Shooting the Mother: Foetal Photography and the Politics of Disappearance”, that the ability of visual and reproductive technologies to capture the foetus on film accords this newly discovered terrain a certain degree of autonomy. This “autonomy” is used in the service of the New Right politics (pro-life, anti-abortion crusades), to ideologically transform the female body from a “benevolent, maternal environment into an inhospitable wasteland, at war with the ‘innocent person’ within” (172). These visual technologies, Stabile argues, has effected an erasure of women’s bodies. What is significant about Stabile’s study is the superseding of the rights of the maternal/feminine body and its transference to a newly discovered subject – the foetus, representing and embodying the future of the human race. The medical documentary thus, through a visualizing of the “vulnerability” of reproductive health and the “pregnant” woman, effects an erasure of her body and unveils instead, a deeper, more vulnerable location – the uterus and its biological potential. The medical documentary also designates certain individual or social identities as “ideal” or “deviant”, as argued earlier in the section on Narrating/ “Storying” Illness/Disease.

Mani Shekhar Singh and Aditya Bharadwaj, in their study of communication strategies utilized by the government of India since the launch of the Universal Immunization Programme (for the eradication of Polio) in “Communicating Immunization: The Mass Media Strategies”, observe that at the level of the family, the government’s communication strategies for immunization in a certain sense had been consciously fashioned to both define and constitute the family (670). The “ideal” healthy family defined by the government’s communication strategies, they argue, was able to simultaneously communicate messages of family planning (by employing images of smaller families with a single child in the service of promoting Pulse Polio Immunization) and presented their particular illustrations of this “model” family as a commonplace one, thereby generalizing this definition of the “ideal” family. The particular instances of a “model” family showed them being responsive to and participating in the State’s programmes and seeking medical care and attention in an ordered manner. Similar to the “model” families observed by Singh and Bharadwaj in the government’s communication strategies for immunization, the Films Division documentaries foreground particular instances of families that are “responsive” to local health initiatives and are “active” in the monitoring of their family’s “health”. The Films Division documentaries also visualize for the viewer, “deviant” bodies in which disease has been allowed to run its course unchecked and such bodies function as “spectacle”. The “spectacle” of the ailing or diseased body, serves to highlight in contrast, “normalized” bodies of “citizens” who ensure a timely medical intervention to check the progress of disease and bodily deterioration.

Craig Hight and Catharine Coleborne's study of the medical documentary series *Superhuman* in "Robert Winston's *Superhuman*: Spectacle, Surveillance and Patient Narrative", has demonstrated that computer graphic imaging provides an "additional layer of spectacle" to the overall aesthetic of the medical documentary (238).Writing about the televising of operations performed on conjoined twins, Jose Van Dijck in "Medical Documentary: Conjoined Twins as Mediated Spectacle" and Catherine Myser and David L. Clark in "'Fixing' Katie and Eilish: Medical Documentaries and the Subjection of Conjoined Twins" have argued that the televising of such procedures have taken the place of the 19th century freak show and testify to the continued fascination with extraordinary bodies that continue to be objects of public spectacle. While expert and professional testimony functions within the medical documentary to "pronounce" the presence of illness and provide assurances as to the competence of modern medicine, the "spectacle" of the diseased body is presented to remind viewers of the consequences of bodies that are beyond medical attention. Moreover, as Van Dijck reminds us, viewers are hardly aware of the voyeuristic nature of their examination of these patients' vulnerable, exposed bodies, presented as they are, within medical scans that legitimize the spectacle (550). The format and content of this popular genre of "hybridized spectacles", she argues, both "reflect and construct specific norms and values about 'deviant bodies'" (552).

The medical documentary thus visualizes "normal" and "diseased" bodies, through the incorporation of "individual" stories of patients, expert/professional testimony, computer graphics enabled illustrations of anatomically "correct" bodies and "microscopic" visions of pathogenic invaders. In the process of "visualizing" disease/illness and its treatment however, the medical documentary designates or "sanctifies" certain gendered social "roles" that supersedes individual rights and constructs specific notions of the "diseased" and "healthy" body. The next section will situate the dissertation within the broader framework of Narrative Medicine and the Medical Humanities.

Section II: Narrative Medicine and the Medical Humanities

This project is located within the larger domain of the Medical Humanities and Narrative Medicine. I will survey in this section, to contextualize these broad areas, M.H. Evans' detailing of the discipline of Medical Humanities in his "Medical Humanities: Stranger at the Gate, or Long-lost Friend?", Rita Charon's definition of the field of "narrative medicine" in her now cult book of the same title and Kathryn Montgomery Hunter's illustration of the "narrative" features and methods inherent in medical knowledge and practice in her *Doctor's Stories*. In addition, I will also detail here, the arguments made by anthropologists and sociologists of medicine, namely Bryan Turner and Vaidehi Ramanathan, who emphasize the centrality of "language" and "discourse" in the experience and treatment of illness/disease. The Medical Humanities is defined by the Literature, Arts and Medicine Database hosted by the New York University School of medicine, as an "interdisciplinary field of humanities, social science and the arts and their application to medical education and practice" (*litmed.med.nyu.edu*). Research in cultures of medicine in departments of cultural studies and Journals like *Literature and Medicine*, *Journal of the Medical Humanities*, *New Genetics and Society* and *Public Understanding of Science*, now subjects medicine (from illness memoirs to technologies of medical investigation, from racialized biomedicine to gendered technologies) to discourse studies. This project does not, however, work with the “medical education” component of the medical humanities. Suzanne Poirier’s work (2002), cited earlier, about the “ethically” limited form of the medical case history and Kathryn Montgomery Hunter’s *Doctor’s Stories*, about narrative means of enriching medical case histories, are some instances of a now widespread critique of “medical education” and the insistence on a “narrative” awareness in doctors’ clinical practice. The many disciplines that constitute the “interdisciplinarity” of the medical humanities include conventional humanities subjects like history, literature studies, philosophy, fine arts, critical theory, drama, historiography, linguistics, law and theology and religious studies, among others.

M.H. Evans argues that humanities disciplines are especially relevant for addressing the “human” aspects of medicine on account of a) their concern with the interpretation, understanding and recording of individual experience and b) their tendency to pay careful attention to subjectivity and its embeddedness in and reflection of the various interpersonal contexts of society (367 – 368). Evans also proposes four crucial tasks that characterize medical humanities work that are of significance to this project. Firstly, such work makes *accessible* and illuminates the practice of medicine by providing insights and ideas that are associated distinctively with the Humanities and Social Sciences. Secondly, through the study of pathographies (the act of recording and interpreting the illness experience), such work attempts to foreground the “human side of medicine” and examines the ways in which illness, medicine, suffering, health and disability are experienced. Thirdly, work within the medical humanities attempts to understand the several “subjectivities” articulated within the experience of medicine, illness, health and suffering, in order to make such an understanding *transferable* so as to allow us to reflect on the "human condition". Fourth, such work will utilize aspects of medicine to further enquiry into embodied human nature (369 – 370).

In her now classic *Narrative Medicine,* Rita Charon (who founded the field, initiated the first program in Narrative Medicine at the Columbia University College of physicians and surgeons and holds degrees in Internal Medicine and a PhD in English Literature) attempts to build a "new philosophy of medical knowledge" by identifying the "narrative features" of medicine. Charon argues for the "narratively inflected" nature of medicine and stresses the need to develop the narrative dimensions of the practice of medicine, to bridge the growing divide between doctors and patients. The contextualization of illness, beliefs about mortality, emotional factors that lead to suffering and understanding the aetiology of disease, are some of divides that exist between doctors and patients and can be bridged, she argues, through a shared understanding about disease (39). Developing the narrative dimensions of medical practice can help identify the material and discursive realms of disease as they are ordered by the "story" of an illness. As Charon notes, a disease or symptom that befalls a person is an "event" that is caused by factors that are sometimes identifiable and occurs within a specific time frame and location and has to be narrated to someone from a particular point of view. More significantly, she identifies the singularity of narrative that is conferred upon it by form. The genesis and structure of every narrative is original and irreproducible, in the sense that a narrative creates as it narrates, something that is entirely new, seen for the very first time. The telling of a story of illness thus not merely reports an event that occurred prior to the telling, but produces it (45). Disease is thus actively "produced" in a recounting/telling of an illness experience, thereby encoding specific notions of the body, health and the illness experience itself.

Similarly, writing about the “interpretative” activity of medicine, Kathryn Montgomery Hunter stresses the grounding of this discipline in “subjective knowledge” (xx). The “methodology” of medicine, which comprises the interpretation of the “signs” of disease in an individual patient’s body and the retrospective detailing of the chronology of a particular ailment, she argues, is distinct from other physical sciences. Instead, the “practical knowledge” of physicians is “narratively” structured, in spite of their scientific and technological training and expertise. Hunter too, like Charon, highlights the “narratively inflected” nature of medicine, by harking to the similarities between literature and the medical case history. Literature and the medical case history are similar, Hunter argues, in the attention accorded to the Individual. The medical case history, like literary narrative, comprises instances that embody the collective human experience, while simultaneously testing our generalizations about the individual human (152). More significantly, the “original” and “grounding” data that characterizes medical knowledge and practice, is subjective experience – the individualized practice of medicine in particular contexts by the physician and his/her engagement with others’ subjective accounts of their experience of illness. The “uncontrolled” and unpredictable variables in an individual case can thus be accommodated by narrative and an awareness of this “narrative” structure of medical knowledge makes possible a certain “flexibility” of traditionally “inalterable” clinical rules (155). While Hunter is essentially arguing for a “literary” curriculum for the teaching and practice of medicine, that includes a study of literary fiction, drama and autobiography about the experience and treatment of illness, she has also signalled at the importance of language, discourse and representation in the understanding of disease/illness.

In her *Bodies and Language*, Vaidehi Ramanathan similarly underscores the ways in which language itself and "texts of body matters", both construct and are constructed by a range of discourses that include societal and biomedical ones. She draws attention to those instances of illness experience where not only the body, but language skills also break down. She thus highlights the "different hues" in narrating illness, where the material conditions of the body and the communities with which one engages become increasingly complex when dealing with specific illnesses like Alzheimer's (narratives of such patients are broken by moments of "coherence" or "incoherence"), Autism or partial hearing (in both these cases, patients feel trapped in silence on account of being unable to deal with the "languaged" world – the primary means of engaging with the emotional and with other humans). The materiality of the illness experience here, like a debilitating medical condition that prevents one from even carrying out everyday activity, precedes the narration or mediation of the experience through language. As such, Ramanathan argues, the only way an ailing individual can articulate his/her experience of illness, is through the colonizing tropes of medical science (4). The discursive realm of disease is thus arguably more central or pervasive than its material one.

Bryan Turner in his *Body and Society*, has also stressed the discursive and material domains of disease by combining the notions that 1) disease is a language 2) the body is a representation and 3) medicine is a political practice (201). He signals to a "medicalization" of the body and society that is made possible in the context of a secularized society, where religion has been replaced by medicine as the social guardian of morality (203). Official definitions of disease and health and their coercive acceptance form the basis for the professionalization of medicine. Such official definitions enable an identification of the "objectivity" and "reality" of disease entities, which exist outside human subjectivity or political judgement (204). Medical science provides criteria for normalcy by drawing upon law and religion, and thus articulates a moral discourse of appropriate behaviour (in terms of lifestyle where the responsible citizen safeguards his/her health through an ascetic adherence to "healthy" habits and the moral deviant through irrational, irresponsible habits, self-induces a state of "unhealth" and thus becomes a burden on the state). Disease, as Turner argues, is neither a unitary concept nor does it signify natural processes. Instead, Turner defines it as a "classification reflecting both material and ideal interests" (214). The "nature" of disease can only be understood when placed within a hierarchy of moral evaluations that are in turn reflective of power in social groups.

The next section will detail the primary texts studied in this dissertation through a brief summary of their content and contexts.

Section III: Primary Texts

Patient Memoirs

Anup Kumar's *The Joy of Cancer* tells the story of Kumar's experience and triumph over lung cancer. Kumar is a postgraduate in nuclear physics and worked in advertising for most of his life. After being diagnosed with cancer in a medical test undertaken before travelling to Abu Dhabi for a job interview, Kumar's life quickly spirals downwards as he struggles to cope with the demands of his family and dwindling finances. *The Joy of Cancer* presents for the reader, a "battle plan" to face cancer that weaves together experiences from the author's life. Kumar's narrative criticizes the fallibility of medical diagnoses, while simultaneously foregrounding the need to identify a form of treatment and the kind of physician that is best suited to an individual. The book combines Kumar's narrative with information about cancer, specialized institutes for its treatment and cure and alternative forms of healing.

Anup Kumar's *Smiles and Tears: A Salute to Cancer* showcases the real-life stories of cancer survivors. Kumar is the editor of the book, bringing together the "stories" of twenty three other cancer patients and prefacing the book with excerpts from his own story in *The Joy of Cancer*. The narratives in *Smiles and Tears* describe experiences with various types of cancer, including lung cancer, breast cancer, colon cancer, leukaemia, thyroid cancer and colon cancer, among others. Anup Kumar here narrates the story of his battle with cancer and identifies the need to bring together information and advisory about the illness in India and stresses the significance of such narratives for other patients. He describes Indian patients' reticence to narrate their experience of cancer and argues that "western" patients' accounts of the illness are "alien" to the Indian experience and treatment of cancer. Narratives of illness in *Smiles and Tears* relate experiences of medical care, chemotherapy, encounters with a community of patients and caregivers and alternative forms of healing.

Anita Jayadevan's *Malicious Medicine: My Experience with Fraud and Falsehood at Infertility Clinics* is translated from the Malayalam by P K R Warrier and C S Unni. Jayadevan is a school teacher, who, along with her husband, underwent treatment for infertility and attempted to conceive a child with the help of ART procedures. Jayadevan's memoir reflects on the ethical aspects of Assisted Reproductive Technologies (ART) in India, in addition to detailing the "social" pressures of attaining motherhood and the consequent lure of "treatments" advertised by infertility clinics.Her memoir is a critique of various methods of "treating" infertility via ART procedures like

Artificial Insemination, Intra uterine insemination and In Vitro Fertilization, among others. Jayadevan recounts her experience of various ART procedures at numerous infertility clinics that not only proved futile, but endangered her life.

Lata Mani's *Interleaves: Ruminations on Illness and Spiritual Life* narrates her experience of permanent transformation after she sustained a head injury from an accidental freeway collision in the United States in 1993. Mani is a noted Indian feminist and historian and taught at the University of California, Davis. Mani's car was one of six vehicles hit by a stolen Pepsi truck, whose driver was speeding away from police patrol cars and as was discovered subsequently, suffering from depression and engaged in a bid to end his life. Mani sustained a closed-head injury as a result of this accident and was chronically impaired. Her memoir is a testimony of the consequences of her injury, which resulted in a heightened and painful sensitivity to sound, cognitive impairment and a drastic reduction in physical activity and productivity. The structure of *Interleaves* is illustrative of Mani's transformed cognition, with each chapter of the first section titled "The Journey", engaging with one single idea or activity like a trip to her garden or the difficulty in "communicating" an experience of illness. Mani testifies to how even a small activity like going to her garden or making her way to the table in her living room for a meal, represented a "challenge" that required hours of preparation.

Yuvraj Singh's *The Test of My Life* is co-authored with Nishant Arora, Singh's manager and former cricket correspondent for CNN-IBN and Sharda Ugra, senior editor at ESPNcricinfo, the world's largest independent website with a single sport focus. The book chronicles Singh's life from his childhood struggles with an ambitious and exacting father, his first coach, his entry into cricket and stardom through to the first "signs" of his cancer during the 2011 cricket World Cup. Singh recalls "dismissing" the first signs of ill-health, ascribing them to anxiety and stress owing to the pressures and chaotic schedules of the World Cup matches. He is subsequently diagnosed with a rare form of germ-cell cancer and *The Test of My Life* recreates for the reader, Singh's acceptance of his condition, his struggle through chemotherapy and his fears and anxieties about being unable to return to being a professional sportsman. As a cricketer, Yuvraj Singh had the support of India's richest sporting body, the BCCI and this ensured not only that he could afford the best treatment in the world for his condition but offered wide media coverage for his "story" and allowed him to return to playing cricket internationally. Singh's memoir however, also emphasizes his "individual" will and endurance, in addition to portraying the selfless labours of his primary caregivers in aiding his recovery and "survival".

Russi M. Lala's *Celebration of the Cells: Letters from a Cancer Survivor* is written in the form of letters addressed to "Vandana", a fellow cancer patient. Lala is a journalist, was the manager of the first Indian book publishing house in London and is well known for his chronicles of the Tata heritage in India. Each letter in his book comprises a chapter and each deals with the central issues of living with cancer, buttressed by Lala's own experiential wisdom. While Lala himself is diagnosed with non-Hodgkin's lymphoma, his addressee Vandana, is a Hodgkin's lymphoma patient. Through Lala's letters to Vandana, the reader learns of his experience of becoming diagnosed with cancer, his struggle to cope with the pressures of work while undergoing chemotherapy and the effects of his illness induced dependency on his wife. In addition, Lala also counsels Vandana and by extension, the reader, on the various aspects of his particular form of cancer and the various socio-cultural coping mechanisms that once can "learn" to overcome the transformation brought on by illness. Lala testifies to instances from his own life where he transforms his social interactions, expectations, ambitions and daily routine, to set a new standard of “normalcy” inflected by the effect of chronic illness.

Doctor Memoirs

Abraham Verghese’s *My Own Country* tells the story of an epidemiologist’s struggle to cope with the outbreak of AIDS in America in the 80’s. Verghese is Professor of Medicine and Chief of Infectious Diseases at TexasTech Health Sciences Center, El Paso. *My Own Country* narrates the author’s experiences with treating AIDS patients in the rural town of Tennessee, at a time in America when AIDS was still believed to be an “urban” disease and treatment and cure were highly stigmatized. Varghese’s story puts together the stories of his many patients, alongside a story of the AIDS virus itself and the trajectory of its arrival in America and the town of Tennessee. Over the course of the narrative, Varghese’s life increasingly mirrors the status of his patients – he feels alienated and helpless in the face of what appears to be a losing battle against a deadly virus.

Noshir H. Antia’s *A Life of Change: The Autobiography of a Doctor* narrates the story of Antia from his modest beginnings in Hubli, Karnataka, to becoming the famous founder of one of the earliest burn units at Mumbai’s JJ Hospital, the Foundation for Research in Community Health and the Foundation for Medical Research. Antia narrates his experiences at Grant Medical College, his nine years of service in Britain’s hospitals during WW II and the inspiration behind his choice of specialty. Although located within the traditions of modern medicine, Antia warns against the technologization of medicine and criticizes medicine’s current emphasis on expensive tests and super specialties to diagnose even the simplest of medical conditions. Drawing from his experiences of working in small hospitals with limited resources and rural health initiatives, Antia attempts to demonstrate how cost-effective and simple medicine can also be effective.

Atul Gawande's *Complications: Notes From the Life of a Young Surgeon* is his first book and draws from his experience as a surgical resident and brings together key "moments" from that eight year training period. Gawande is a 2006 MacArthur Fellow and a General Surgeon at the Brigham and Women's Hospital, Boston. *Complications* offers an insider's view of medical practice and narrates incidents from the author's life and borrows "stories" from other doctors to tell the story of an "imperfect science". While Gawande focuses on the fallibility of physicians, the dilemmas and uncertainties of practical medicine, he constantly foregrounds the little understood "extraordinariness" of medicine. Gawande examines a variety of subjects, while narrating his own experience of treating illness and working in a medical institution, that range from fatal errors made by doctors, mysteries and unknowns in medicine to what it takes to make a "good" doctor.

Sandeep Jauhar's *Intern: A Doctor's Initiation* tells the story of Jauhar's experience of a gruelling residency at a New York Hospital. Jauhar, now a practicing Cardiologist and Director of the Heart Failure Program at Long Island Jewish Medical Center, recounts his initiation into the medical profession, positioning his story as one that will be both instructive and inspiring to aspiring doctors and will simultaneously work to dispel the popular myth that doctors are "Type A overachievers with little self-doubt" (xv). The book chronicles Jauhar's crisis and doubt as he enters medical school after spending years training as a physicist. Jauhar struggles to find his footing at the prestigious New York Hospital, where the rigors of residency are markedly different from his earlier, more sedate, professional life. Over the period of a three year residency, leading up to a fellowship in Cardiology, Jauhar narrates his feelings of scepticism, self-doubt and eventual triumph at surviving residency and pride at having attained membership into an elite profession.

The Films Division Medical Documentaries

The Films Division India, part of the Ministry of Information and Broadcasting is the main film-medium organization of the Indian Government. Established in 1948, the Films Division both produces and aids freelance and in-house filmmakers to create and distribute films that record social, political and cultural realities and events in the country. Under the category of “Health”, the Films Division, often in association with other medical/scientific research institutes in the country, produces documentary films and “shorts” (two or three minute public interest messages about various health and sanitation issues) that are intended to spread awareness about various diseases and illnesses. The Films Division documentaries are telecast on national and local television networks, in addition to being available to the public for sale in their distribution offices, as screenings in film festivals and various cinema houses in the country and boasts an audience of about ninety to a hundred million per week (*Filmsdivision.org*). This dissertation studies several medical documentaries produced and distributed by the Films Division in the late twentieth century and I will offer here a brief summary of the main documentaries under study.

The Films Division documentaries typically integrate “individual” testimony or “stories” to contextualize disease/illness and health for the viewer. Medical documentaries like *Cancer* (1997), *Conquest of Cancer* (1980), *Gita Ki Kahani* (The Story of Gita) (2001), *Glaucoma – A Race to Blindness* (1990), *Your Enemy-TB* (1980), *Sexually Transmitted Diseases* (1982) and *There is Life for Selvi* (2004) for instance, integrate images of patients' bodies in varying stages of disease/illness and also present fictionalized stories of individuals' lives affected by disease. *Cancer*, for instance, directed by C.K.M. Rao and winner of the National Film Award in 1997 in the category "Best Scientific Film", integrates several "individual" stories as part of its narrative. The film presents several tobacco users who exhibit visible malignant "growths" and directly address the viewer to testify to the harmful effects of their prolonged tobacco consumption. *Gita Ki Kahani* and *Your Enemy -TB*, in addition to focusing on several such "cases" where the effects of disease are "visible" on the body, also primarily revolve around fictionalized "stories" of the effect of TB and Hepatitis B respectively. *Your Enemy-TB* focuses on a fictionalized representation of a couple, "Mala" and "Gopal", meant to represent the average Indian couple who are vulnerable to infection by TB and *Gita Ki Kahani* narrates "Gita's" experience of being diagnosed with Hepatitis B and "stages" the various problems and anxieties she faces, as a result of her infection through the virus.

In addition, the Films Division medical documentaries also inform the viewer about the government's efforts at preventing disease and hail the advances made by medical science, instructing viewers to seek remedy and diagnosis for any "signs" of ill-health immediately. "Early detection" is emphasized by the narrators of these documentaries, sometimes portrayed as a disembodied voice that contextualizes the images and "stories" on screen and often as an expert, "professional" health care worker. Doctors and researchers are also integrated into the narrative, through "comments" about the particular disease/illness recorded at their place of work, emphasizing their institutional affiliation and authority. Medical documentaries like *Controlling Leprosy* (1989), *AIDS* (1995), *Preventing Anaemia through Nutrition* (1994), *H1N1 Flu*: *Few*

Facts (2010) and *Health for All* (1982) focus on the government's efforts at eradicating disease and ensuring a wide distribution of treatment and diagnostic centres. In addition, these films involve a direct address by doctors/experts (sometimes an actor/narrator who dons a white coat to symbolize expertise and also "real-life" doctors whose names and affiliations testify to their professional authority) who urge the viewer to "monitor" themselves and their families and ensure a "timely" medical intervention. The Films Division documentaries cited above, also instruct viewers about what determines a "healthy" and "ailing" body and visualize the ways in which such bodies can be identified.

The next section will defend the time frame of the project and offer the major cultural contexts that underpin and contribute to the relevance of the texts examined in this dissertation.

Section IV: Time Frame/Rationale

As argued earlier, narratives of disease organize viewers'/readers' perception of the various aspects of the "reality" of disease. Our interpretation or understanding of the experience of illness and its treatment is governed by a "cultural imaginary" framed around disease. This "cultural imaginary" informs and is informed by the various non-fictional accounts of illness experience and its treatment examined in this study. In addition to memoirs by doctors and patients and medical documentaries produced by the Films Division, India, the "cultural imaginary" that determines information about and perceptions and definitions of disease, is also influenced by popular fictions about disease and epidemics, State authorized medical and public health discourse and media reports on "scientific" research about disease. Rodale Inc.'s *Men's Health* and *Women's Health* magazine launched via the India Today Group, Apollo Hospital's *B Positive* magazine, *Healthy-India.org*, a web resource for matters of healthcare and disease prevention launched by the Public Health Foundation of India and the Ministry of Health and Family Welfare, Government of India and the regular science and technology and health columns and features in major English dailies like *The Hindu* and *The Times of India* are a few major popular instances of medical and health discourse in the public domain in India.

This study of doctor and patient memoirs as an instance of the medical *Bildungsroman* and the narrative ordering of an experience of illness and its treatment in these memoirs and the medical documentary, are thus located within the "cultural imaginary of disease". My focus in this dissertation is on doctor and patient memoirs and films division documentaries produced in the late twentieth century and this section provides two main contexts to justify the chosen genres/texts. The first is the rising popularity of the "memoir", which characterizes the present-day cultural moment in the U.S and U.K.This, along with the related rise in the culture of "publicly" sharing a private experience like illness can be used, in the context of India in the late twentieth century, to understand a culture of publishing and reading "stories" about an experience of illness and its treatment. Commenting about the history of the memoir and reviewing Ben Yagoda's (2009) book on the subject, for instance, Daniel Mendelsohn notes that the genre's popularity in our contemporary time should be viewed alongside the parallel rise in the popularity of the reality show, the use of cell phones and internet publishing, that now blur the lines between "real" and "artificial" and "private" and "public" (2010). These related phenomena have set the tone in the late twentieth century, for a culture of self-exposure and self-discussion on which the popularity of the memoir depends.

Mendelsohn via Yagoda, likens the memoir boom in the seventeenth century, caused by the rise in printing technology and paper production that accelerated the scale of publishing, to the current explosion of the personal narrative genre, similarly fuelled by the advances in media and distribution (microblogging and social networking platforms).

Journals like *Biography, Auto/Biography Studies* and *The Journal of Medical Biography, Slate* Magazine observing a "Memoir Week" from 30 March 2007, with invited pieces from prominent memoirists and critics of the genre focusing on the difficulties, history and appeal of the genre, are significant instances of the rise in academic and popular interest in the personal narrative in our contemporary times. The second is the existence of a "social literacy" of disease and the increase in the "public critique" of medical practice by doctors and patients.

(a) The Memoir

In her "But Enough about Me, What Do You Think of My Memoir", Nancy Miller challenges the charges of "narcissism" and terminal "moi-ism" levelled against the contemporary memoir, which she defines as the "most important narrative mode of our contemporary culture" and reads it instead as an encounter with the "other" (422-23). The "memoir craze", Miller argues, can be productively understood as the "hunger" for a "narrative" through which one can make sense of his/her past. Unlike the novel, the biography and other prose forms including the reader's own unrecorded history, all of which rely on a measure of "identification", the memoir cannot do without it. The memoir for Miller initiates a "process" of remembrance, where the "reading" of a memoir is an "interaction" between the reader and the memoir as a screen, that "prompts" memory construction itself ("But Enough About Me" 427). Moving this "craze" out of a distinctly American context, Miller identifies the popularity of this genre as being about its ability to function as "prosthesis" or "aid" to cultural memory ("But Enough About Me" 432).

Similarly, writing about the "booming" industry of the memoir, in his *Introduction: Disability and Life Writing*, Thomas Couser notes that this popularity of writing about the "self" is not a first of its kind phenomena, but is still one that surpasses any other in literary history in terms of scale. With specific reference to recounting or "testifying" to a condition of being ill or treating the ailing, as argued earlier via Arthur Frank, the "authority" and "appeal" of narratives about illness and disease are rooted in the belief that "truth" is produced by the body at the extremes of suffering ("The Rhetoric of Self-Change" 48). The "cultural imaginary" that frames the doctor and patient memoirs and medical documentaries under study in this dissertation, can also be contextualized within a rise in the "sharing" of a private experience and its initiation of a "process" of remembrance. Memoirs written by doctors and patients and the medical documentary, as seen earlier, are about encountering an "other" in various ways. These narratives are "relational" – doctors rely on the "accounts" of patients to build a "case history", patients rely on the accounts of "carers" to render their ailing selves "familiar" and the documentary relies on individual "stories" of illness and testimony to "sentimentalize" illness/disease for the viewer. This is therefore a study of a "rise" in the culture of *narrating* an account of experiencing/treating illness, so as to "organize" the ways in which readers/viewers make "sense" of their own vulnerability/experiences of illness/experiences of encountering medical science. The doctor and patient memoirs and medical documentaries under study thus reflect an emerging culture in India, of initiating a process of "remembering" through narrating and "interacting" with narratives of others.

These texts provide a way of engaging with our experience of illness, its treatment and the transformation it generates in our interactions with others in society. They offer a means of "constructing" our very memory of a chaotic experience like illness and its management, very often dispersed amongst a diverse group of actors, social contexts and causes. While the recording of an experience of illness is by no means a new phenomenon, as Michael Bury ("Chronic Illness") and Kathryn Montgomery Hunter have noted, it is only recently, with the rise in "chronic" illness and the "lengthening" of human life made possible by advances in medical science, that stories about the "individual's" experience and examination of illness been written/made possible.

Hunter has noted the rising "particularization" of widespread experiences like illness, through "individual" stories about the experience of organ transplantation, serious illness, hospital crisis and obscure medical cases in an array of genres like television drama, fiction, autobiography and media reportage. However, Hunter also emphasizes the importance of these "medical narratives" in enabling us to think about our lack of control, the limits to our autonomy, the threat of extinction and our attitudes towards chance, choice and authority. It is thus significant that Hunter likens the contemporary illness narrative in American culture, to a "midlife version of the growing up novel" (153). Here, Hunter argues, the author and hero-narrator merge into one figure, in an "autobiographical (or autobiographically fictional) account of an individual's growth in circumstances not of his or her own choosing" (153). Thus, in our contemporary age of the "memoir craze", the *Bildungsroman* emerges as a form of life writing popular among those writing about their engagement with illness and its treatment. The significance of this "growing up novel" and its cultural manifestation as an account of "growing", in an unforeseen circumstance of experiencing and healing illness, lies in its functionality for narrators experiencing anxieties about “choice”, “authority”, “control” and “autonomy”. As noted earlier via Joseph Slaughter, the modern *Bildungsroman* is characterized by an individual’s struggle to attain “fixity” for his/her “self”. Any restriction to the resistance to oppression and security, property and liberty, tend to limit an individual’s ability to attain “fixity”. The self’s “fixity” is dependent, in the modern *Bildungsroman*, on an ability to narrate one’s story (Slaughter, 412). The modern *Bildungsroman* and the medical *Bildungsroman* in particular, give rise to questions of agency and voice, the second context for the present study.

(b) A “Social Literacy” of Disease and a “Public Critique” of Medical Science

Hunter, as seen earlier, has postulated that personal stories of illness have attained a great prominence in the late twentieth century. In addition, Hunter also illustrates how issues of health-care policy are debated and their meaning negotiated in legal terms, not in abstraction as “public policy”, but as “individual cases”. She argues that it is the names of “individuals” that come to stand for particular issues and their resolution. Most notable among her several illustrations of such “individuals” who represent health care issues is Dax Cowart, victim of a propane gas explosion which left him severely disfigured and disabled and his “fight” to resist the “violence” of his medical treatment/rehabilitation. Cowart became symbolic of the patient’s autonomy with his widely publicized consistent refusal of medical treatment, carried out against his wishes, and the pain and violence of the “medical” efforts to prolong his life. Such medical “cases” that are “particularized” in their association with an “individual” abound in India in the late twentieth century.

Two of the patient memoirs being studied here for instance, Anita Jayadevan's *Malicious Medicine*: *My Experience with Fraud and Falsehood at Infertility Clinics*

and Yuvraj Singh's *The Test of My Life*, are instances of a particularization of a widespread experience. In the case of Jayadevan, who testifies in her memoir to the filing of over two thousand representations to the Supreme Court and their culmination in the passing of the ART (Regulation) Bill & Rules, 2008, her real-life "struggles" with unregulated and erroneous reproductive technologies, converge with the hero-narrator of her "story", to become symbolic of the ethics of practicing such procedures in the country. Yuvraj Singh's memoir, chronicling his experience of a rare form of cancer that threatened his life and career and his cancer support group YOUWECAN, symbolize the "heroism" of cancer survivors. YOUWECAN's website for instance, collapses the figure of Singh with the organization's mission, through the tag in the section detailing his "story" that reads "Yuvi can", thereby stressing the links between Singh's particular experience and survival and the transferability of his (widely publicized) experience with other cancer patients. More recently, the widely publicized case of Anuradha and Kunal Saha in India became symbolic of medical malpractice suits and the patient and caregiver's "rights". Anuradha Saha, an Indian-American child psychologist, did not receive appropriate treatment from doctors at the Advanced Medical Research Institute, Kolkata who failed to diagnose her affliction from the rare disease, toxic epidermal necrolysis. Anuradha Saha subsequently died as a result of incorrect diagnosis and the administering of a steroid overdose by her doctors. Kunal Saha, Anuradha's husband and a doctor specializing in HIV/AIDS, waged a fifteen year legal battle with three doctors responsible for his wife's incorrect diagnosis and death and the AMRI hospital, which culminated in the highest ever compensation (5.96 crore rupees) awarded by the Supreme

Court of India in a medical negligence case. Media reports about Kunal Saha's legal battle, significantly emphasized his "persistence" and the "precedents" set by his example that urged "others" to speak up against medical negligence and was seen as defining the medical professional's "mission" in our society, in addition to raising the "value of human life" in India ("In Support of Patient Rights"; "NRI Doctor Wins Record Medical Negligence Payout").

These particularized stories of illness, survival and medical negligence, in addition to sporting a human face with an "individual" story, are also seen as "representative" of a larger collective. "Individual" stories of triumph and resilience are also significant in their emphasis on the "social" or "community". For instance, writing about his legal battle and the "historic" Supreme Court compensation awarded to him, Kunal Saha writes in an *Outlook India* piece that his efforts to bring justice for his wife's death and his establishment of PBT (People for Better Treatment, a non-profit organization set up for patients' rights), was to ensure that "other Anuradhas" may get a chance to enjoy life ("End the Omerta of the Lambs"). Personal stories of the ill, thus, play an important role in our contemporary era. As argued earlier via Michael Bury, the "grand narrative" of biomedicine has given way to the patient's right to speak about his/her individual experience of illness and his/ability to express scepticism about medical care/cure ("Illness Narratives"). As chapter two will demonstrate, patients "perform" the labour of acquiring "expertise" and are located in a social network of disease literacy.

As chapter three on the doctor memoir will demonstrate, doctors also articulate an anxiety about the shortcomings of medical practice and perform a "social" role through the voicing of their critique. Several of the doctor writers studied in this dissertation, namely, Sandeep Jauhar, Abraham Verghese and Atul Gawande, are regular contributors to major newspapers and magazines. Verghese's articles, for instance, have appeared in the *San Francisco Chronicle*, *Wall Street Journal*, *Texas Monthly*, *Outlook India*, the *New Yorker* and the *New York Times*, engaging issues about the doctor's bedside manners, narrating individual "stories" of patients, medical education and the practice of modern medicine. Gawande has been a staff writer for the *New Yorker* since 1998, having been recognized for his "insider's view" of surgical residency in his early writings about the life of a surgical resident in *Slate* magazine. Jauhar has similarly contributed to *Slate* and the *New York Times*. The most notable of his writings is his critique of the "night float" system (where medical residents work exclusively night shifts for a certain period of time, meant to replace an earlier system of interns and residents working up to 36 hours at a stretch) in "When Rules for Better Care Exact Their Own Cost" (1999), published in the *New York Times* during his medical residency.

These doctors testify to the "controversial" nature of their critique of medical practice, both within their place of work and outside, where journalistic writing during residency has resulted in conflict within the workplace. Jauhar for instance, testifies to his article on the "night float" system causing a "firestorm" at his hospital, resulting in a meeting of the medical board which feared that he had created a "liability risk" (163). Gawande similarly recalls asking for "permission" from the chairman of surgery at the hospital where he was a resident, before publishing an article about doctors making mistakes (xiii). Although these doctor writers rely on a certain degree of professional and textual (afforded by the autobiographical form) authority to "write" about their experiences of healing/treating illness and to voice their critique of medical education and practice, they also contribute to the "opinion" pages and columns of popular newspapers and magazines in a “social” role. While the doctor voices his critique from within the medical institution, he/she is speaking in a public forum from a wider socio-cultural location that transcends the professional. The testimonies provided by these writers about the feared “backlash” from their articles in the public media and their “risky” choices of exposing “errors” in their own places of work and about their own professional practice, is an instance of “transcending” a professional identity and moving towards a more “social” identity.

Doctors’ contributions to the open page of *The Hindu*, a feature that has attained regularity since 2011, are a significant instance of the developing of a “socialized” identity by medical professionals in India in recent times. These contributions are often followed by a brief biography of the contributor that cites his/her specialty and institutional affiliation, providing the professional “authority” underpinning these pieces. Their content however, is a non-specialized or non-academic address to the general public about the issues that plague healthcare, medical education and practice in India, in addition to personal accounts about their patients, advice about the management of disease/illness or “real-life” instances that serve as the germ for the ideas developed in these articles. The study of the doctor’s development of a “socialized” identity, through a condition of treating/encountering disease, is thus located within this contemporary tradition of “voicing” a personalized/individualized account of experiencing medical education and practice and the public “sharing” of this experience.

The next section will provide a brief overview the organization of the thesis.

Section V: Organization

This dissertation consists of seven chapters, organized around three main sections, to study the narrative ordering of illness/disease at the level of the Individual, the Filial and the Social. I will now proceed to a summary of individual chapters.

The Introduction sets out the aim and scope of the dissertation, surveys its theoretical contexts, namely narrative and cultural studies of medicine and the representational turn in studies about disease/illness. The scope and aim of the dissertation, as seen in this introductory chapter, addresses questions about the importance and relevance of studying non-fictional accounts of disease/illness in the late twentieth century. In addition, this chapter has presented brief summaries of the primary texts studied – doctor and patient memoirs and medical documentaries of the Films Division, India.

The First Section of the Dissertation titled "Illness, Healing and the Individual" comprises two chapters, chapter two on the patient memoir and chapter three on the doctor memoir. Chapter two will examine the recounting of a particularized "story" of the corporeal experience of illness, at the level of the Individual in the patient memoir. This "story" takes the form of a medical *Bildungsroman,* particularly, the *Bildungsroman* of suffering, where the patient-narrator charts his/her movement through the various institutionally governed roles of "patient" (at the moment of medical diagnosis), "dependent" (recognizing the need for care) and "convalescent" (through a recognition of the necessity to improve and return to a condition of "health" and socio-cultural "productivity"), occasioned by the onset of illness.

The third chapter of this dissertation studies the doctor memoir or the *Bildungsroman* of healing, which charts the development and transformation of the doctor from novice “trainee” to “professional”. The period of “youth” in the *Bildungsroman* of healing or the doctor’s “novice” self, is finite and must eventually give way to “maturity” and expertise. The doctor’s *Bildungsroman* of healing marks a shift from the individual, “novice” self to the social/expert self, with the filial/familial intervening. This chapter will study the *Bildungsroman* of healing at the level of the Individual. This chapter anticipates the next section of the dissertation, “Towards the Social”. This next section, Section B, comprises chapter four titled “Filiation and Affiliation: The Contexts of Illness and Healing”.

The fourth chapter will study filial connections in the doctor memoir, the patient memoir and the representation of the “filial body” in the medical documentary. This chapter will examine the doctor-narrator’s transcendence of his/her filial networks which comprise, in addition to the family, the passively acquired education during the period of “training” and the treatment of individual cases within the medical institution, where this narrator has a small or no measure of agency. I will also examine here the construction of a “filial-self” in the patient memoir that recognizes the dependence on filial networks of care and performs the “labour” of improvement that is seen as being “owed” to his/her network of carers. The “filial body” in the medical documentary similarly visualizes, via a sentimental or affective narrative, the filial networks of care that the individual body is embedded in. This chapter will examine how the “filial body” is visualized in the medical documentary – this body is seen simultaneously as requiring care and as posing the threat of infection/contagion. I will now move on the final section of the dissertation, “The Social” which comprises Chapters Five and Six.

Chapter five titled “ ‘The Doctor is IN’ ”: Community and the Doctor Memoir”, addresses the doctor-narrator’s framing of his individual, labouring self as relevant for the community, in addition to focusing on the emergence of a “social self” in the doctor memoir or the *Bildungsroman* of healing. The “Expert” and “Social” self in the doctor memoir, is a culmination of the arc of development initiated by the doctor-narrator, where his/her individualized “story” and identity are “socialized”. The doctor-narrator’s “expert” self is socialized through certain agential moves – namely, through the voicing of a moral discourse in the text, through an engagement with the global/general contexts of medical practice while being rooted in the particular/filial and the articulation of a critique of medical practice.

Chapter Six titled “Disease, Prophylaxis and the Narrative Society” will study the construction of a “narrative society” by doctor-narrators, via James Dawes’ formulation that a narrative society conceptualizes society and people *as* “narrative” rather than *through* “narrative”. I will also examine here the pathologization of the body in the medical documentary, where disease/illness in *particular* instances, is made relevant in a *general* context. In addition, this chapter will also study the sentimental narrative in the medical documentary, which works through the forging of *affective* links for the viewer between the individual body visualized on-screen and the spaces inhabited by this body, and by extension *all* bodies, at the level of the individual, family and community.

The representation of the “filial body” in the medical documentary has been examined earlier in chapter four on filiation and affiliation. This chapter will focus on the forging of affective links in the medical documentary at the level of the individual and the community. In my final and seventh chapter, I sum up the key arguments of the preceding chapters.

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Chapter Two

Personalizing Pathogenesis:

Re-Storying Illness Experience in the Patient Memoir

Chapter Plan

Section I: Performing Illness

  (a) Locating Pathology

  (b) Storying/Emplotting the Ill-Self

Section II: Self-Improvement

  (a) Recognizing Dependency

    (*i) Recognizing Dependence on a Prior Self*

  (b) The Acquisition of New Skills

    (*i) Ethical Expertise*

    (ii) The Narration of Progress or Learning to Narrate Progress

This chapter examines the construction and performance of illness and recovery in the patient memoir.I will argue here that the narrative ordering of illness experience and its treatment, maps the "growth" of its narrator through the conditionsof illness, dependency and recovery. This "ordering" of illness experience in the patient memoir moves from an ill-self narrative to a "recovery" narrative and has been studied here in two sections: Performing Illness and Self-Improvement. The first section on "Performing Illness" will study the construction and performance of an ill-self in Anita Jayadevan's *Malicious Medicine: My Experience with Fraud and Falsehood at Infertility Clinics*and Anup Kumar's *The Joy of Cancer*. This section will demonstrate how the patient-narrators in these texts construct a *social narrative of disease aetiology*, which is characterized by a particularized rendering of the onset and disruptive effects of illness. This social narrative of the ill-self, this section argues, restores agency to the narrator through an imaginative reconstruction of the events leading to illness, while also disrupting the biomedical narrative of disease causation. The second section on "Self-Improvement" examines the individual efforts carried out by the patient-narrator towards recovery and rehabilitation. This section, in addition to detailing the "learning" occasioned by illness and its management outside the medical institution, will argue that the patient-narrator instantiates a *relational* self, one that is seen as the antecedent to qualities embodied in the "recovered" or "recovering" self. These qualities, like stoicism, a "will" to survive, the "strength" to withstand illness and its treatment, are integrated into the patient-narrator's life story as always already present, even prior to the onset of illness. Both illness and the ability to recover, this section will demonstrate, are seen as "potential" that is embodied by the individual. In addition to *Malicious Medicine* and *The Joy of Cancer*, this section on Self-Improvement will also study the discourse of self-improvement in Lata Mani's *Interleaves: Ruminations on Illness and Spiritual Life*, R. M. Lala's *Celebration of the Cells: Letters from a Cancer Survivor* and Anup Kumar's *Smiles and Tears: A Salute to Cancer*.

Section I: Performing Illness

In patients' narrative accounts of their experience of illness and medical treatment, an ill-self is constructed by the patient-narrator who physically encounters and simultaneously recounts in narrative, the individual corporeal experience of illness. Thus, in these narratives, the material (physical pain and discomfort, physical transformations caused by disease) combines with the discursive (recovery as “triumph” and the experience of illness as “battle”, pathogen as an “intimate” entity to be “accepted”, given that it is now resident in the body/self), to create a “reality” of disease. This ill-self conveys the embodied nature of the illness experience, while attempting to dramatize the conflict between the embeddedness of this experience for the ill-self in the social and the particular and its universalized (because medical procedures are standardized by pathology/disease rather than by patient) management in the medical institution. The ill-self of the patient-narrator, also makes an agential move to emplot a parallel, personal diagnosis of the ailing body that cannot be narrated or apprehended outside the “colonizing” tropes of medical science. This allows the patient-narrator to regain some measure of control over his/her own story, identity and self, all of which are threatened and disrupted by the sudden onset of illness. Michael Bury has made a case for illness constituting “biographical disruption” (1982). The patient-narrator’s ill-self is performed, not only via an imaginative and retrospective detailing of suffering and chaos induced by disease, but also through a visualizing of the violence of medical intervention. The patient-narrator typically presents an ill-self whose resilience is tested as much by the rigor and discipline imposed by a treatment plan, as he/she is by the invading pathogen/disabling condition.

In narrating the ill-self(constructed by the patient-narrator retrospectively as a “self” that was transformed by illness and medical intervention and which exists in contrast to an earlier, normal/able “self”), the patient-narrator relies on pre-existing bio-medical and socio-cultural definitions of the “healthy” or “normal” and “ailing” body. The illness memoir also forms a part of a growing body of disease/illness literacy that is now available to the reading public. State authorized medical discourse exists simultaneously with a growing body of information about health, disease and medicine available through the media and the internet. As Michael Bury has argued, illness narratives constitute a part of the rising critique/scepticism against medical practice and thus find a new "voice" ("Illness Narratives" 267). The "grand narrative" of biomedicine, has thus been disrupted by the patient's voicing of his/her subjective experience of the "heterogeneous" character of chronic illness and its everyday management. As argued earlier, grand narratives of biomedicine are increasingly countered, supported or even subverted by *petite histoires*, or the personal stories, of the ill.

The ill-self in the patient's narrative thus also teaches, albeit collaboratively with doctors, biomedical discourse and folkloric medical literacy, how one can survive the onslaught of illness, medical treatment and biographical/narrative disruption. The performance of the patient-narrator's ill-self can be organized under (a) Locating pathology (b) Storying/ emplotting the ill-body/self

(a) Locating Pathology

As argued earlier in this chapter, while conveying the embodied experience of illness, the ill-self of the patient-narrator dramatizes the conflict between the social embeddedness and particularity of this experience and its universalized management in the medical institution. The patient-narrator situates the ill-self at a point of intersection in the narrative, between the events that led to the "medical"/ "personal" discovery of illness in the body and those that follow this discovery. The appearance of disorder, subsequently identified by the patient-narrator as either a "symptom" or an occasion to seek medical assistance, crystallizes the initial appearance of the ill-self. This ill-self performs the emotional, ethical and imaginative reconstruction of illness, *after* it has been medically pronounced as “visible” in the body. The events that lead to the appearance of disorder in the patient’s narrative perform the crucial function of locating the patient-narrator in a social network of disease literacy. The chronological detailing of events, leading up to the moment of disruption by illness and the formation of the ill-self, comprise the incipient *social* narrative of disease aetiology. This is in conflict with the biomedical narrative, represented in the patient’s account as reproduced medical reports, clinician’s diagnosis, information and advisory about medical conditions. This incipient *social* narrative of disease aetiology serves as the patient-narrator’s retrospective attempt at decoding, both medically and discursively, his/her own early signs/symptoms of illness. In her account of seeking Assisted Reproductive Technology to rectify what she thought was infertility, Anita Jayadevan’s “story” of infertility perhaps begins in the first detail she offers about undergoing a medical scan, in a section titled “The First Therapist” in the chapter “A Flowering Tree without Flowers”:

> After a clinical examination, the therapist assured us that there was no abnormality in either of us. Before marriage, I had an ovarian cyst, which was removed. (7)

Jayadevan’s confession here, to both the reader and the first doctor she visits, about her past medical history, serves, from a biomedical perspective, to mark the beginning of a “story” about physical abnormality. However, the reader is also offered a parallel and perhaps conflicting origin story that foregrounds Jayadevan’s own recognition of a sense of disorder and dysfunction:

> Yet another Onam, which was also our first wedding anniversary, came unheralded by the stamp of faltering baby feet. I was twenty-four when we sought solace in an infertility clinic a year later. (7)

The decision to seek medical assistance/intervention is preceded here by the recognition that failure to conceive after a year of marriage is a sign of bodily disorder. The twenty-four year old ill-self that sought solace in an infertility clinic, is rooted in the social pressure of assuming the role of motherhood. Writing about first encountering the slogan of the infertility clinic where she would later experience medical malpractice and almost fatal septicaemia, Jayadevan notes the "social" necessity of assuming motherhood. She writes of this "social pressure":

> 'For the emotional consummation of wedlock, birth of a baby is paramount, particularly in our society' said the slogan printed in bold letters at the top of the brochure. I was quite taken in by it. (14)

Jayadevan is here testifying to being "taken in" by the slogan that pronounces the birth of a child and the onset of motherhood as a necessity for the emotional "consummation" of marriage. The awareness that even after two years of marriage, she has not yet assumed the role of a "mother" is a socially mediated awareness of abnormality that is not recognized as such by the clinical exam. The dysfunction recorded by Jayadevan's patient-narrator, in the social narrative, who also senses it to be an occasion for medical assistance, is not recognized as such in the biomedical one. Moreover, as Jayadevan later records, both she and her husband are reminded of their infertility only when they consume the medicines prescribed to them by the same clinician. The medicines are now paradoxically linked to the condition that was earlier only recognized socially, outside the domain of the clinic. Jayadevan's *Malicious Medicine*,is largely an account of experiencing malpractice at an infertility clinic and a meditation on the ethics of Assisted Reproductive Technology, rather than a detailing of living, however briefly, with infertility. On account of this, the patient-narrator recounts an even earlier event that functions as the start of the social narrative of disease aetiology. Jayadevan's patient-narrator remembers how afraid she was when her younger sister, who has an accident while the two were playing as children, has to receive stitches:

> Looking gingerly at the stitches, I asked, 'Did it hurt a lot?' 'No,' she said, smiling, 'just a bit'. I was immensely relieved but also surprised. I was scared of pain and could not bear the thought of an injection-whenever a nurse approached me with a syringe and needle, I used to run away crying. Little did I know that pain, which I dreaded in my childhood, would fortify me and become a source of strength in my adult life. (2)

This confession of a fear of needles in particular and perhaps medical intervention in general, is situated as the ironic start of a "story" about a tryst with an abundance of medical procedures that Jayadevan is subjected to, in order to rectify a dysfunction that she is first made aware of socially. The social narrative of disease aetiology thus, in both instances cited above, functions not only as a personalized/subjective decoding of the signs of illness, but also serves as a means of "testing" the validity of a "lay" diagnosis. In both instances cited earlier, two kinds of anxieties are articulated by the ill-self and are subsequently "tested" in the narrative against "professional" opinion. Jayadevan's "fear" as a young girl about her sister's stitches and the extent of pain she would experience is seen as being "unfounded". Later however, as an adult, Jayadevan's fears about her own bodily disorders are confirmed by subsequent tests, even though the first infertility therapist she visits declares her to be "normal". The imaginative, narrative reconstruction of illness by patient-narrators thus problematizes the arbitrary process of assigning importance to medically/professionally verifiable "signs" of illness. By "imaginative", I mean a personal or subjective reordering of the events that lead to illness and dependency. These events include the patient-narrator's memories of a time well removed from the period of illness and are generally excluded in the official/professionally prepared case history. These events are also "imaginative" in the sense that they entail a transcendence of the patient-narrator's immediate material and cultural contexts. The ill-self is crystallized in the illness memoir not through the medical "pronouncement" of illness or the verifiable "presence" of disease in the body, but in affective modes like fear/anxiety/premonitions of bodily disorder and consequent social dysfunction. What is also significant about this social aetiology narrative is that it foregrounds Jayadevan's awareness, even as a child, that medical intervention is painful, fearsome but also necessary. The patient-narrator's ill-self is thus embedded, as argued earlier in this chapter, in a social network of disease literacy. This ill-self learns to recognize signs of dysfunction and disorder in the body and is able to articulate them as such, based on pre-existing narratives about the onset of illness that circulate socially. While these pre-existing narratives are also shaped by biomedical discourse and its insistence on a close monitoring of the body for signs of disorder, the social narrative of disease aetiology is also rooted in the particular and individual instance of bodily disorder.

Anup Kumar's *The Joy of Cancer* for instance, retrospectively attributes the onset of cancer in the body to various factors ranging from stress, a family history of the condition, years of being a heavy smoker and harbouring resentment. While lifestyle and heredity are also frequently attributed as causes for a condition like cancer within the biomedical narrative of aetiology, Kumar's ill-self is already embedded in an instance of social ruin prior to his "diagnosis" with cancer. Kumar's account of living with cancer begins with the moment when he loses his job and is heavily in debt:

> That was how the new millennium began for me. It was not entirely unexpected but the timing was terrible….And suddenly, in one fell swoop, the world around me had collapsed. (11)

Kumar's "collapsed" world is what motivates his search for a new job and having finally located one overseas, he is required to undergo mandatory medical exams that reveal a "patch" in his lungs. Detailing the social ruin that precedes a physical one, serves the purpose of locating the origin of bodily disorder in a more ambivalent manner than the precision with which a biopsy zeroes in on the cancer cells' location within an individual body. In the retrospective dramatization of the moment of clinical diagnosis, when he is informed at the Breach Candy hospital in Mumbai that his "biopsy results show malignancy. Poorly differentiated adenocarcinoma" (14), Kumar says:

> Perhaps I should have been prepared. Right from the beginning the doctors had warned me that because I had been a heavy smoker for over 35 years, the chances of malignancy were high. (14)

Kumar here, like Jayadevan, acknowledges awareness, even prior to his entry into the medical institution, that his was a body that is predisposed to requiring medical intervention. He is also reminded, on his journey to conduct the biopsy at Mumbai, of a similar journey he undertook years before, to discuss his mother's breast cancer with a doctor in Mumbai. The ill-self is thus located in a filial and social network of disease literacy and draws upon this to narrate a "particular" and "individual" account of illness. Contrary to the "precision" and "truth" of medical ascertainment of disease, Kumar's stresses on the "uniqueness" and "individuality" of a story of illness:

> In no way should my experience or some of the examples cited earlier be taken as complete truths. Each patient must decide for himself or herself. (41)

The social narrative of disease aetiology also serves to destabilize the "precision" of the biomedical diagnostic narrative. The ill-self locates breaks and fissures in the biomedical diagnostic narrative, by recounting experiences of erroneous diagnosis, unnecessary medical intervention and by enacting a deliberate "choice" with regard to the course of medical treatment.

Patients relating their experience with illness, offer extensive details about their clinical "diagnosis" in addition to describing their own embodied "experience of illness". The two are often inextricably linked in the narrative, making it difficult to separate the identity of the narrator as "patient" (as defined by medical reports and accounts of bodily discharges and "symptoms") and as an "individual" with the usual social markers of class, profession and family. Anita Jayadevan for instance, remarks in her preface to *Malicious Medicine*, that "my misfortunes and painful experiences are inextricably entwined with medical science" (xi). She explicitly states in her preface, that had it not been for her traumatic experiences, her "story" could have been told in a few lines, since "Mine *was* a very ordinary life" (xi). It is significant to note here that at the very outset, the reader is warned that he/she is not only reading about an "experience of illness" but an "experience of medical science" as well. *I argue that in illness narratives, medical "cure" and "treatment" are folded imperturbably into the "experience of illness" within the narrative.* What we encounter while reading these narratives, thus, are also stories of "experiencing treatment" and encountering medical science. The ill-self, however, attempts to destabilize the imposed linearity and accuracy of the clinical diagnosis, by locating this diagnosis itself as an "event" that led to bodily dysfunction and disorder. Medical intervention is thus not only viewed as curative or palliative, but also as engendering pathology. Locating medical causes of bodily dysfunction, Jayadevan writes:

> The price I had to pay for the misdeeds of others was too heavy. I had contracted peritonitis due negligent, unscientific and unskilled follicle aspiration. While gynaecological experts stood by as helpless onlookers, it escalated into septicaemia. Bacteria not only escaped into the blood stream, but started multiplying. The contaminated blood circulated through the placenta, where my blood and my baby's blood were separated only by a membrane. (38)

Jayadevan is describing here her physical state after having received an embryo transfer during ICSI (intracytoplasmic sperm injection, used in the treatment of a certain type of male infertility). The embryo transfer results in a twin pregnancy, although on account of "negligence" and "unscientific" procedures, her life is threatened and she loses both foetuses to the infertility clinic's failure in detecting an ovarian cyst. In the retrospective construction of events that led to a life-threatening state and genetic abnormalities in one of the twin foetuses, Jayadevan blames "unscientific" and "unskilled" procedures, thereby somehow vindicating "skilled" and "scientific" procedures. *Malicious Medicine* frequently alleges, that the (unnamed, in the narrative) infertility clinic where Jayadevan receives negligent and "unscientific" care should be brought to justice, for having flouted

"national guidelines" issued for the practice of ART's by the Indian Council of Medical Research. It is thus significant that Jayadevan criticizes an individual instance of medical error and malpractice and states at the very outset of *Malicious Medicine*,that:

> In spite of tormenting me and making my life a living hell, medical science, I strongly believe, has been vindicated, since it helped me survive against difficult odds, and in the process lent me the courage to pen this book. (xi)

This is significant because the ill-self in *Malicious Medicine* displays awareness about not only the dangerous consequences of medical intervention, but emphasizes its palliative effects as well. Summing up the experiences of two years of infertility treatment she says:

> I had started infertility treatment with two normal ovaries and fallopian tubes. That I lost one each during my fertility treatment was a painful fact. Was this the price I had to pay for two years of infertility treatment, I wondered bitterly. (11)

Jayadevan is yet to be reinstated socially as “healthy” and as “fertile”, despite having undergone a bodily transformation. The loss of an ovary and fallopian tube on account of delayed treatment and the resulting medically induced pathology, destabilizes the linear course of diagnosis-treatment-recovery imposed by the biomedical narrative. Similarly, in his *The Joy of Cancer*, Anup Kumar recounts the pathological effects of an unnecessary surgery:

> The whole effort had been a huge waste and yet I would have to go through the various stages of post-operative recovery. Worse, I had to pay the exorbitant fee for the operation despite the fact that I had nothing but a massive scar to show for it. Worse yet, I was now too weak for chemotherapy and precious time had been lost. (17)

Though he is advised surgical intervention for the removal of malignant cancer cells in his lungs, it is only once Kumar is opened up that the "full" extent of the cancer's havoc is clear to the surgeon. This results in the abandonment of surgery, but Kumar's body retains the physical marks of medicine's indeterminacy. The ill-self thus serves as a "fragmentary" and disjointed account of medical diagnosis itself. The patient's body thus serves as a space for the inscribing of medical uncertainty. Through an instantiation of medicine's errors and indeterminacy, the narrative of the ill-self destabilizes the linear route imposed by the biomedical narrative from diagnosis to treatment. The ill-self is instead situated within the biomedical narrative of treatment, as a body that continues to be tormented and ruled by chaos while simultaneously being interpreted through biomedical diagnostic statistics (scans and medical reports) as "responding" to medical intervention. Kumar further testifies to the inducing of pathology, in the violent medical bid to send his cancer into remission, by detailing how chemotherapy, designed to fight cancer, also sends the entire body into disarray. He suffers from hypotension and peripheral neuropathy, as a direct consequence of chemotherapy and records:

> Towards the end new drugs were administered to reduce the side effects of the treatment. All this while my x-ray and CT scan results were indicating that I was making progress. (19-20)

The ill-self thus dramatizes the conflict between the biomedical narrative of disease aetiology and treatment and the embeddedness of this ill-self in the social and physical materiality of illness. Patients' accounts of illness experience, thus also point to the ethical dimension of biomedical diagnostic practices that designate individuals within the problematic category of "previvors", persons susceptible to the onset of disease, despite the lack of proper treatment and cure for such conditions. Belling has identified this rise of this problematic category within diagnostic practices associated with particular types of cancer (241).

This section on performing illness has charted the narrative of the ill-self, which anticipates the "recovery narrative", the subject of the next section. The narrative of the ill-self is representative of the "work" carried out by the patient-narrator towards authenticating a unique, individualized and corporeal experience of illness. This narrative thus differs from the recovery narrative in the nature of "work" carried out by the patient-narrator, while reconstructing the onset of illness and the medical "pronouncement" of disease. In the ill-self narrative, the patient-narrator "performs" the extent and effects of illness through an emphasis on suffering, bodily transformation, pain and the effects of medical intervention. The patient-narrator thus "works" here to order a personalized account of the onset of illness and to locate the transformative and destructive nature of the illness experience not only corporeally, but also *socially*. The ill-self narrative thus disrupts the biomedical narrative of disease causation, by inscribing medical uncertainty on the patient-narrator's body. This is achieved, by questioning the precision of the medical ascertaining of disease and by complicating the linearity imposed by medical diagnosis from the "discovery" of the pathogen to treatment and recovery. The ill-self narrative disrupts the biomedical one at the point of framing the "events" surrounding the onset of illness, through affective modes like fear/anxiety/premonitions of bodily disorder and consequent social dysfunction. During the course of her infertility treatment for instance, Jayadevan records several "premonitions" that are ignored or cast aside at the infertility clinic. For instance, she recalls how pregnancy was clinically "confirmed", at the end of the second round of ART procedures after the first resulted in an abortion. Jayadevan, however, experiences persistent abdominal discomfort that "worried" her. She wonders, “Could this be the harbinger of another abortion?” (20).The attending medical personnel however, Jayadevan records, do not recognize her “pain” as requiring medical attention and she is dissuaded from coming in to the clinic. Jayadevan’s “worry”, however, narratively precedes the medical “discovery” of the danger her twin foetuses face. The perishing of her unborn children is thus *anticipated* in the narrative, not by medical diagnostic procedures, but by Jayadevan’s “premonition”. After the first of her twin foetuses perish for instance, Jayadevan records that she “had a premonition of some impending disaster” (22). Subsequently, she begins to exhibit symptoms of peritonitis that her doctor misdiagnoses as a consequence of pregnancy.

It is thus Jayadevan’s premonition that anticipates for the reader, her emergency surgical procedure to remove a cyst that was thus far medically “ignored” and resulted in a second abortion. These affective modes allow for multiple origin stories, creatively reconstructed by the patient-narrator and refer to an “intimate” and therefore “authentic” experience of illness. Kumar for instance, relates his cancer to his habitual smoking and hereditary propensity to the illness, recalling that he should have “always known” he would become a cancer patient. Knowledge about his status as “patient” is thus retrospectively constructed in the narrative as anticipating medical “pronouncement”. Moreover, by locating the patient-narrator within a social network of disease literacy, the ill-self narrative circumscribes the biomedical one and makes this patient-narrator always already aware of the transformative and disruptive effects of illness. However, the ill-self narrative also eventually merges with the biomedical narrative, through the performance of “recovery” for the reader.

Thus, in the following section, I will demonstrate how the “recovery narrative” engages the tropes of heroism, triumphalism, demonization or partial anthropomorphosis of the pathogen and hope. Here, the ill-self narrative eventually merges again with the biomedical narrative, in attempting to secure a degree of professionalism in the management of illness and the required validation of “recovery”. “Recovery” and the “remission of illness”, as the following section and the second part of this chapter titled “Self-Improvement” will demonstrate, require professional or institutional recognition. “Work” performed in the ill-self narrative, aims to authenticate the patient-narrator’s suffering, through a demonstration of uncertainty and imprecision in institutional diagnostic procedures. “Work” performed towards rehabilitation, acquiring the skills of managing symptoms at home and recovering the potential for productivity in the “recovery narrative” however, paradoxically requires institutional “recognition” in order to be authenticated. It is at this point that the ill-self narrative merges with the biomedical one, in attempting to articulate, using the “colonizing” tropes of medical science, the labour of recovering and improving. The articulating of recovery, however, as the following section will demonstrate, restores a measure of agency to the patient-narrator.

(b) Storying/Emplotting the Ill-self

The “narrator-agents” in patient narratives relate the story of their “heroic” battles against disease, empowered by the textual authority afforded by the autobiographical form. Smith and Watson suggest that writers often subvert a fiction/non-fiction distinction to interrogate the dominant modes of truth-telling and self-representation (363). Moreover, the illness narrative draws its appeal and authority, from the belief that “truth” is what is produced when a body is at the extremes of suffering (Frank, “The Rhetoric of Self-Change” 48). In addition, the autobiography or memoir is also dependent upon a heightened degree of identification. The autobiographical “act” can only be performed by “two” and similarly, though prose narrative generally requires that readers identify with the story to a certain extent, the memoir relies almost entirely on such identification. Illness causes a biographical disruption that thwarts an individual’s capacity as a social actor. As argued in the earlier section, the ill-self of the patient-narrator, also makes an agential move to emplot a parallel, personal diagnosis of the ailing body that cannot be narrated or apprehended outside the “colonizing” tropes of medical science. The illness narrative embodies a “change” or “transformation” that restores agency to the narrator, who gains a “new” identity through a public reliving of a private illness experience. Interruption by illness, changes a person living an “ordinary” life into a “patient”, whose agency is relinquished to medical care and treatment and whose identity is now inextricable with that bestowed by medical science in terms of reports, scans and vital signs. The “patient’s”“new” identity, articulated through a recounting of the experience of illness or relating a story of survival, restores this lost agency to the teller who is now empowered to plot a story of recovery. As Lois McNay argues, agency can be reconfigured with a “creative or imaginative” base, thereby recognizing certain acts of “autonomous” agency as the ability to act in creative or unanticipated ways (22). The patient thus, following “recovery” from illness, articulates a “new”, creatively fashioned identity, rather than reverting to his/her “identity” prior to the onset of illness. This “new” self is able to reclaim agency by “re-interpreting” illness in a creative fashion. In *The Joy of Cancer* for instance, Anup Kumar recalls how he “spoke” to the cancer cells inside his body:

> …I decided to have a serious chat with my lungs. I reasoned with the cancer cells. I asked for their forgiveness. I asked them to be good friends with me. I made peace with them. (27)

This forms the first in a series of a seven-stage battle plan that forms the bulk of Kumar's book. This first stage is titled "Accepting Your Cancer" and Kumar details a strategy of re-identifying with a body that has been rendered unfamiliar by disease. This re-configuring of what it "means" to be affected by illness, restores agency to the "narrator" who is now empowered to "plot" his/her own story of illness. The ill-self of the patient narrator, presents an individualized, imaginative and ethical reconstruction of the experience of illness that reconfigures the "story" of the ailing body narrated scientifically. As Belling has demonstrated, narratives about the origin of cancer rely on a "partial anthropomorphosis" of the cancer cell (237). This partial anthropomorphosis of the cancer cell in scientific narratives, as a "renegade cell" and an "enemy" that is invested with agency, also informs narratives like Kumar's, as evidenced by the above extract and other instances in *The Joy of Cancer*, where cancer cells are designated as the "enemy", chemotherapy drugs as "trillions of fighting-fit soldiers" and territorial descriptions of the body's insides as a "battle-ground".

However, Kumar offers this imaginative reconstruction of the experience of cancer and its treatment, as one of several possible narrative visualizations in the sixth stage of his battle plan titled "Visualizing Your Way to Health". Kumar posits that the significance of visualizing cancer and its treatment for the patient is that it allows for a "participatory" role in an event that can only be reconstructed imaginatively or creatively. The patient-narrator gains a measure of narrative agency in the recounting of events, whose progress is otherwise recorded only via biomedical tools of visualization. Storying or emplotting the progress/remission of bodily disorder implies an ordering of events and details that are unnarratable. Not only do illness narratives present an "extreme test case", in the words of Rimmon-Kenan, because of "the embodied nature of both continuity and disruption in them" (244), but they also seek to articulate and interpret the visceral body. The visceral body can only be accessed via biomedical tools of visualization, and as Belling has argued, is not "human". This visceral body has to be narrated, imagined and humanized, so that the body can be marked by "subjective habitation" and its materiality can be reconfigured as "place". The patient-narrator seeks to reclaim this body-as-place through an imaginative reconstruction of events that take place at a microscopic level. Dramatizing her lack of agency in visualizing the foetus, whose presence, gender and subsequent termination had only been carried out medically, Jayadevan recreates what she imagines this baby girl would have looked like:

> A frightening emptiness pervaded around me. For my child and I had suffered more pain than most people are destined to suffer in a whole lifetime. Yet I could not hold her in my arms even for a moment. I tried to imagine my child sleeping by my side, imagined her cry, her dimples, the curly locks tumbling down her forehead. She was, I imagined, very much like what I was like in my childhood. (44)

Although Jayadevan would later learn that the embryo transferred to her womb was not entirely genetically composed of material from her and her husband, in this imaginative reconstruction of what was not a fully formed child, she invests it with a "human" appearance and her own genetic character. Although establishing parentage requires a DNA test, Jayadevan here lays claim to her body-as-place and invests a biological, genetic link between her and the foetus she carried as only a surrogate mother. Anup Kumar similarly emplots his ill-self by embracing in his *Joy of Cancer* the role of the "flag-bearer" for cancer in his family. Citing the experiences of his mother and grandmother's battles with cancer before him, he realizes that his role is one that was drafted in heredity, leaving him little choice in being the “new flag bearer”. In his imaginative recounting of his own battle however, Kumar rewrites this hereditary transmission he interprets as karma:

> Somehow I had to alter that karma. Ensure not only that cancer was forever banished from my system but from my children’s future, their children’s future….Changing my karma was essential. I have no logical explanation for this thought process. Perhaps it arose from the heart of a father, full of fear for what he might pass on to his children. It was *my* way of coping, of creating some sense out of chaos. (32-33)

Kumar here visualizes the removal of cancer cells from his heredity, thus rewriting and reimaging the role of the “flag bearer”, who now wishes to leave no trace of this role in any inheritance he may pass on to future generations. Rita Charon suggests, for instance, that the body co-authors the story of the life that is being lived in it. The body, however, communicates only through representation and this is in turn mediated by sensations and meanings that are ascribed to these sensations (87). Narratives of illness, as argued in the Introduction, thus seek to order the narrative of the body as well.

Moreover, the “drama” in a story of illness is not only present as a conflict of forces, but is also enacted in the process of arriving at a story. This process includes “resisting or provisionally accepting and then rejecting other stories” (Frank, “Five Dramas of Illness” 384). The patient-narrator arrives at a story, in which he/she situates the ill-self, by retaining a measure of order and control over medical treatment or intervention. This is enacted through an exercising of “choice” in the method of treatment, and the parallel, creative construction of a sense of disorder that interprets bodily sensations as “signs” outside of the biomedical apparatus of the medical institution. Patient-narrators of these texts often pursue alternative treatments alongside their primary allopathic treatments, but these are soon abandoned for lack of “proof” regarding their effectiveness and more significantly, for their “harmful interactions” with primary treatments. The patient-narrator thus allows his/her agency to be subsumed by “primary treatment”, however, he/she maintains a relative degree of autonomy in practicing the sphere of “health” and “well-being”. The “patient” in the narrative, practices yoga, takes a relaxing sojourn, controls his/her diet, re-discovers the “pleasure” of everyday life and time with family on account of the hiatus offered by the “recovery period”. It is control over these activities that offers the “patient” partial autonomy, described in the narrative as efforts to “regain” health made by the “patient” of his/her own volition, in addition to treatment offered by the medical institution. “Health” and “well-being” measures undertaken by the “patient” on his/her own however, need to qualify a set of standards and have to be deemed “safe” for use alongside primary treatment.

Anup Kumar, for instance, narrates his choice of Ayurvedic treatment and Reiki healing to “support” his chemotherapy. In addition to “choosing” the right balance of primary and alternative treatments, patient-narrators also enact an “evaluation” of the primary care facilities they choose for treatment/medical intervention. Jayadevan’s ill-self enacts the provisional acceptance and subsequent rejection of several infertility treatment facilities. These patient-narrators, however, also demonstrate the social circulation of information about these facilities/institutions that are often harnessed by institution’s own discourse about its efficacy. Jayadevan travels to Chennai’s Mediscan Prenatal Diagnosis and Foetal Therapy Centre, to attempt correction of genetic abnormalities in her foetus and learns about the centre from one its doctors:

> The astounding surgical feats of the centre that he narrated had filled me with expectations. I rated them as miracles of medical science crafted by geniuses and I looked upon Dr. Suresh, the chief surgeon, as a beacon in the medical firmament. (36-37)

Dr. Suresh would later refuse to conduct a DNA test that he promises to arrange, to determine the parentage of Jayadevan's ICSI-generated foetus, prompting her to re-evaluate his role at a centre of "miracles". In addition, the patient-narrator's ill-self also retains partial autonomy in terms of expanding his/her own knowledge of/about disease. Both Kumar and Jayadevan stage an accumulation of knowledge about their condition outside of the medical institution where primary treatment is offered, through a reliance on filial and social networks of knowledge. Authors' acknowledgements in both these texts recognize the help of doctors and medical personnel in a collaborative construction of medical information and advisory. *The Joy of Cancer* frequently encourages the reader to accumulate "knowledge" about their particular condition through online resources and even offers, in the form of appendices, a glossary of cancer-related terms, important websites for cancer research and a list of further readings.

As argued earlier in this chapter, the patient-narrator's ill-self also enacts the parallel, creative construction of a sense of disorder that interprets bodily sensations as "signs" outside of the biomedical apparatus of the medical institution. Recounting her experience of medical negligence that leads to renal failure and septicaemia, Jayadevan expresses the "anxiety" that led to her "desire" to stay on in the clinic until her delivery. Instead, she writes:

> At the clinic, my anxiety and desire to stay on until delivery made me a laughing stock. I was advised to go home, stay in bed, take plenty of water and stop worrying. (21)

And later, when she continues to experience unbearable physical pain, she records:

> I had a premonition of some impending disaster. But my confidence in the clinician was so implicit that I felt he would be able to tide me over any crisis. (22-23)

Jayadevan's "anxiety" and "premonition", retrospectively constructed, present a parallel account of interpreting "bodily" signs and symptoms, outside of the biomedical apparatus of the medical institution. These signs, imaginatively reconstructed as the "real" warning signs of bodily disorder by the ill-self, restore the body-place of the patient-narrator in the story of illness experience. They re-evaluate the implicit trust placed in the "colonizing" tropes of medical science and its account of the progress/remission of illness and attempt a destabilizing of the imposed linearity of this account. Anup Kumar similarly recognizes the "complexity" of medical pronouncement of cancer and its subsequent management:

> The day before chemotherapy was to begin, the story was once again turned on its head. After re-examining my reports and films, the doctors at Batra Hospital once again came to the conclusion that surgery was a better option. More tests were conducted to confirm their diagnosis. I even took a second opinion from the Tumor Board at the Rajiv Gandhi Hospital. So chemotherapy was suddenly cancelled, the drugs returned, and I found myself waiting to be operated upon for the second time. I had no idea that a cancer diagnosis could be so complicated. (17)

Kumar’s description of the “story” that was once again “turned on its head”, is a recognition of the disorder and chaos caused as much by the medically-mediated account of disease as the pathogen’s own destruction of the patient’s temporal and physical ordering of the experience of illness. The ill-self enacts a parallel emplotting and storying of the illness experience, through an imaginative reconstruction and visualizing of the microscopic, visceral body and the interpreting of bodily signs outside the “colonizing” tropes of medicine.

This section has detailed the “labour” of recovery performed by the ill-self in the patient memoir that entails a parallel emplotting of the onset of illness and its effects. This restores a measure of agency to the patient-narrator, in interpreting the “signs” of disease outside of institutional and universalized narrative tropes. The following section on “Self-Improvement”, will examine the personalized and individual tropes of narrating “recovery” and “improvement” in the patient-memoir (reinstating productivity, heroism, hope). Here, I will argue that the patient-narrator traces his/her essential qualities, like the “will to survive” and the “ability” to fight the transformative effects of illness, as having antecedents in a “prior” self. I will also demonstrate how the “presence” of illness or a lack of “well-being”, is also constructed as a consequence of heredity, lifestyle and other risk factors, thereby locating a “potential” for both illness and the “will to survive” within the individual body. Illness itself can therefore be constructed not as a “disruptive” event, but as integrated into a retrospectively narrated life “story” that encompasses multiple states of ill-health and well-being. Patient-narrators can be seen here as *relational* selves, where they are always already embedded in multiple, personalized narratives of illness and recovery/cure, capable of inheriting both diseases and the ability to withstand and conquer them. While these patient-narrators “work” to make clear the unique routes taken by illness in and through their bodies, the following section will demonstrate how the labour of recovery, the management of symptoms and development of a certain temperament necessary for rehabilitation, is also uniquely rendered in the patient memoir. “Improving” the self is seen as “work” performed by the individual, *despite* medical assistance and intervention, as we shall see in the next section.

Section II: Self-Improvement

Patients’ recounting of their experience of illness and medical treatment/intervention comprises the “performance” of an ill-self. In other words, the narrating of an individualized or particularized story of disorder and chaos, is constructed outside of the medical pronouncement of illness (though medical technology and expert diagnosis). This ill-self narrates a social aetiology of disease, that emphasizes social embeddedness and situates “rupture” and “disorder” as stemming from factors as varied as lifestyle, heredity and professional risk. The conflict between a biomedical narrative of illness, (following an imposed universal linearity of disease identification, management, cure and recovery) and a particularized narrating of the social origin of bodily disorder is thus dramatized in the patient’s performance of an ill-self. The patient-memoir however, while recounting its narrator’s experience of being disrupted by illness and his/her subsequent management of and recovery from this state, is not restricted to or defined by this alone. The patient-memoir performs a narrative alteration of self and identity that proceeds from an illness experience but is not limited by it. The self that comprises the occasion for story telling in the patient-memoir is one that is fractured by illness experience. However, the narrative organization of this experience by the patient-narrator foregrounds the labour performed outside the medical institution before and after a necessary "entry" into the domain of medical science. The retrospective narration of an illness episode often precedes the "event" or medically ascertained "advent" of the disease in the patient-narrator's body. This patient-narrator is characterized in his/her memoir, as always having possessed a will to survive, an extraordinary "self" whose essential nature is not entirely effaced by the illness experience, despite having felt its material effects. The labour of recovery, of negotiating caregiver's experiences, of re-integrating oneself within the workplace, family and inter-personal relationships performed in addition to medical intervention (which is portrayed as not always being curative and often also has pathological consequences which then requires a "laborious" recovery), is portrayed in the patient-memoir as having its antecedents in the narrator's normal/healthy self.

The patient-memoir thus comprises a public exposure or affirmation of uniqueness, particularity and individuality, through a narrating self that articulates a battle of self-constitution. By self-constitution, I mean the process through which the patient-narrator reorders or reimagines the "self" transformed by illness. This "self-constitution" restores in a particularized narrative, a measure of agency relinquished to universalized social/institutional modes of understanding the onset and treatment of and recovery from illness. What constitutes or characterizes this narrator, is his/her desire to return to a prior state of "normalcy" and "health", to reform and educate the reader about experience of illness, its medical treatment and the importance of safeguarding "health". The genesis of these "extraordinary" qualities in the narrator is plotted, like the illness itself, along a personal axis of such traits. Thus, illness is seen as a distorted version of the self, whose beginnings are often also recognizable (in terms of lifestyle practices, hereditary factors). The valiant, heroic self similarly, that strives to attain normalcy and ability, is traced to an earlier, precursor self that was possessed with an indefatigable will to survive. The experience of illness is thus made intimate, through a mapping, in the patient-memoir, of multiple states of ill-health and well-being and their corresponding care and treatment that do not always stem from the medical institution. An inherited condition or lifestyle factors, that predispose the narrator to an illness for instance, can thus be incorporated into a "life-story", without the "interrupting" nature of the sudden visibility/appearance of disease in the body through medical diagnosis. Similarly, the labour of "improvement" or "recovery" is plotted along the axis of the "individual" experience of illness, where it is the "particular" efforts of the patient-narrator rather than medical intervention, that lead to recovery and social reinstatement. Chris Shilling has theorized the individual's self-identity in the late modern age as an "embodied biography" (4). Bodies, Shilling posits, are unfinished and are "transformed" as a result of their entering society. This is particularly significant, as argued earlier in this chapter, in the case of a "patient" narrating his/her individual experience of illness, which comprises a moment of change in this individual's "embodied" biography. Illness narratives attempt to create a sense of "unity" in their narrators' identity, thereby overcoming the "rupture" caused by illness. The process of the patient's recovery is thus articulated as a "necessary", "painful" and yet "fulfilling" enterprise that should be accomplished, in order to restore a unified sense of self and to re-gain an entry into normal society.

The performance of illness in the patient memoir is also about performing the socially sanctioned "role" of being ill. As Talcott Parsons has argued, illness is one of the sanctioned or "conditionally" legitimized modes of "deviance" in a society. The "conditional" aspect of this legitimized mode of deviance is that the person who is ill will take on a "sick role" – this role requires the ailing individual to accept a certain measure of disability and the obligation to get well expeditiously. While the patient's status as such is socially and institutionally determined, he/she is bound by the "responsibility" to return to a state of health and activity. *"Performing" an ill-self in the patient memoir thus also necessitates the emplotting of a recovered or "improved" self, one that is not simply free from disease, in the medical sense of "remission", but is committed to the task of improving oneself "expeditiously" and is convinced of the "good" in this exercise*.

Writing about the practice of "caring" for or "cultivating" the self in Greek culture, Foucault emphasizes the increased correlation of this tradition with medical practice and thought (54). This correlation drew from the belief at the time that afflictions of the body could have an impact on the soul and similarly, a lack of attention to the "bad habits" of the soul could result in physical misery. Foucault notes the increasing medical coloration of the practice of "improving" or cultivating the soul that the Greeks sought in Philosophy, where even the Philosophers' School espoused the interconnectedness of education and caring for oneself (55). Such an interconnected education is also illustrated by the patient memoir, where *learning* or *educating* oneself about the "roles" to be embraced during illness, is an important aspect of caring for the self. The recounting of an experience of illness is thus also about representing the *learning* or *acquiring* of new skills – managing the illness, learning to interpret intimate physical symptoms in the language of medicine, adhering to treatment regimens like changing diet, exercise and the intake of medication. In addition, the patient memoir also presents the reader with a self that is not only changed through the acquiring of new skills, but one that must learn to interact with the world in a changed capacity. Parsons has identified the significance of family for the “sick role”, in serving as the structure of support. The legitimized “deviance” of the sick individual, is conditional on a relationship of dependence with other individuals who are not sick, like the family, the medical practitioner and personal circle, rather than other “deviant” or sick individuals (312). Foucault has also noted, as argued earlier, the importance of “recognizing” the need for assistance from competent sources in the practice of caring for the self. The patient-narrator, thus, enacts an agential move not only in the emplotment of a social aetiology of disease, but also retains a measure of control in the *recognition* of a state of need. Self-knowledge is necessarily cultivated and performed by the patient-narrator, through the acquiring of skills to manage an experience of illness and the recognition of a dependent state – a state that requires a new kind of role. This “dependent” role requires a performance of an “improved” or “improving” self, not only to attain eventual independence (the mandate of the “sick role” where “independence” and self-sufficiency are seen as the sign of recovery and “expeditious” return from the state of illness and need), but is seen as part of the emotional labour owed to those that one is dependent on (the medical and filial support system). While the presence of illness and its remission can only be “accurately” proved and recorded through the technological and diagnostic expertise of the medical institution, the patient’s ill-self is able to acquire intimacy with his/her own experience through the performance of acquiring “self-knowledge”.

Self-improvement in the patient memoir is thus performed through the acquisition of self-knowledge, which is contingent upon (a) the recognition of being in a state of dependency or need (b) the acquiring of new skills, the learning of which is occasioned by illness. Recognizing dependency comprises three parts: (i) Recognizing Dependence on a Prior Self (ii)Defining a “Relative Normalcy”, (iii) Recognizing the “Duty” of

Improvement. I will focus here on the first part of recognizing dependency and the acquiring of new skills occasioned by the onset of illness. The patient-narrator's realization and defining of a "relative normalcy" and his/her recognition of a "duty of improvement" are related to the instantiation of a "filial self" in the patient memoir, and are themes I will return to in a later chapter on filiation and affiliation.

a) Recognizing Dependency

(i) Recognizing Dependence on a Prior Self: A crucial aspect of recognizing dependency at the level of the individual in the patient-memoir is the dependence on a "prior self". As argued in the earlier section, the genesis of the "extraordinary" qualities of "forbearance", the motivation to "survive" and "endure" illness in the narrator is plotted, like the illness itself, along a personal axis of such traits. Thus, illness is seen as a distorted version of the self, whose beginnings are often also recognizable (in terms of lifestyle practices, hereditary factors).Similarly, the valiant, heroic self that strives to attain normalcy and ability is traced to an earlier, precursor self that was possessed with an indefatigable will to survive. Self-knowledge in the patient-memoir, thus also proceeds from recognizing a dependence on this "precursor" self, a dependence on qualities that were always already inherent in the narrator but are harnessed now in the plotting of a "story" of recovery. The patient-narrator thus presents a "survivor aetiology" narrative, where the "work" of recovery is performed entirely through a reliance on the self. R.M. Lala writes in his *Celebration of the Cells,* about respecting oneself rather than pitying one's altered state after being diagnosed with cancer. "There is a vast difference", he writes:

> between self-pity, which tends to take over with the 'why me' syndrome, and a healthy respect for oneself. A disease can be treated either as a

> challenge or a curse. I find that one's mind and spirit can carry the body, as I experienced in those days of May. (53)

The time that Lala refers to in "May", when his spirit and mind could "carry" his body, is when he is being administered a second round of chemotherapy for a recurrence of cancer. A "healthy" respect for his own ability to overcome even a recurrence of cancer is here framed as a "mind and spirit" that has been cultivated to bear the burden of an ailing body. Earlier in *Celebration of the Cells*, Lala traces this "healthy" respect for himself, to a time prior to diagnosis with cancer when he recounts for the reader, how he deals with negativity in his immediate environment. Lala confesses to having experienced bitterness on account of a rude remark made towards him by a colleague. However, rather than confront this colleague or allowing the incident to "ruin" his "spiritual life", Lala recalls how he instead apologizes to the man for having closed his heart to him after the event. This episode is significant for what the colleague later remarks about Lala – he meets Lala to tell him that what he said required "a lot of courage" (40). This incident, along with Lala's testifying to his commitments at work (he continues to work during his treatment at the cost of inducing a greater severity in his condition), naturalize the image of a "self" that always already possessed a degree of hardiness. Lala's dictum of "healthy respect" for oneself thus coincides with the reader's perception of a self worthy of this "respect". Similarly, writing about the rigor of an ART (Assisted Reproductive Technology) treatment for infertility, Jayadevan records in *Malicious Medicine* about the "forbearance" required for participating in such a procedure. The process involves several hospital visits, medical examinations, hormone monitoring and complete bed rest, "all of which", she writes, "required forbearance" (16). Jayadevan traces this forbearance, like Lala, to an essential self which in her case is filially determined. In addition to testifying to withstanding the rigor of ART procedures, some of them administered in an unskilled and unhygienic manner, by narrating the story of how she was able to conceive without medical assistance, Jayadevan also acknowledges her "forbearance" as being inherited. In a chapter titled "motherhood", Jayadevan credits several "mothers" in her family tree as being responsible for several of those qualities she has inevitably inherited. Her "individuality", she writes here, was "moulded by my parents" (64). Jayadevan here performs a "self" that has been determined, even prior to the onset of illness, as one that can withstand adversity. The recognition of dependency and the ill-condition in the face of medical platitudes is thus an assertion of the ill-person as subject or agent.

Indra Jerath's account of being diagnosed with non-Hodgkin's lymphoma in *Smiles and Tears*, testifies to the "indignation" she feels when her doctors treat her as someone who needs to be protected from the "shock" of her diagnosis. Jerath, who nursed her husband through his leukaemia for over twenty one years, feels no "fear" or "awe" for the disease as she is not only skilled in the management of its symptoms but also expresses a desire to become independent. She writes of her indignation when her doctors, feeling the need to "protect" her from the "news" of her cancer, bypass her altogether and relay the diagnosis instead to her children:

> It was my battle and I was determined to ensure that my cancer was going to affect the lives of those around me in the minimum manner possible. After all my children and their children had their own lives to live. (231)

And later she records, "I was in charge. Also I knew how to look after myself" (231).Jerath is able to draw a link here, between her own past as a caretaker and her present state as a cancer patient. The patient-narrator recognizes dependency on a prior self, through a bridging of the gap between the time prior to the onset of illness and the period of recovery. This bridging of the "gap" introduced in a patient's biography through the onset of illness, is a significant aspect of the move towards performing independence through a reliance on the self for effecting recovery. Lata Mani also records in *Interleaves*, about the inability to "shut the door" on her past self as she learns to manage her chronic disability. She writes of the "gift" of surrender to "physical weakness", as being a condition where it is "impossible to place the weight of one's body on the door of the past, thereby hoping to prevent it from leaking or flooding to the present" (15). Framing the telling of her story itself as a narrative "bridge", she states that she "Looks to words as a way of composing something like a bridge, however partial, between where I have been and where I am today" (14). Recognizing dependence, is therefore also about the acknowledgement of reliance on the "experience" of illness, of reliance on the "self" that was transformed by illness, which frames and lends credence to the performance of "recovery" and "independence".

(b) The Acquisition of New Skills

Self-Improvement in the patient memoir, as argued earlier in this chapter, is performed through the acquisition of self-knowledge, which is also contingent upon the acquisition of new skills, the learning of which is occasioned by illness. Patient-narrators recounting an experience of illness, acquire new skills required to manage a life that is now intimate with a disabling condition or pathogen. These skills range from learning to identify "symptoms" that require expert assistance, to administering medication, an altered lifestyle and diet and as argued in the previous section, a critical reordering of notions of “normalcy” and “ability”. The acquisition of these new skills, brought on by the occasion of illness, lends a mantle of “expertise” to the patient-narrator, who is authenticated by his/her experiential authority. The acquisition of new skills performed by the patient-narrator consists of (i) Ethical expertise,(ii) The Narration of Progress or Learning to Narrate Progress and(iii) Learning a New kind of Social Embeddedness. I will focus here on a discussion of the first two aspects of the acquiring of new skills in performing self-improvement in the patient memoir. The third aspect, which is learning a new kind of social embeddedness, I will return to in chapter four, which deals with filiation and affiliation.

(i) Ethical Expertise: The patient-narrator performs the role of an “ethical expert” in the disseminating of practical knowledge about the experience of illness. The importance of the “sharing” of practical skills is viewed in the narrating of illness experience, as being on par with the labour of acquiring skills to manage one’s illness. Knowledge gained during the course of experiencing and managing illness, is thus seen as being “productive” only when “shared” with another or harnessed in the betterment of others – both ill and potentially at risk. Anita Jayadevan, for instance, records her interest in conquering her “ignorance” on the subject of ART in *Malicious Medicine,* after a clinical confirmation of pregnancy (without the assistance of any reproductive medicine). Despite being clinically pronounced as pregnant, and thereby rendered “cured” of what she had so far thought of as infertility, Jayadevan immediately reminds the reader of how difficult it was for her to overcome the trauma of her previous attempts at medically assisted reproduction. Jayadevan’s self-education thus continues, in spite of being clinically pronounced as “cured” of her infertility. She writes about her quest for information about

ART procedures on the internet, given the lack of professional knowledge about the subject in India (Jayadevan records that ART procedures are not part of the medical curriculum in India). Jayadevan performs her "perseverance" in learning about ART, through her admission of a poor knowledge of English, the language in which most information on ART was to be found. Jayadevan's quest for knowledge on the subject finds its culmination in her records in *Malicious Medicine*, of correspondences with the then Union minister for planning, the minister of Health and Family Welfare, India and petitions and a Public Interest Litigation filed with the Kerala High Court and Supreme Court demanding a bill to regulate ART procedures in India. She testifies to filing over two thousand representations to this end in three stages and records that after several failed attempts, her special leave petition to the Supreme Court led to the passing of the ART (Regulation) Bill & Rules, 2008. This draft bill recognized the need for regulating ART procedures and technology in the country, and invited comments from the general public and medico-legal experts for a period of two months, before being presented before the parliament. Jayadevan's "expertise", gained through her own labour of learning and seeking counsel from filial networks of expertise, is thus harnessed in the service of "millions of infertile Indian couples" (78).

The patient-as-expert is now responsible for harnessing his/her newly acquired skills in the service of others. The patient-narrator thus performs "improvement" through the labour of "expertise". This labour is performed through the active seeking out of knowledge about one's own condition and the circulation and transfer of this knowledge to other bodies, similarly transformed or with the potential to be transformed through illness. This labour of acquiring and disseminating knowledge becomes a substitute for the lack of social/economic productivity brought on by a period of illness. R.M. Lala in *Celebration of the Cells* recalls how he explained the "horrors" of smoking and the "dangers" of passive smoking to a train ticket conductor. The conductor, who occupies a vacant seat next to Lala and enquires if he can smoke, is met with a "forceful" response from Lala, who performs the function of an "ethical" expert and explains the dangers of tobacco use. Informing him of the dangers of passive smoking, Lala writes in a particular letter to Vandana, that he even provides the conductor with literature on cancer. "We cancer survivors can help others", he instructs Vandana, while recounting how he was also able to elicit a promise from the conductor that he would quit smoking (18). Similarly, in Manoj Thaker's account of suffering from oral cancer in *Smiles and Tears*, titled "The Truth About Tobacco-Related Cancer", a cautionary tale about tobacco use is presented for the reader. Thaker, who, as the postscript announces, succumbed to his cancer prior to the publication of the book, spent his last few years alive educating others about the dangers of tobacco use. He writes of his efforts:

> My cancer has taught me to look inside myself and see things as they are and not as I want them to be. Every day I am learning new ways to improve myself, before attempting to change the world. (133)

What is significant about Thaker's tale of his own tobacco addiction that leads to his oral cancer is his framing of the "teaching" offered by the experience and how he "learns" to harness this teaching in the service of others. Thaker testifies to travelling to far-flung areas in Mumbai to educate tobacco users about the dangers they face – Thaker's education thus comprises not only the acquisition of new skills to manage his condition (having lost most of his jaw to the radical surgery required to remove his oral cancer, Thaker is now able to consume food only in liquid form), but the dissemination of this "practical" expertise to a wider network of people. He becomes a member for instance, while convalescing after bouts of surgery and radiation, of a volunteer group called CATs (Crusade against Tobacco), that works with underprivileged sections of society like industrial workers where the incidence of oral tobacco use is high.

Vijay Bhat too, in his e-mail correspondences reproduced in *Smiles and Tears*, confesses to a parallel development that took place during his period of recovery from cancer treatment – "The second development is that I am being increasingly drawn into sharing my own experiences more widely and in actively helping/counselling others" (91). Bhat is here appropriating the "new" ethical role of expert that he has taken on, as part of his period of recovery and self-education (Bhat also needs to learn how to "transition" into a new life and job in a different country while simultaneously undergoing treatment for his cancer). Illness experience is thus an occasion for "learning" that necessitates "teaching", a necessary movement made from a condition of dependency (on filial and professional networks of care and information), to being depended upon for "experiential wisdom" and "caution". Writing about the necessity of "unburdening" oneself of a "story" of illness, Lata Mani also confesses in *Interleaves* to taking on the role of a "teacher". She writes of the "tiring" activity of teaching performed by those that are severely ill, an activity that is tiresome only on account of truant students. She emphasizes the importance of listening to the "teachings" of one who is ill and writes that the "teaching itself is not tiring unless those who claim they wish to be students are never to be found in the classroom when the instruction begins" (50). Mani here underscores the importance of the labour of performing the role of “expert” and the difficulty it entails, on account of the rarity in encountering a “good” student or listener.

“Expertise” in patients’ accounts of an illness experience thus has two modes – biomedical and experiential. Biomedical “expertise” is concerned with the learning and management of the symptoms of illness both at home and within the medical institution. This kind of expertise engages with the effects of disease and medical treatment on the body and thus relies on a reproduction of information regarding the nature of disease, methods of treatment and its consequences. Experiential expertise on the other hand, draws from the patient-narrator’s “authentic” corporeal experience of disease and thus relies on a personalized, creative reconstruction of the onset and management of illness. While biomedical expertise is also perhaps experientially acquired (in the sense of exercising “choice” over treatment plans and their execution at home and the everyday management of illness), it is rendered in more neutral terms than experiential expertise. In the instances cited earlier therefore, Jayadevan, Lala and Thaker narrate the *general* effects of medical malpractice and tobacco-related cancer use on *any* body. Jayadevan, though herself a victim of medical malpractice, is still speaking in the instance cited earlier from the point of view of a “recovered”/”cured” self while espousing by example, the importance of being “informed” before seeking medical intervention. Lala similarly “educates” his fellow passenger about a form of cancer and causative lifestyle factors that he has never experienced himself. Thaker, despite demonstrating intimate knowledge about tobacco use and oral cancer, disseminates “expertise” about his condition among “diverse” sections of tobacco users (his teaching in “far-flung” areas of Mumbai and his educating of industrial workers). Thaker thus has to *translate* his expertise, like Lala and

Jayadevan, to apply to *any* body that is potentially at risk from tobacco-related cancer and medical malpractice respectively. Experiential expertise, like Mani's and Bhat's, draws from an "authentic" corporeal experience of disease that is therefore necessarily individual/particular. This kind of expertise is thus contingent on the *sharing* of an experience and its unique/creative rendering, rather than a *translation* of this experience to ensure relevance with any context. Illness thus occasions "learning" to successfully manage the acquiring and translating of knowledge about one's condition.

(ii) The Narration of Progress or Learning to Narrate Progress: Self-knowledge in the patient-memoir is seen as "improvement", only when framed as moving from a state of dependency to one of independence. One of the means through which the performance of improvement is achieved, is through the individualized social aetiology narrative, presented in the patient memoir as contrary to or disruptive of the universalized medical narrative of illness. A second means through which improvement is performed, is through the emotional labour of "wellness" performed even prior to a regaining of control over the body during treatment and convalescence. The patient-narrator "learns" and "teaches" the framing of the labour of improvement as part of the narrative of progress, that must necessarily appear as an individual effort, as arising from sources outside of medical and filial assistance. Louise Woodstock identifies the elision of the influence of social factors in the narration of an "individual" story of success (325).

The narrative authority of these authors proceeds from their "articulation of similarity" with the reader and they place considerable responsibility and power on the individual. Lisa Diedrich has also signalled to the "brightsiding" at work within the "mainstream culture" of breast-cancer."Brightsiding", as elaborated in the Introduction, involves a relentlessly positive attitude about cancer, also seen as an opportunity for creatively transforming the self (Diedrich 51). Treatment, in such narratives, is seen as the source of pain and suffering, rather than the disease itself. Patient-narrators similarly perform a selective process of affiliation, where only some qualities possessed by the narrator's self are rendered "identifiable", thereby "learning" to eliminate aspects of the self that do not qualify as worthy of "survival". As Diedrich and Woodstock have argued, these narratives promote an exclusive reliance on the self through an emphasis on "progress" and "improvement" and attempt to "teach" readers to circumscribe an experience of illness.

Writing about pushing himself towards a more demanding exercise regimen, Lala advises Vandana in one of his letters in *Celebration of the Cells*, about the significance of relying on one's ability outside of seeking medical assistance. "Not by drugs alone", he writes, "but by thought, discipline and adaptation are we able to go on" (30). Lala recommends the commitment to a narrative of progress and "labour" of improvement undertaken on the body, outside the remission of illness brought about by medication. The "thought, discipline and adaptation" carried out to improve the self, are qualities that require cultivation outside the disability brought on by illness and its treatment. These are qualities that one learns to selectively integrate in a narrative of progress. Narrators in *Smiles and Tears* similarly carry out a selective process of affiliation with members of their family who "bravely" fought cancer. The quality of being a "survivor" is thus traced through a selective affiliation with heredity, where a similar lens of progress through an emphasis on "heroism" and "bravery", is applied to stories of family members who were previously affected by the illness. The narratives of these family members are incorporated into the patient-narrator's filial history of "battle" with the disease and emerging triumphant. Anup Kumar in his *The Joy of Cancer* for instance, defines himself as the current "flag bearer" for cancer in his family. His mother and grandmother, both of whom were cancer patients, are invoked in his narrative however, to compare their relative roles as "survivors". While his mother and grandmother succumb to their cancer (despite putting up a "brave fight" at a time when cancer treatment was not yet very advanced) and (in Kumar's narrative reasoning) pass the disease on to him, he vows to end his family's tryst with cancer and declares to the reader, his desire to improve if only to avoid passing it on to his children.

Aneeta Kalra, in her account of suffering from lung cancer in *Smiles and Tears*, similarly testifies to drawing inspiration from her mother's battle with cancer. While retrospectively narrating her mother's fight with cancer, Aneeta emphasizes what she admires about her mother's mode of "overcoming" her illness – she fulfils her duties as a mother in spite of physical devastation by the cancer. Aneeta recounts how her mother survived long enough to fulfil her promise of performing her daughter's wedding ceremony, and having "fulfilled" her commitment, succumbed to her cancer. Aneeta subsequently informs the reader of her own drive to overcome her cancer, to finish the many duties that she too must fulfil. Aneeta's narrative of her mother's progress, is framed by and incorporated into her own narrative of improvement – fulfilling one's commitments is seen to be more significant for the narrative of improvement, rather than premature death on account of illness. Jayadevan similarly plots her own "individuality" and "forbearance" along a family tree of such women in her *Malicious Medicine*. She learns to plot her family history (as well as her husband's, whose mother appears in

Jayadevan's "family tree" of mothers who nurtured large families and whose "strength" Jayadevan inherits through the "plotting" of this family history) along the axis of her own story of surviving erroneous ART procedures, severe illness and yet experiencing a "natural" or biological pregnancy. "Improvement", is thus also a responsibility "owed" to a community/socially embedded body. The patient-narrator "improves", in order to fulfil his/her social responsibility/role in the various networks (filial, professional) within which he/she is embedded. The family is seen as enjoying a social right over one's sick body, a point I will return to later in this dissertation in the chapter on Filiation and Affiliation.

This chapter has argued that the patient-memoir presents a voluntary "diagnosis" of a life that integrates accounts of the material effects of illness but is not subsumed by it. Patient-narrators plot an imaginative reconstruction of the onset of illness and its effects, via affective modes that destabilize the precision and linearity of the biomedical narrative of illness. This ill-self narrative that locates pathology and "performs" suffering and pain for the reader, anticipates a "recovery" narrative that details the individual's efforts towards a return to productivity. The reader is not called upon to recognize that the narrator is "ailing", but that he/she is characterized by the unique ability to surmount not only illness but any of several such adversities. This "ability" is plotted along a personal axis or redefinition of the notion of "normalcy" and "ability" brought on by the occasion of illness. The patient-narrator thus performs improvement, through the recognition of his/her state of dependency on socially mandated norms of "ability" and "progress". Moreover, the patient-narrator, embedded as he/she is in a filial and professional network of care, is in turn depended upon to "improve", just as receiving care and support during a period of illness is the prerogative of the patient’s “role”, a point I will return to in chapter four of this dissertation. The patient-narrator also depends upon a “prior” self to recognize the “ability” to overcome a state of illness. “Improvement” is also performed in the patient-memoir through a detailing of new skills, the learning of which is integral to the performance and management of illness. The patient-memoir performs the “learning” of managing responses to his/her illness and the narrating of progress, through a focalizing of one’s particularized story of surviving illness via “selective” narratives of improvement.

Just as the “work” of performing suffering and improvement is central to the narrating of illness experience in the patient memoir, the “work” of learning to identify with one’s professionally mandated identity is central to the doctor memoir, the subject of the next chapter. The ill-self and “recovery” narrative examined in this chapter trace the “growth” of the patient-narrator through the conditions of illness, dependency and recovery where this narrator performs the role of a “patient”, “dependent” and “ethical expert”. The next chapter will chart the “growth” and development of the doctor narrator, through the narrative ordering of the experience of medical training and the treatment of illness. The doctor-narrator also “works”, this chapter will argue, to construct a *labouring, cosmopolitan self,* who embodies expertise (as a professional practitioner) gained through an overcoming of his/her novice, trainee self (the period of medical education).

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Chapter Three

Medicine's Rites of Passage:

Narrating Healing and Coming of Age in the Doctor Memoir

Chapter Plan

Section I: The Individual
    The Embodied Physician
Section II: The Editorial Self, Voice and Agency in the Doctor Memoir
    (a) Effecting a Transformation or Change
    (b) Textual Authority and Cultural Authority
    (c) Truth-Telling/Prophetic Role

This chapter will study the doctor memoir as plotting the emergence of a socialized identity for its narrator, whose "growth" and "development" is negotiated via various institutionally governed roles like the "medical student", "the practitioner" and "the expert". These "roles" are examined in the doctor memoir, as key "moments" in the ordering of an experience of learning and eventually treating, ailing bodies and disease. *I will argue here that the narrative circumscribing of the period of youth (medical education) and the "performance" of acquiring expertise (medical practice) in the doctor memoir takes the form of a medical Bildungsroman*. The doctor memoir is an instance of the *Bildungsroman* of healing and a variant form of the classical *Bildungsroman*. The *Bildungsroman* of healing is concerned with the "growth" and eventual "social integration" of an individual, through the condition of "working" or "training" to apply universalized medical knowledge in particular instances. This chapter will study the *Bildungsroman* of healing at the level of the Individual, while subsequent chapters will deal with the filial and social.

Section I of this chapter on the Individual, will study how the doctor-narrator performs the embodiment of knowledge and expertise. The doctor-narrator’s accruingof knowledge is constructed in the *Bildungsroman* of healing, as “work” that is carried out not only out of professional necessity and training. Instead, I argue in this section, the *Bildungsroman* of healing presents an active engagement performed by the doctor-narrator, with the cultural and social contexts of ailing subjects and medical education and practice. This section will trace how the doctor-narrator stages a move from a “novice” to an “expert” self in his/her memoir by demonstrating for the reader, the overcoming or circumscribing of youth. “Youth” in the doctor-memoir or the *Bildungsroman* of healing, symbolizes the period of education, personal standards of professionalism (the ambition of becoming a doctor, the individualized methods of learning and practicing medicine’s rituals) and the “work” of learning to embrace a professional identity. I will argue here that such a circumscribing of youth in the *Bildungsroman* of healing is achieved by demonstrating the physical transformations experienced by the doctor-narrator in the journey from “novice” to “expert”. These transformations are symbolically marked on the labouring doctor body, thus presenting a “professionalized” and also “socialized” self who bears the visible marks of having once been inexperienced and “young”. To this end, this first section of the chapter will look closely at two doctor memoirs, Atul Gawande’s *Complications: Notes From the Life of a Young Surgeon* and Abraham Verghese’s *My Own Country*.

The second section on the “editorial self” and voice and agency in the doctor memoir will examine, in addition to Gawande’s *Complications* and Verghese’s *My Own Country,* Sandeep Jauhar’s *Intern: A Doctor’s Initiation* and Noshir H. Antia’s *A Life of Change: The Autobiography of a Doctor*. This section will argue that the physician writer is able to improvise an “editorial self”, who is able to exert editorial or textual control over the narrating of the bodily symptoms of disease. He/she is able to “improvise” this “editorial self”, by utilizing the epistemological and interpretative authority bestowed by the medical profession and is thus able to establish editorial authority over the patient’s narrative. In addition, this section will examine how the doctor-narrator is able to carve out a space in his/her account of medical education and practise, from where the story of a “heroic” emergence of a “social self” can be plotted. The doctor body is substitutable, this section will demonstrate, with the sign/value of medical education and expertise. He/she is thus able to exert editorial authority over social worlds outside the medical institution that also typically intersect with an individual patient’s case history. The doctor-narrator, I argue here, acquires agency in the voicing of particular narratives of patients.

Section I: The Individual

The Doctor-Memoir takes the form of a medical *Bildungsroman* and is an instance of the *Bildungsroman* of Healing. The doctor-memoir or the *Bildungsroman* of healing charts the development and transformation of the “doctor” from novice “trainee” to “professional”. The period of “youth” in the classical *Bildungsroman*, that is finite and must eventually give way to “maturity” and socialization, shifts to fit the doctor-writer’s chronicles of his/her period of education, learning, errors and experimentation that must also necessarily end to give way to expertise, perfection and professionalism. The doctor's *Bildungsroman* of healing marks a shift from the individual to the social with the filial/familial intervening. This chapter will study the *Bildungsroman* of healing at the level of the Individual and the following section examines the doctor-narrator's performance of the embodying or integrating of medical knowledge/training.

(a) The Embodied Physician

The physician-narrator in the medical *Bildungsroman* is embodied and set apart in the performance of a labouring, expert, cosmopolitan self who can, by virtue of this "cultural body work", identify and be identifiable to others whose embodiment is similarly marked. The physician-narrator's journey from "trainee/novice" to "professional/expert" is staged as a process of physical transformation through a "marking" (symbolic) of personal and professional experiences on the body. The physician-narrator is shaped by the many bodies he/she encounters (the patient body, the body of the pathogen) and bears the marks of these necessary integrations. Suzanne Poirier has demonstrated that the "role" of the physician's body and those of his patients are significant for the work of medicine and in "preparing" the physician for positioning himself in the world (525). The ritualized professional practices of the medical history and the physical exam are inseparable from the idiosyncratic cultural and material contexts in which the physician (as reader of the body-as-text) and the patient (as the body presented to medical knowledge) are embedded. The physician-narrator is "marked" by the process of growth from the filial/novice trainee to the expert/professional, manifest as dramatized encounters between the physician's body and the patient, the pathogen and the institution, and thus embodies the inherent "tension" of medical practice. In his study of the "culture of dissection" in the Early-Modern period, Jonathan Sawday illustrates how the body during this period is understood as an unexplored territory that demanded the kind of "heroism" and skills from the anatomist-explorer, as those demonstrated by real-life voyagers to various parts of the terrestrial globe at the time. This gives rise to a "new figure" of the "scientist as heroic voyager and intrepid discoverer" (24). The doctor-narrator in the medical *Bildungsroman* is thus embodied, through an individualized articulation of a process of learning and practicing medicine through varying levels/stages of expertise, like the anatomists who "come of age" during the seventeenth century with a "new" map of the body and a "new" grammar of understanding its inner recesses. At the level of the Individual, the physician-narrator's novice/trainee self is presented in a state of "becoming", a "not-yet-integrated" self that performs the "body work" essential for a future identification as "expert/professional". The physician-narrator as a novice *labours* to make his/her body identifiable, in the various official and unofficial contexts in which he/she is simultaneously embedded.

The physician-narrator's process of self-discovery is rooted in the labour necessary for the accumulation of expertise. The physician's body labours officially, to detect and cure disease in an individual body by translating universal medical principles into local, particularized knowledge and unofficially, to make his/her "productivity" easily identifiable. In order to maintain the viability of his/her embodied self within the waged labour environment, individuals perform a set of unofficial tasks or "body work" (Shilling 73). Work, as argued earlier, is the primary marker of identity in the medical *Bildungsroman*. The doctor-narrator circumscribes his/her youth (the period of medical education/learning/training) through performing the physical rigor of professional "work", embodied as the labouring, cosmopolitan "expert" self. The professional/expert self via a cosmopolitan attitude, is able to bring a range of professional and cultural experiences, acquired through professionalization and socialization, to bear on the study or interpretation of the individual body and the performance of his individual, particular role. The necessary “body work” performed by the physician-narrator in the medical residency, returns metonymically as the “valuable” and “real” education (as opposed to the theoretical training and learning that takes place in the pre-training period of medical education), that the physician-as-expert embodies. The medical residency is thus a period marked by an anxiety of identification. The physician-narrator during residency is alien to his/her own self on account of the irreconcilability of the individual case with the universalised body of medical theory. He/she is also alien to the patient (while the physician-narrator’s identity as “expert” is premised on his/her identification in such terms by the patient, as a “novice/trainee”, the physician-narrator articulates an anxiety about the inability to “perform” just yet, the “role” of the “expert”). Writing about his first day as a surgical resident, Gawande recalls the “body work” necessary when he meets one of his first patients:

> I tried very hard to look like someone who had not just got his medical diploma the week before. Instead, I was determined to be nonchalant, world-weary, the kind of guy who had seen this sort of thing a hundred times before. (8)

Gawande draws attention to the “necessary” posturing carried out by the physician, the “performance” of “expertise” carried out by the novice even before his “training” has begun, in order to be identifiable to a patient whose body and authority are relinquished on the basis of this “performed expertise” by Gawande. We are speaking here, therefore, of the symbolic, semiotic posturing and marking of/on the physician's body that helps the patient identify Gawande as a trained, expert physician.

Physician training tales are also characterized by the "body work" necessary during medical residency, on account of the "unintegrated" medical knowledge that "weighs" on the physician-narrator's sense of self. Consider, for instance, the following passages from Verghese's *My Own Country* and Gawande's *Complications* that describe their narrator's experiences with the intern's coat – the first, from *Complications* describes Gawande in his fourth week of surgical training:

> The pockets of my short white coat bulged with patient printouts, laminated cards with instructions for doing CPR and using the dictation system, two surgical handbooks, a stethoscope, wound-dressing supplies, meal-tickets, a penlight, scissors, and about a buck in loose change. As I headed up the stairs to the patient's floor, I rattled. (3)

Recalling his and fellow interns' coats, Verghese writes:

> We strutted around with floppy tourniquets threaded through the buttonholes of our coats, our pockets cluttered with penlights, ECG callipers, stethoscopes, plastic shuffle cards with algorithms and recipes on them. (25)

And later:

> Carried casually in sterile packaging in our top pockets were seven-gauge, seven-inch needles with twelve-inch trails of tubing. We were always ready—should we be first at a Code Blue-to slide needle under collarbone, into the great subclavian vein, and then to feed the serpent tubing down

> the vena cava in a cathartic ritual that established our mastery over the human body. (25)

In the above passages, it is evident that the medical intern literally “carries” or “bears” the weight of his/her yet-to-be-integrated expertise. For the physician-narrator’s sense of self, this is literally “rattling” – as suggested by Gawande’s deliberate pun on “rattled” in the first passage. While the passage from *My Own Country* describes the accumulated “mastery” of the intern over the human body, it is utilized by the physician-narrator to highlight the impotent nature of this mastery as it fails in the face of the AIDS epidemic. The “cathartic ritual” learned during his internship is reminisced sardonically by Verghese, an AIDS specialist whose experience with treating what is essentially an incurable disease as a professional, is at odds with his pre-AIDS internship. Verghese is retrospectively narrating the “confidence” that he and fellow interns exude during their medical training, believing that were AIDS to arrive (which it hasn’t as yet at the time of internship) then they would certainly be able to offer a cure, or “swallow it and digest it in the great vats of eighties technology” (25). However, as Verghese soon discovers when he chooses to practice at Tennessee, he is not only able to cure those patients who exhibit symptoms of HIV, but is also unable to maintain a professional “distance” from their individual circumstances. As a “master” of his profession, Verghese is still imbued with a sense of loss as he loses more of his patients to the AIDS epidemic. “I was a doctor”, Verghese later writes, “a scientist, trained in professional detachment, but all the usual procedures seemed satirical in the face of AIDS” (229).

The physician-narrator’s identification as “expert” is thus rooted in this metonymic recurrence of the “body work” of internship. The physician-narrator stages his process of growth through this yoking of experience and reflection, where the “body work" of internship appears as a "valuable" lesson. The physician-narrator as "expert/professional" may have shed the trappings of medical education (the intern's coat, for instance), but bears the marks of this period of learning nevertheless. Therefore, the "mark" becomes, in one sense, invisible, auratic, even without the visible signage. The signage becomes "invisibilized", where the value and meaning of the trappings is transferred onto, and translated as, the expert body: the physician, after a point, *is* the sign.

The physician-as-expert is able, through a metonymic invoking, to frame the internship critically – it is circumscribed both in terms of the nature of "body work"and its degree of viability. The physician-as-expert engages in "cultural body work" – the physician-as-expert is a cosmopolitan, labouring self whose "productivity" is framed as relevant or viable not only for the individual, but for the community. The doctor-narrator's framing of his individual labouring self as relevant for the community is a point I will return to in chapter five, where I focus on community in the doctor memoir. This section has examined the doctor-narrator's staging of a process of symbolic physical growth or transformation, where the doctor-body, once transformed as expert, comes to signify the "body work" carried out to attain expertise. The sign/value of the "body work" performed during internship and the physician's body, therefore become interchangeable as metonyms for each other, as the next section will demonstrate. This second section of the chapter on the doctor memoir, or what I am calling the *Bildungsroman* of healing, focuses on the construction of an "editorial self" by the doctor-narrator. In addition, this section also studies the carving out of a space in the *Bildungsroman* of healing, from where the doctor-narrator voices the story of his/her emerging "social self" and acquires agency through the voicing of particular narratives of patients. Section Two of this chapter will argue, through an analysis of the “Editorial Self” and the “Social Self” constructed in the doctor memoir, that the doctor-narrator is a relational self that comprises a certain degree of fluidity. This fluid, relational self of the doctor-narrator, can insinuate himself/herself into various narrative events and levels in the ordering of an experience of treating/healing illness.

Before moving on to an examination of the various instances where the protean doctor-narrator facilitates the easy transition from professional/institutional contexts to more social and cultural ones, it is important to reflect first on the interchangeable nature of the doctor body and the value/sign of medical training. It is this metonymic substitution between the “body work” that becomes invisibilized and the doctor body that allows for the ease of “improvising” a narrating voice and self at various levels and locations in the *Bildungsroman* of healing. The value/sign of medical training or the “trappings” of medical education in the doctor memoir, include the memories of its rigor and almost pathological severity, the not-yet-integrated information of medical text books, the intern coat and memories of an imperfect, trainee self that committed near fatal errors. These “trappings” can be productively read as “boundary objects” that retain a recognizable structure across various social worlds. “Boundary objects” are defined by Starr and Greisemer as “objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites” (393). The “trappings” of medical education or the “body work” performed by the doctor-narrator, functions as a “boundary object” that validates “work” and “expertise” in social worlds outside of his/her immediate corporeal and material contexts. Therefore, as the next section will demonstrate, when the doctor-narrator improvises an “editorial self” that can approximate the experiences of patients before their entry into the medical institution, the doctor body is here interchangeable with the “body work” already performed during internship. The invisibilized “signage” of medical education validates the accuracy with which patients’ stories, “presented” to the doctor in their own words, becomes translated or integrated into the doctor’s own particularized narrative of treating illness.

The doctor body and his/her narrating of particular instances of the application of universal medical knowledge, incorporates, and is substitutable with, the “body work” of rigor, having learned from prior errors and having integrated medical knowledge. Medical education’s “trappings” as “boundary objects”, are governed by the frames of interpretation provided by the doctor-narrator’s detailing of the process of physical transformation effected from “novice” to “expert”. When he/she is insinuated in other social worlds (medical, social and cultural events experienced by patients outside the doctor body’s narrative reach, before and after their entry in the medical institution), the doctor-body is substitutable with medical trappings as “boundary object” and thus makes this improvised insinuation “recognizable”. The doctor-narrator is thus able to *translate* universal medical knowledge, to particular, idiosyncratic contexts, through a reliance on the “robust” and “plastic” nature of this knowledge or medical education. In addition, however, medical knowledge or the period of education as “boundary object” invests the doctor-narrator with a certain authority or validates his/her narrativizing of non-medical or social and cultural subjects and contexts as well. “Boundary objects” are also significant in enabling the creation of “scientific authority”, that is invested in the hands of “entrepreneurs” who enlist “participants” or “allies” from a range of locations and “re-interpret” their interests. It is in this manner that the concerns/interests of the non-scientist are translated into those of the scientist, who subsequently establishes himself/herself as the gatekeeper of the mode of articulating these interests. The doctor-body similarly functions as the “gatekeeper” of knowledge about the patient-body, authorized by the auratic “trappings” of medical education. The patient’s “presentation” of his/her own story of illness to the doctor, is “enlisted” as an “ally” and “re-interpreted” in the doctor’s case history, prepared using the authoritative “trappings” of medical knowledge. The following section will examine in greater detail, the doctor’s acquiring of agency in voicing particular narratives of patients and his/her improvising of an “editorial self”.

Section II: The Editorial Self, Voice and Agency in the Doctor Memoir

The Physician Editorial Self

The physician “self” is in part constituted by the stories that this “self” narrates to the reader, about other individuals’ lives with whom the physician-writer has come into contact professionally. In a manner similar to the recording and interpreting of an individual’s medical case history, the physician writer fashions a medical narrative for each case study that he/she presents to the reader. The individual’s medical history, is a careful process of selection (from assorted symptoms) for the “attentive” physician, whose skill lies in his/her ability to assemble those “codes”, that a patient’s (normally chaotic, non-linear and non-medical) story of illness experience offers, to map an aetiology of disease. The physician writer similarly presents a medical narrative for the individual body, *prior* to its entry into the hospital/medical science and consequently into his/her narrative reach. This medical narrative attempts to elide the violence inherent in the transition the medical narrative/history makes, from “symptoms” into “ascertainable presence of disease” and consequently, the transition from normal, healthy individual outside the narrative realm of the physician writer, to patient, in need of diagnosis, treatment and restitution.

The individual’s journey towards the “event” of disease and its diagnosis and treatment in a medical institution, is narrated through a process of editorial (re)construction by the physician writer. This journey undertaken by the individual, though accessible by the physician writer only via the “story”, not always offered willingly, by the individual, is still re-told in the medical narrative to improvise an editorial physician self. The physician writer “invents” a medical narrative for the passage made by the individual body into medical science. I use the term “invent”, to indicate the deployment of representational strategies that “shift” the individual, corporeal body into medical science/laboratory. This serves to improvise an editorial physician self who is so absorbed into the “patient’s” story so as to no longer appear extraneous, but rather, is internalized and then revealed to be indispensable for the narrative constitution of the individual *as* “patient”. The physician writer is able to insinuate himself/herself into the individual’s story, via an improvised editorial self that is created and made powerful by the invented medical/diagnostic narrative. By “invented” I do not mean “fictional”, but rather, gesture at the editorial or textual control the physician self is able to exert, over assorted symptoms and the body, because s/he is qualified to do so through the medical system and institutions. “Improvisation” thus includes, (i) the utilisation of the epistemological and interpretive authority bestowed by the medical profession and (ii) positioning oneself, armed with this authority, as an editor-self for the patient’s narrative.

The structural constraints imposed on the medical narrative by the editorial physician self in terms of causality, linearity, point of view, “resolution” (or diagnosis), presuppose a physician self, with attendant implications of authority, attentiveness, the ability to “read” the individual body for signs of disease, the ability to “read” the individual as representing a set of codes that make visible the larger structures through which disease permeates the social body. As argued earlier in this section, this physician self or the doctor body is metonymically interchangeable with the value/sign of medical knowledge.

Voice and Agency in the Doctor Memoir

In the medical *Bildungsroman*, the physician narrator emerges as “heroic” through the construction of a space for his/her voice. The narrating “self” created by the medical *Bildungsroman*, I argue, is at once made possible and legitimized by a certain cultural and textual authority that this narrating “self” is invested with. As Ananda Mitra argues, voice is the acquiring of agency through which a speaker can assume the position of the “speaking agent” in order to “produce a specific kind of voice for himself/herself” (493). The doctor-narrator in the medical *Bildungsroman* thus acquires agency in the recounting of his/her experiences of medical education and “speaks” authoritatively about a particular “mode” of transforming into an “expert”. This doctor-narrator is able to carve out a space, from which a story of education accruing independently from the medical institution, through real-life forays into “treating” illness can be voiced. A “social” self for the doctor-narrator thus emerges, by creating a “position” from which a “story” of transcending the immediate professional “role” of the doctor can be voiced. The doctor-narrator’s “social” self engages in a kind of narrative activism and sets him/her apart, through a call to ethical action or through the articulation of an ethical response to illness and the practice of modern medicine.

At the centre of this "ethical response" is the ability, on the part of the doctor-narrator, to "narrativize" the *particulars* of the many "stories" of illness/disease that he/she is privy to in everyday life. Voice can be conceived as a "dialogic event" which constitutes emotional and ethical dimensions (Mitra 483). Moreover, voice is "public" in its presumption of an addressee/listener and an examination of voice must necessarily consider the process through which acts of "public discourse" constitute the sustenance and reinvention of communities (Mitra 484). The dialogic event that comprises the doctor-narrator's voice in the medical *Bildungsroman*, I argue, is the *voicing of particular narratives of patients*. As argued earlier in this chapter, the doctor-narrator's *Bildung* proceeds from experiences of naiveté and disillusionment during the period of "formal" education (training/internship) to experiences of "real-life" encounters with disease, embodied in patients whose life stories often take the doctor-narrator's education outside the medical institution (the practice of medicine). Thus, when he/she voices the story of the emergence of a social self, the doctor-narrator utilizes as raw material, the methods of isolating, recognizing and observing the progress of disease in the body (learned during formal education) and the process of applying these methods to the *individual*, particular body. This body is not only socio-culturally and idiosyncratically embedded, but is also first rendered or "presented" in a language that is not the doctor-narrator's own (encountered during the practice of medicine). M L Pratt describes the "predicament" of the neocolonial cultural state, as the inability to subscribe to and fulfil the values of the metropole, in order to be modern and at the same time, to be unable to chart a separate course and exit the system. She writes, "norms generated elsewhere cannot be implemented where one is, but cannot be refused either. One is forced to be a second-class member of a club in which membership is not optional" (226). The doctor-narrator as novice "trainee", upon becoming a "member" of the medical institution when he/she makes initial forays into the practice of medicine, faces a similar predicament to the neocolonial cultural subject. As a "new" member of a community that values stability, self-assuredness and experience, the "novice" doctor-narrator struggles to implement the "norms" that he/she has assimilated in formal education in the particular, individual case encountered within the confines of the medical institution that will not allow a bypassing of these "norms". The individual "case" however, is first presented to the doctor-narrator by the patient in his/her language, particulars of which the doctor-narrator translates and *narrativizes* and thus voices a particular narrative of an individual/patient/medical "case".

The doctor-narrator thus, in an incipient agential move, armed with the narrative "presented" by the patient and the methods of narrativizing learned during formal education (preparation of the case history, nosology, and aetiology), particularizes a set of data (recorded by the doctor-narrator in accordance with the "norms" of collecting this data in the medical institution).The doctor-narrator also particularizes his/her experiences (narrativized from the experiences "presented" by the patient and populated with the doctor-narrator's experience of this encounter) in connection with a particular, individual patient. The doctor-narrator here voices in a heteroglossia, and seeks to include patient voices as well, a point I will return to later. *The doctor-narrator's agency, I argue, is concretized in the voicing of particular narratives of patients.*

It is significant to note at this point, that the claim to authority over the knowledge of another made by the doctor-narrator, moves from material acquired through affiliation/expertise (during education and through the medical institution) to narrative particulars that are acquired from patients' presentations of their ailments. The doctor-narrator records these particulars through acts of recognizing narrativizability in everyday medical encounters. The doctor-narrator functions in a manner akin to the neocolonial traveller, in his/her insistence in recording their travels (through patients' bodies and lives in the case of the doctor and through Western Europe in the case of the traveller from the neocolony) in "experiences in recognition" rather than "acts of representation" (Pratt 228). These "acts of recognition" or "*antecedentes literarios*" comprise the neocolonial traveller's "uneasy insistence" on book knowledge and his recording, only of those sights he "recognizes" from earlier travel accounts. This traveller, thus, only claims authority to "recognize" what he has "learned" or been "taught" to know would be there in the places he visits (Pratt 228).The doctor-narrator similarly, in his "travels" through the landscape of the patient's experience of illness (comprising vital signs, social/cultural contexts, medical case history), asserts his/her "recognition" of the narrativizable particulars of individual patient "stories" or cases. The doctor-narrator's literary antecedents comprise his/her medical education and the "known" universal case of the indication of a particular disease in the body. However, this narrator also performs access to patients' individual, particular representations of their illness experiences. These "representations" to the doctor by the patient, as argued earlier, represent a "cultural predicament" as the doctor in this situation, like the neocolonial autodidact, is a "peripheral intellectual". The "real" reality and "history" of the disease collated by the doctor, has been lived elsewhere and it is only through his "book knowledge" or medical education, that the doctor can lay claim to what he "sees" in each patient's case. The doctor-narrator exercises agency in the particularizing and voicing of the narrative of the individual patient. He also exercises agency in recognizing these particulars as originating from the patient's own narrative, which is the literary antecedent to his/her own record of the experience of practising/exercising treatment in the individual case. The physician-narrator's "social" self in the medical *Bildungsroman*, emphasizes the "ethical" and "moral" and thus creates a space that concretizes agency not only for the speaker, but for the community of addressees presumed by the narrative.

The construction of a particular voice/self in the medical *Bildungsroman* is achieved through the following processes/stages of self-fashioning effected by the doctor-narrator at the level of the Individual: (a) Effecting a Transformation or Change, (b) Textual authority and Cultural authority and (c) Truth-telling/prophetic role.

(a) Effecting a Transformation or Change

The doctor-narrator in the medical *Bildungsroman* possesses the ability "transform" or change over the course of the narrative. As argued by Lois McNay, agency can be reconfigured in terms of creativity of action. A creative or imaginative foundation for action, McNay argues, a type of "autonomous" agency, illuminates how action transcends its social, economic, cultural, corporeal and material context (22). Physician-narrators in the medical *Bildungsroman* perform a "creative" ability to "transform" or "change" over the course of the narrative, thereby transcending their cultural, corporeal and materiel contexts in new and unanticipated ways. Verghese's "narrator-agent" for instance, is distinguished by his ability to conflate his "foreignness" as an Immigrant Indian physician with the "foreign" status of his patients and the AIDS virus. Verghese's narrator is able to first adapt to his "foreign" setting, Johnson City, Tennessee, in America and makes it his "home" and even sets himself apart from others in his "foreign" community. When a fellow Indian doctor displays a lack of social etiquette, Verghese's narrator in turn cringes when the Americans amongst the hospital staff associate this doctor's "boorishness to his foreignness" (45). Verghese's narrator instead, works at "blending-in", to earn the local title of "good 'ole boy" (the highest compliment a "Johnson Citian" would pay another), by working to expand his "Appalachian folk lexicon" and making it a "challenge" for the locals to find food that he would not eat. Verghese's narrator then transcends this identity of a "good ole boy" to become the "foreign" physician who attracts AIDS patients with a similarly "foreign" status. After meeting a gay couple infected with AIDS, Verghese's "narrator-agent" thinks aloud about whether or not his patients feel relieved after narrating the story of their "foreign" illness to him – "I may have been flattering myself with these thoughts, but more than once I had the sense that a patient was opening up to me for this very reason, *because* of my foreignness" (116-117). Moreover, the physician-narrator in the medical *Bildungsroman* is able to speak at various instances in the narrative, outside his/her corporeal, material and cultural context. Verghese's narrator for instance, "speaks" at several points in the narrative, recounting or describing the final moments of patients' lives, their encounters with family members, based purely on knowledge of their case histories and despite not being present "physically" at the site of narration.

Antia's narrator, for instance, sets himself apart through his ability to transform attitudes towards the treatment and care of leprosy patients, in general wards of plastic surgery wards in the country. "My success", he writes:

> I believe, lay in the fact that I was able to break the stigma surrounding leprosy that had hitherto prevented the admission of leprosy patients in a general plastic surgery ward of one the oldest and most reputable non-missionary hospitals of our country, the J.J Hospital and Grant Medical

> College. This had a country-wide effect. Medical and surgical care of leprosy is now part of the general medical wards of most hospitals in India. (49)

Antia's narrator also refers to the simple and effective treatment that he was able to pioneer at the Thane civil hospital for the treatment of burns. This "soap-and-water" method of treatment, he observes, proved to have exactly the same mortality rate amongst patients as the more sophisticated and also unaffordable burns unit at the J.J Hospital. Antia's narrator thus, emphasizes his ability to bring about radical changes in treatment through an emphasis on the social – "All these benefits", he writes of the Thane civil hospital burn treatments, "came at a tenth of the cost of the far more sophisticated burns unit at the J.J Hospital" (75). Jauhar's narrator in *Intern* is troubled by the "transformation" that he observes in his attitude towards medicine and other doctors by the end of his internship year. He applies for a fellowship at the Bellevue Hospital at the end of his internship year and is struck by a debate he overhears between a first-year resident and a senior fellow, over performing a surgical procedure for a heroin addict. The senior fellow believes a heroin-addict has poor chances of recovery and is thus not entitled to an expensive valve-replacement surgery. The debate reminds Jauhar's narrator of a moment during his internship year when he was in the first-year resident's shoes, fighting for the rights of a patient who his superiors believed was too obese to risk the surgical procedure he required. He finds, however, that he is not sympathetic to the resident's cause. Instead, he writes:

> At one time, I too had felt passion like this resident. I too had felt deeply disturbed by a surgeon's refusal to operate. Now, listening to this

> discussion, I wondered if the resident wasn't just a bit naïve. It was a transformation that troubled me. (286)

The narrator's anxiety at his transformation is offset later in the narrative, by his admission that he becomes the kind of doctor that he didn't expect to become. This kind of doctor that he "transforms" into, however unwittingly or accidentally, is significantly, a socially conscious doctor. Now transformed into the doctor he didn't think he would be, Jauhar's narrator identifies with his brother, his wife and his classmates (all of those from whom he felt alienated during the course of his internship), who are all he says, "fundamentally good people trying to do good everyday" (286). He says:

> I thought I was going to make big changes, more of an impact, reform the profession somehow, but in the end I adapted to the culture around me. I came to accept the workings of the hospital and of my colleagues. I became less judgemental – of doctors, not patients (there was a time when it had been the other way around) - and more forgiving of, faithful to, my guild. (286)

Jauhar's transformation is, again, unique in that it happens in reverse. His transformation occurs when, at the end of his residency, he is able to identify the value of his education and the social potential, the ability to "do good", that medicine facilitates. He transforms from feeling alone to isolating a feeling of "belonging" to a "guild" that he now identifies with.

Gawande's narrator in *Complications* traces his transformation through the recounting of a near-fatal error he commits during his surgical residency. Through narrating this story, Gawande's narrator also signals at the transformative power that medicine offers its practitioners. Later in his residency, when Gawande's narrator is performing a fairly routine procedure, (a gall-bladder operation, presented as fairly uncomplicated in comparison to the earlier procedure when Gawande's narrator admits to failure – the earlier incident involved an "emergency" and was thus already "complex", given a shorter time period within which an already severely traumatized patient needed to be resuscitated) he manages to avoid yet another fatal complication, this time on account of "a little extra fastidiousness" on his part. Recalling his earlier error in the context of his now miraculous "save", Gawande's narrator says, "Yet although the odds were against me" (the previous time), "it wasn't as if I had no chance of succeeding. Good doctoring is all about making the most of the hand you're dealt and I failed to do so" (65). And then, speaking of the "routine" gall-bladder operation, where he prevented a potential mistake in time, he says, "Operations like that lap chole have taught me how easily error can occur, but they've also showed me something else: effort does matter; diligence and attention to the minutest details can save you" (65). Gawande's narrator thus calls upon his reader to reflect on the transformative potential that exists within the scope of the medical practitioner. It is not that medicine is without its errors, but the doctor-agent within the institution does possess the ability to transform both his own practice and through it, the institutional practices as well. "No matter what measures are taken", he writes, "doctors will sometimes falter, and it isn't reasonable to ask that we achieve perfection. What is reasonable is to ask that we never cease to aim for it" (65-66).

(b) Textual Authority and Cultural Authority

Verghese's *My Own Country* (subtitled "A Doctor's Story"), Jauhar's *Intern: A Doctor's Initiation*, Gawande's *Complications: Notes From the Life of a Young Surgeon* and Antia's *A Life of Change: The Autobiography of a Doctor*, for instance, are suggestively titled and expressly proclaim to narrate the “true” story of their respective authors. These texts employ a narrative structure that, firstly, creates a narrating agent as a representation of the author’s “self” and enables this self to create a space from which a specific kind of voice is produced and utilized to various ends. The narrating “self” created by these texts, I argue, is at once made possible and legitimized by a certain cultural and textual authority that this narrating “self” is invested with. Donald Pollock asserts in his study of medical autobiography, that the life story of an individual is only worth recounting if it deviates from the ordinary and commonplace (109). The author’s “life story” thus, should comprise an experience that can be seen as different from the ordinary. The voice of the “narrator-agent” in *My Own Country* thus takes on particular significance precisely because it recounts an insider’s perspective on a deadly, infectious disease’s spread in America. More significantly, however, the “narrator agent” in the medical *Bildungsroman*, is invested with a kind of social and textual authority. The “narrator-agent’s” tale in *My Own Country* for instance, is worth recounting precisely on account of this cultural and textual authority that sets apart his life story from that of other accounts of the AIDS crisis in America in the early 80’s. The “narrator-agent” in this text is invested with cultural authority on account of his particular real-life “professional” role with respect to the AIDS virus (Abraham Verghese as an Infectious Diseases specialist treating AIDS patients). As a member of a community facing the risk of infection by AIDS, his experience is constructed as being different from the “everyday” experience of AIDS and is instead presented as an authoritative “report” of the epidemic. Moreover, *My Own Country* is also invested with a certain textual agency by virtue of its temporal framework. Narration, as Rimmon-Kenan reminds us, “can entertain various temporal relations with the events of the story” (90). Thus, Verghese’s "narrator-agent" is invested with textual authority, as he is presented as having recounted experiences that coincide with the beginning of the epidemic. *My Own Country* specifically links the narrator's arrival in America with that of the virus – the narrator says, "I had arrived in America as a rookie doctor in 1980. At about the same time, HIV, the virus that causes AIDS, landed in the port cities of the United States: New York, San Francisco and Los Angeles" (14).

Similarly, Antia's "narrator-agent" emphasizes the "new" nature of plastic surgery as a sub-speciality of surgery and is immediately invested with a degree of authority as having pioneered this field in India. Antia's narrator acknowledges his debt to his teacher, Sir Harold Gillies, to whom, in his words, he owes his "interest and expertise in plastic surgery" (26). But he is also careful to point out to the reader that at the time (1950), plastic surgery was "new in England and unheard of in India" (27), thereby setting himself apart immediately as being one of the first plastic surgeons in India. In addition, Antia's critique of the state of medical practice today and its corruption by "market forces" draws upon his "authority" as a narrator who witnessed the beginnings of the antibiotics era. Antia's narrator is able to witness the use of penicillin soon after it was discovered in 1944, as a student at the J.JHospital. A British medical officer brings this antibiotic in its crude form (the penicillin fungus) from England to an ophthalmic operation that Antia's narrator witnesses with awe, along with his fellow students. Two years after they witness this procedure, penicillin is made available in India in the form of an injection and as students, Antia's narrator, along with others at the J.J Hospital, marvel at the dramatic effects it has when they treat patients in terminal stages of peritonitis and pneumonia. Antia's narrator then calls upon his "authority" as witness: "I have been privileged to see the very beginnings of the antibiotics era and the wonders it could achieve. Unfortunately, market forces have captured the medical profession, leading us to the end of the dramatic antibiotics era" (11). Antia's narrator thus assumes his speaking power based on a unique advantage of having witnessed the "birth" and "death" of the antibiotics era. Gawande's "narrator-agent" declares at the start of *Complications* that his authority arose from "what I have encountered and witnessed in the day-to-day caring of people" (xix). Gawande's narrator is thus invested with textual authority upon having "witnessed" and experiencing real, "day-to-day" "encounters" with disease during his internship. Gawande's narrator goes on describe his distinctive textual authority – "A resident has a distinctive vantage on medicine. You are an insider, seeing everything and a part of everything; yet at the same time you see it anew" (xix-xx). Gawande's narrator thus acknowledges his unique position vis-à-vis the practice of medicine – as an intern, (not yet integrated into the profession and yet very much a part of it and with most exposure to "practice" since learning during the internship is through as much practice as is possible, given the ethical constraints of pairing inexperienced doctors-to-be with complex, individual cases) who sees things "anew" and is thus set apart from others encountering disease day-to-day.

Jauhar's narrator in *Intern* similarly utilizes his distinctive vantage as an intern to critique the "night float" system of resident rotation. The "night float" system, instituted by the Bell work-hours commission in the mid-80's, was meant to curtail medical errors that may occur in teaching hospitals on account of overworked and fatigued interns. The night-float, however, is not without its problems (interns and other staff at the hospital, for instance, while performing their "night" rotation have no connection with or understanding of patients admitted during the day and thus, though well-rested, may miss essential details of cases the are "signed out" to them by day interns) and Jauhar's narrator attains recognition both within his hospital and at a national level for his critique of the "night float" system, which was published in the *New York Times*. Jauhar's narrator provides the reader with evidence of this "recognition", by reproducing a letter written by Dr Bertrand Bell (who headed the original work hours commission) to the New York State Department of Health, citing Jauhar's article in the *Times* and demanding corrective action. Jauhar's narrator-agent is invested with textual authority, through an indication in the narrative to the social recognition that the "real-life" narrator achieves by critiquing a flawed medical system.

As argued earlier via Wayne Booth (1961) and Jan Marta (2011) in the Introduction, the doctor-narrator in the medical *Bildungsroman*, as "author" of a "story" of practicing medicine, exercises control by creating a world of norms and by relating his/her story to universal truths. To this end in the medical *Bildungsroman*, the narrative function of the patient-character is curtailed, to bring to prominence the physician-narrator's authority over both the primary narrative as well as the "written medical truth". *In the medical Bildungsroman, the doctor-narrator's textual authority draws upon his cultural/professional authority, to enable him/her to set his/her narrative account apart from other such accounts and by extension, set the narrator-agent apart from other characters in the narrative*.

(c) Truth-Telling/Prophetic Role

The narrator-agent in *My Own Country* is empowered to act and speak on account of specific strategies utilized by the narrator-agent to speak the "truth". The narrator-agent in the medical *Bildungsroman* of course, possesses the faculty to speak the "truth", precisely through the cultural and textual authority invested in him, as argued in the previous section. In addition, these “narrator-agents” construct an “experiential” truth that lends power to their voice. These “narrator-agents” are able to “speak”, even when they are not physically present at the events they recount, on account of their capacity for experiential “truth-telling”. The “narrator-agent” in *My Own Country* presents the “facts” of a case for the reader, only to unravel a “truth” from these facts, that only the agent is in a position (in this case, by virtue of his authority as a doctor) to speak. Very often, while presenting the case of an AIDS patient at his medical facility, Verghese’s “narrator-agent” is in a position to “see” beyond what the patient is describing as “symptoms” or “risk factors”. While describing his treatment of a particular patient, Verghese’s narrator-agent mediates the patient’s “voice”, through a presentation of what the patient says about his own body and the narrator-agent’s subsequent summing up of the “true facts” of the case. Take for instance the following description of a patient who does not admit to having any HIV “risk factors” (summed up in the narrative as being a homosexual, an intravenous drug user, a haemophiliac, as having had contact with a prostitute, among other common stereotypes about AIDS infection in the early years of the epidemic):

> He vigorously denied any risk factors for HIV infection… He admitted only to occasional contact with prostitutes while in the service. He had come in for Pneumocystis carinii pneumonia. An astute medical student spotted a strange skin lesion in his armpit which, when biopsied, turned out to be a Kaposi’s sarcoma lesion. In all my years in AIDS (ten at the time of this writing), I have never seen Kaposi’s except in gay men. (163)

The “narrator-agent” here clearly distances himself from a) the patient’s description of his symptoms, b) the student’s “astute” observation about a nonetheless “strange” lesion. The patient’s “true” identity as a person with definitive “risk factors”, and the “strange” lesion's "true" identity as a Kaposi's sarcoma lesion, is established by the "narrator-agent" precisely through this distancing from the patient and the medical student.The patient's "true" identity is also established by the doctor-narrator's ability to interpret the biopsy, and place the Kaposi's Sarcoma lesion within a larger framework of his "experience" with AIDS.

Antia's narrator for instance, also roots his capacity for truth-telling in the "experiential". He writes:

> In my travels to countries of the East and the West, I have been exposed to new ideas and approaches to medical, surgical and political problems affecting health care in various parts of the world. This accumulated experience makes me speak with some authority. (188)

Jauhar's doctor-narrator identifies the fundamental "experiential" realm of all doctors as a kind of origin for all such experiences – "I write only of my own experiences", he says, "but I am sure that most residents have undergone similar ones. Doctor's professional lives are built brick by brick, case by case, but the foundation, residency, is much the same" (xv). The narrator-agent's truth here stands in for a "collective" truth that he is able to isolate, on account of a larger realm of experience with "internship". Gawande's narrator similarly recounts the story of a patient who chooses a surgical procedure while already in a near-terminal state, against the advice of his doctors. Like Jauhar's narrator, Gawande's doctor-narrator situates the "true facts" of this particular case, against a larger framework of experience of knowing when surgical intervention will be successful and when it can be fatal. Significantly, when Gawande's doctor-narrator first meets this patient, he believes he is already dead. He recalls:

> When people are asleep—or even when they are anaesthetized and not breathing by themselves—it does not occur to you to question whether they are alive. They exude life as if it were heat. It's visible in the tone of an arm muscle, the supple curve of their lips, the flush of their skin. But as I bent forward to tap Lazaroff on the shoulder I found myself stopping short with that instinctive apprehension of touching the dead. (195)

Gawande's narrator's description is significant for how much attention has been paid to detailing the "normal" body, suffused with life. While narrating the story of Lazaroff, Gawande's narrator-agent relies on his patient chart for the purpose of presenting the "true" story to the reader – reading the chart enables him to read the "story" of the patient against the "story" conveyed by his body's deathly appearance. The "truth" revealed by the patient's chart, which contains a biopsy report, is that Lazaroff suffers from an "untreatable cancer" that had spread extensively in his body. Gawande's narrator goes on to reveal to the reader, that Lazaroff's operation was unsuccessful and he dies a painful and violent death. Lazaroff's unfortunate story is related by Gawande's narrator, to highlight the importance of the doctor's role in leading patients towards the right decisions, given their "experiential" authority in the workings of medicine and in making difficult decisions. The "true" outcome of Lazaroff's surgical procedure is something Gawande's narrator is able to predict, on account of his deliberate distancing from Lazaroff's own request for the surgery, and reading his "chart" within a larger framework of diagnostic experience with terminal conditions like cancer. Jan Marta has argued that the patient's "secondary" discourse in the medical narrative is both dangerous and endangered. Endangered because it faces the threat of collapse from the doctor-narrator's primary narrative and is dangerous because it is in fact a "suppressed metanarrative" (54).

To establish medicine's objectivity therefore, narrative level and person are introduced, along with an atemporality that helps to establish in the narrative, medicine's claim to absolute knowledge and universal truth (Marta 57).

The doctor-narrator in the medical *Bildungsroman* is thus able to construct a particular voice/self through the above stages/processes. This *Bildungsroman* "voice" appropriates particular discourses (originary/experiential) and generates some discourses of transformation and improvement, reinventing and sustaining the status/retaining the fixity, of the doctor-narrator's "self". Such a *Bildungsroman* narrative constructs a "self", who will deal with the social by giving voice to a moral discourse in the text and emphasizes the ethical dimension of narrative, by finding a new narrative voice that brings together the personal and professional dimensions of medical practice.

This chapter has examined the "growth" charted by the doctor-narrator, from a "novice" to an "expert" self, through the staging of symbolic physical transformations to the doctor body. The "trappings" of medical education, like knowledge yet to be integrated, the posturing/temperament to be learned so as to be "recognizable" as a professional, the authority signified by the doctor's "coat", become a sign/value that is transferrable to and substitutable with the doctor body. This doctor body is therefore able, this chapter has demonstrated, to transcend his/her immediate professional, corporeal and cultural contexts, to extend editorial authority over other social worlds that intersect with the study of an individual's history of disease. The doctor-narrator thus performs the "labour" of translating universalized medical knowledge/tools to individual/idiosyncratic instances and narrates particular stories of the ailing bodies he/she encounters. The doctor-narrator in the *Bildungsroman* of healing, is able to construct a particular voice/self that is able to harness particular discourses of patients, and generate transformative, agential discourses of improvement/perfection/critique, that sustain the "fixity" of this doctor-narrator's "self".

The first two chapters of this dissertation have explored the narrative ordering of an experience of illness and its treatment at the level of the Individual as seen in memoirs written by patients and doctors respectively. *Both doctor and patient narrators are seen to "perform" for the reader, the individual "work" of "growth" achieved through the negotiation of various "roles" occasioned by illness and its treatment.* In the case of the patient memoir, as seen in chapter two, the patient-narrator's ill-self is seen to trace "growth" as something the individual labours towards, in performing the institutionally governed roles of "patient", "convalescent", "dependent" and "ethical expert". Moreover, the patient-narrator instantiates a *relational* self, seen as being always already imbued with the potential for both illness and recovery. This *relational* self of the patient-narrator, is therefore not defined by illness alone and can be insinuated in a creative, non-medical reconstruction of the events leading to illness and recovery. The doctor-narrator is similarly seen to perform the "body work" necessary for circumscribing the "novice" self who symbolizes the period of "youth". The doctor-narrator, in his journey from "novice" to "expert", also negotiates the institutionally governed roles of "medical intern" and "resident", before he/she can embrace the role of "expert". However, as this chapter has demonstrated, the doctor-narrator's self can also be seen as *relational*, where the doctor body or his/her voice, can be insinuated at various events and levels in the narrative ordering of an experience of treating/healing illness.

The narrating "self" in doctor and patient memoirs however, are also embedded in a filial network, another significant aspect that is seen as necessitating "transformation" or "growth" in the medical *Bildungsroman*. The next chapter, on Filiation and Affiliation, will deal with the filial networks within which the narrating "self" in doctor and patient memoirs is embedded. These narrators are also seen in these memoirs as being passively embedded within the filial network, with a small or no measure of agency. The patient-narrator for instance, also constructs a "filial self", who is seen as "owing" the duty of improvement to filial networks of care. The family is seen to enjoy a "social right" over one's sick body and the patient-narrator "works" to fulfil his/her duty of improvement, owed primarily to the filial network of care. The doctor-narrator similarly traces his/her filial network as one that encompasses not only family, but the medical institution and the period of medical training. The doctor's "filial" self is seen in his memoir, as being passively embedded within certain inherited or acquired traditions of medical education and practice (a family tradition of medical careers, the ritualized methods of practicing medicine within a particular institution, for instance). These narrators however, as the following chapter on Filiation and Affiliation will demonstrate, experience an anxiety towards the extent and reach of the "filial". The overcoming of an "inherited" form of the "self", to present a seamless route from "individual" to "professional" (in the doctor memoir), or "ailment" to "recovery" and "improvement" (in the patient memoir), is a significant aspect, as chapter four demonstrates, of narrating "growth" and "development" in the medical *Bildungsroman*. Chapter four will also examine the "filial body" in the medical documentary, where the filial networks within which the individual pathological/pathologized body is visualized as being both vulnerable to and a source of contamination.

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Chapter Four

Filiation and Affiliation: The Contexts of Illness and Healing

Chapter Plan

Section I: The Doctor Family

Section II: The Patient Family

- (a) The “Filial-self” and The Caregiver *Bildungsroman*
    - (*i) Learning/Acquiring the Caregiver’s Role*
    - *(ii) The Mutuality/Reciprocity of the Caregiver’s Role*
    - *(iii) Cultural Audit*
- (b) Recognizing Dependency or the Embeddedness of the Ailing-Self
    - (*i) Defining a “Relative Normalcy”*
    - *(ii) Recognizing the Duty of “Improvement”*
- (c) Learning a New Kind of Social Embeddedness

Section III: The “Filial Body” in the Medical Documentary

The previous chapters examined how the doctor-memoir, or the *Bildungsroman* of healing, charts the development and transformation of the “doctor” from novice “trainee” to “professional” and how the patient-memoir traces the journey that the patient-narrator undertakes, from the moment of medical “diagnosis” to “convalescence” and “recovery”. Chapter three on the doctor’s *Bildungsroman* focused on the Individual in the process of transformation charted by the doctor-narrator and the second chapter on the patient memoir, similarly focused on the individualized labour of the ailing body towards locating pathology, performing illness and self-improvement. This chapter will study filial connections in the doctor memoir, the patient memoir and the representation of the "filial body" in the medical documentary.

The first section of the chapter on the Doctor Family, will examine Gawande's *Complications: Notes From the Life of a Young Surgeon* and Abraham Verghese's *My Own Country* and will argue that the doctor-narrator's "professional" self emerges with the circumscribing of the "filial" self. The narrators of these texts are marked by a distinct filial advantage, whose influence is curtailed in the narrating of growth from a "novice" or rookie self to an expert or "professional". The doctor-narrator as "professional", this section will demonstrate, strives for a narrative closure of the "filial" self (understood in the narrative as a passive state), so as to achieve a "cosmopolitan state of becoming". This "cosmopolitan" state of professionalism is understood as the ability to simultaneously engage local and global contexts in the practice of medicine. The "professional" doctor engages the changing contours of medical practice and the uncertainties of medical knowledge at a global level, simultaneously with the local, everyday practice of medicine on individual cases that arise from multiple cultural/social contexts. The doctor-narrator's engagement, I argue here, with treating disease in plural and globalized cultural contexts, sets his "professional" self above the "filial", thereby charting "growth" and a move towards the social. This section will also detail how the doctor-narrator is seen to chart a move towards the social, by placing "filial" interests either on par with or as located *outside* his "professional" engagement with medicine. The doctor-narrator's performance of relinquishing the personal or "filial" in favour of the public/social, anticipates his/her integration into a wider social network.

The second section on the Patient Family, examines the construction of a "filial self" in the patient memoir to make evident the "mutuality" inherent in patient-carer relations. This section will look closely at the "filial-self" in Jayadevan's *Malicious Medicine*, Kumar's *The Joy of Cancer* and *Smiles and Tears: A Salute to Cancer*, Lata Mani's *Interleaves: Ruminations on Illness and Spiritual Life*, R. M. Lala's *Celebration of the Cells: Letters from a Cancer Survivor* and Yuvraj Singh's recent memoir, *The Test of My Life*. The "filial-self" improvised by the patient-narrator, this section will argue, serves to order the transformation brought on by illness and the resulting dependency on filial networks of care. To this end, this section demonstrates, the patient-narrator instantiates a caregiver *Bildungsroman*, which is mediated through the patient's reconstruction/testimony of "acts of care" received by him/her during the period of illness-induced dependency. An experience of illness, this section will demonstrate, is seen as bringing about a mutuality of transformation in the patient body and the filial networks within which this body is embedded in the patient memoir. The "role" of caregiver, for instance, is seen as developing concomitantly with the "role" of the patient and both necessitate the acquisition of new skills, require social and professional legitimation and "recognition". Moreover, as argued in chapter two, "improvement" is seen as being owed to the filial network within which the patient-narrator is embedded. This section returns to the "filial" aspects of "self-improvement" performed in the patient memoir, namely recognizing embeddedness in and dependence on, "filial" networks of care. "Caregiving" labour, I argue here, is similarly constructed as being "owed" to the patient-narrator and the patient-narrator's "filial-self", is thus one that necessitates a particular response and responsibility from the filial networks within which he/she is embedded.

The third section on the Filial Body in the Medical Documentary, will examine how the film's visualization of the individual's interrelatedness with the family, enables the sentimentalizing of a shared vulnerability to disease. This section will look at several medical documentaries – *AIDS*, *Sexually Transmitted Diseases*, *Alcohol-The Killer*, *Preventing Anaemia through Nutrition*, *There is Life for Selvi*, *Saying it Again* and *Conquest of Cancer*, to demonstrate how affective ties are forged between the individual and the space of the family. The social and biological roles of the individual, this section argues, collapse and merge through a "sentimental narrative" in the medical documentary, to highlight the vulnerability to and potential for contagion posed by this individual's filial embeddedness. The "transformation" brought on by disease, I argue here, is visualized in the medical documentary as "unrest" at the level of the family, and is articulated as an undesirable "deviance" from the "designated" and "familiar" roles played by the individual within the family. The "filial body" in the medical documentary, this section will demonstrate, is gendered and is constructed at the level of the family, as a "constitutive" role or "function" performed by this "filial body" within the space of the home.

Section I: The Doctor Family

Filial Connections in the Doctor Memoir

The young doctor/narrator in the medical *Bildungsroman* is first introduced to a professional role via a "filial" network of relations. Atul Gawande in his *Complications*, for instance, recalls "learning" how to judge the degree of "emergency" in patients' frequent phone calls at his physician parents' home, while still a young boy.Similarly, in his *My Own Country*, Abraham Verghese sees his immigrant status in America, as being the result of his parents' "herald migration" to Ethiopia that "presaged their own subsequent wanderings and those of their children" (16). The formation of the doctor's self as "expert" or "professional", however, depends upon a departure from, or an elision of, the filial, to present to the reader, a seamless and uncomplicated route from individual to professional. This elision is in part due to an anxiety about the extent of influence exerted by the physician's "filial" self, over his carefully fashioned "professional" identity. The "filial" in the doctor's *Bildungsroman* signifies those set of relations in which the doctor/narrator perceives himself/herself to be embedded passively, with a relatively small or no measure of agency. In addition to family, the "filial" in the doctor's *Bildungsroman*, encompasses the medical institution, education and training. The extent of the doctor/narrator's socialization and integration into a community relies heavily upon the reach and influence of the filial. The doctor's narrating "self", however, seeks to transcend and circumscribe what is perceived as an "inherited self", as a necessary precondition for adequately representing the "professional" self.

Franco Moretti has argued, that youth in the *Bildungsroman* has to represent features opposed to those characterizing modernity – it is thus circumscribed and isperceived as having to "end". Youth thus, rather than being symbolized as "similar" to modernity (seen as a bombarding, hostile force that threatens with an "excess of stimuli"), establishes a formal constraint on the depiction of modernity. Modernity is thus "humanized" and integrated into our intellectual and emotional system. The doctor as "professional" is thus "humanized" and can be integrated, only through the circumscribing or elision of the "novice", "filial" self. This doctor circumscribes his/her "novice" self, by performing a transcending of his/her passively acquired inheritance (medical education and filial advantage/influence) to become a "professional". The "professional" reflects this "overcoming" or circumscribing of the "filial", but also alters in new and unanticipated ways, the scope and degree of transformation and socialization for the doctor protagonist in the medical *Bildungsroman*.

Atul Gawande and Abraham Verghese, both second generation Indian immigrant doctors practising in the United States, plot the story of their entry and subsequent immersion into a foreign culture in their memoirs. While the narrators of *Complications* and *My Own Country* presumably encountered a culture different from their own as young "individuals", the memoirs are narrated from the point of view of a "professional", as evidenced by the sub-titles of these memoirs – *My Own Country* is "A Doctor"s Story" and *Complications* brings together "Notes From the Life of a Young Surgeon". In telling their stories however, though the "young individual" or "rookie" is portrayed as inexperienced, idealistic and prone to errors and disillusionment, he/she is still marked by a distinct social advantage, which is enabled by the filial network. Gawande, for instance, records visiting the hospital ER with his parents as a child. He writes:

> We'd go to the hospital together, and I'd be put in a chair in the ER hallway to wait. I'd sit watching the sick children crying, the men bleeding into rags, the old ladies breathing funny, and the nurses scurrying everywhere. I got more used to the place than I realized. Years later, as a medical student entering a Boston hospital for my first time, I realized I already knew the smell. (xi)

The institution of medicine and the "sight" of disease have already come to signify a sense of familiarity and intimacy for Gawande, even before he becomes a "medical student". It is interesting to note, however, that the narrative establishes a distance between the youthful "memory" of "passively" watching the internal workings of a hospital and the subsequent memory of "entering" a Boston hospital as a "medical student". Despite his filial intimacy with the medical institution on account of doctor parents, Gawande still describes his "entry" as a "medical student" in Boston, as his "first time". Verghese similarly describes his advantageous position as an Indian medical student in the United States:

> By the time I completed medical school in India and returned stateside, a few of my seniors from my medical school in India had begun internships at county hospitals across America. Through them and through their friends and through their friends' friends, an employment network extended across the country. … And the network invariably provided me with the name of someone to stay with. (17)

Through filial culture, Verghese has access to no ordinary employment network, but a culturally specific one. Through this employment network, Verghese is able to map cultures of medical residencies across the US, with respect to their treatment of foreign graduates. Yet in *My Own Country* too, the narrator attempts to distance himself from the filial, by opting out of this employment network. "Now that I had returned to America," he writes, "with my medical degree, a certain perverseness and contrariness made me want to buck this system. What was the point in coming to America to train if I wound up in a little Bombay or a little Manila" (19). So instead, he travels with his wife to rural America, to be a resident at the East Tennessee State University. The relative advantage of the filial is thus glossed over to make way for the forging of the doctor/narrator's professional self.

As Tobias Boes has argued, the process of translating historical time into a narratable pace in the *Bildungsroman* always contains a culturally specific component

(278). I have also argued earlierin the Introduction, that in the case of the medical *Bildungsroman*, the culturally specific component of the protagonist's translating of historical time,is via a territorialized vernacular cosmopolitanism. As defined byEmily Johansen, a cosmopolitan world view entails moral and ethical accountability to the world, as well as a specific local place (3). The doctor as "professional"is committed to the global (the challenges and changing contours of medical science/knowledge) and the local (the everyday practice of medicine on individual bodies that exist at multiple cultural locations) contexts of medical practice and is ethically and morally responsible to both.The doctor's ethical and moral accountability to disease prevention and cure atlocal and globalized cultural contexts sets his "professional" self apart from the filial. The filial, understood as the doctor/narrator's "passive" state of "being" and embodied by a localized, individual context, must attain narrative closure in the medical *Bildungsroman*, to allow for the representation of the "professional", cosmopolitan "state of becoming".

The Doctor Family

The family in the medical *Bildungsroman* is located outside the "professional" practice of medicine to necessitate the distancing of the filial from the professional. Moreover, the doctor/narrator always places filial interests either on par with or "outside" his practice of medicine, as this determines the extent of his integration in a given community. The doctor/narrator is thus presented as relinquishing the personal in favor of the public and is thereby integrated into a wider social network.

Writing about the inevitable isolation that results from practising medicine, Gawande says:

> Doctors belong to an insular world – one of haemorrhages and lab tests and people sliced open. We are for the moment the healthy few who live

> among the sick. And it is easy to become alien to the experiences and sometimes the values of the rest of civilization. Ours is a world even our families do not grasp. (78)

It is interesting to note, that despite Gawande's exposure to his doctor parents' experiences, he emphasizes the family's *lack* of understanding of the workings of the medical profession. The "insular" and "isolated" world of the doctor is thus not only "alienating", but a necessary precondition for "professionalism". The filial is thus portrayed as existing "outside" the professional practice of medicine. Verghese's account of an infectious diseases practice echoes several of Gawande's characterizations of surgical practice as "insular". While Verghese recognizes the vulnerability of his own family in the context of his intimate interactions with deadly and infectious diseases like AIDS, he perceives their fears and anxieties about his profession, as a lack of comprehension of the many roles he is expected to fulfill in addition to the professional – father, husband, son and mentor to his marginalized AIDS patients, to name a few. Reflecting on his father's queries, about whether or not he takes adequate precautions with his AIDS patients, Verghese is indignant at his father's suggestion that he should wear gloves. He should think of his young child and pregnant wife, his father goes on to recommend. At this point, Verghese reflects:

> I seemed to be living in a separate world which those who had not been touched by the disease could not enter. I felt alone at my own table, alone and unclean, chastened by my father's attitude. I thought at that moment of the gay men I had met during the last months. I thought of how often they had felt alone at the table among family and friends. (168-169)

The threat to the doctor’s family on account of disease is superseded by the doctor’s concern for the community, and the community of patients. Verghese’s family cannot “enter” the world in which he is an AIDS specialist, a world in which he is the heroic savior of a community of marginalized people. While narrating the arrival of his first AIDS patient in Johnson City, Verghese recalls that his wife was afraid, first at his pronouncement that his first AIDS patient was coming to town and then later, at his unmasked excitement. What is interesting about this episode is that he perceives his wife’s anxiety and subsequent lack of a response as “recognition” of his “expertise”. “And now, finally, as if to justify my expertise”, he writes, “to justify my existence, my first AIDS case was on its way down. … The excitement in my voice had been difficult to keep out. And Rajani had recognized it for what it was” (78). The doctor/narrator’s “expertise” and even “existence”, is thus justified by the expansion of professional practice. This can, however, only take place at the cost of the family.

Gawande, like Verghese, illustrates the complex nature of the “physician’s dodge”, by narrating the story of his eleven day old son’s hospitalization for congestive heart failure. “Learning”, for the resident, Gawande argues, must be stolen, as he/she does not yet have the “expertise” to legitimately qualify for experimenting with treating real people. Yet this “stolen” education is what eventually accumulates as “expertise”. When Gawande is approached by a young cardiology fellow, from the team that was caring for his son, however, he is faced with a moral dilemma. Though Gawande knows the fellow *needs* the experience with his son’s rare condition, he is also painfully aware, as an insider himself, that the fellow may not be as “qualified” as the hospital’s cardiologist-in-chief (who is his eventual choice) to care for his son. Reflecting on the episode, however, Gawande remembers that on many occasions during his son’s hospitalization, learning was, in fact, stolen, by residents, trainees and fellows, despite his seeming control over the events. “A resident”, he writes, “intubated him. A surgical trainee scrubbed in for his operation. The cardiology fellow put in one of his central lines. None of them asked me if they could” (24). Though he would have opted for each of these procedures to be carried out by people with more expertise, in the absence of choice, he is forced to relinquish his autonomy to a system that follows a “cold-hearted” method of teaching and learning. “If choice cannot go to everyone”, he writes, “maybe it is better when it is not allowed at all” (25). The process of learning for becoming a “professional” thus transcends the personal and the family.

As argued earlier in this chapter, the doctor/narrator’s intimate engagement with disease prevention and cure in plural and globalized cultural contexts sets his “professional” self above the filial. The doctor/narrator transcends the filial by expanding its scope and degree (he/she makes a move from the local (filial) to simultaneously engaging the local and the global (professional)). However, this move elides the filial advantage described earlier, to present a “professional” self that charts a new trajectory or “directs the plot” of the doctor/narrator’s life. For instance, Gawande recalls being taken along with his doctor parents to medical conventions – a necessary routine for any doctor, “big deals in medicine”, as he describes it. He writes that as a young boy, he “vaguely remembered” the convention as “dense, enormous and exciting”. Years later, as a senior surgical resident, Gawande is invited to attend the eighty-sixth annual Clinical Congress of Surgeons, since he had at the time, “reached the stage in training” that allowed him to be a part of this medical tradition. Despite being introduced to the tradition of conventions as a child, Gawande’s detailing of his experiences at the convention as a resident, are premised upon being able to reinterpret and transcend his “filial” baggage.

As otherwise isolated professionals, whose isolated and insular world precluded any wider professional/social interaction, the convention strikes Gawande as possessing several "good, practical" considerations for anyone interested in "networking". While the convention itself is only partly academic and almost "carnival", in its display of the latest medical gizmos and merchandize, Gawande finds a "deeper", more "poignant" and "vital" reason that draws doctors to these conventions – the desire for contact and belonging. Providing an illustration of these "deeper than mere carnival" moments at the convention, Gawande describes the paradoxical familiarity with which doctors speak to one another, on the bus rides between the convention centre and their respective hotels. Contrary to any other "bus ride", as Gawande puts it, doctors on these bus rides, rather than choosing to keep an anonymous distance from co-passengers who are almost always strangers, instead talk to one another. "You were", he says "you felt, among your tribe – connected though knowing no one" (77). Attending the convention as a resident, Gawande forges connections with a "professional" tribe and the filial now returns merely as an "anecdote", a moment in the past shared casually with a co-passenger. Gawande narrates to his co-passenger on the bus, the story of how his parents chose the city in which they would practice:

> I told him of how, almost thirty years before, my parents had narrowed their choices of where to take up practice to either Athens, Ohio, or Hancock, Michigan, in the upper peninsula. Arriving in Hancock by prop plane for a mid-November visit, however, they found three feet of snow already on the ground. Stepping out in her sari, my mother nixed the place immediately and chose Athens, though she had yet to visit it. (77)

In Gawande's words, his co-passenger, "like my parents, was a native of India". Although, unlike them, he believes like "all deep northerners" that the bitter cold is "really not so bad". The "trading" of this filial anecdote is interesting, because of the transition it evidences from one generation to the other. As senior residents on the road to becoming "professionals", these two doctors share not only the "bonds" of being members of a "tribe", but together sense the transition they have made from their own local, native past.

Similarly, Verghese senses the increasing "Indianization" of medical practice in rural America – through the same "employment network" that allows him an entry into this culture. However, he also recognizes how he and his wife are from a generation that is able to move easily between cultures – their identity more malleable than the many "foreign" physicians who look to practice and settle into "Indian" communities in America. "For the Indian parties", he writes:

> Rajani wore a sari and we completely immersed ourselves in a familiar and affectionate culture in which we had our definite place as the juniormost couple; but at night we could don jeans and boots and go line dancing at the Sea Horse on West Walnut or listen to blues at the Down Home. (23)

Once Verghese begins to practice in Tennessee as an infectious diseases specialist and becomes the town's only "AIDS doctor" however, his "expertise" begins to conflict with this earlier "filial" harmony that he shared with his wife and the Indian community in the rural town. At another Indian party, like the one Verghese referred to earlier, he finds himself alienated by his specialty (at these parties, where financial success determined the root of the hierarchy, *procedural* specialists like thoracic surgeons were at the top of the pecking order), but recovers from it quickly by blaming the payment system in the US that unfairly places more importance on procedural specialties. “I was every bit as well trained”, Verghese notes about his own worth at this party, where as an Infectious Diseases specialist, he ranks lowest in a hierarchy of salaries paid to “specialists”, that comprises thoracic surgeons, urologists, plastic surgeons, cardiologists and gastroenterologists. But later, Verghese attributes the “monetary disparity” among the specialties to the US payment system:

> The monetary disparity was not due to their skill or their intrinsic worth (even though at times I think they succumbed to this delusion); it was due to a payment system that placed greater value on procedural specialties than on those without them. (206)

Interestingly, Verghese finds his niche alongside the teenagers at the party, who flock towards him – the boys attracted by his motorcycle (other doctors in the community, many of the teenagers’ fathers, drive expensive cars) and the girls (with ambitions to get into medical school) are drawn towards his heroic tales of AIDS care. Describing the East Tennessee Indian doctors as “staunch republicans”, Verghese recalls “deliberately planting a seed of dissension in their family” by “marshalling a passionate argument against Reagan” to the group of teenagers gathered around him. His wife however, “is perfectly at home” in this party, now having receded to the background to make way for the heroic fashioning of an “AIDS doctor” at the party. Verghese is ill at ease at this party as an AIDS specialist, alienated from the culture he once described as “familiar and affectionate”, precisely because his “professional” self is now “set apart” from the filial. *The filial has come to represent passivity and homogeneity, while the professional is premised upon a critical and ethical commitment to the practice of medicine that extends* *beyond the local.* The doctor/narrator however, attempts to transcend the local and filial, in an attempt to integrate into a larger, more global community.

The following section on the Patient Family will examine the “filial self” constructed by the patient-narrator in the ordering of an experience of illness. This “filial self”, as argued earlier in this chapter, situates the patient-narrator in a network of filial care and improvises a “caregiver *Bildungsroman*”, constructed through the narration of “acts of care” received during the period of illness.

Section II: The Patient Family

(a) The “Filial-self” and the Caregiver *Bildungsroman*

The patient-memoir, as argued in chapter two, reconstructs for the reader, an individualized account of the “locating” of pathology in the patient-narrator’s body (outside of the medical pronouncement of disease), the transformation brought on by illness to his/her professional, physical, filial and emotional aspects and the struggle to integrate this transformed self within universal and normative structures of medical care and cure. The patient-narrator, in his/her account of transformation-by-illness, details the effects of illness, its treatment and the resulting dependency on the filial structures within which he/she is embedded. A prolonged period of illness and its medical management, results in an inevitable reliance on filial networks of care which determine, to a large extent, the expeditiousness of the recovery period and the at-home management of symptoms. The patient-narrator performs his/her dependency through the construction of a “filial self”, who is not only transformed through illness, but simultaneously enacts a transformation of the filial networks of care on which he/she is dependent. The patient-narrator's transformation by illness, affects the "role" played by him/her in the filial and professional networks within which he/she is embedded. The onset of illness thus brings about not only physical transformation, but simultaneously effects a decrease in and often lack of, economic, sexual, social and emotional productivity. The patient-narrator improvises a "filial-self", in narrating the transformation brought on by illness, to reconstruct for the reader, the "potential" inherent in the body rendered dependent and to validate the investment of filial caregiving labour.

The patient-narrator's "filial-self" instantiates a caregiver Bildungsroman, *mediated through a testimony of "acts" of care received by him/her during the period of dependency resulting from illness*. The patient-narrator's "filial-self" is thus one that necessitates a particular response and responsibility from the filial networks within which he/she is embedded. Dependency is, on the one hand, mandated by the "sick role" occupied by the patient-narrator, where the family is seen to be significant in serving as the structure of support. As argued by Parsons, the sick individual exists in a relationship of dependence with his/her family, the medical practitioner and his personal circle, rather than with other similarly "deviant" sick individuals (312). The patient-narrator testifies to the transformation effected by illness on his own body, as well as the filial network of care within which he/she is embedded. The patient-narrator thus testifies to a mutuality of transformation, where the act of providing care for ailing others, is spatially and temporally linked to the time and space of illness. As the patient-narrator records a gradual decline in his/her normal self and the growing transformation brought on by illness, he/she improvises concomitantly a caregiver *Bildungsroman*, where the occasion of illness and its consequent disruption is seen as a moment of voluntary and deliberate transformation.

While the patient-narrator's identity is premised upon battling the suddenness and inevitability of the transformation of the self brought on by illness, the caregiver identity is characterized through the voluntary acceptance and *imposition* of a certain temperament, manner and way of life, on account of the physical distress experienced by another's body. The "performance" of the caregiver's "role" and the development of the caregiver "self", is contingent upon being recognized as such by the patient-narrator. In addition, the caregiver *Bildungsroman* develops as a quasi-professional role that also needs to be recognized as such by the medical institution, responsible as it is for the scientific or verifiable pronouncement of the patient-narrator's "recovery" from illness. The caregiver *Bildungsroman* improvised by the patient-narrator, can be seen as an instance of a "relating narrative". Whitehead has argued that "relating narratives" originate in a desire we all have "to tell others who we are" (68). Narratives about "ourselves", she argues, are essentially "relational", since we need to rely on the information others have about our origins or birth in order to narrate our own story from the beginning (68). The caregiver *Bildungsroman*, composed as it is through the patient-narrator's empathetic reimagining of a time when he/she was represented and translated by another, is also a relational narrative. It relates to the shared suffering borne by another's body, as though he/she too was affected or transformed by illness. *The caregiver Bildungsroman serves to emphasize the patient-narrator's relational existence – his/her embeddedness in the caring acts/narratives of others, just as these others are circumscribed in the patient-narrator's account of illness experience*. The patient-narrator must thus look to the caregiving acts of others, for a “complete” account of his/her own story of illness experience – the “birth” and “origin” of the “sick role” is thus inextricable from the origin story of the carer.

(i) Learning/Acquiring the Caregiver’s Role: As argued earlier in this section, the patient-narrator testifies to a mutuality of the transformations brought on by illness to his/her own body, as well as the filial/caregiving networks within which he/she is embedded. Patient-narrators effect an empathetic reimagining of their period of illness-induced dependency and the physical and emotional burden imposed by them on the caregiver’s body and emotions. This empathetic reimagining reconstructs for the reader, the pronouncement of the patient’s diagnosis and the prescription of “being depended upon” to the caregiver, by the medical institution. While patient-narrators themselves narratively pre-empt or locate “pathology” outside of its medical/scientific “pronouncement” through diagnostic apparatuses, they also re-imagine, through an empathetic lens, the definitive or medical pronouncement of the necessity of caregiving – the moment at which the concomitant transformation of the caregiver also begins. However, as we shall see later, just as the patient-narrator traces his/her ability to “improve” along an axis of traits that are also based on a “prior” self, the caregiver is also seen to possess the “potential” for performing the role that he/she learns/acquires. Therefore, despite being medically “pronounced” or rendered a caregiver on account of the patient-narrator’s diagnosis, the caregiver *Bildungsroman* develops as an account of learning to harness qualities that draw from the caregiver’s “prior self”, as much as it is about learning to negotiate illness-induced transformations. The reader only “accesses” this caregiver *Bildungsroman* and

the learning/ “acquisition” of new attributes, from the patient-narrator’s testimony and point of view.

Poonam Bagai in her account of colon cancer titled “I am a Cancer Survivor” in the anthology *Smiles and Tears,* records her first encounter with grief after being diagnosed with a tumour in her colon. The tumour required an emergency colostomy while Bagai was in Warsaw and prior to her medical diagnosis, she describes her experience of severe digestive dysfunction. However, while narrating her story of battling the symptoms of colon cancer and being subjected to an “emergency” surgical procedure, she records having experienced grief for the first time, only when she has time to reflect on the effect of her diagnosis and treatment on her family. She writes:

> I cannot even begin to imagine what that night or this announcement did to my husband. But when many months later I did ask him about it and how he told the boys and the rest of our family, it was the first time that I actually cried. (94)

Here Bagai empathetically reimagines for the reader, the emotional effects of her diagnosis and treatment on her primary caregivers – her husband, children and the rest of the family – despite having access to this experience only through her husband’s account after the surgery. It is significant that Bagai’s record of a first physical manifestation of grief is in response to the transformative effects of her illness *on her caregivers*. Anu Gupta, in her account of surviving Acute Lymphoblastic Leukemia in *Smiles and Tears,* similarly reimagines the transformed life of her siblings, who had to learn to live without the care of their mother during the period of her illness. She writes of how she had to fight to survive for the sake of her brothers and sisters, who “survived for one whole year without the influence of their mother, whose entire energy and compassion was concentrated on my well-being" (213). Gupta here draws attention, in addition to reimagining the transformed lives of her siblings and the new role taken on by her mother, to the entirety of the physical and emotional labour of caregiving. Caregiving duties are performed here at the cost of "prior" duties and "roles" – Gupta's mother is now transformed by Gupta's illness and is committed to her care, while simultaneously setting aside her prior commitments to her other children (Gupta's brothers and sisters) and family members.

In addition to empathetically reimagining the transformative effects of illness on the caregiving networks within which patient-narrators are embedded, they also testify to the change brought on by illness and its at-home management, to the home itself and by extension, the caregiver. In Lata Mani's *Interleaves,* where she chronicles her experience of living with chronic brain injury, she writes about her "transformed" home which she shares with her partner Ruth. Mani records an expedition to her garden, an activity that was simple enough prior to her injury, but that now requires an hour of mental preparation before (even though her trip to the garden only lasts about twenty minutes) and eventually, assistance from Ruth in order to make her way back. Excited about the prospect of stepping outdoors (after her injury, Mani records how walking to the table to eat a meal, situated a mere ten feet from her bed, was the greatest accomplishment of her day), Mani writes:

> I went slowly down the stairs. Suddenly, I heard a bone rattling, blood curdling sound. It was Ruth listening to music. I turned around and climbed up the steps and reminded her that I had not died, merely gone

> into the garden and that she could not possibly play such music if she expected me to survive! (19)

Ruth, as Mani's caregiver, is spatio-temporally embedded in Mani's chronic condition and the management of its symptoms at home. Mani, whose whole world is now "an orchestra of sound" and is sensitive to sounds no louder than a whisper and as far away as in a neighbour's house, records here the transformation brought about to Ruth's daily life and activities as well. Her "survival" is dependent upon Ruth's transformation, on Ruth's living, as though she too were sensitive to sound. Mani's symptoms and their disruptive effects or rather, Ruth's act of listening to music (perhaps a remnant of life prior to or in the absence of Mani in the home), becomes the "disruption" in their home. Mani's symptoms are thus now Ruth's own, just as Ruth's acts outside of her role as caregiver are physically traumatic for Mani.

The caregiver *Bildungsroman* instantiated by the patient-narrator's filial-self is thus characterised, by an empathetic reimagining of the transformative effects of illness on the caregiver, as much as the patient. The transformation effected by illness is seen to be a *shared* one, a *mutuality* that is the result of the onset of illness – the ailing, transformed and dependent body of the patient-narrator gives rise to the occasion for caring, bringing about the "role" of the caregiver. Caregivers, along with the space of the "home" itself, share the burden of illness, its symptoms and treatment, along with the patient-narrator. Several patient-narrators, for instance, testify to the seamless integration of the hospital and the home, with caregivers carving out a medically sound environment within the space of the home. In his *Joy of Cancer*, Anup Kumar writes about how he loses the distinction between his home and the hospital:

> I would barely spend a few days at home before being rushed back to the hospital on account of one emergency or another. The house itself began to look like a mini-nursing home. For a period I took 27 tablets a day, apart from daily injections. (19)

He later also testifies to the necessity of "barrier nursing", when his immunity levels dropped dangerously low on account of the chemotherapy treatment for his lung cancer. Kumar's treatment integrates and transforms his home, such that in order to enable a successful recovery, the conditions of a "nursing home" have to be simulated even when he is not in the hospital. The medically mandated regime that has to be executed at home (his intake of tablets and injections), transforms the everyday life and routine of the home and is thus also spatio-temporally embedded in the ailing body of the patient-narrator and his/her caregiver. The space-time of others located in the space of the "home", is now reorganized around the patient-narrator. Illness and the ailing body, in its narrative ordering in the patient-memoir, is now the organizing principle of the home. Thus, the patient-narrator's improvising of a caregiver *Bildungsroman* reorganizes the "roles", functions and labour performed by the "space" of the home and the members of the filial network of care who occupy this space along with him/her. Bashini Rao, in *Smiles and Tears,* also records the gradual transformation of her home into a "hospital" during the period of her husband's battle with lung cancer. While her account of her husband's struggle primarily emphasizes his bravery and stoicism in the face of a fatal illness, she also draws attention to the transformed space of their home and its subsequent effects on their relationship. She writes about her husband Laxman:

> The fact that our home had gradually turned into a hospital had not caused much of an alarm. The presence of the 24-hour nurses had made him happy. Gave him more company to entertain. Even the shifting of the marriage bed that we had shared all our life, and being replaced with a hospital bed had not caused much concern. (60-61)

Rao goes on to say the she continues, at her husband's request, to sleep in the same room in another smaller bed, but her description of the transformation of an intimate space in the home draws attention to her "new" role. She is no longer the spouse who shares her husband's marital bed, but his caregiver, whose proximity is mandated by illness and its medical management, rather than by domestic/filial ties. Rao and Kumar's descriptions of the transformed spaces of the home and the everyday, also testify to the necessity of "recognizing" the space of illness and its management. Though the patient-narrator and his/her caregiver, learn to manage symptoms of illness and its treatment outside the medical institution, the "spaces" where illness and convalescence occur still need to be "medically"/scientifically and "emotionally" recognized. The caregiver's role, while concomitantly arising with the "sick role" of the patient, is also subject to the professionalized standards of executing medical care. By learning to simulate a medically sound environment and through the carving out of a professionally organized space (altering the spaces of the home to accommodate medical apparatus, altering the domestic routine through the compliance with a "prescription", the periodic intake of medication and the recording of its effects) within the home, the caregiver's role is governed, specified and legitimated by the medical institution. Moreover, the caregiver's role must be "recognized" by the patient-narrator, as aspiring to a quasi-professional standard of care. Just as the medical institution is seen as being professionally/officially “bound” to offer treatment and care to the ailing body, the “home” and the “caregiver” are not bound by filial, affective ties alone but are reorganized as semi-professional combatants of the symptoms of illness.

Omesh Khattar, in his account of surviving colon cancer in *Smiles and Tears* for instance, recalls how his wife Neeta “learned how to monitor my pulse and heartbeat when it became weak or feeble” (112). Rohit Vasavada, in his chronicle of fighting cancer of the small intestine in *Smiles and Tears*, also records how his wife “managed to keep track” of even the most minor changes in his health condition. “Her mind used to go on an overdrive” he writes. “if I ever complained about the slightest of pain or discomfort” (168). The caregiver’s role is thus one that necessitates the acquiring of a quasi-professional standard of medical care/assistance, that is governed and mandated by the medical institution. In his *The Test of My Life*, Yuvraj Singh recalls meeting the doctor who was to treat him at Indianapolis, for his rare form of germ-cell cancer and the doctor’s prescription for the inevitable period of chemotherapy that lay ahead:

> I would be able to handle the chemotherapy he said and smiled. ‘It is going to be difficult. But you will need to remember you are going to get better.’ Everyone around me would have to be strong for me. My mother, my family, my friends. (119)

Yuvraj Singh here testifies to the prescription by his doctor, of not only a course of chemotherapy to treat his tumour, but the simultaneous mandate that “everyone” around him would have to support him. The triad of mother, family and friends that Singh identifies here, are his primary caregivers during his treatment at Indianapolis and their "role" is as much medical decree as it is spurred by filial/affective ties. The patient-narrator developing this narrative of selfless care and commitment, as part of the caregiver *Bildungsroman*, is also able to demonstrate filiation being strengthened through this narrative. A commitment to "care", shown as developing over the course of an experience of illness, demonstrates a deepening of "filial" ties. This narrative of commitment is also a narrative of family. However, the "prescription" for Singh's caregivers to ensure a display of "strength" during his treatment process, is a significant one. Several patient-narrators for instance, in addition to applauding, as demonstrated earlier, the concomitant voluntary transformation of the caregiver and his/her effacement of prior roles and duties, also testify to the importance of the emotional labour of performing tolerance and stoicism. Patient-narrators often recall the near-pathological transformation of their caregivers on account of the severe physical imposition of caretaking duties, but nonetheless applaud the labour of *masking* pain and burden, rather than the actual everyday management of another's illness. The caregiver thus performs an "ability" to mask the physical, emotional and financial burdens of caregiving, in addition to the voluntarily acceptance of the mutuality of transformation brought on by illness. Recalling his mother's reaction to being informed about his diagnosis with cancer, Yuvraj Singh records that "My mother had been told. When we spoke she was completely in control. She wasn't panicked, she wasn't crying" (113). Singh's mother's reaction is placed in his memoir in contrast to his own, when, after receiving definitive proof of the presence of a tumour in his chest (a CT scan), Singh remembers being "shattered", "gutted". He simultaneously describes however, his memory of his mother exercising control and of how "somewhere in the background" there were "people" who began their work of planning and researching his treatment options (113). The caregiver thus works from the “background”, rendered visible only through the labour of making his/her own pain and burden less apparent.

Recognizing the near-pathological effects of the labour of caregiving, Anup Kumar writes in his *Joy of Cancer,* about the slipped disc that his wife Amrita suffers on account of the mounting physical burden of her duties. In addition to recording her many “acts” of care however, Kumar also recalls how, “All that while she had suffered in silence.Ignoring something that had needed immediate attention. Sacrificing her pain for the sake of mine” (72). While Amrita’s temporary disability, resulting from her caregiving labour, demonstrates the extent of her duties, Kumar’s description of the “silence” that was characteristic of her suffering, is the significant aspect of her role. Amrita has here learned to perform the emotional labour required in the role of the caregiver, a particular mode of engaging with the cared-for, where the other’s suffering is centered in the place of one’s own, just as the patient-narrator empathetically reimagines the care-induced pain of the carer. Kumar also testifies to how Amrita shelters him from the full extent of their growing debt owing to his treatment. She has to sell all of her jewellery and borrow money from other members of their family to meet Kumar’s hospital expenses – something that Kumar only learns about after his recovery. “Only I know what it must have cost her”, he writes, “how she would have suffered. But the subject of funds for my treatment and our increasing debt was never discussed. She maintained a stoic silence” (45). Kumar later rejoices at not having to experience even the “slightest degree of negativity” in his life, in an “ivory tower filled with only positive energies”, made possible by Amrita’s “silent” and “stoic” carrying of caregiving burden. To perform the role of caregiver, then, is to highlight through “silence”, the patient-narrator's articulation of a story of suffering. The caregiver's role of masking pain gives rise to and makes possible, the patient-narrator's empathetic reimaging of suffering borne by his/her own body and by extension, those others on who he/she is dependent.

In his account of battling with intestine cancer titled "The Power of Relationships" in *Smiles and Tears*, Ranjan Ray also recollects how he never "witnessed" his wife's grief – "If she ever shed tears, she never did so in my presence" (156). Writing about her diagnosis and treatment for breast cancer in *Smiles and Tears,* Gopa Ramanathan describes the "strength" she drew from her husband, her primary caregiver – "Krishna was my rock. He never once complained. He never talked about what he was going through. He discarded his own feelings. His pain.His grief" (199). Similarly, attempting to recall the factors that led to her optimism despite being diagnosed with Acute Lymphoblastic Leukemia, Anu Gupta ascribes it to her parents' stoicism:

> Maybe it was the fact that nothing about my health was ever discussed in my presence. Maybe it was the serene and calm presence of both my parents, especially my mother, stoic as ever, who never left my bedside. (212)

All of these patient-narrators testify to caregivers acquiring a particular set of emotional attributes, during the period of illness and its treatment at home. Just as the caregiver also learns to transform the space of the home to uphold a medically mandated regimen of care/treatment, so as to be recognized "professionally", he/she also has to be recognized "socially" by the patient-narrator. While a mutuality of transformation is brought on by illness, in turn bringing about a caregiver "role" owing to the inextricability of caregiving labour from the space and time of illness, the patient-narrator, like the "professional" mandates of the medical institution, must also recognize the caregiver's self-effacement. *The caregiver's "personhood" is thus dependent upon the patient-narrator's recognition of the caregiver's role and is thus premised upon his/her recognition of the caregiver's self-effacement and the centering of the patient's own priorities*. The caregiver "role" thus requires professional and social sanction, while aspiring to silence one's own suffering and performing strength and stoicism.

(ii) The Mutuality/Reciprocity of the Caregiver's Role: As argued earlier in this section, the caregiver *Bildungsroman* instantiates a mutuality of transformation brought on by illness, shared by the patient-narrator and caregiver and brings about a new "role". Michael Rowe has emphasized, for instance, the importance of the caregiver in representing the "prior" self of the patient transformed by illness. Rowe draws attention to the significance of the caregiver's memory and narrativizing of his/her role, for the "humanity" and "personhood" of the patient. The patient-narrator, as we have seen earlier in this section, empathetically reimagines the period of dependency on a caregiver brought about by illness. This empathetic reimagining of the caregiver's "silent" labour and suffering, is the only reminder of the patient-narrator's period of transformation andis as such essential for his/her own recognisability as a "person"/ "individual". The patient-narrator is made recognizable and "familiar" for the reader, like Rowe's son becomes "dearer" at his hospital, once his prior self is reimagined by his caregivers for the doctors and nurses.The patient-narrator thus empathetically reconstructs the time when he/she was cared for, represented, in turn made "familiar" for others. The patient-narrator's concomitant improvising of a caregiver *Bildungsroman*, that centers his/her own suffering, situates him/her in a network of family, friends and others, who recognize

him/her socially, culturally and personally – outside of the limiting and universalizing marker of "patient" or "dependent" during the period of illness. The caregiver *Bildungsroman* is thus not only about a mutuality of transformation, but a mutuality of recognition as well.

This mutuality evident in the caregiver *Bildungsroman* can be productively read through the figure of the parasite. The caregiver *Bildungsroman*, improvised as it is via the patient-narrator's account of an illness experience, is *parasitic* upon his/her story. The caregiver *Bildungsroman*, characterised by self-effacement and the constant centering of the story of another, unlike the traditional *Bildungsroman* which allows the unhindered development of the ego (Moretti 11), is parasitic in the sense of being accommodated by the narrative of another. In a different context, Nayar argues that the postcolonial novel inhabits a "global" space and likens exchanges and intersections between the First and the Third World, represented by the postcolonial writer, to an instance of the "parasite". Nayar suggests, via Michel Serres, that the figure of the parasite in fact "plays at being the same",rather than being different or "another" (forthcoming). The caregiver as parasite, here plays at "being the same" as the patient-narrator, altering himself/herself along with the host, to produce and bring to prominence only one story – that of the host. The "silent" labour of the caregiver is in turn circumscribed by the patient-narrator, whose representation of the "period" of mutual transformation and dependency renders it "familiar". The patient-narrator as host here changes himself/herself to accommodate the caregiver as parasite and is made paradoxically more "recognisable" with his/her presence. However, the parasite also brings about change through the assertion of agency, by consciously or unconsciously reordering and interrupting information (Nayar forthcoming). The caregiver, as has been illustrated earlier in this section, transforms the space of the home to ensure a medically sound environment for the management of illness outside the hospital. Through the seamless integration of the home with the hospital, the caregiver aspires to a "professional" standard of "care", whose effectiveness is eventually validated through the "medical" confirmation of recovery. Patient-narrators however, also testify to the altering or "changing" of their hospital rooms by caregivers, to accommodate the individuality and familiarity of the home. The caregiver's "presence" in the hospital, and his/her "familiarizing" of aspects of the patient-narrator, aside from his/her illness-induced identity (individual circumstances, filial and personal networks and multiple affiliations), is an act of parasitic agency. Through the reimagining of the caregiver's ability to negotiate the hospital room, by carving out a particularized inhabiting of this space that is not only limited to illness and its treatment, the patient-narrator testifies to the initiation of change through the exercise of agency.

Anita Jayadevan in her *Malicious Medicine*, records how while recovering from septicaemia at the hospital, her father and sister visited her daily to bring home-cooked meals to "offset the dreariness of canteen food" (33). "On holidays", she writes, "the whole family assembled in my room and made me forget that I was in a hospital" (33). She also recalls celebrating Vishu (the Kerala New Year) in her hospital room with her family – complete with the traditional arrangement of the *kani* (the first auspicious sight on the first day of the year) comprising "the ripe cucumber, reminiscent of the innocence of a newborn, surrounded by seasonal flowers, bathed by the light from the flickering lamp, fed by ghee, the traditional arrangement that augurs year-long peace, happiness and prosperity" (34). Jayadevan refers to this event as a "grand celebration in a hospital room" (34). Jayadevan's description of this elaborate transformation of a room, in which she has been convalescing after a near-fatal illness, is significant for the extent to which her individual, ethnic and cultural affiliations override the medical (her identity in the hospital room as a "patient" recovering from septicaemia). Her caregivers have here carved out a space of "familiarity", intersecting an event traditionally celebrated in one's "home" with a space mandated primarily for the execution of medical care. Jayadevan however, marks this event as one that brings her joy and "hope", however short-lived, as she subsequently discovers that she is carrying a baby that may have severe genetic defects. The caregiver has here reordered and "changed" the appearance and functionality of the hospital space, through an act of mutually transformative agency – Jayadevan's pain is alleviated through this non-mandated "intrusion" by her family in the hospital room. While caregivers strive to maintain professional standards of caregiving at home, patient-narrators and caregivers also testify to the sustaining of individual standards of care within the medical institution. In her account of coping with her son's acute lymphoblastic leukaemia, Sangeeta Kapur writes about maintaining her own standards of hygiene within her son's hospital room. Kapur instructs the hospital staff themselves about the particular needs of her son:

> I had to keep a strict vigil on everyone who came into contact with Rohan. Nurses were made to wash their hands a number of times before they came close to his bed. Hospital staff had to be warned that Rohan could not travel in crowded lifts with other patients, when being taken for x-rays and other investigations. (219)

Kapur, through an act of agency, has altered the space of the hospital by representing her son's individualized treatment needs. The host's conditions have been interrupted, subject and object positions reversed – the medically mandated regimen that hosts the caregiver, since the caregiver's duties comprise the professional execution of the treatment plan, has been changed to incorporate individual preferences. The parasite now dictates the terms of executing treatment, following standards and protocol that the host now has to emulate. In her *Malicious Medicine,* Anita Jayadevan too recalls how her mother was never at ease with the state of their hospital room. "Mother used to hate the smells left by the previous occupants", she writes, "and she would wear herself out scrubbing the room and cleaning the toilet" (32). The caregiver's duty is thus to not only aspire to professionally/medically mandated standards of care, but to simulate and strive for a quality of life that existed prior to the entry into the medical institution.

Caregivers also assert agency in order to bring about an individualized change in the treatment regimen, through attention to the emotional aspects of caregiving and subjecting/modifying the treatment plan to individual standards. Writing about her husband's control over her treatment process after being diagnosed with breast cancer, Rita Misra recalls how he harnessed the support of diverse treatment options. She writes:

> He sought opinions of a large number of doctors, each a specialist in his or her field. He analysed the options available in alternative forms of medicine. From ayurveda to faith healing, from reiki to aura reading, from homeopathy to salt baths, and much more. He did all he could to find out what was best for me. (188-189)

Misra recognizes the multiple therapeutic affiliations pursued by her caregiver, in the interest of well-being. Striving for the patient-narrator's recovery thus, is not only through a zealous adherence to a primary course of treatment, but the attempt to integrate multiple therapeutic possibilities, so as to fulfil a personal/particular standard of "improvement" and commitment to a return to productivity. Misra's husband is, as she records, "always one step ahead of my treatment" (189). Yuvraj Singh, in his *The Test of My Life*, records the individualized treatment and care he receives from his mother, while undergoing chemotherapy at Indianapolis. In addition to managing the apartment they rent close to the hospital, Singh's mother manages the effects of his chemotherapy at home. He recollects how:

> She catered to whatever I wanted. If I couldn't change my socks, she bent to the floor and changed them for me. I felt two years old again. If she looked across the room and saw tears in my eyes, she quickly came over and softly stroked my head and patted my back. At 10.30 in the morning or 2 in the night, if I wanted something she ensured I had it. (130)

In his memoir, Singh recollects not just the physical toll of his cancer and chemotherapy, but its emotional/affective effects as well. His recording of his mother's attention to "everything" encompasses the affective dimension of caregiving duties, in addition to the medical. The caregiver here attends to the emotional effects of illness and its management as well, thereby personalizing and individualizing the medically mandated regimen of care. Through the exercise of agency, the treatment plan is individualized and its execution at home made more humane through an attention to its affective dimension.

The caregiver's performance of emotional labour, his/her ethical and empathetic execution of the treatment plan, is also parasitic upon the patient-narrator's performance of recovery and a return to productivity. Patient-narrators often testify to their "duty" of improvement, owing to the debt of caregiving labour incurred by them. Thus the host (the patient-narrator) also aspires to perform the stoicism and commitment to improvement, idealized in the parasitic caregiver. Just as the caregiver functions as an extension of the patient-narrator's body and suffers the effects of illness to his/her productivity and is thus altered by the patient-narrator's own transformation, the patient-narrator himself/herself must commit to masking pain, to returning to a state of well-being and productivity, in response to the caregiver's altered state. Anup Kumar, in his *Joy of Cancer*, recalls how many people were unfailing in their commitment to visiting and helping him during his illness and how he too was infected by their perseverance. "All this", he writes, "made my resolve to win my war against cancer stronger. I could not let them down. I had to live up to their expectations" (68). The host (patient-narrator) begins to mimic the parasite, resolving to strive against illness, narrativizing improvement while setting aside the pain of recovery. Aneeta Kalra, in her account of being diagnosed with lung cancer in *Smiles and Tears*, also testifies to becoming motivated to recover, after realising the extent of caregiving support she was receiving. Kalra writes, "I was part of the daily prayers of almost everyone I knew. And that bolstered my determination to fight in a manner that I had never fought before" (72). Identifying the "duty" she now owes to those caregivers she is indebted to, Kalra says that not "fighting back with every resource at my command would be a betrayal of their trust" (72).

Omesh Khattar too, in *Smiles and Tears*, remembers being informed at the hospital one day, that all of the workers at the various offices and factories in the Polish branch of his company had pledged to pray for his recovery from colon cancer. Khattar says about his discovery that nearly 70, 000 workers from all over Warsaw would be praying for him, that "These are the kinds of things that lift you during your weak and vulnerable moments. I was in no mood to disappoint my friends and well-wishers" (110). Khattar is here registering the change introduced by the affective and empathetic labour of the caregiver – this change or "interruption" in his narrative of illness, is the debt of care that must now be repaid through the performance of improvement and recovery. This "debt" of care is also part of the patient-narrator's empathetic reimagining of caregiving labour – fulfilling or acknowledging the debt to another, also makes the patient-narrator recognizable to the reader, as being part of an interconnected web of relations of care. In her *Interleaves*, for instance, Lata Mani testifies to sensing this "debt", by acknowledging it as one of three things that were able reach the "deepest part of her being" during her illness (11). Other than prayer and the play of light, Mani records how she also felt deeply touched by "the simplest acts of human kindness extended to me by my partner, my family and friends" (11). Caregiving "affects" and changes the patient-narrator, yet again reversing subject and object roles, where the purpose of the host (the patient) becomes the fulfilling of the parasitic goal – the betterment of the ailing body and the return to productivity.

Writing about setting himself a target, during his training sessions at the National Cricket Academy in Bangalore after completing his chemotherapy, Yuvraj Singh describes it as something no one "forced" upon him. "I was doing this for myself", he writes, “and for the people around me who had believed in me during cancer and had lived through my pain with their love and patience” (171). His decision to return to a training regimen as rigorous as the one prior to his diagnosis with cancer, is here framed as being “owed” to those who invested in his potential for improvement. The narrativizing of progress or improvement, also changes to incorporate the labour and investment of caregiving. The caregiver's “representation” or “translation” of the patient's transformed body in the medical institution and his/her “representation” of the treatment regimen at home is thus an act of parasitic agency. The caregiver disrupts the universalized treatment plan mandated by the medical institution, through an individualized rendition or administering of treatment at home. The medical treatment plan mandated by the hospital for any patient with a particular diagnosis, is disrupted through the caregiver's individualized management and execution of this treatment plan - through the interspersing of home cooked meals with a pharmaceutical diet, by carving out a space of individual familiarity in the hospital room, by tending to the emotional, in addition to the medical symptoms of illness, through an empathetic, humane and particularized management of illness. The caregiver *Bildungsroman* thus disrupts the medical/diagnostic narrative of illness, through an act of agency that individualizes the management of illness. The caregiver *Bildungsroman* is also a disruptive presence in the patient-narrator's account of illness, by creating a “debt” of caring, where the patient must perform productivity/recovery/change not only in medically/scientifically ascertainable terms, but to repay the physical and emotional labour of caregiving.

(iii) Cultural Audit: The caregiver *Bildungsroman*, as argued earlier in this section, develops in a mutuality of transformation and through an act of agency, disrupts the

medical/diagnostic narrative and the patient-narrator's account of illness and recovery. In addition, however, the patient-narrator's "filial-self", which improvises a caregiver *Bildungsroman*, imaginatively reconstructs the economic, social and emotional "potential" inherent in his/her prior and future state, and thereby lays claim to dependency during illness as a right. The patient-narrator's "filial self" is situated in the patient memoir in a reciprocal relationship of care. Caregiving is seen as being both owed *to* and owed *by* the patient-narrator. The "potential" inherent in the "filial-self" of the patient-narrator, is often based as much on prior caregiving acts performed by him/her in the period preceding illness, as it is on the "potential" future prospect of returning to a state of productivity. The caregiver *Bildungsroman* is thus also contingent upon a contract - the fulfilling of caregiving duties and being recognized as such, determines the caregiver's place in such a system of reciprocity.

In his *The Joy of Cancer*, Anup Kumar reminisces about the resentment he feels towards those who did not show him any concern during the period of his illness. He also recalls his own efforts at providing care, at a time prior to his illness:

> I remembered the amount of time and effort Amrita and I had devoted to them when they were in trouble. People who just did not find the time during my hour of need. Had I misunderstood them? Had Amrita and I over-stepped and done more for them than what was necessary? Had we been wrong in assuming that they cared as much for us as we did for them? (69)

Kumar here points to the reciprocity of care, a characteristic of caregiving acts, whether performed before or during the time of illness. Kumar and his wife are already implicated in a system of reciprocal acts of caregiving, owed to them from their own prior acts of caring for others. The performing of caregiving duties, places one in a reciprocal contract of care that is yet another condition of being "recognized" as a caregiver. The caregiver himself/herself also often repays a "debt" of care, while simultaneously ensuring his/her own place in a reciprocal system of care. Aneeta Kalra, in *Smiles and Tears*, for instance, testifies to having cared for her husband when he had suffered with cardiac problems, ten years before she was diagnosed with lung cancer. She remembers, "I had been by his bedside all the time. Holding his hand. Comforting him. Looking after all his needs. In the same manner, he is now my pillar of strength" (73). Kalra and her husband are thus situated in a reciprocal relationship of care that draws from "prior" acts of caregiving. Speaking of caregiving duties that are "owed" to her, Sultana Abdullah writes in her account of surviving breast cancer in *Smiles and Tears* of being "betrayed" by her family. Subsequent to announcing to her family that she has been diagnosed with breast cancer, Abdullah is shocked that they are unaware of what their role should be. She records, "I felt betrayed. I felt cheated. After all that I had done for them, this was their one opportunity to do something for me in return" (181). Abdullah is here referring to being denied a reciprocity of past acts of caring, a conditionality that is her "due", even outside of filial ties. She later records how this affects her recognisability within the medical institution – without someone to represent her "individually", she is unable to negotiate the universalized medical institution. "For them", she writes, meaning the hospital:

> I was just another customer. Another patient. I did not feel any warmth or receive any emotional support from the doctors that I met. Most of them

> were cold and business-like. Some of them were surprised that there was no other person who was accompanying me. (182)

Abdullah subsequently moves to Mumbai from Delhi, where she is cared for by friends, who, through their performance of caregiving duties, "became family" (182). Abdullah can thus only be "recognized" as familiar, if she can perform her rightful place in a network of reciprocal caregiving relationships. She can only carve out a space socially and within the medical institution, by being represented within a framework of caregiving support. What is significant here, however, is that Abdullah exercises a choice of caregiving networks, just as her family "chooses" not to care for her during the time of illness. Caregiving qualities in the caregiver *Bildungsroman* are thus chosen through an act of agency, in the form of a "cultural audit" of character. A "cultural audit" implies the exercising of agency in the "choice" of carers and the mode of performing caregiving labour. As argued earlier in this section, the "role" of caregiver develops in a mutuality of transformation and as evidenced by Abdullah's "unrecognizability" within the medical institution when she seeks treatment unaccompanied by carers, this "role" is also partially "mandated". Yuvraj Singh's testimony, cited earlier, that he would require the "support" of "everyone" to enable the successful execution of his medical treatment, is also attributed to being part of his doctor's "prescription". The caregiver's "role" is thus encountered as a professional/institutional mandate as well as a social one, rooted in a system of reciprocity and seen as following from "prior" acts of care performed by individuals. The time of illness in the patient memoir, however, is a "crisis" of affiliation, where one exerts a choice over the nature of executing care and medical treatment. Abdullah thus chooses to travel to Mumbai in the interest of acquiring a network of caregiving, that will ensure a greater degree of identifiability within a medical institution and with a treatment plan – she testifies to her changing attitude towards her illness in Mumbai owing to support from her friends which “gave me the courage, hope and desire to live and fight back” (182).

As argued earlier in this section, the caregiver, in his/her parasitic relations with the patient-narrator, “plays at being the same”. This relationship of mutual transformation and change also operates upon a conditionality – the set of qualities idealized in the caregiver are plotted along an axis of prior traits inherent in him/her and a set of “prior” conditions shared between him/her and the patient-narrator. *Caregivers are chosen through a system of cultural audit which ensures the sustenance of a socially normative “ideal” of caregiving*. This “ideal” is partially mandated and controlled through professional/institutional measures, as seen earlier in the “misrecognition” of patients who are unaccompanied by carers (Abdullah) and in the “prescription” that caregiving is essential for recovery (Singh). This “ideal” is also naturalized and defined, through the parasitic relations shared by the patient and caregiver. The caregiver can only “play at being the same”, if he/she can also be viewed as possessing the “potential” for performing caregiving duties. This “potential” includes the ability to commit to a mutual transformation, the “presence” within a system of reciprocity by having performed “prior” acts of care and most significantly, the ability to “play at being the same”.

The patient-narrator, as argued in chapter two, performs self-improvement through a demonstration of the ability to surmount difficulty and the plotting of such ability as always already embodied in this narrator. Caregivers are similarly defined as always already embodied as such through “prior” acts of caring, that therefore predispose them to such a “role”. Such carers as seen as being able to perform “stoicism”, a belief in improvement and rehabilitation, not merely motivated through “filial” duty, but on account of a commitment to caregiving which can be traced to a “prior” self. This “prior” self zealously pursues the labour of caregiving, like the patient-narrator’s pursuit of “self-improvement” or knowledge/expertise about his/her illness and “works” to care for an ailing other outside “filial” or “professional” mandate. The “cultural audit”, is thus a process of selection or an exercise of agency by the patient-narrator, through which caregivers are designated as “ideal”. The patient-narrator performs this “cultural audit” through a process of affiliation or narrative affirmation of the choice of caregiver – patients and carers are seen in the patient memoir to be brought together not by the sudden onset of illness, but through the operation of a contract and a process of selection. Caregiving “labour” or “acts of care” implies membership in a mutual, reciprocal relationship, the basis of which is the “ability” to “commit” to and “perform” the duties of caregiving. The patient-narrator’s exercise of his/her “ethical expertise”, as argued in chapter two, is a narrative elaboration of the “labour” of disseminating information, that “compensates” for the unproductivity and inability induced by illness. The caregiver’s “commitment” to his/her “work” and the “ideal” qualities of “caregiving” constructed in the patient memoir (spatio-temporal proximity to the ailment/ailing body, performance of stoicism, a mutuality of transformation, belief in improvement and a quasi-professional diligence in the conduct of caregiving duties), similarly “compensate” for the universalized/impersonal nature of the medical/institutional treatment plan. The “ideal” of the caregiver, moreover, “compensates” for a perceived “lack” in the filial network, also viewed as vulnerable to “contamination” and thus a possible source for the onset of illness. An “ideal” caregiver, plotted along the axis of a “prior” self as someone always already imbued with the “potential” for caring, thus serves to compensate any “lack” or “lapse” in caring that may be responsible for an onset of illness while also particularizing the treatment plan.

The “cultural audit” performed by the patient-narrator in the improvising of the caregiver *Bildungsroman*, results from the asymmetry of the “experience” of caregiving, as testified by Kumar and Abdullah. Both these narrators testify to having themselves performed “prior” acts of caring, for which they have now received no recompense. The “cultural audit” serves to rectify this asymmetry and crystallizes the “ideal” carer, whose duties are “performed” not merely as “filial”/ “professional” mandate.

Several patient-narrators for instance, testify to the “selection” of caregivers based on an inherent potential for acts of caring. Speaking of how she was assisted by her father in acquiring information about Assisted Reproductive Technology procedures, Jayadevan draws attention to his already frail state of health. “Though his heart was weakened by rheumatic arthritis”, she writes, “he had a mind that was reluctant to accept defeat” (73). Her description of her father’s assistance in the narrative, while drawing attention to the pathological effects of caregiving labour (she later testifies to her father suffering from overexertion on account of their persistent efforts with studying ART), also frames him as someone who was always “reluctant” to give up. His resilience thus sets him apart, augmenting his “potential” as a carer. Other patient-narrators testify to only surrounding themselves with the kind of people who embody the “ideal” character of carers. In her account of caring for her husband after he was diagnosed with lung cancer, Bashini Rao in *Smiles and Tears* records how they lived “as normal a life as possible” (65). Explaining what “normal” entails, she says:

> We stayed away from people who had a depressing influence on us. Some of the elder members of the family were never informed about his health status for this reason. (65)

The ambit of "normalcy" here includes people who are "evaluated" by the patient-narrator and caregiver, as being most likely to contribute to well-being and improvement. Barrier-nursing, it would appear, is required not only to eliminate pathogens that may threaten the patient-narrator's vulnerable immunity, but also to exclude those "qualities" or "characteristics" and persons embodying them, from the narrativizing of improvement and recovery. The caregiver who does not embody the socially mandated "ideal" qualities required of him/her, threatens the patient-narrator's record of progress. In his *Celebration of the Cells* for instance, R.M. Lala instructs Vandana (a friend suffering from Hodgkin's Lymphoma, to whom Lala's book, written in the form of letters, is addressed), about how the period of illness is often one where patients carry out what he terms a "social audit". Writing about how the recognition of one's mortality after being diagnosed with a fatal illness urges people to put their lives in order, Lala notes that one of the things they may do is "realize it is time for a social audit of their lives and their relationships with people" (32). He also identifies the reason behind this necessary "social audit", by describing the harmful effects that "strained" relationships have on one's health – "Strained human relationships or bitterness towards something or someone can cause one great pain and anguish" (40). Patient-narrators thus depend not only upon the caregiver's learning and proper execution of his/her role, but on the nature of their relations with each other. The "cultural audit" is here seen as being "socially" significant, since the "work" of "reviewing" one's "relationships with people", especially relationships with carers or even potential carers, is of direct consequence to improvement and recovery. The "cultural audit" is significant for ensuring the elision of those characteristics and modes of caregiving that are not "ideal" and can therefore become detrimental to the narrative of progress and recovery. This has "social" consequences in terms of limiting the patient-narrator's potential to regain productivity.

Anup Kumar writes in his *Joy of Cancer* for instance, about the kind of support that one should not encourage:

> It is easy to succumb to the support of people around you in moments of weakness. Thereby, you virtually deny yourself the opportunity of learning to take care of yourself. Always remember that such kind of support only reinforces the illness. (78)

Kumar is here drawing attention to the unequal relation of care that the patient-narrator is implicated in, when in a period of vulnerability and dependency. Ideal caregiving relations are based on an equal, shared status – whether through shared transformation and change or through a shared spatio-temporal proximity to illness. Support or caregiving offered only based on the period of illness or dependency, is thus an unequal one – Kumar is referring to a relationship of care that is not reciprocal and is thus unequal. Caregiving extended only during "moments of weakness" are not based in empathy or reciprocity or a faith in the past or imminent "potential" of the patient. The cultural audit of caregiving duties is thus also performed to ensure a parity of status, a sharing of the entire period of transformation induced by illness and a faith in the "potential" for improvement. Aneeta Kalra in *Smiles and Tears* similarly testifies to ensuring that during the course of her lung cancer and its treatment, she "would never entertain that segment of friends that had a pitying ‘poor-Aneeta’ attitude” (73). Kalra too is confessing to the cultural audit she performs, choosing not to surround herself with those who “pity” her rather than empathize and who are not invested in “hope” for improvement and a return to a “prior” state. In shunning their “pity”, Kalra has also illustrated how the period of illness is one that serves to test the “ideal” character of the caregiver. Several patient-narrators for instance, also assert that relationships forged with those who are “recognized” as caregivers, are ones that last even beyond the period of care. Having being “tested” for their resilience, stoicism, their faith in a “potential” to improve and having performed “parity” of status, the caregiver’s position in a reciprocal contract of care is secured. Writing about his caregivers in *The Test of My Life,* Yuvraj Singh describes them as people who “stayed with me, left their problems and their families behind to be with me and my problems. For them I was their family, and for me they were my allies. Relationships made in these times seldom change” (144). The cultural audit thus serves to situate caregivers in the reciprocal contract of care, where indebtedness to “acts” of caring exist both prior to and extend beyond the time of illness. Similarly, writing about illness’s role in crystallizing identity not just for the patient, but the caregiver, Sultana Abdullah writes in *Smiles and Tears*, about the “surprise and horror” she felt when she discovered that her family chose not to care for her. However, Abdullah in turn chooses her caregivers – her friends in Mumbai, who, through an adopted relationship of care, “become her family” – and learns that “At least now I recognize the people who I can always rely on” (185). The people that Abdullah is referring to are her friends, her “adopted” caregivers with whom she is now in a reciprocal contract of care. By caring for Abdullah, her caregivers make her more recognizable when she is a patient within a medical/institutional and social framework, as someone embedded in a network of care even as she “recognizes” them as being implied in a contract that extends beyond the period of illness. These are now people for whom, in Abdullah’s terms, she would be “even willing to sacrifice my life for” (185). The caregiver *Bildungsroman* thus determines the manner of receiving care through the selection and endorsement of a set of qualities that are seen as “ideal”. In addition to ascribing to a professional standard of providing care and managing the symptoms of illness at home, the caregiver is also defined through a socially normative “ideal” of care and caregiving relations. Anu Gupta, in *Smiles and Tears*, summarizes what “care” entails in her description of an “ideal” support group:

> Their sympathy is the last thing that you need. They must behave in as normal a manner as before. As they always had. And learn to hide their emotions, their own trauma, in your presence. They must believe in themselves first; believe in the doctors; believe in having a positive attitude. Only then they can communicate the same belief to the patient. (215)

Gupta’s description of a support group serves to emphasize that the caregiver acquires certain emotional attributes – performing stoicism, eliding pain and suffering – but they are also “chosen” on the basis of their “former” selves. “Normal” or “as before” here describes the basis for the cultural audit, caregivers who embody a “potential” for empathy and for “believing” in turn, in the patient-narrator’s “potential” for improvement. The “ideal” caregiver, thus chosen through a cultural audit to participate in a reciprocal contract of care, “communicates” health and well-being to the patient-narrator. In a system of parasitic relations, as argued earlier in this section, it is the "ideal" caregiver who "plays at being the same", thereby "communicating" or "infecting" the host with a positive mutual transformation. The host mimics a parasite that is carefully chosen for the "disruption" it will bring to the narrative of improvement. *The caregiver Bildungsroman thus posits a particular kind of contract that instantiates a discourse of the "ideal" carer, one who is selected in accordance with socially mandated normative modes of caring, that situate him/her in a reciprocal relationship of care that extends outside the period of illness.*

The caregiver *Bildungsroman* enacts a mutuality of transformation brought on by illness and is improvised by the patient-narrator's "filial-self". This "filial-self" is made more recognizable for the reader, through an enactment of its embeddedness within a network of caregiving relations that are subject to a reciprocal conditionality. The patient-narrator empathetically reimagines "acts" of caring performed by selfless others, whose particularized and individualized representations of his/her transformed body within the medical institution, renders him/her more recognizable. Further, the caregiver *Bildungsroman* illustrates the parasitic relations between the patient and caregiver and its premise in an exclusionary politics of caregiving relations. Carers are chosen, not merely dictated by the circumstance of illness, through an act of agency and on the basis of a socially normative ideal of caregiving. Caregiving thus emerges as a role that requires social and professional sanction and illustrates the relational nature of narrating an account of illness.

(b) Recognizing Dependency or the Embeddedness of the Ailing-Self

This section will examine those aspects of “self-improvement” performed by the patient-narrator that contribute to the instantiation of a “filial self” in the patient memoir. As argued in chapter two, the patient-narrator’s realization and defining of a “relative normalcy” and his/her recognition of a “duty of improvement” are related to the instantiation of a “filial self” in the patient memoir. I return here to the acquisition of self-knowledge performed by the patient with an emphasis on the “filial”.

(i) Defining a “Relative Normalcy”: Patients recounting an experience of illness testify to the extent of the impact of disorder and chaos brought on by loss of health not only on their own lives, but those comprising the filial and medical network of support. Recognizing a state of dependency, is thus often about the acknowledgement made about the impact of illness on the various social networks within which the ailing body is embedded. These include the consequences of a decline in health and ability on one’s official/professional duties, filial responsibilities and life goals. The patient-narrator here acknowledges and recognizes dependency, through a re-examination of or a redefinition of normalcy. In her account of experiencing medical negligence at an infertility clinic in *Malicious Medicine*, Anita Jayadevan describes her return to work (as a schoolteacher) as a welcome break from the strict regimen imposed on her by her mother (who, along with her husband, assumes primary caretaking responsibility during Jayadevan’s numerous hospital visits). She does acknowledge however, that it is this “strict regimen” that helped in regaining her strength, after several months of being bedridden. Jayadevan also identifies “friends” as a source of support and solace, in addition to her filial network of care. Jayadevan recalls how one of these “friends” visits her while she is convalescing and asks about her “Future plans”. She writes:

> Future plans? My mind wandered over the verdant piece of land we had bought to build a home. I thought of the innumerable dreams that we had woven around the image of our perfect house. (57)

Jayadevan's internal monologue and lack of response to being questioned about her "future", is a response to the "socially" imposed "role" of a normal existence – such as planning for the future, becoming a homeowner, starting a family. She admits in subsequent lines, in keeping with the description of her "innumerable dreams" surrounding a "perfect house", to harbouring dreams of bearing children whose footsteps would "reverberate" in this future home. Jayadevan, who experiences severe peritonitis and septicaemia on account of negligent infertility treatment, is here articulating the "gap" that patients' experience, between a condition of impaired health or ability and the socially mandated goals of their former, able "selves". Being asked about her "future", a subject brought up by her friend perhaps even casually, is here framed as a question that prompts a certain kind of response as well as responsibility. Now that she is recovering, Jayadevan is expected to resume planning her future, resume the pursuit of her "innumerable dreams". However, having lost her twin foetuses on account of her illnesses, she is unable to articulate a "future" plan, except in terms of an as-yet-unfulfilled *previous* one. Jayadevan is here acknowledging dependency on a socially sanctioned or mandated life goal. Other patient-narrators similarly articulate the impossibility to returning to the social norm of "ability" and "health".

In his account of being diagnosed with and treated for colon cancer, Omesh Khattar writes in the anthology *Smiles and Tears*, how his definition of his "capacity" transformed after becoming a cancer patient. He writes about his transformed “needs” and the end of his “workaholism”:

> I spend less and less time at office, concentrating only on important issues. I have become more tolerant of things in my environment. Earlier I had always insisted on perfection. Now I realize that everybody cannot be perfect. We are human and prone to making mistakes. As long as we don’t repeat them often, as long as we are willing to learn from them, I am willing to accept the occasional error. (114)

Khattar here recognizes that being “human” is not bound imperturbably with perfection and an absence of error. What is interesting here is that Khattar’s realization of the “impossibility” of perfection proceeds from the experience of illness, which imposes a certain degree of “inability”. However, Khattar’s definition of his “future” life, following treatment and the subsequent remission of cancer, continues to be framed within a “deliberate” choice of embracing imperfection. While medical and expert diagnosis deals with precisely calculable moments of the “discovery” of illness and its “remission” and sometimes “disappearance”, Khattar here chooses to define “normalcy” or a return to health and ability, as a willingness to “accept” error and malfunction. Anup Kumar similarly recounts in his *Joy of Cancer*, the difficulty in sustaining a three-month long consultancy while undergoing chemotherapy for his lung cancer. Kumar undertakes the job, to offset rising medical expenses and to gain respite from a life now consumed with lengthy hospital stays and an array of prescriptions and precautions to guard his low immunity levels. However, he is unable to withstand the pressures of working while undergoing treatment. Forced to retire from his work assignment, Anup Kumar warns the reader about being cautious while setting goals for oneself while recovering from illness:

> Objectives and priorities have their own way of adjusting with the situation and the circumstances. (86)

And later:

> In critical moments, we find it easier to define and relate to our priorities, to what we are up against and to what we must accomplish. (87)

Kumar is here suggesting a fluidity or flexibility of life goals, that can be modified and redefined in a period of crisis. “Normalcy” is here dictated by the self that is now transformed and altered by illness and whose “priorities” and “accomplishments” can be in a permanent state of flux. However, as Kumar reminds the reader, “This is the time to remember that striving to meet your goals is as important as actually achieving them” (82). The self that recognizes dependency on socially mandated norms like the accomplishment of success, identifies a distinction between the “time” of illness (where the “aspiration” to reach a state of “achievement” replaces the actual realization of goals) and “normalcy”. Kumar lists the kinds of aspirations held by those unaffected by a major illness and these include “a fancy new car”, “promotions at work”, “an exotic holiday”. Kumar,thus, also identifies the gap between what is “achievable” or even aspired for by a body affected by illness and the socially pervasive ideals of what comprises a “successful” life goal.

Lata Mani records in her *Interleaves* about realizing the “folly” in considering a job well done only if it is completed. Mani, whose brain injury requires daily efforts at managing debilitating pain and makes even the effort of leaving her bed to walk to the nearby table to eat her meals gargantuan, testifies to the sense of accomplishment she feels even when she carries out trivial activities like tending her garden. Mani's description of her visit to the garden is significant on account of the fact that it is accomplished "independently" – she leaves her apartment unassisted by her caretaker and spends twenty minutes alone in the garden, where she deadheads a few flowers and prunes a couple of unhealthy branches. This minor (to a healthy, able body) activity is rated by Mani along a personal scale of achievement and normalcy, when she writes about what she learns from this visit: "I wish to take to heart the idea that what is important is the doing, just the doing, just the attempting to do, just the planning to do; not finishing, but trying" (21). Though Mani eventually requires assistance to leave the garden and return to her apartment, the description of an activity that comprised merely twenty minutes of independence as a "majestic" adventure that leaves her "no longer tempted by the folly of believing that a task is only done when it is completed" (22), testifies to her reoriented perception of "normalcy" and "ability". In R.M. Lala's *Celebration of the Cells*, he too testifies to the changed notions of "ability" that is essential for a cancer patient. Writing about how he struggled with his work pressures while undergoing chemotherapy, Lala writes, "Know your limits and reconcile yourself to work within them. Do not be concerned with what people will say" (47). Elsewhere, Lala recommends, "If your capacity is eight hours of work, stop at six, take it from me – doctor's advice!" (11). While Lala is here presenting his "experience" as expertise, he is also drawing attention to the pervasive influence of socially mandated "limits" on the normal human body that is at odds with the "reduced" or reordered capability of the ailing body. Lala also recommends, like Khattar, making a deliberate choice to lower one's "limits" and sense of what it is possible to achieve. Recognizing dependency is thus contingent upon recognizing one's dependency on socially mandated narratives of "progress" and "achievement".

While these patient-narrators plot their own definitions of a "relative normalcy" along a personal axis of achievement and accomplishment and frame this as a "deliberate choice" or philosophy of life, they also make evident, the gap that exists between the social and biomedical model of a "normal" or "able" body and the experiential model of the "recovering" or "ailing" body. In her *Interleaves,* Lata Mani even frames her "story" as a "journey" through "the social landscapes of our time, through the ways in which society constructs wellness, illness, success, failure, worth, worthlessness, as these are experienced by one woman attempting to live consciously through the trials and tribulations of brain injury" (73). Illness is thus an occasion, not only to perform the "obligatory" journey back to a state of health and wellness, but to critically re-examine notions of "normalcy", "health" and "ability". These notions require reassessment on account of their significance to the state of "dependency" from which the patient is required to "expeditiously" recover.

(ii) Recognizing the "Duty" of Improvement: The patient-narrator situates "improvement" as a responsibility or "duty" that is one's own. While the narrators of these accounts of experiencing illness, emphasize the importance of finding the right kind of medical treatment and assistance and critique the impersonal and often "erroneous" diagnosis offered by medical experts, they also situate the "responsibility" of managing and improving one's condition on the self. In one of his letters to Vandana in *Celebration of the Cells*, Lala makes a case for how all patients are not necessarily "innocent"

victims. He writes, “A person who does not change his or her unhealthy stress pattern is as responsible for the cancer he or she gets as a smoker is for his lung cancer or an alcoholic is for his cirrhosis of the liver” (39). Lala is here emphasizing the “duty” of the cancer patient, whether or not his “risk factors” are popularly recognized (the “scientifically” proven and popular belief in one’s lifestyle resulting in pathological consequences), to live a healthy life and eliminate any “risky” practices. The role of the patient is here identified as entailing educationabout “risks” and taking care to avoid them. Writing about the time when he is first diagnosed with his cancer, Lala testifies to Vandana about his immediate reactions – his biggest anxiety, surprisingly, is not the possibility of losing his life. Instead, Lala writes:

> The possibility that my life would terminate was still distant. When the diagnosis came, I frankly had little time to analyse my feelings. I had to reckon with the feelings it aroused in my wife. I was rushed from one test to another, in addition I had my work to attend to and engagements to keep. (20)

Lala is here performing “improvement” as a responsibility he now bears but more significantly, he recognizes the dependence of his filial and professional network on his “recovery”. The patient-narrator thus performs a recognition, not only of a state of dependency and the “duty” to improve, but recognizes the significance of this “improvement” for the networks within which his/her body is embedded. Anup Kumar’s anxiety in *The Joy of Cancer*, to undertake a work assignment in the middle of his rigorous treatment regimen, stems not only from the incommensurability of his reordered levels of “ability” and what is socially mandated as “success”, but also from what is mandated by his role as “provider”. The rising financial burden imposed by him on account of his treatment, is as important a motivation for his looking for work and performs for the reader, the dependence of his filial support system on his earning potential.

Khattar, in his account in *Smiles and Tears,* records how he is inundated by prayers and wishes from his friends and family while he is undergoing treatment. He is in no mood, he writes, “to disappoint my friends and well-wishers. I had to prove that my doctors were wrong” (110). Khattar here recognizes the reciprocal relationship that caregiving has with the ill-self, where a failure to “improve” is a disappointment not only for the self, but for those that are in a dependent relationship with this self. Vijay Bhat reproduces in *Smiles and Tears,* the e-mail correspondence he maintains with his family and friends, during the course of his treatment for colon cancer. The e-mails, ordered chronologically for the reader to reflect the periodic detailing of his treatment and progress for his family, record Vijay’s examination of the meaning of this “experience” of becoming a cancer patient. In one of his e-mails, writing about the kind of changes that are now required in his life, Vijay emphasizes his family’s dependence on his recovery. He writes:

> We need to make some changes, recognizing the simple reality that I have a wife and two young children to provide for; that my responsibilities to them do not end because of what has happened. To the contrary, the stakes have now been raised even more! (85)

Recognizing dependence in the patient memoir is thus also about recognizing that one is depended *upon*.While these narrators plot a “relative” normalcy along a personal axis of achievement, to emphasize the divide between socially mandated norms and what it is possible to achieve when operating in a "reduced" capacity, one's embeddedness in a filial and professional network also implies a "duty" and "responsibility" to improve. *The patient-narrator's knowledge of the self thus also proceeds from recognizing that one is embedded in a filial and professional responsibility of "providing", just as one is entitled to be "cared" for by a medical professional and family member during a period of illness.*

In *Interleaves*, Lata Mani compares the situation of a chronically ill patient to that of a new mother, where days are filled with numerous tasks that when one is called upon for an account of time spent, there is a difficulty in translating these tasks as a "productive" engagement of one's time. The chronically ill patient is only aware, like the new mother whose is suddenly faced with a great many demands on a daily basis, that a great deal of time has been spent in coming to terms with and managing this new identity. The comparison with a new "mother" is significant here for the kind of labour involved in "mothering" and "managing illness" – both carry an implication of "responsibility" that one owes to another. Just as the new mother is expected to care and provide for her child, the chronically ill patient is expected to perform the labour of "recovery" to fulfil the duties arising out of a situation of social embeddedness. Lata Mani however, also underscores the relatively marginal nature of this "labour" performed by the patient, by emphasising the difficulty in translating the tasks undertaken towards recovery and improvement in socially "productive" terms.

(c) Learning a New Kind of Social Embeddedness

The patient-narrator, as argued earlier in this section, also testifies to the acquiring of a new set of skills occasioned by illness. Chapter two focused on the ethical expertise or the performance of the "patient-as-expert", in addition to the patient-narrator's acquisition of the skill to "narrate progress". The patient-narrator, however, also learns a new kind of social embeddedness and I return here to the filial aspect of learning new skills in the patient memoir.

While the patient-narrator, as argued earlier, recognizes his/her dependency on a socially embedded body and the duty and responsibility to overcome illness required by this embeddedness, he/she also performs the acquisition of learning new modes of engaging with these networks of care. Illness is also seen to require a labour of substantiating illness and its recovery. Lata Mani writes in *Interleaves* for instance, of the difficulty involved in convincing people of the extent of her disability and pain, on account of a lack of visible markers of illness in the case of brain injury. She has to perform therefore, a labour of substantiating illness (wearing dark glasses to combat her sensitivity to light) and recovery (her celebration, in her account of experiencing chronic illness, of trivial activities whose significance lies in the effort made to achieve them rather than their completion). The narrators of these accounts however, also testify to the emotional labour of performing wellness and a semblance of order, even prior to recovery, as part of managing one's changed relationship with filial networks of care. This labour of performing "recovery" or stability and masking internal disorder is contingent upon an "etiquette" of listening or ethical response from the reader/listener. Lata Mani writes that what she often needed was someone who would just listen and recognize her suffering. Someone who would just say, she writes, “I am so sorry that you are going through this” (49). She does, however, recognize the difficulty in “learning” how to cultivate this practice of listening, as much as “teaching” about an experience of illness requires skill. “It is not as though everyone would always already know how to conduct themselves in a new context”, she writes subsequently (50). Conducting oneself while “listening” to an account of illness is as much of a new skill and a new context, as speaking or teaching of one’s experience of being ill.

The patient-narrator has to thus learn to manage the activity of speaking and listening, now transformed through the onset of illness. The socially embedded body of the patient narrator now exists in an altered state with those around him/her that occasions the “learning” of new kinds of labour. R.M Lala testifies in *Celebration of the Cells,* to being more anxious about the impact of his cancer diagnosis on his wife’s feelings, rather than of his own premature death. Lala is here recognizing the importance of the emotional labour performed by patients, to assure others of the possibility of improvement and remission. In Khattar’s account of experiencing colon cancer in *Smiles and Tears*, he confesses to rejecting “sympathetic” responses to his condition, for fear that it would lower his self-esteem. He writes about excusing himself from the company of those who looked upon him with sympathetic eyes during his treatment, while describing a time prior to the remission of his cancer. Describing what he “chooses” to accept with regard to responses, Khattar writes, “Their concern for my well-being I could understand. Their wanting to know more about my health status I could tolerate. But their sympathy was something that I did not need” (112). Khattar is demonstrating for the reader, the importance of “learning” to manage responses to his experience, an inevitable outcome of the embeddedness of the ailing body. Khattar learns that accepting sympathy is recognizing a state of "need" and detrimental to the labour of progress and recovery necessitated by the onset of illness. Khattar, like Mani, emphasizes the "learning" required in the management of speaking and listening during an experience of illness – not everything that is spoken or offered as "response" to illness can be "heard" or utilized. The labour of recovery also depends upon an eliding or omission of internal chaos, a performance of recovery relies on the recognition of this "labour" – Khattar's rejection of a sympathetic response to his condition, is a rejection of a refusal to "recognize" the labour of eliding suffering in the narration of progress.

Jayadevan also testifies to "learning" the masking of anguish from her family, who stay by her side while she is being treated for septicaemia at the ICU. It is significant that Jayadevan traces her "education" or the "learning" of performing well-being to her family, thereby situating herself in a reciprocal relationship that necessitates learning to elide suffering in the narrating of recovery. She writes:

> It was with great pain that I watched them struggle hard to mask their mental anguish, while reassuring me that everything was fine. Those days taught me to face death with equanimity, while loving life intensely and wanting desperately to live. (30)

Jayadevan testifies to learning the lessons of "equanimity" while simultaneously feeling a desire to "recover" and fight for her survival, when faced with a similar "duty" performed by her caregivers. Jayadevan's lesson is thus the altered nature of her relationship with a filial network of care, a relationship which now demands a reciprocal "labour" of recovery that is contingent upon the performance of well-being, even while eliding internal suffering and chaos. The next section will examine the “Filial Body” in the Medical Documentary.

Section III: The “Filial Body” in the Medical Documentary

The medical documentary narrates stories about the prevalence of disease and its cure that moves from the documentation of a particularized instance, to a contextualizing of the relevance of this particularity for the general public. In narrating particulars of the incidence of disease in the individual body, the documentary inevitably visualizes for the viewer, the many social and material contexts in which this body is embedded. The “story” of disease incidence (by “incidence” I mean the documentary’s visualized of how disease/illness originates in individual and social contexts) in the medical documentary, is thus typically one of *locating* various aspects of the condition of being ill. As a part of this “story”, the viewer is taken through the various locations of disease or illness at the personal, familial and communal level. The documentary realizes these locations through a visual representation of the individual’s interrelatedness with the family, the community and city. This section will detail the representation of the “filial body” in the medical documentary. I will return to the representation of individual and communal aspects of disease in the medical documentary, in chapter six of this dissertation.

The individual is seen to pose a threat to the family through a visualization of the interior locales of the body in the medical documentary, a point I return to in chapter six. The family is presented as a space that is both vulnerable to disease, as well as the socially legitimate space for the containment and protection of sexual and reproductive health. The family and the home are thus constructed as vulnerable, precisely on account of their role in the protection of the sexual and reproductive health of the individual. At the level of family space, the individual's right to health is superseded by the "responsibility" to protecting the health of one's progeny. Discordance caused by disease at the level of the family is thus articulated in the medical documentary, in terms of a reorganization of the "designated" or "familiar" roles played by the individual. The individual's identity in the medical documentary is *gendered* and is produced at the level of the family, in terms of constitutive roles or functions performed by this individual in the space of the home. The woman's role in the documentary narrative is thus typically visualized as an "instinctive" one of child bearing/rearing and the management of the "home", while the man is cast as breadwinner and protector of this "home". In the documentary *AIDS* for instance, a woman is seen to be waiting for her husband to return from his tour and organizes the day's events entirely around his imminent arrival. The documentary opens with a scene of her speaking to an unidentified woman friend on the phone, with whom she is cancelling a prior social engagement on account of her husband's return from his travels. Her friend, whose voice the viewer can hear, tells her that she "understands" her desire to be home to receive her husband after a period of separation and the viewer can see the woman protagonist's bashfulness at the mention of this "desire" to be reunited with her husband. When he returns from his tour however, the husband is preoccupied, is without appetite both for the meal prepared in anticipation and his wife. With some coaxing, he reveals to his wife that he is experiencing severe discomfort that will cause him to stay out of their bed that day and the viewer is shown the wife's horror at this admission. The viewer subsequently learns, when the man visits his doctor, that he is suffering from syphilis and while "presenting" his case to the doctor, he admits to have been with an "unknown" woman during the course of his tour. He admits to this being a recurrent pattern with him, that is, a different girl every time he travels, thus establishing through his confession, an indulgence in high-risk behaviour. The doctor, after having determined the presence of syphilis through a series of tests, proceeds to educate the man about precautionary measures required to keep sexually transmitted diseases at bay. He is advised not to indulge in sexual relations with his wife until his symptoms subside, and is reminded that he is fortunate in not having contracted the most deadly consequence of his "high risk profile", the AIDS virus. The discordance caused by disease is visualized here as a break-down of the social roles ascribed to the individual in the family space. The man as "protector" and "breadwinner" has now become a liability to the home and the sexual and reproductive health of the woman. The inability to perform sexually is pathologized through a visualization of the wife's horror upon discovering that she cannot expect sexual fulfilment from her husband. The medical documentary often constructs the man as the source of income, security, sexual pleasure, as well as infection to the home.

The natural/biological roles played by the man and woman within the space of the family are seen to be socially sanctified and vulnerable to corruption by disease. Paula Treichler has signalled to the gendered construction within AIDS discourse of "vulnerability" to the virus, where the woman is seen as a "passive" and thus "infective" carrier (17). Priscilla Wald similarly illustrates the socially sanctified nature of the "husband" who when infected, is seen as bringing disease into the "home". This infected man is seen to "disrupt" the natural order through which social roles metamorphosize, by preventing the women in his household from attaining "motherhood" (87). In *Sexually Transmitted Diseases* for instance, these social roles are universalized, through the employment of a synecdochal representation of the male and female roles in the household. The viewer is able to see the working hands and lower half of two bodies that are marked by dress and the work they perform, to indicate their gender and respective function in the household. The "man" sits at the table, reading a newspaper, while the "woman" sets the table and places a packed lunch inside a suitcase, also placed on the table. They move to the door as the "man" leaves for work and the viewer overhears a conversation about the "woman" wanting to see the doctor about a certain kind of discomfort she is facing. The camera then follows this man who sets up a meeting with the doctor, but to the viewer's surprise, for himself rather than his ailing wife. Upon meeting the doctor, this "man", whose face we still cannot see, confesses to having been with a "prostitute", upon being urged by friends and worries that he has passed on the disease that ails his wife, now revealed to be pregnant. He expresses his regret at having threatened the well-being of his family and unborn child. The emphasis here is the threat posed by the infected man, not only to his wife, but to his progeny. The threat posed to the individual woman, universalized through her synecdochal representation to indicate all women, is superseded by the "threat" to the child she carries. The "future" of the family, represented by reproductive health and progeny, is constructed as being more vulnerable than the individual. In *Alcohol-The Killer*, for instance, domestic discordance is demonstrated through the influence an alcoholic has, on harmonious family life. The narrator invites the viewer to follow him to the scene of an "average home", before moving into the individual story of the alcoholic and his family. Designating the home portrayed in the story as the "average home", raises it to the status of a "general" measure of what characterizes *any* home. Here again, the woman is portrayed alongside a young girl child, waving goodbye to the husband who is leaving for work. When he returns however, the husband is drunk and enraged and is seen to be physically abusive towards both mother and daughter. He is shown to be wresting money from the hands of his wife, while the narrator describes how a typical alcoholic actually suffers from a disease, a condition where he has no control over his actions. Rather than view alcoholism as a “moral backslide”, the narrator says, it should be regarded as an illness, that forces its victim to abandon reason and blame others for the frustration and discomfort he is experiencing. The scene of domestic violence against the woman is thus rewritten as the effect of an “illness”, over which the man/patient has no control. Subsequently, the young girl is herself pushed to the ground, while her father drinks and forces her mother to give him money. The narrator then contextualizes the effects of this “disruption” in the home. The children of alcoholic parents, he warns, are more likely to become alcoholics themselves and alcohol causes sterility in both men and women. This contextualizing of the effects of alcoholism on progeny, reproductive and sexual health, effects an erasure of the violence carried out against the woman and recasts this as secondary to the primary violence exacted on progeny. The film also repeatedly warns the viewer that alcohol affects sexual performance. This again produces a gendered discourse of the woman as passive recipient of sexual pleasure, as the alcoholic male is constructed as being unable to gratify the woman. A woman shown seated in front of a mirror, for instance, exclaims to the viewer that a man who drinks cannot be considered a man at all.

Similarly, in *Preventing Anaemia through Nutrition*, *There is Life for Selvi*, *AIDS*, *Sexually Transmitted Diseases* and *Saying it Again*, a woman’s social and biological roles are collapsed through the visualization of the “threat” caused by the woman to her unborn child. While the child in these films is constructed as the “innocent” victim of disease, especially in the case of sexually transmitted disease, where the “individual’s” responsibility and behaviour come under particular scrutiny, the mother is generally cast as “responsible” or as a passive and dangerous conduit of disease to her unborn child. “Mothers infected with HIV” rank among the profiles of “high-risk” patients visualized in documentaries about AIDS, thereby likening the female body to the unsanitary and negligent practices and spaces, within which other such high-risk patients like drug addicts and prostitutes are visualized. *There is Life for Selvi* centres around Selvi, an HIV positive child abandoned by her mother. Implicit in the scene of Selvi’s abandonment by an unidentified woman, is the double pathologization of the mother body – shirking the biological duty of motherhood and transferring disease to the child. The narrator of the film even asks the viewer, why one should be abandoned by “one’s own”. As demonstrated by Carol Stabile, foetal photography enabled an “erasure” of the woman’s body and accorded the foetus a “new” subjectivity and autonomy. The rights of the maternal/feminine are thus superseded and transferred to the newly discovered subject, the foetus, viewed as the future of the human race. The female body is thus ideologically transformed through these new technologies of visualization, into an “inhospitable” environment at war with the “innocent person” within (172). The medical documentary thus, visualizes the “vulnerability” of reproductive health and the “pregnant” woman, performs an erasure of her body and unveils instead, a deeper, more vulnerable location – the uterus and its biological potential. In the “average” family visualized in the medical documentary thus, identities are constituted on the basis of unequal rights. The woman’s body constitutes the “location” of threat and vulnerability in the home and her familial role is confined to one that is construed as “innate” and biological. As Nancy Fraser has argued, the biological and social roles of women are conflated in the public sphere, through a designation of the space of the home/family, as the socially sanctioned location for reproductive and sexual roles. Individual rights are thus superseded by the rights of future members of the family in the public sphere, where culturally specific institutions filter and accommodate only some kinds of expressive modes (69). The erasure of domestic violence and its rewriting as violence to the bloodline is carried out in *Alcohol-The Killer*, through a "familializing" or personalizing of issues and interests that form part of the "public" sphere. The domain of the family is constructed in the medical documentary as rightfully enclosing reproductive and sexual rights, thus privatising these expressive modes and excluding them from other "public" or political matters.

Preventing Anaemia through Nutrition for instance, stages a visible difference between the "healthy" and "unhealthy" mother. "Health" is constructed here as the biological inheritance that a pregnant woman owes to her child and in the case of this particular documentary, comprises the transferring of reserves of iron to the blood of the foetus. "A healthy mother", the narrator informs the viewer, has rich reserves of iron to pass on to her child and we are shown a corresponding image of the said "healthy mother". In contrast, an unhealthy mother (also visualized for the viewer), as the viewer is informed, does not have much iron to pass on to her child and may thus give birth to an anaemic baby. While the viewer is here urged to "look through" the women on screen, to see their respective biological *potential* and to sense the relative threat they pose to their unborn children, he/she is also presented with very visible differences between the two women. While the "healthy" mother is marked by her dress and appearance as belonging to an elite socio-economic group, the "unhealthy" mother is characterized by her low socio-economic status. The viewer is consistently reminded throughout the film, that the incidence of anaemia is seen to be greater in low-income groups with the help of the narrator’s explication of anaemia causes, coupled with visual records of poor sanitation, nutrition and ill health, in low-income areas. The “healthy” mother is thus normalized, both with respect to fulfilling her biological responsibility and her relatively elite social status. As Ann Travers has argued, the public sphere’s apparent “universality” is characterized by the representation of the subjectivity of an elite group as *the* “objective category of normalcy” (229).

The medical documentary forges affective ties with the individual and the spaces in which he/she is embedded, a point I will return to in chapter six. The space of the family is thus represented in the medical documentary, as a space to which the individual “owes” a certain responsibility. Sexual and reproductive health ought to be monitored and contained in the service of the future of the family, embodied by progeny. The family is territorialized through an “imagining” of ties of belonging, concern and productivity. The individual has to be a “productive” member of the family, to be “needed” by them. In *Conquest of Cancer,* for instance, a woman identified as a “cancer survivor” in the film, testifies to the role played by her family in her recovery from illness. She designates herself as a “cancer victor” and testifies to sensing that her family never stopped treating her as the “same” person, though she was transformed by disease (she has presumably had a breast removed after treatment and surgery for breast cancer). She subsequently informs the viewer, that her family made her feel like they “needed” her. What is significant in this testimony, is that it is made from a location designated as one that is past the stage of illness and is defined as a “victorious” stage. Having recovered from the disease, this “cancer victor” can be reinstated in her family and can once again belong and be “of use”. Her reintegration is however, contingent upon her recovery and upon her being "recognized" as the same person, on being considered "familiar" despite being changed by disease.

The family in the medical documentary is also constructed as the "safe" economy for the harvest/supply of organs/blood. While reminding viewers of the dangers of blood transfusion and transplants from "unknown" donors, narrators of medical documentaries like *AIDS*, *Sexually Transmitted Diseases* and *Saying it Again* also advise that family members are a vital and more significantly "safe" source of blood and organ donation. The individual is thus constantly reminded of the immense profitability of the home and family and can thus only be a member, contingent upon participating in/contributing to and protecting this profitability. As the narrator of *Alcohol-The Killer* remarks, "If you truly love your family you will spare them the horrors of alcoholism".

This chapter has studied filial connections in the doctor memoir, the patient memoir and the representation of the "filial body" in the medical documentary. I have argued here that the "professional" self of the doctor-narrator emerges with the circumscribing of his/her "filial" self. The doctor-narrator's engagement, I have argued, with plural and globalized cultural contexts of disease, sets his "professional" self above the "filial", thereby charting "growth" and a move towards the social. "Filial" interests are seen in the doctor memoir to be either on par with or as located "outside" his "professional" engagement with medicine. The doctor-narrator's performance of relinquishing the "personal" or filial in favour of the public/social, anticipates his/her integration into a wider social network, the subject of the next chapter. This chapter has also examined the construction of a "filial self" in the patient memoir, which makes evident the "mutuality" inherent in patient-carer relations. I have argued here that the patient-narrator improvises a caregiver *Bildungsroman,* which emphasizes the parasitic and relational nature of the narrative ordering of illness experience. Accounts about "acts" of caregiving and the experience of illness are mutually constitutive, and through a system of parasitic relations, mutually "communicate" and are transformed by normative "ideals" of "caring" and "improvement". I also revisit here, the "filial" aspects of "self-improvement" performed by the patient-narrator, namely recognizing their embeddedness in and dependence on, "filial" networks of care.

This chapter has also examined the representation of the Filial Body in the medical documentary, through a sentimentalized territorializing of the "spaces" occupied by this body. The Filial Body is localized in the medical documentary within the "home" and the "family", which is seen as being threatening and vulnerable to the "sick" body. I have argued here that the space of the home/family is designated in the medical documentary as the socially sanctioned location for reproductive and sexual activity, which enables a conflation of biological and social roles of women in the home. Individual rights are thus superseded by "future" members of the family, embodied by progeny. The "filial body", this chapter has demonstrated, is "situated" within the "family"/ "home", through an "imagining" of ties of belonging, productivity and concern. The next chapter will explore the doctor's integration into a "community" in the doctor-memoir, through the instantiation of a "social self". This "social self", the following chapter will demonstrate, illustrates the acquisition of "expertise" as a break-down of the awe and confidence inspired by medicine in the "novice" or "rookie" self. This "expertise" serves to set apart the doctor-narrator as a "cosmopolitan" and "labouring" body, who "works" to make himself/herself viable for the community. The "community" into which the doctor-narrator is eventually integrated, the following chapter demonstrates, is narrated into being by this narrator who orders and designates "selective" traits or attributes as being vital for the sustenance of "community". The doctor-narrator thus performs "informational labour", which perpetuates the viability of his "professional expertise" for the community and narrativizes patients' experiences with illness as "battles" or a "struggle for survival", thereby designating an "ideal" method of encountering illness. The community into which the doctor-narrator is integrated, the following chapter proposes, is thus narrated into being via an emphasis on "productive", "labouring" and "active" patient bodies and a critique of reticent and passive responses to illness. The "community" is thus understood in the doctor memoir, as a conditional membership that entails the performance of "productivity", the perpetuation of such "productivity" and a belief in the achievement of an "ideal" level of productivity in the management of illness.

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Chapter Five

"The Doctor is IN": Community and the Doctor Memoir

Chapter Plan

Section I: The Professional

(a) Cultural Work, Expertise, Technology

Section II: The Social

(a) The Social Self

(*i) Transcending the "Filial"*

(ii) Carving out a Space to Speak

(iii) Engaging the Real

(b) The Labouring Doctor Body and the Community

As argued in chapter three on the doctor memoir, the physician-as-expert engages in "cultural body work" – the physician-as-expert is a cosmopolitan, labouring self, whose "productivity" is framed as relevant or viable not only for the individual, but for the community. This chapter will address the doctor-narrator's framing of his individual labouring self as relevant for the community, in addition to focusing on the instantiation of a "social self" in the doctor memoir or the *Bildungsroman* of healing. The chapter follows the route charted by the *Bildungsroman* of healing for its doctor-narrator, whose portrayal of a "novice" self that seeks to transcend passively acquired institutional and filial knowledge and advantage, has been addressed in previous chapters at the level of the individual and filial respectively.

As argued in chapter three on the doctor memoir, the period of "youth" in the classical *Bildungsroman* is finite and must eventually give way to "maturity". A "socialization" of the doctor-writer is performed in his/her memoir, where the period of education, learning, errors and experimentation (an individual "role" with personal standards/illusions), must also necessarily end to give way to expertise, perfection and professionalism (a social "role" that requires a practice of ethics, a development of judgment and an awareness of "publically" held standards). Here, I will focus on the emergence of a "Professional" and "Social" self in the doctor memoir, a culmination the arc of development instantiated by the doctor-narrator, where his/her individualized "story" and identity are "socialized".

Section I of this chapter on the "Professional" will demonstrate through an examination of Verghese's *My Own Country* and Gawande's *Complications,* the performance of "expertise" as the break-down in a "novice" confidence and the acquisition of "belief" in the power of medical practice. This section will demonstrate how the doctor-narrator as "expert", articulates encounters with the *actual* "impotence" of medical practice and the futility of its technological processes in the face of invading pathogens. In addition, this section will argue that the doctor-as-expert utilizes diagnostic tools and systems outside of those readily available to him, through and inside the institution, to collate information. Chapter three of this dissertation has already examined how the doctor-narrator's medical education functions as an invisibilized "signage" and can be read as a "boundary object". When the doctor-narrator insinuates himself/herself as an "editorial self" in contexts/social worlds outside the medical institution, the "boundary object" of medical education and its "trappings" are substitutable with the doctor-body and render this insinuation "recognizable". The "robust" and "plastic" nature of the doctor-narrator's medical education as "boundary object", allows this narrator to translate universal medical knowledge in particular, idiosyncratic contexts. This section will examine the doctor-narrator's testimony/reconstruction of a patient's "story" of illness, as an "immutable" or "combinable" mobile. *I will argue here that the doctor-narrator is able to create a "cycle of accumulation" that renders the "stories" of patients stable, mobile and combinable, so that they can be transported to the medical institution as informational representation*. This informational representation ensures that patients are transported (through the doctor-narrator's "accounts" of such patients) not as individuals, but as information required to make "familiar", the unfamiliar pathological/abnormal nature of their bodies and to reduce the actual distance between them and the "expertise" accumulated by the doctor-narrator through this act of representing.

Section II on the "Social Self" will examine, in addition to Verghese's *My Own Country* and Gawande's *Complications*, Sandeep Jauhar's *Intern: A Doctor's Initiation* and Noshir H. Antia's *A Life of Change: The Autobiography of a Doctor*. Here, I will argue that the doctor-narrator is integrated into a "community", through a privileging of those experiences that are perceived as "productive" for this community. The doctor-narrator frames stories of patients' experience with illness as a "battle", the protagonist of which is the "heroic" patient who possesses a "will" to survive. These "survival" strategies of patients are reconstructed by the doctor-narrator, as a necessary conditionality for membership in a "community". This section will argue that the doctor-narrator's attempts to equate a critical, "activist", professional self with an "activist" patient self and articulates a critique of passive and reticent responses to illness. This section will also demonstrate how the doctor-narrator in the medical *Bildungsroman*, is able to carve out a space to speak from where he/she can critique medical practice and identify a "social role" for the doctor. Narrating an experience of medical internship/practice provides a space for voicing personal indecision and inadequacy, which subsequently dovetails into a critique of this very practice. This discursive act reinvents and sustains the doctor's role in the community and concretizes agency for the creator of this act. Moreover, this agency is perceived as being in a state of threat/vulnerability, without a reinvention of the doctor-narrator's role. The doctor-narrator is embedded in the community in multiple contexts, through diverse social worlds and a simultaneous engagement with these contexts/worlds is seen as necessary to perpetuate this narrator's role. I propose here, that the labouring cosmopolitan physician self "works" to insinuate himself/herself into a community that is constructed in narrative through an inscribing of disciplining cultural norms on the patient's body. In addition, the doctor-narrator makes his own professional "expertise" viable, through a performance of informational labour which makes visible, a continued engagement with global and local contexts of medical practice.

Section I: The Professional

(a) Cultural Work, Expertise, Technology

This section proposes that cultural work is what enables the nascent cosmopolitanism of the physician-as-expert to become a fuller cosmopolitanism.

The medical *Bildungsroman* offers a "new" kind of doctor-body that perpetuates the viability of the role played by the doctor, medical technology and the medical institution, for the individual and the community. The physician-narrator in the medical *Bildungsroman* is embodied, not only, obviously, as a corporeal presence, butalso through his relations/encounters with the pathogen, the patient and the medical institution. Another crucial component dramatized in the physician-narrator's journey from novice/trainee to professional/expert-self, is the doctor's everyday encounter with technology necessitated by the very nature of 21st century medicine. Technology in the medical *Bildungsroman* appears not only as prosthesis for the patient's damaged body, but also to the doctor's body. For instance, the doctor's everyday encounter with the bodies of patients and the pathogen is mediated through technologies of representation (EKG reports, X-rays and MRI scans) that "re-present" the patient to the doctor, after the patient's initial "presentation" of his/her condition to the medical institution. These technologies of representation are also tools for the accumulation of "facts" about the nature of any given state of unhealth, against which the doctor measures the accuracy of his/her "expert" diagnosis.

The doctor-narrator's filial and novice self regards the technological processes of medical practice with a certain degree of awe and more crucially, places implicit trust in their diagnostic accuracy and is imbued with what Gawande describes as 21st century medicine's "tall-in-the-saddle confidence" (181). Writing about his experience of "learning" to read an EKG, Gawande recalls the unmanageable complexity of the exercise. "When I was a medical student," he writes, "I first learned to decode the EKG as if it were a complex calculation. My classmates and I would carry laminated cards with a list of arcane instructions" (28). Gawande goes on to describe the list of arcane instructions that the medical student has yet to integrate, in his journey towards becoming an "expert", whose accumulated experience with such technologies of diagnosis will enable him/her to recognize a heart attack in the EKG "the way a child can recognize his mother across the room" (28). Similarly, Gawande recalls the exhilaration he experiences at the first surgical convention he attends as a medical student. Although he is critical of the "carnival-like" nature of the convention and is disillusioned by how senior surgeons are drawn into the "petty bribery" of the technical exhibit booths that "hawked" their merchandise, he is drawn to certain aspects of the convention that strike him as "genuine". One of these was what is called the "Surgical Forum", where Gawande witnesses researchers from various subjects in medicine, discussing the work they had underway. A recurring topic that year, Gawande reports, was tissue engineering and he marvels at the fact that the researchers were not discussing the *possibility* or *potential* of being able to grow human organs, but were instead worrying about how these organs could be grown better. Gawande watches in awe as the researchers present evidence of tissue engineering *actualized*, they display photographs of lengths of blood vessel, heart valves and segments of intestine grown entirely in laboratories. "Sitting in the audience", he writes:

> I experienced a sudden giddiness upon realizing what these doctors had done. And I began to wonder if it was at all like what Joseph Lister's colleagues at the Royal College of Surgeons had felt when he first presented his findings on antisepsis, nearly a century and a half ago. (75)

In comparing his own feelings to those of Joseph Lister's (Lister, in 1865, demonstrated the use of carbolic acid for the sterilization of wounds and surgical instruments which then ensured patients' safety during surgery and led to a dramatic reduction in post-surgical infection) colleagues, Gawande is not only signalling to medicine's giant leaps forward in the span of a century and a half, but also insinuates himself in what he identifies as a key historic moment for the social role played by the medical practitioner and medical technology. As a medical student at the surgical convention, when Gawande witnesses the "edges of knowledge" and the "approachable frontiers" of current medical research, his "giddiness" arises from the knowledge that he is being offered a glimpse of the "expertise" he journeys towards. The doctor-narrator's journey towards "expertise" or "becoming-professional", however, is premised upon an overcoming of this novice awe and implicit trust in techno-scientific advances in medicine. The doctor-narrator as "expert" sets himself apart from the medical student, in his ability to see the futility of many common technological aids to medical care.

Verghese for instance, is inspired with a growing sense of loss as an AIDS specialist, whose status is "expert" is threatened with negation in the face of an incurable epidemic. Recalling the ICU care provided to one of his patients, now in the terminal stages of HIV infection, he writes, "A novice in medicine sees only the drama of the pacemaker and the Swan-Ganz catheter; more years in medicine and you see how suffering is prolonged, hospital bills multiplied tenfold, the possibility of a dignified death diminished" (159). Verghese and Gawande both experience as "professionals", the "impotence" of medical science in delivering their patients from the throes of illness. Recalling his days as a medical student in the 1980's in America, Verghese writes:

> To say this was a time of unreal and unparalleled confidence, bordering on conceit, in the Western medical world is to understate things. Only cancer was truly feared, and even that was often curable. When the outcome of treatment was not good, it was because the host was aged, the protoplasm frail, or the patient had presented too late – never because medical science was impotent. (24)

While Verghese, for instance, journeys towards professionalism and "expertise" in the era of AIDS, Gawande comes of age in an era where medicine's techno-scientific capabilities were unparalleled.As "experts", however, in addition to grappling with the divide between medical education and practice (the incommensurability between text-book education in medical school and the idiosyncratic cultural and material contexts in which the physician (as reader of the body-as-text) and the patient (as the body presented to medical knowledge) are embedded), they were also experiencing a “divide” within or “misidentification” with, the very nature of the “expertise” they were expected to embrace. Writing about the choices of professional specializations available to the medical student for instance, Verghese writes:

> Basic research had become so complex: No one cared if in a certain disease you discovered that some protein in the blood was either high or low. The question being asked was what *gene* was controlling this protein? And how quickly could you clone it? Science had gone molecular. An investment of a couple of years after fellowship training was necessary just to learn the *methodology* of molecular biology. (32)

Gawande also expresses a similar anxiety about the learning curve that awaits a novice, during his/her period of professional training. For most of his residency, Gawande admits, he thought surgery was a “fixed body of knowledge and skill which is acquired in training and perfected in practice” (17). He finds out however, that the “reality” ends up being “far messier”. Quite significantly, it is Gawande’s father (also a practicing surgeon), who signals at this “reality” of the learning curve that operates in a field increasingly dependent on technological innovations. His father warns Gawande, “You do get good at certain things”, however, “no sooner than you do, you find what you know is outmoded. New technologies and operations emerge to supplant the old, and the learning curve starts all over again” (17). Gawande’s father goes on to explain that most of what he does today (as an urologist), he did not learn during his residency. The novice doctor-narrator thus experiences a break-down of the confidence and awe inspired by medicine's techno-scientific *potential*, when he/she encounters the everyday, *actual* "impotence" of medical practice and the futility of its technological processes in the face of invading pathogens. Moreover, the "expertise" that the novice journeys towards, starts to resemble medicine's technological apparatuses – a state that once achieved will just as quickly become outmoded and then subsequently replaceable by something better.

The medical *Bildungsroman*, as argued earlier in this chapter, offers a "new" kind of doctor-body that perpetuates the viability of the role played by the doctor, medical technology and the medical institution, for the individual and the community. This is achieved by underscoring the importance of "informational" labour performed by the doctor-body, in everyday medical practice. Chris Shilling signals at the increasing significance and scope of informational labour in the late twentieth century – a direct consequence of the development of technological means to enhance the body and the expansion of cyberspace. He argues, via M. Castells, that we have entered a "new informational mode of development" and its main feature is "the emergence of information processing as the core fundamental activity conditioning the effectiveness and productivity of all processes of production, distribution, consumption and management" (182). The doctor-narrator in the medical *Bildungsroman* frequently emphasizes the importance of processing information for the "expert" in medical practice. Writing about the "curious faith" he has, when he believes he can solve the diagnostic puzzle presented by an individual, idiosyncratic case, Gawande says:

> I have never seen this woman before in my life, and yet I presume that she is like the others I've examined. Is it true? None of my other patients, admittedly, were forty-nine-year-old women who had had hepatitis and a

> drug habit, had recently been to the zoo and eaten a Fenway frank, and had come in with two days of mild lower-right-quadrant pain. Yet I still believe. (187)

The "expertise" acquired by the doctor-narrator comprises individual elements like the case above. The informational labour performed by the doctor includes fashioning his/her "expertise" with not only the education acquired "passively" in medical school and the straightforward case that fits ready-made medical parameters for diagnosis, but in learning from the "oddities" in medical practice. Gawande describes this function for the surgeon thus:

> Every day, we take people to surgery and open their abdomens, and, broadly speaking, we know what we will find: not eels or tiny chattering machines or a pool of blue liquid but coils of bowel, a liver to one side, a stomach to the other, a bladder down below. There are of course, differences – an adhesion in one patient, an infection in another – but we have catalogued and sorted them by the thousands, making a statistical profile of mankind. (187-188).

The doctor thus integrates into medical knowledge, the *differences*among various cases that are presented to him/her, making these "oddities" as familiar as the scene of a surgeon looking inside an anatomically correct model of an abdomen described above. Similarly, Verghese reports the extensive informational labour he undertakes, while profiling various symptoms of HIV patients – an accumulation of knowledge he considers necessary, especially since there was no known cure for the fatal infection. Writing about a particular case of *Pneumocystis* pneumonia (specific to persons with AIDS) he recalls, "The only cases of *Pneumocystis* pneumonia I had ever seen were in persons with AIDS. This was unique to my generation of infectious diseases physicians: We had all come of age in the era of AIDS" (226). Verghese views his role in the history of the AIDS virus as an informational one – he witnesses and records information about the disease, as a substitute for the "cure" that neither he nor medical science can provide. This act of witnessing and recording has an aspirational quality, in the sense that it signals to a future or *potential* use/significance of such information for researchers/medical science. For instance, contextualizing the significance of such acts of information compiling for the doctor, Verghese writes about the *actualization* of a corpus of knowledge – contributed to, no doubt, by acts of compiling similar to his. He writes, recalling an unfruitful biopsy, "The biopsies of the ulcers in the oesophagus were not revealing. In later years there would emerge a body of knowledge about these mysterious ulcers: they are aphthous ulcers", however, "at the time when I was taking care of Will, such knowledge did not exist" (256). Verghese's future acts of compiling and interpreting information thus resolve the past "mystery" of Will's ulcers. These ulcers are no longer unfamiliar since Verghese, in his recounting of the events of the era, is able to "name" them for his reader. More significantly, however, the doctor-as-expert uses diagnostic tools and systems outside of those readily available to him through and inside the institution, to collate information.

Both Verghese and Gawande build relationships with their patients outside the medical institution. As Lisa Diedrich has quite rightly observed, in narrative, Verghese attempts to overcome medicine's "failure of vision" by describing his patients "as subjects who are ill, not as subjects with a disease to be diagnosed; as individuals, not ideal disease types" (98). This is because, as argued earlier in this chapter, the new doctor-body presented in the medical *Bildungsroman*, is interested in bringing to the centre of medical knowledge, as yet unfamiliar aspects of disease and ailing individuals that are yet to be integrated into the corpus of information that constitutes the doctor-as-expert. This process of accumulating a corpus of information about unfamiliar/marginal aspects of disease by the doctor-body generates what Latour defines as immutable and combinable mobiles. Latour defines knowledge as coming into being through what he calls a whole "cycle of accumulation", which is a way of making "familiar", events, people and things that are distant. This "familiarity" or "recognisability" of elements that are transported from the peripheries to a knowledge-building centre, is achieved by devising ways of informatizing, that increase the "mobility, stability or combinability" of the transported elements (243).Once the doctor-narrator "familiarizes" those marginal and peripheral aspects of medical knowledge (patients' accounts of their experience of illness, lived partially "outside" the medical institution) into mobile and combinable elements, he/she can bring patients back into medicine's knowledge centre. These patients are brought back to the centre not as individuals, but with as much representational information as can render them once again "familiar" subjects of medical science/intervention, thereby becoming dominated from afar. The distance between the doctor-body accumulating knowledge and the "unfamiliar" patient bodies is thus diminished. Writing about his interest in defining his patients by means other than those available to him, Verghese says:

> But I was also interested in the patients' stories for their own sake. I was fascinated by the voyage that had brought them to my clinic door. The anecdotes they told me lingered in my mind and became the way I identified them. Most of these stories I kept in my head. Some I recorded in a journal that I kept faithfully and that became very important to me as

> time went on. Occasionally, I would hear a story so outrageous that I would dictate it to be included in the chart for the sake of posterity. (126)

Verghese here makes explicit, his interest in integrating the story of his patients as "individuals" (before their entry into the medical institution and an official pronouncement of the presence of disease in their bodies) and as medical case-study. His act of integrating an "outrageous" incident narrated by the patient, along with the medical narrative contained in the patient's "chart" for "posterity" within the institution, signifies a renegotiation of the doctor's role within the institution and the community. Similarly, writing about the role of technology in medicine, Gawande argues that the two need not be viewed as incompatible, but can in fact be mutually reinforcing. As "systems" take on the technical work of medicine, he says, "individual physicians may be in a position to embrace the dimensions of care that mattered long before technology came – like talking to their patients" (37). The doctor can thus return to his/her traditional role as "healer", to ensure a better integration of technology with medicine. With the renegotiation of roles performed by the doctor, he/she is integrated into the larger culture. "Maybe machines can decide," Gawande concludes, "but we still need doctors to heal" (38). We still *need* doctors therefore, if we are willing to recognize the value of traditional medicine. As Chris Shilling has argued, prosthetic technologies and devices *restore* rather than extend a person's capacities (175). In his discussion of humans' desire to transcend bodily boundaries through technological mediation, Shilling argues that such technology-aided-transcendence should be viewed not as externally imposed, but as inherently connected to people's plans and capacities (177).The "expertise" that the novice doctor-body journeys towards is seen in the medical *Bildungsroman*, to be threatened by the pace of technological advancements and the ineffectuality of modern medicine against disease and illness. Technology in the medical *Bildungsroman* is thus construed as prosthesis for the doctor-as-expert, who integrates institutional and personal accounts of patients, to improvise and restore the viability of a "new" role for the doctor. By incorporating technology as "prosthesis", the doctor-body in the medical *Bildungsroman* elides the institutionalized technological processes that make the compiling of information possible. This "informational labour" is instead integrated as prosthesis in the "expert" doctor-body, which now functions as a "restored" space where the institutional and social contexts of the individual intersect.

The doctor-body is set apart as possessing the skill to perform the informational labour required to effectively perpetuate the viability of his/her professional expertise. In the medical *Bildungsroman*, the doctor-body is marked by his/her skill to *locate* the patient's story. However, it is the individual who, before his/her entry into the medical institution and the doctor-narrator's informational representation, *presents* his/her story (personal and medical) to the doctor-narrator. This is carried out by virtue of a) authority invested in the doctor-narrator by the institution (b) through technological processes of collating information that are instituted by medical practice and are imparted via institutional structures (medical residency). The doctor-narrator's encounter with this "received" story is, however, staged as a "discovery". For instance, writing about Bess Johnson, one of the few heterosexual patients with AIDS that Verghese treats, he emphasizes her "need" to tell him her "story". Verghese assures Bess that "they have all the time in the world", therefore breaking down the conventional set-up of the doctor's consultation, generally constrained as it is in a professional context, to a limited period of time as indicated by the need to "schedule an appointment" and the possibility of prior engagements with other patients and professional commitments.

This is a recurring characteristic in Verghese's descriptions of "consultations" with patients, where he often willingly does not constrain the passage of his patients' stories with a set time frame. This official commitment of "consulting" with a patient often stretches to constrain his own personal commitments at home to his family and often extend outside the confines of his clinic, during his visits to patients' homes. This is also true of Gawande, who travels to meet patients after a surgical procedure not only to monitor their progress, but to "discover" the personal and professional aspects of their life and to give them an opportunity to share with him, their experiences of what are presented as varying degrees of restitution to normalcy. Writing about Bess Johnson's reaction to being told she has as much time as she requires, Verghese says, "She opened up now, as if she *needed* to tell her side of the story" (265). Verghese's patients *need* to tell him their stories not as a doctor, but as an individual who inspires such a desire in them. In addition to Bess's *need* to confide, Verghese often draws parallels between his own status as a foreigner in America that endears him to his homosexual patients, who are similarly *foreign* in their social milieus. Similarly, Gawande also writes about the significance of the doctor's role outside what is defined professionally and the necessity to devise a new set of rules for such interactions with patients. Writing about how doctors need to help patients' decide when to avail life-prolonging technologies, in order to avoid the physical and emotional violence that often result from such difficult decisions, Gawande says:

> I had come into residency to learn how to be a surgeon. I had thought that meant simply learning the repertoire of moves and techniques involved in doing an operation or making a diagnosis. In fact, there was also the new

> and delicate matter of talking patients through their decisions – something that sometimes entailed its own repertoire of moves and techniques. (204)

Verghese is here acknowledging the need for the "new" doctor-body, one that can restore the imbalance introduced by the nature of medical practice itself, thereby ensuring the viability of the doctor's role as "expert". This "expertise" is, however, set apart from the soon-to-be-outdated model of technological expertise that both Verghese and Gawande glimpse during their residency. As Verghese explains, in the absence of a cure for the AIDS virus, his job was to "minister to the patient's soul, his psyche, pay attention to his family and his social situation" (272). He is cognizant, however, of the fact that this comes with a price professionally. Verghese says:

> We were trained in hospitals, not in patients' homes; we were biased toward technological interventions in the form of drugs and needles; words like the 'soul', the 'spirit', were considered dirty words. There was no or little payment for the non-technological kind of medicine: hand-holding, family visits, home visits had no billing codes; bronchoscopies, colonoscopies and PAP smears did. (272)

The doctor-body is thus set apart in its "discovery" of a new network of "cycles of accumulation" that exist outside the institutional framework. Although Verghese's non-technological kind of medicine has no billing code, it possesses for him an informational code, through which the new doctor-body brings back to the centre of his/her expertise, the mobile, combinable elements of these family and home visits.

The following section will examine the integration of the doctor-body within a "community", through the designation of conditions necessary for membership in such a "community".

Section II: The Social

(a) The Social Self

(i) Transcending the "Filial": Rajini Srikant (2004) has argued that Verghese functions as a "cultural insider" in his memoir, by transforming relative disadvantages like being a "foreign" doctor in America to the position of an ultimate insider in rural America. Through the "conduit of AIDS", Verghese is able to integrate himself into the rural community in Johnson City, a part of the land that arguably exists outside the consciousness of most Americans. "Thus, being an insider in such a community", Srikant argues, "may represent a kind of dubious belonging to America; on the other hand, in Verghese's case, the particular nature of his doctoring enables him to move from the privilege of being an insider in Johnson City to being an insider nationally" (440). The doctor/narrator is integrated into the community through his role as "professional doctor", achieved through an elision of the filial. However, the doctor/narrator as "professional" must necessarily recognize the significance of the "filial" for the rehabilitation of illness in the community. As argued earlier in Chapters Three and Four however, the doctor/narrator is socialized or integrated into a community, by transcending his/her "passively" acquired inheritance (in terms of knowledge acquired from the medical institution and family) to become a "professional". The doctor-narrator as "professional" reflects this emergence, but also alters the scope and degree of transformation and socialization for the doctor protagonist in the medical *Bildungsroman* in new and unanticipated ways. While recognizing the significance of the filial in the treatment of illness therefore, the doctor/narrator privileges those experiences that are perceived as "productive" for the community. This is achieved by framing stories of patients' battles

with disease, as an "ideal" method of dealing with an experience of illness. The doctor/narrator attempts to equate his critical, "activist", professional self with an "activist" patient self and is critical of passive, reticent responses to illness. Verghese for instance, feels a greater degree of identification with his "activist" patients and frustration and self-doubt when faced with those who give up "without a fight". Describing a gay couple that he is treating, Fred and Otis, Verghese writes about Fred:

> He had spent a lifetime training for the role of AIDS activist in Johnson City. The stakes had never been higher; his activism now had a clear focus. It would be his therapy, it would give him long life, it would greatly better the lives of persons infected with HIV in upper east Tennessee. Otis could object all he wanted to; but he had better realize that Fred *needed* to be involved in TAP for his psychic well-being, as much as I needed to be a physician for mine. (194)

Fred's activism is almost directly linked to the degree of his suffering from AIDS. As an activist and a *productive* member of the community, (Fred is an active member of TAP – the Tri-City AIDS project, a rehabilitation or support group for AIDS patients in Johnson City) Fred faced a longer life than Otis, his fatalistic and reticent lover, who will succumb to his symptoms earlier. Here, Verghese provides the moral code necessary for the doctor/narrator's integration into the community – the physician depends for his "psychic well-being" on the medical and personal care he/she extends to the community. Adapting Christian Penzold's arguments about the "symbolic" rather than the "structural" constitution of communities in the case of Wikipedia communities (705), it is possible to argue that the doctor-narrator's "community" in the medical*Bildungsroman*, is constituted through the "symbolic" or through discursive acts and attempts to concretize social meaning, rather than through actual, material interaction/participation in a community. The doctor-narrator, as argued earlier in this chapter, sees himself/herself as "growing" out of a "filial" context, by relinquishing the "filial" or personal in favour of the public/social. His/her integration into a "community" however, is largely symbolic, contingent upon the cultivation of particular values, a moral code and a set of norms. As argued in the Introduction, the doctor-narrator frames an *ethos community* in his memoir, whose membership is governed by this narrator's self-understanding and self-description. Pentzold defines the "ethos community" as an "open body", which does not have clearly demarcated boundaries and is a "group of concepts" linked around the understanding of the term "community". The members of this community, Pentzold argues, are linked by committing to "a set of norms, behavioural standards and attitudes – by sharing its ethos" (712). The doctor-narrator's ethos community is thus formed through his/her designation of "productive" and "activist" patient stories, as "ideal" responses to illness and in his/her articulation of a particular set of norms.

An integral aspect of self-formation for the doctor/narrator for instance, is the desire to re-integrate, to give back to the community. The TAP is interesting in this regard, as it exists for sometime in Johnson City, unknown to Verghese. He first hears of TAP from Fred and is "incredulous" that it escaped his knowledge – "I was incredulous! I had been unaware of the group which was already having regular meetings. I felt left out. How had TAP come about?" (183). Feeling "left out" of this group, Verghese manoeuvres himself into the story of TAP through his patients' stories of TAP meetings. When several of his patients start to attend the group, Verghese writes:

> Up until this point, most of the HIV patients, who slipped in and out of my office as discreetly as they could, had no awareness of the others in town

> who had the virus. They might have spotted each other in my waiting room, made informed guesses, but that was it. By February of 1988, however, TAP – the Tri-City AIDS Project – was holding regular meetings and many of my patients were attending. They spoke to me about it often. (314)

The doctor/narrator, therefore, is able to establish himself at the centre of a community activist project, through his intimate relationships with patients. Verghese senses the formation of a "community" outside the confines of his office and establishes himself at its centre, through his status as the members' doctor. The *Bildungsroman*, as Moretti has argued, not only "builds" the ego but then establishes this ego as the "indisputable centre of its own structure" (11). Verghese has here located his "practice" and work as "expert", as the epicentre of a community building exercise. His own "psychic well being" is equated to that of the patient members of the TAP community, thereby establishing a shared negotiation of meaning about what it means to "contribute productively". Verghese through his cosmopolitan "practice", engages professional and social aspects of medicine simultaneously and this "moral code" of providing both professional and personal care, forms the basis for his ethos community. This "moral code" extends to and becomes substitutable with the "ideal", "activist" patient, who is narratively improvised in doctor-narrator's ethos community. This "activist" patient, like the doctor-narrator, "works" to "perform" improvement, engages with the experiences of others and labours towards the rehabilitation of these others, in order to "belong" to a community.

Similarly, Gawande also recognizes the significance of activism in his patients' stories. Writing about a news announcer who suffered from chronic blushing, Gawande describes her efforts to rehabilitate herself after undergoing a surgical procedure to reverse her condition. The news announcer, Christine Drury, is, however, reluctant to share information about her surgery with co-workers and friends, for fear of being judged about the “nature” of her surgery. The first time she shares information about her surgery with a friend, he responds with shock and horror. This event, as Gawande plots it, leads to a gradual break-down in Drury’s confidence (confidence that had been regained after surgery to keep her from blushing too often) and she spirals into unemployment and depression. Recording her progress from this state, Gawande writes:

> Matters changed for her only gradually. She began, against her instincts, admitting to friends and then former co-workers what had happened. To her surprise and relief, nearly everyone was supportive. In September 1999, she even started an organization, The Red Mask Foundation, to spread information about chronic blushing and to provide a community for its sufferers. Revealing her secret seemed to allow her finally to move on. (149)

It is thus essential for an experience of illness to not only be shared, but to form the basis for the organization of a community of sufferers. The ethos community here is linked through a shared understanding of behavioural norms to be adhered to during a period of illness. Drury “changes” and has to act “against her instincts” to obtain membership in the “community” of sufferers. In order to “identify” with the “community”, as Pentzold has demonstrated in the case of “communication” dependent discursive communities like the ethos community, members have to be “socialized” and have to “commit themselves to its ends, norms and procedures” (718). The doctor/narrator is able to integrate himself/herself into the ethos community, by foregrounding the “potential” for activism within the patient community. The doctor-narrator is socialized here through an emphasis on the governing principles of an ethos community of suffering – the commitment to sharing an experience of illness, to inform and educate other sufferers, actual and potential.

In addition, the doctor/narrator as "professional" makes medical practice "relevant" for the community. He/she is able to provide, through a "medical" narrative closure, a coherent progression of disease from the "event" of diagnosis to recovery or "discovery" of the "real" cause of illness or death resulting from illness. Demoralized by the many deaths caused by HIV related illnesses among his patients, Verghese is able to record a "victory" in the death of one of his patients, when he is allowed to perform an autopsy:

> I got three or four more pieces of liver. Stab. Stab. Stab.
>
> Then Spleen. Stab. Stab. Stab. Heart. Stab. Lung. Stab. Into formalin.
>
> A small victory here: this virus had killed Hobart. But it was not going anywhere from here but to formalin or to the crematorium. (402)

Through the repeated "stab", Verghese is able to dramatize a physical victory over the virus. Armed with a biopsy needle, the doctor is cast in the role of "defender" or "protector" of the community, able to "capture" the killer virus in formalin, to further "tame" it by careful analysis and study in the laboratory. The doctor/narrator provides a "medical" closure to the story of the patient, whose "physical" death is transcended by his contribution to the expansion of medical knowledge. It is interesting to note, however, that it is unwittingly and in death that the patient surrenders this "evidence" of a pathogen, itself at a certain stage of its development in the patient's body, to the biopsy needle guided by the doctor/narrator. The doctor is thus, yet again, reinstated at the centre of his own narrative structure, providing as he does, a "medical" closure to the story of the patient and pathogen. The doctor-narrator here ensures the sustenance of his/her expertise for the community, with regard to the collection and dissemination of knowledge, even outside the medical institution or even in circumstances where there can be no “cure” or “treatment” available. Here, again, the doctor-narrator harnesses the patient body in narrating an ethos community, where the patient’s private experience of illness and subsequent death does not limit the dissemination of knowledge/information/expertise about this individual illness experience.

Gawande, too, notes how the popularity of the autopsy has perhaps rested on its ability to “give the story of a loved one’s life a comprehensible ending” (181). However, Gawande also recognizes the significance of the doctor’s role in making the post-mortem “comprehensible”. Tracing a decline in the popularity of autopsies in the twenty-first-century, Gawande attributes it to a “tall-in-the-saddle confidence”, arising from technological advancements like “MRI scans, ultrasound, nuclear medicine, molecular testing, and much more”, that are touted to significantly reduce the possibility of errors. Since an autopsy is intended to be a “review” of errors, a system that prides itself on reducing such errors does not have much use for this arcane practice. However, Gawande warns against such confidence and illustrates how medicine is itself an “inexact” science with plenty of room for error. Reflecting on surgery itself as a kind of autopsy, he writes:

> ‘Autopsy’ literally means to ‘see for oneself’, and, despite our knowledge and technology, when we look we’re often unprepared for what we find. Sometimes it turns out that we had missed a clue along the way, made a genuine mistake. Sometimes we turn out wrong, despite doing everything right. (188)

Gawande thus foregrounds the importance of the surgeon's "perspective" on the body. Whether in death or during medical intervention to prevent/treat illness, the surgeon/doctor must "see for himself" the progression/journey of the pathogen in the patient's body, so that the patient, his/her experience of illness and subsequent rehabilitation (the medical history), can attain closure. The doctor/narrator can construct a "coherent" sense of self by establishing "for himself", the extent to which medical science and he/she as its "human" mediator, have succeeded or failed. Failure can, in fact, be elided, by being able, as the surgeon is, to "see for oneself" the "exact" nature of the "error" made. Once "discovered", the doctor/narrator can harvest these "errors" to reflect critically as a "professional" on the knowledge and practice of medicine – manoeuvring himself/herself yet again, via the patient's body, into the community.

(ii) Carving Out a Space to Speak: The doctor-narrator's "social" self is constructed in the narrative through an ability to carve out a space to speak. The doctor-narrator in the medical *Bildungsroman*, who narrates the story of an individual's experience of treating illness, carves out a space to speak from, by creating a community of readers who share a "vulnerability" to the risk of infection. A chronicle of the private experience of illness, in terms of a physical experience of the illness or treating it, is a public enactment of a private experience. A testimony, however, cannot take place in isolation, as Nancy Miller and Jason Tougaw have argued. A testimony attempts to build a bridge between an individual's suffering and a community of listeners, through the establishing of a "contract of listening". This contract, as argued earlier, involves an empathetic response on the part of the listener/reader, which is palliative for the witness/speaker (11). Tougaw argues that AIDS memoirists' abandonment of writing (since many of them do not survive to experience the effects of their writing), does not take away the power of their

memoir as a "speech act". This "act" speaks for a collective and attempts to disseminate the "story" of the trauma underpinning this collective, to prevent the recurrence of the historical conditions that led to this trauma. In the case of the AIDS memoirist however, the conditions which led to the writing of his/her memoir continue to exist in the reader's present. This has resulted in a reconfiguration of gay discourse and gay communities, as the memoir reminds readers of the grim conditions that led to its production (175). The narrating "self" in *My Own Country* carves out a space from which to speak, in the form of a community of readers/listeners, through a negotiation with the continuous "present" of the story of AIDS. The "reality" of AIDS described by Verghese's doctor-narrator inhabits the "present" of readers and the conditions that led to its development are unresolved, thereby threatening the "self" created by the narrator, through a negotiation with the "story" (implying something that is manifestly "finished" or "complete") of AIDS. *The doctor-narrator thus projects his "speech act" as a moral or ethical call for action that gives voice to a moral discourse in the text.* Donald Pollock argues for a "professional conscience" that novice physicians voice, in tales recounting their medical training (123). Physician autobiographies, he argues, provide a "projective screen" that helps their authors concretize uncertainties and anxieties about medical science and bureaucracy (124). Verghese's doctor-narrator, therefore, describes his anxiety at having the only "rural" and "intimate" experience of AIDS in America and gives voice to a moral discourse in the text. "I was their [his patients] surrogate activist, their link to the larger consciousness of AIDS" (276). Reports in academic journals about AIDS which the narrator compares to "dispatches from the front reaching me in my war room", don't give him any definitive information on a cure for AIDS. "So far, no one had described the rural experience with AIDS I was seeing", he says (277). He thus gives voice to the moral discourse in the text that is contingent on a "response" to the illness, rather than an attempt at a definitive understanding or comprehension of the "story" of the unknowable AIDS virus.

Noshir H. Antia's doctor-narrator joined the Grant medical college as a student in 1940. Reflecting on his education and subsequent practice in the years following the Indian Independence, places him in a unique position with regard to the evolution of medical practice in post-Independence India. Antia's narrator thus frequently contextualizes post-Independence India for the reader, whose "present" is the consequence of the years of medical advancements/transformations that Antia has borne witness to. His anxieties towards the state of medical practice in the country are expressed thus:

> I studied medicine at a time when caring for patients was as important as curing their diseases. Careful documentation of the patient's history and thorough physical examination often yielded a remarkably effective diagnosis without resorting to expensive investigations as is the practice today. (11)

In a chapter titled "Health for All", Antia's narrator criticizes the government's failure to implement the report presented by the ICSSR and the ICMR (*Health for All: An Alternative Strategy*) in 1983, which proposed an alternative model for effective health care, with a specific emphasis on rural health care. Antia's narrator informs the reader that the prescriptions of this report, which sought to "integrate preventive and curative functions and to combine the best Indian tradition and practices with modern science", were not implemented at the time and were rejected in favour of the "eagerly adopted" prescriptions of the WHO and the World Bank (113). Antia frames this transformation of the principles of public health at the time for the reader via Ivan Illich and says, “in his prophetic understanding of both education and health [Ivan Illich] had predicted that ultimately body image and food fads would also be converted into a marketable commodity like medicine. This has now come true” (113). Antia’s narrator thus gives voice to the moral discourse in the text, signalling to the growing divide between public health, the medical practitioner and the patient and consequently, the treatment of illness that informs the reader’s “present”. Gawande’s doctor-narrator similarly criticizes what he identifies as medicine’s “twenty-first century, tall-in-the-saddle confidence” (181). Gawande’s narrator is writing with specific reference to a decline in the number of autopsies conducted at hospitals and his belief that this comes from a medical culture steeped in an unfounded confidence that no errors can be unearthed through this arcane practice. “Today”, he writes, “we have MRI scans, ultrasound, nuclear medicine, molecular testing and much more. When somebody dies, we already know why. We don’t need an autopsy to find out” (181). The narrators of *My Own Country* and *Intern*, similarly write about the changing trends in students’ choices of medical specializations (Verghese writes of the financial allure of procedural specialties like Cardiology, over those such as Infectious Diseases and Jauhar similarly attests to high medical school debts and the lucrative nature of procedural specialties being significant factors that influence students’ choices).These narrators articulate an anxiety over medical practices that were iconic for them as students that were now vanishing – like house visits, the physical exam and even the use of the stethoscope to “ausculate” the patient’s body.

Jauhar’s doctor-narrator records in his diary in *Intern*, that he does not see any attention to the psychosocial aspects of medicine at his hospital. The diary entry, provided at some length in the narrative, goes on to decry the callousness with which the aged are treated at his hospital – “They are heavy, dead evolutionary weight. They sap our resources” (90). The diary entry continues, with a critique of the numerous tests that are no doubt part of the intern’s routine interactions with patients:

> What are we doing, poking and prodding people at two in the morning, drawing blood like vampires? The 2 am blood draw is just an exercise, a way to protect yourself from being questioned on rounds for neglecting something. (90)

And later:

> Today, when I was walking up Second Avenue, I was thinking: so much of medicine is simply supportive. Nothing is definitive; there are so few things we do that cure: some chemotherapy, I’m told, antibiotics, maybe angioplasty. The therapeutic taps don’t work; the fluid reaccumulates. The studies to find lung cancer – so what, death is inevitable. And then it’s made worse by the futile interventions at the end. (91)

The doctor-narrator in the *Bildungsroman* often gives voice to a critique of the medical establishment through the carving out of a space from which he/she can articulate anxieties. These anxieties include: the futility of medical care in the face of bureaucracy, antibiotic-resistant pathogens, individual malaise, difficult patients and the difficulty of integrating medical education with the individual, idiosyncratic case.

As already noted in the Introduction (via Tom Rice), the doctor’s “diagnostic agency” is seen to be threatened by the introduction of modern “dispersed” diagnostic technologies, that rely on a wider network of actors. The stethoscope, Rice argues, possesses “agency” in the manner in which it “enables” medical students and doctors to “perform” individual “skills, experience and competence” (288). As merely a “collator” of test results rather than a performer of specialized "auditory" skills via the stethoscope, the value of the doctor's role is greatly diminished with the introduction of modern diagnostic technologies. The doctor-narrator in the medical *Bildungsroman* thus, carves out a space from which to speak to give voice to a moral discourse in the text, to articulate a critique against the practice of medicine. The doctor-narrator thus identifies a "social role" for the doctor and this specific discursive act reinvents and sustains his/her role in society and concretizes in that instance, agency for the speaker – agency that is viewed as being in a state of threat/vulnerability.

(iii) Engaging the Real: The physician-narrator in the medical *Bildungsroman*, as argued earlier in this chapter, sets himself/herself apart through an emphasis on the "social" or the "moral". In his *Intern: A Doctor's Initiation*, for instance, Sandeep Jauhar justifies his unusual choice of a career in medicine after a PhD in theoretical Physics, both to himself and his family, by frequently alluding to a desire to get out of the "ivory tower" of academia. "Physics was an enterprise of reflection, ideas. Medicine was", he writes, "an endeavour of prescription, of action" (22). Jauhar reveals to the reader that through the larger part of his academic career, he struggles to come to terms with his older brother's successful medical fellowship and their parents' evident (and typically immigrant) pride at his achievements and pragmatic professional choice. He is warned, for instance, about the "secure" professional choices for an Indian immigrant in the United States and medicine is seen as something that guarantees independence, even to a "foreigner" (13). Medicine thus, for Jauhar, signifies "action" and equally significant, social recognition, both within the family and in the wider community. Like Jauhar, Abraham Verghese is forthright in his portrayal of the favoured choice of profession for Indian immigrants in the United States. "Some hospitals", he writes, "like Coney Island Hospital in New York,

sent contracts to graduating medical students in India who had been recommended by their seniors. Come July, the seniors were dispatched to Kennedy to pick up the new blood fresh off Air-India, bring them to Coney Island and orient them" (19). The doctor-narrator in the medical *Bildungsroman* thus engages the "real" in the narrative, by giving voice to social "realities" and situating such reflections in the narrative as a "critique", especially since the narrator is set apart by his/her ability to articulate these observations/anxieties.

Verghese's *My Own Country* is framed via the perspective of a narrator who is an infectious diseases specialist, dealing with the AIDS epidemic first-hand at a hospital in Johnson City, Tennessee. Johnson City is constructed in the narrative as an idyllic, pastoral, rural setting that was "untainted" by the presence of AIDS, which was a "city" disease. When the first AIDS patient arrives at the Johnson City Medical Center where Verghese practices, the narrator recounts the shock experienced by the Medical Center employees:

> When I heard the story, the shock waves in the hospital had already subsided. Everyone thought it had been a freak accident, a one-time thing in Johnson City. This was a small town in the country, a town of clean-living, good country people. AIDS was clearly a big city problem. It was something that happened in other kinds of lives. (13)

Through the narrative, Verghese negotiates the construction of his doctor-narrator's "self" through an ability to report the "reality" of AIDS in a small town, where other members of the town carried on with a semblance of normalcy. The narrative simultaneously charts a biography of the AIDS virus' entry into rural America and that of patients treated by Verghese. The doctor-narrator plots the "story" of AIDS while simultaneously outlining the history of patients who travel to the city and return to their home in the country to be treated, thereby definitively unravelling for the reader, the "real" course taken by the virus in its travel to the country from the city. The narrator is able to "see" this pattern, where others do not. For instance, describing the "disturbing" sense of normalcy that prevails in Johnson city, the doctor-narrator in *My Own Country* sets himself apart from the townsfolk – "My problem was the opposite: I saw AIDS *everywhere* in the fabric of the town; I wanted to pick up a megaphone as I stood in a checkout line and say, "ATTENTION K-MART SHOPPERS: JOHNSON CITY IS A PART OF AMERICA AND, YES, WE DO HAVE AIDS HERE" (166-167).

Similarly, in his *Intern*, Jauhar's doctor-narrator is set apart from other students at his medical school because where he sees futility, inertia, indecision and fear during his first year of residency others see a lucrative career and a predestined path to medicine. Jauhar's doctor-narrator feels alienated from his fellow interns from the very beginning. At a party for instance, when he questions a fellow intern about whether or not she ever regretted her choice of a medical career, he is met with "It's pretty much all I ever wanted to do" (27). Jauhar's narrator then records, "Evidently, motivation for a career in medicine was assumed if you were standing in that room. It made me feel even more alone" (27). As the internship progresses, Jauhar, significantly, is the only one in his class of interns to succumb physically to rigor of the course. Again, writing about how the effect of medical education is unusual in his particular case, Jauhar's narrator recalls the words of one of his medical school professors. The professor informs him that the brutal rigor of the internship is deliberate, "It forges loyalty to the profession through shared hardship" (160). In the words of Jauhar's narrator however:

> For me, it had done just the opposite. My spirit was broken after four months of toil and compromise. The pain in my neck was unrelenting; my right arm was starting to feel heavy. Midway through my week of night float at Memorial, I informed Dr. Wood that I was going to take a break from residency. I suspect he knew that more than just my neck needed to heal. (160)

Jauhar's narrator goes on to admit that he suffered from "depression" during the course of his break from residency (a slipped disk that he develops over the course of his internship necessitates this break).He also envies the activity, health, sense of purpose and accomplishment that his colleagues continue to enjoy, almost in accordance with the "tradition" signalled to by his professor. Jauhar's narrator's account of his medical education, is certainly unique in his sustained feelings of indecision towards a career in medicine, even while his brother and his fiancé (who, he reports, is from a family of doctors with a thriving private practice) appear, like his fellow interns, to be following a predestined path. The "reality" of internship, however, is something only Jauhar's narrator experiences, almost to a pathological degree. Over the course of his "break" from residency, Jauhar even goes on to write an article in the *New York Times*, criticizing the "night float" system of residency rotation, of which he had been the most recent victim. Although the "night float" system was instituted to ensure that medical school residents have humane working hours and are not prone to error on account of fatigue, Jauhar's narrator takes issue in the *Times* essay with how little "night floats" know about the patients that are "signed on" to them and the resultant complications that arise for both resident and patient.

Gawande's physician-narrator in his *Complications* similarly voices concerns about medical practice during the course of his internship. Like Jauhar, Gawande too goes on to publish his experiences with accidents and "mistakes" during his residency in *The New Yorker*. Gawande recalls the specific problems he experiences as an intern-writer – "Trying to write as a surgical resident is a sensitive and tricky matter, particularly when one is interested, as I am, in writing about how things go wrong as how things go right" (xiii). Gawande, then, like Verghese and Jauhar's narrators, is able to see "mistakes" and "how things go wrong" as a "real" subtext to the practice of medicine. What interests these narrators then, is the space provided by the experience of internship/the practice of medicine, to voice personal indecision and inadequacy that then dovetails into a critique of this very practice. Writing about the "disturbing business" that is medicine, Gawande writes for instance:

> We drug people, put needles and tubes into them, manipulate their chemistry, biology, and physics, lay them unconscious and open their bodies up to the world. We do so out of an abiding confidence in our know-how as a profession. What you find when you get in close, however— close enough to see the furrowed brows, the doubts and missteps, the failures as well as the successes—is how messy, uncertain, and also surprising medicine turns out to be. (xvi)

Gawande's narrator is thus set apart by his ability to "get in close" as a surgical resident and experience first hand, medicine as it "really" is – "messy, uncertain" and surprising. In addition to voicing the particular narratives of patients then, the doctor-narrator exercises a second agential move by expanding the context of a singular, particular experience/narrative of a patient, into a larger set of questions about medical science and the medical profession. The doctor-narrator's agency is thus also concretized in the ability to narrativize generalities. In his *A Life of Change: The Autobiography of a Doctor*, Noshir H. Antia similarly reveals the "reality" of the consequences of plastic/reconsructive surgery on leprosy patients in India. As the founding member of the Tata Department of Plastic Surgery (TDPS) housed in the Grant Medical College and Sir J.J Group of Hospitals in Mumbai, Antia was responsible for pioneering low-cost reconstructive surgery and treatment for leprosy. Antia narrates to the reader, how he came to realize that "rehabilitation" was an equally significant activity for his plastic surgery unit at the Grant Medical College. Before founding the TDPS, Antia worked at the Jehangir Nursing Home at Pune and it was here that he chances across a government-run leprosy hospital at Kondhwa. Antia becomes convinced at Kondhwa that "basic principles of plastic surgery" would help restore the deformed patients he sees inside to "normalcy". On one of his visits to Pune from Mumbai, Antia is stopped by a group of leprosy-afflicted beggars. Antia's narrator then records:

> Two of them came up to me and thanked me for having corrected their deformities at Kondhwa. Instead of feeling proud of my achievement, I thought that if, even after reconstructive surgery, they were still reduced to begging, my ultimate goal should be rehabilitation, and that surgery was only an incident in that process. (63)

Here, Antia's narrator is able to provide for the reader, the "real" consequence of reconstructive surgery for a leprosy patient, who is not also subsequently rehabilitated. It is significant that Antia's narrator views surgery as "incidental", whereas social rehabilitation is viewed as what ultimately restores a "patient" to "normalcy". Antia's narrator thus underscores medicine's social role by periodically highlighting the medical "realities" in a country like India, where the practice of Western medicine needs to be reinterpreted to address local/regional needs. Writing about the reluctance of his own staff at the TDPS to trust the simpler and more cost-effective treatments they develop for leprosy and burn victims, Antia's narrator believes that:

> It would have been more appropriate to send our staff to China, Vietnam and Thailand, countries that have made remarkable advances in burns as well as in other medical and surgical care under conditions that are comparable to and compatible with the requirements of a country like ours. (77)

Antia's narrator then goes on to cite specific instances of cheap and effective methods of treatment for burns devised in Shanghai and Bangkok, to which he says significantly, he can "bear personal witness" (77).

(b) The Labouring Doctor Body and the Community

As argued earlier in chapter three, at the level of the Community, the physician-narrator labours to make individual "body work" communally relevant. The professional/expert self, via a cosmopolitan attitude, is able to bring a range of professional and cultural experiences to bear on the study or interpretation of the individual body and the performance of his individual, particular role. The degree of relevance of individual "body work" is therefore enhanced, as the physician-as-expert now embodies his/her medical internship only as metonymic "lessons", while constantly working to expand his/her "expertise" in the realm of "real-life" bodies. In his *My Own Country*, Abraham Verghese is able to particularize the AIDS epidemic in the 80's in America, by studying its entry into and manifestation in rural Tennessee. Verghese is able, by virtue of his professional expertise (an infectious diseases specialist), to visualize for the reader and the people of Tennessee, the various routes taken by the AIDS virus (primarily believed at the time, to be a "city-disease") to enter the rural town. These "routes" are inscribed on the *bodies* of the AIDS patients that he treats in the town, mostly homosexual men whose individual stories of travel are then re-plotted by Verghese on a map of America, to dramatize the virus's entry into the national body. Verghese is thus able to make the "city-virus" relevant to his rural town, while simultaneously engaging this locally acquired expertise to read the character of what is in fact, a global threat. Verghese describes himself as a "surrogate activist", the rural town's link to "the larger consciousness of AIDS" (276), thereby embodying the tensions inherent in treating a "city" epidemic in a rural town.

Verghese's embodiment of this "paradox" in his rural practice is further complicated by the frequent foregrounding of his status as an immigrant doctor. As Anne Balsamo has argued, the body can be seen as a product and process where it is defined by a performance of health, personal identity and beauty as well as a way of "knowing and marking a self" (217).*The physician-narrator is thus embodied and set apart in the performance of a labouring, expert, cosmopolitan self who can, by virtue of this "cultural body work", identify and be identifiable to others whose embodiment is similarly marked.*

The labouring, cosmopolitan physician is often set apart in the medical *Bildungsroman* to promote a greater degree of identification for this body that is professionally "marked". Chris Shilling defines "cultural body work" as forms of presentation that individual members of a group develop, to allow them to recognize "safe" and "familiar" others or "strangers" who pose a threat to their existence and lifestyle (77). For instance, Verghese constantly foregrounds his ability to adapt to his "foreign" setting, Johnson City, Tennessee, in America and make it his "home" and even sets himself apart from other "foreigners" in his community. As seen in chapter three, Verghese cringes when the other Americans on the hospital staff link this doctor's "boorishness to his foreignness" (45). Verghese instead works at "blending-in", to earn the local title of "good 'ole boy" (the highest compliment a "Johnson Citian" would pay another) by working to expand his "Appalachian folk lexicon" and making it a "challenge" for the locals to find food that he would not eat. Verghese also constantly juxtaposes various specialties in medicine alongside the "work" performed by infectious diseases specialists, to underscore the "value" of labour in medical practice. After describing the various steps of investigation, analysis, report and prescription of treatment that he carried out on a patient with inexplicable spiking fevers in the ICU, Verghese comments on the "help" later provided to the same patient, by a surgeon who was required to perform a tracheostomy, based on Verghese's recommendation – "The surgeon meanwhile had telephoned in, approved my recommendations and told his chief resident to do the tracheostomy – a twenty minute procedure – for which the surgeon would bill $500 or more. This without leaving his house" (77). Although the surgeon's example is cited by Verghese to contrast the discrepancies in income between specialties like ID (Infectious Diseases) and those with operative procedures, it is significant that he also contrasts the amount of labour contributed to by him and the surgeon. He has already mentioned that he spent "two hours" on the case and carefully details his "personal" investigation and recommendations to the case, to finally offer in contrast, the surgeon's assigning of his work to another body, the chief resident. Comparing his own personalized practice in rural Tennessee with those in big cities like Boston, Verghese finds that he is treating larger numbers of patients than the Boston University Hospital faculty. “Yes,” he writes, “the big city hospitals were following hundreds of patients. But since infectious diseases faculty like Stuart had with them a flock of interns, students, residents and fellows, they never personally assumed care for anyone, except perhaps one or two patients in their private clinics” (277). Verghese, with a practice spanning nearly fifty patients, reacts with anger when a fellow ID specialist recommends that he hire “drones” to take care of day-to-day clinical care, so that he can invest his time in the “intellectual” labour of laboratory research and academic lectures. Underscoring the value of “physical” labour however, Verghese writes:

> I spared him embarrassment by not pressing him on who these “drones” were. I could well imagine: Indians, Pakistanis, Koreans, Filipinos, Middle Easterners – all doctors with visa problems and the need to remain in a “training” situation until they could make the switch from a J1 visa to an immigrant visa. In Johnson City, I was my own drone. And I was getting very tired. And sometimes very angry. (279)

Immigrant doctors’ labour is thus foregrounded as the unacknowledged “work” of medical practice, in addition to setting apart the “physicality” of the ID speciality. As an immigrant doctor himself, Verghese embodies the cultural and professional markers of his identity, while simultaneously engaging in a critique of the medical institution that heirarchizes medical labour as well as institutional racisms. Verghese’s detailing of this exchange with a fellow ID specialist, also serves to highlight his personal critique of the negative effects of cosmopolitanism – the free flows of cheap labour from relatively disadvantaged nations perpetuates the exploitative conditions under which such bodies labour.

Writing about the significance of doctors in the realm of palliative care, Atul Gawande argues that there exists a crucial difference between suffering and symptoms. The doctor’s role, he argues, is not confined to the interpretation and diagnosis of symptoms, but is premised on the alleviation of suffering. For some patients, he writes, “simply receiving a measure of understanding – of knowing what the source of the misery is, seeing its meaning in a different way, or just coming to accept that we cannot always tame nature – can be enough to control their suffering. A doctor can still help, even when medications have failed” (134). The physician’s labour is made viable, even in a context where it is threatened with displacement by the uncertainties of disease. Similarly, writing about the role of technology in medicine, Gawande argues that the two need not be viewed as incompatible, but can in fact be mutually reinforcing. As “systems” take on the technical work of medicine, he says, “individual physicians may be in a position to embrace the dimensions of care that mattered long before technology came – like talking to their patients” (37). The doctor can thus return to his/her traditional role as “healer”, as described earlier in this chapter, to ensure a better integration of technology with medicine. With the renegotiation of roles performed by the doctor, he/she is integrated into the larger culture. “Maybe machines can decide,” Gawande concludes, “but we still need doctors to heal” (38). We still *need* doctors therefore, if we are willing to recognize the value of traditional medicine.

As argued earlier in this chapter, the physician-narrator is set apart by his/her performance of a labouring, expert, cosmopolitan self who, by virtue of this “cultural body work”, can identify and be identifiable to others, whose embodiment is similarly marked. Both Gawande and Verghese express an anxiety over the cultural rehabilitation of patients who are perceived as “passive” or “idle”, upon their return home from the medical institution. Both these doctor-narrators build intimate relationships with their patients, whose stories are re-plotted by the doctor-narrators to narrate their process of development. The bodies of "idle" or "passive" patients threaten to defy the doctor-narrator's labouring cosmopolitan self and these narrators are quick to impose a "critical" frame of reading such bodies. Verghese describes the patients on the open wards of Mountain Home thus:

> At the very end of the ward was a chronic ventilator unit where six ventilators did the work of breathing for six patients. Some of the men in the unit had been on the machine for years. Their day consisted of sunshine coming through the window, the TV being turned on, watching the shifts change, being bathed and fed, afternoon turning to evening, the night shift arriving, and finally the TV being turned off. It was sad. (43)

For Verghese, the bodies of these patients, rather than signifying the inadequacy of medicine's capabilities to restore health and prevent disease, become symbolic of idleness and stasis. He is struck by the monotony of the everyday lives of these patients, their bodies preserved by the labour of machines and the staff of the institution. In sharp contrast, he is quick to identify with Norman Sanger, the only HIV infected haemophiliac among Verghese's patients. "It was easy for me to identify with Norman;" he writes, "he was my age, he was male and he was heterosexual" (333). However, despite this generalized description of Norman, it becomes clear that what Verghese identifies with is Norman's ethic of "courage" and "dignity" and his active response to treatment. Norman's body, in addition to displaying the most "dramatic response" to the AZT trials carried out by Verghese, is also the most "normative" body that he attempts to rehabilitate. Verghese writes, "I often tried to compare Norman Sanger with other haemophiliacs I had taken care of. Many had a reckless quality to their lives, as if to compensate for all the admonitions they had heard to 'be careful'". But Norman, he writes, "had none of this recklessness" (338).

The individual's body often functions as a location for communal norms and this helps determine how he/she intervenes in his/her environment (Shilling 76). The physician's labouring cosmopolitan self is embodied in its interactions with other bodies that are similarly marked. The physician as expert stages the encounters with "idle" and "ideal" bodies, to inscribe onto them the disciplining cultural norms of the able, healthy body. Anne Balsamo defines the labouring body as "all reproductive bodies involved in the continuation of the human race in its multiple incarnations" (227). The labouring cosmopolitan physician self thus "works" to make viable (through a translation of universal medical practice to the particular, individual case and through "cultural body work") firstly, his own embodied practice within a globalized, cosmopolitan medical institution. Secondly, through an inscribing of disciplining cultural norms on the patient's body, the physician inserts himself/herself into a project of rehabilitating and normalizing reproductive bodies, thereby participating in the perpetuation of an "able" human race. Shilling has posited that work can be viewed as a "project", as something that has to be assembled in "contingent and creative ways" (85). The "productive" body is similarly viewed as something to be constantly "worked upon" in order to retain its viability. Gawande writes, "I am in my seventh year of training. Only now has a simple slice through the skin begun to seem like nothing, the mere start of a case. When I'm inside, the struggle remains" (14). At the end of his training thus, Gawande still acknowledges the presence of "struggle". The doctor's labouring cosmopolitan body is thus in a state of "becoming", constantly worked upon – through self-improvement and through constant work on other reproductive bodies – to ensure their continuing viability. Moreover, the doctor-narrator's "work" as expert, in his individualized articulation of an experience of treating illness in the medical *Bildungsroman,* is seen as "requiring" constant assembling to retain its viability.

This chapter has argued that the doctor-narrator performs informational labour that renders the "stories" of patients stable, mobile and combinable and enlists these stories in the creation of an ethos community. This ethos community is organized around a shared understanding of normative behavioural criteria during an experience of illness. The doctor-narrator, this chapter has demonstrated, inscribes these normative criteria on the patient body through a reconstruction of selective aspects of illness experience – the "will" to survive, "sharing" and "disseminating" knowledge about the experience of illness and being a "productive" body. The doctor-narrator, through narrative affiliation, equates a critical "activist" self who simultaneously engages the professional and social, with an improvised patient narrative. In the improvised patient narrative, a suffering individual not only "works" to improve at a personal level, but engages "professionally" with other sufferers, through the sharing of knowledge and information.

This chapter has also demonstrated how the medical *Bildungsroman* offers its narrator, a space from which to articulate a critique of medical practice, now seen through an "expert" lens. The doctor-narrator as "expert" circumscribes the naïve "wonder" he/she experiences during medical education, by making evident the many situations in which medical science "fails" to deliver care and cure. The doctor-narrator's agency is concretized in the voicing of this critique and sustains the viability of his practice (now seen as encompassing contexts outside his immediate "professional" circumstance) for the community. While this chapter has examined the doctor-narrator's enlisting of accounts of patients in an ethos community, the next chapter will study the construction of a "narrative society" in the medical *Bildungsroman*. I will examine here, via James Dawes' assumption that a narrative society is premised on an understanding of people and society *as* narrative, the "stories" that comprise the unified "self" of the doctor-narrator. The next chapter will also study the routine incorporation of "particular" accounts of illness and the visualizing of an individual ailing body in the medical documentary and its role in the "pathologizing" of all bodies. The medical documentary also employs a sentimental narrative, as the next chapter will demonstrate, to forge *affective* links between the individual and the social contexts within which he/she is embedded.

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Chapter Six

Disease, Prophylaxis and the Narrative Society

Chapter Plan

Section I: The Appeal to, or Construction of, a Narrative Society
Section II: The Pathologization of the Body in the Medical Documentary
    (a) Ascertaining Disease
        (*i) The Moral Imperative*
        (ii) The Spectacle of the Ailing Body
    (b) Social Restitution/ Rehabilitation
Section III: The Sentimental Narrative in the Medical Documentary
    (a) The Individual: The Microgeography of the Body
    (b) Community
    (c) The City

The previous chapter examined the emergence of a "professional" and "social" self in the doctor memoir. The stories articulated by doctor-narrators about patients' experience of illness in the medical *Bildungsroman*, are crucial to the construction of the "social self". This chapter will study the construction of a "narrative society" in the medical *Bildungsroman*. In addition, this chapter is interested in the ways in which the medical documentary visualizes and locates pathology in the individual body and the social contexts within which this body is embedded. The first section of this chapter will study the construction of a "narrative society" by doctor-narrators, via James Dawes' formulation that a narrative society is a conceptualization of society and people *as* "narrative" rather than *through* "narrative". To this end, this section will look closely at Gawande's *Complications* and Verghese's *My Own Country*, Sandeep Jauhar's *Intern: A Doctor's Initiation* and Noshir H. Antia's *A Life of Change: The Autobiography of a Doctor*.

The second section of this chapter examines the pathologization of the body in the medical documentary, where an individualized instance of disease/illness in *particular* instances is made relevant in a *general* context. This section studies several Films Division documentaries like *AIDS*, *Sexually Transmitted Diseases*, *Alcohol-The Killer*, *Preventing Anaemia through Nutrition*, *There is Life for Selvi*, *Sanctuary of the Ostracized*, *Controlling Leprosy*, *H1N1 Swine Flu: Few Facts*, *Saying it Again* and *Conquest of Cancer* among others. The narrative of pathologization in the medical documentary, this section will argue, moves from the individual case, situated as a particular, instructive example, to the *potential* for violation by disease that exists in *all* bodies. The third and final section of this chapter will study the sentimental narrative in the medical documentary through several of the documentaries detailed in section two. The sentimental narrative in the medical documentary, this section demonstrates, works through the forging of *affective* links for the viewer between the individual body visualized on-screen and the spaces inhabited by this body, and by extension *all* bodies, at the level of the individual, family and community. The representation of the "filial body" in the medical documentary has been examined earlier in chapter four on filiation and affiliation. This section will focus on the forging of affective links in the medical documentary at the level of the individual and the community.

Section I: The Appeal to, or Construction of, a Narrative Society

A "story" is what Mieke Bal identifies as the "signified" of a narrative text. In its turn, Bal argues, a story signifies a fabula (6). Moreover, as detailed earlier, Susan Onega argues that the "story" is a cognitive scheme of events that could, in turn, give rise to a number of texts (8). The several "stories" negotiated by the "narrator-agent" in *My Own Country*, *Intern*, *Complications* and *A Life of Change* are crucial to the construction of the doctor-narrator's social self. This social self conforms to any of a number of "story" types, "restoring understanding" and "alleviating the damage" brought on by disease. The doctor-narrator's presentation of disease as "story", James Dawes argues, exploits linear narration and causality to restore order and unify the narrator's "self", after being transformed/fragmented by illness. This narrator presents his/her "story" in a "narrative society", a society, in Dawes definition, that conceptualizes itself and people as "stories" and as "narrative", rather than through narrative. The doctor-narrator in the medical *Bildungsroman* emphasizes the importance of "story", by referring to the therapeutic potential of narrating experiences of suffering from/healing illness. He/she integrates several "stories", significantly those of patients, to present a unified, social "self" that is attentive to the ethical dimensions of the medical narrative. Human rights itself, as suggested by Joseph Slaughter, can be productively reconceived in terms of narratability (412). As we have seen earlier, any restriction to "liberty, property, security and resistance to oppression" in the modern *Bildungsroman* tends to limit the individual's ability to attain fixity for his/her "self". The hero in the modern *Bildungsroman* thus strives to achieve fixity, which is dependent upon his/her ability to narrate his/her story (412). The doctor-narrator in the medical *Bildungsroman* is able to narrate his/her "story" of heroic self-discovery, to attain fixity for the “self” thus created, through the articulation of a particular kind of voice that emphasizes the social and draws upon the textual and cultural authority of the author.

While narrating the story of his encounter with a particularly difficult patient, (a woman who requires a referral to a chiropractor for the treatment of her backache) Jauhar’s narrator describes his frustration over the meeting. The woman is unwilling to provide a history to Jauhar’s narrator and thus denies him the opportunity of a diagnosis and instead insists that her backache responds better to chiropractic treatment. After trying unsuccessfully to obtain a history from the patient, Jauhar’s narrator finally relents and provides her with a referral. However, he decides to present this particular case at a morning report, when asked by his clinic chiefs to make a presentation. The subject of his presentation is “difficult patients” and Jauhar’s narrator shares his experiences with those gathered for the morning report presentations. Though sceptical about how his presentation will be received, Jauhar realizes after he has finished, that he unwittingly started a flurry of anecdotes that the doctors in his audience are eager to share with one another. “The atmosphere had the charge of catharsis”, he writes, “as one anecdote led to another. The stories were fascinating in a baroque sort of way, and I felt pleased that my presentation had engendered such a robust discussion. (Evidently, sometimes doctors need to vent too)” (198).It is significant here that Jauhar’s doctor-narrator is discovering the therapeutic power of sharing stories and that they are presented in the narrative as such, rather than as presenting “cases”, as would normally transpire at a formal presentation at a morning report.

David H. Flood and Rhonda L. Soricelli have signalled to the case history possessing many narrative traits. They identify the importance of finding an “appropriate narrative voice" for the case history, one that can fulfil the humanistic and technological demands placed on this particular document (67). The doctor-narrator in the medical *Bildungsroman*, as argued earlier, attempts to provide the ethical dimension otherwise missing from a medical case history through narrating his/her "story". This "story" presents a narrative voice that unifies an otherwise fragmented experience of treating and rehabilitating illness. Jauhar's narrator also refers to the therapeutic power of narrating experiences during internship. While speaking to one of his classmates for instance, he learns that he (the classmate) started a conference for residents to talk about their mistakes amongst themselves. The classmate informs Jauhar's narrator:

> I saw residents cry at that conference. I talked about the lady with the low potassium. It felt good to get it off my chest. I felt like, if I don't make this public – not out in public, of course, but just to my own colleagues, - if I don't talk about it, then it would become one of those things that never really happened. It would cease to exist. (204)

The classmate here identifies the significance of narrating, as it only through the narrative that his experience is made "real" and the "cases" discussed can take on a "real" dimension. Farrar, Straus and Giroux's website for Jauhar's *Intern* interestingly, hosts a section titled "advice on your first year", that provides a forum for first year students to voice their "questions" (*sandeepjauhar.com*). The doctor-narrator thus makes an appeal for a narrative society, as it is seen as a way of "making real" the experiences of treating illness, confessing to errors and learning to practice medicine.

Gawande's narrator mentions at the start of *Complications* that "Residency is a gruelling experience, and in the midst of all the paperwork and pages and sleep deprivation, you can forget why what you do matters. The writing let me take a step back and, for a few hours each week, remember" (xii). Verghese's narrator too, confesses to being interested in the stories of his patients for their own sake – "But I was also interested in the patients' stories for their own sake. I was fascinated by the voyage that had brought them to my clinic door. The anecdotes they told me lingered in my mind and became the way I identified them" (126). Verghese's narrator here isolates the importance of stories for his practice, as he begins to view his patients as "stories". Individual accounts of the experience of illness are the identifying features of individual patients and are crucial for the construction of the ethically conscious narrator's "self". Being attuned to patients as "stories", is what sets the doctor-narrator apart from others in the narrative. As Verghese later observes, "My patient did not exist as a person in the radiology department: He was a cluster of echoes recorded on smoky paper, he was a gallbladder, and finally he was a homosexual who quite possibly has a bug "from the kitchen sink" in his belly" (325). The doctor-narrator, in recording his patient as a person with "hobbies, aspirations, foibles and eccentricities", is able to transcend the prejudices of stereotyping and recognizes each individual patient as such, rather than as a collation of statistics. The doctor-narrator thus, recognizes the therapeutic potential of narrative not only for himself, but for his patients. *The doctor-narrator's social self is contingent upon a narrativizing of the patient as well – in creating a space for the voice of the patient as well.* The doctor-narrator's agency is concretized in the voicing of particular narratives of patients. The doctor here voices in a heteroglossia and seeks to include the voices of patients as well. Heteroglossia, as Bakhtin has argued, refracts the author's intentions, by serving two speakers simultaneously and expressing two separate intentions (324). The doctor-narrator, as noted earlier, seeks to particularize and voice the patient's narrative, itself already entangled in "someone else's discourse about it" (Bakhtin, 330).This patient's narrative is then rendered in his own language thereby becoming an individualized utterance of a patient's story, thus serving two speakers simultaneously. The doctor-narrator, however, seeks to overcome in the medical *Bildungsroman,* in his/her voicing of the patient's narrative, the inherent "otherness" of this narrative, to make it his own.

Antia's narrator in *A Life of Change,* similarly recounts his experience with a patient's "story" that he discovers by accident. This incident teaches him to view his patients "as human beings with social, emotional, economic and other problems" (38). Antia's narrator requests a patient to return for a follow-up appointment after a major colectomy operation. The patient does not keep his appointment and Antia's narrator is rude to him upon his return after two weeks. "When he told me", he writes, "that he had to walk twelve miles from his village since he could not afford the bus fare, I felt ashamed of myself" (38). Later, Antia's narrator also recounts how a patient was angered by the appearance of special footwear that was designed by the plastic surgery unit for persons with leprosy related deformities. Antia's narrator recalls:

> At the follow-up footwear clinic this once helpless patient held up his footwear, and looking straight into my eyes flung it at me and demanded to know whether I would be prepared to wear something so ugly! (66)

Although the students present and the physical therapists were shocked by the patient's bold manoeuvre, Antia's narrator admits to congratulating the patient. For Antia's narrator, the act demonstrates "the ultimate success of surgery and rehabilitation because it had given him the self-confidence and self-respect to speak out" (66).

The doctor-narrator in the medical *Bildungsroman* thus strives to create a space for the patient's voice as well and is set apart by his call to the creation of a narrative society. The following section will examine the creation of “pathologized” bodies and spaces in the medical documentary through the subjective narration of non-scientific/non-medical aspects of illness experience.

Section II: The Pathologization of the Body in the Medical Documentary

The medical documentary pathologizes the body through a visual rhetoric that serves explicitly, the purpose of instructing and aiding the viewer in the identification of pathogens/disease and simultaneously and perhaps more insidiously, the purpose of locating these pathogens/diseases in particular bodies and spaces whose “anomalous” nature needs to be rectified through the normalizing intervention of medical science. To this end, this chapter will study select films on health and illness produced and distributed by the Films Division, Ministry of Information and Broadcasting, Government of India in the late twentieth century.

Catherine Belling (1998), Michael Renov (1993) and Brian Winston (1993) have theorized a pedagogic function of the documentary, its reliance on fictional and non-fictional modes of representation and the “evidential” and “scientific” associations built into the documentary’s “cinematic apparatus”. The Films Division documentaries thus address a mass audience and attempt to “teach” them about the common threats to their health and the various avenues for treatment that are available to those infected, through the advances of modern medicine. The documentary, however, is also effective on account of its ability to “narrativize” the “event” of illness, through elements distinctly unscientific in their particularized and subjective rendering. Non-fiction films, as we have seen via Michael Renov, may contain fictional and non-fictional elements. Fictional and non-fictional forms are thus mutually constitutive. While "instructing" viewers about the "real" dangers face by normal/healthy bodies, these documentaries have to nonetheless "creatively" reconstruct and narrate what in turn constitutes a "healthy" body and what factors led to its deterioration by illness.

The medical documentary strives to tell its viewers a story. A story purportedly objectively recorded and buttressed with scientific validation, but subjectively narrated. This "story", which chronicles the "real" experience of illness and the existence of disease and its invasion of the body, orders the viewers' perception and understanding of illness. This narrativizing of *a* story of disease and the condition of being ill is a story of infection, suffering, hope and inspiration. This story is extended in the documentary, to become *the* story of disease and illness that frames the organizing of the otherwise disparate elements of scientific evidence, archival footage, personal testimony, indexical representations like maps, graphs and animated sequences and photographs that constitute the documentary. Such a documentary narrative moves from the particular to the general, for instance, from a particular instance of a healthy body or a particular instance of the diseased/ailing body, to the general. For instance, the Films Division medical documentary frequently intercuts images/instances of an individual patient being examined by a medical professional, with footage of teeming populations in cities and people at work in fields or in their homes in villages. The voice-over/narrator at this juncture, stresses the importance of periodic monitoring of the body for signs of illness (the viewer sees an individual patient undergoing scans or tests at the hospital/clinic) and simultaneously warns of the dangers that *all* individuals face from deadly diseases (the viewer sees montages of a bustling city, village-dwellers involved in everyday activity or the crowded corridors of hospitals). The individual, perhaps “potential” patient is thus interspersed with the general, the city montages suggesting hundreds of such “potential” victims of disease.

Similarly, a particular instance or “reenacting” on screen of a case of illness inevitably moves from the story of an individual victim, to an indexical/animated representation of *the* human body or the slide stained by the particular pathogen and viewed via a microscope. This anatomically correct rendering of the human form or microscopic view of the pathogen, serves to “visualize” for the viewer the invisible contours of the insides of not only the particular patient/victim on screen, but all our bodies. The animated human form thus serves to reconfigure our imagination/perception of the body in scientific terms. The documentary moves from the particular case of illness through the indexical representation of the human body, to “communal” statistics of the incidence and impact of disease on the population, on the nation. The viewer is thus taken literally “through” the body to see those “vulnerable” locales that are susceptible to invasion by disease (see Figures 1, 2 and 3). Here, in the film *Alcohol – The Killer,* for instance, the film opens with two individual sharing a bottle of alcohol. As the evening wears on and both are seen to be visibly intoxicated, an argument breaks out and one of them kills the other in a fit of rage. The film then goes on to explain the harmful effects of alcohol on one’s seat of reason – the brain. The film subsequently presents an animated representation of the human brain (Figure1), the effects of alcohol on brain cells (Figure2) and then moves to a series of ethnographic visual data on alcoholics. This “ethnography” includes (possibly staged) various groups sharing drinks at what are seen to be typical situations (parties) or locations (local bars, seen in Figure3) for alcohol use.The film thus visualizes previously and presumably objectively collected data, projected on a graph or table or ethnographic evidence that demonstrates the incidence of a particular disease in the national population.

Similarly, the medical documentary often portrays an individual instance of a doctor-patient relationship, with its attendant notions of trust, familiarity, authority and expertise or the individual instance of a community health worker and a particular village and moves to governmental and institutional efforts at the eradication and prevention of disease. *The politics of the documentary thus moves between two poles: the scientific and the affective.* The first is literal, is aimed at factual accuracy and serves to anchor the universal, “objective” “truth” behind the “real” instances of disease depicted on screen. The second is metaphoric, sentimentalizes the particular pathologized body and is contingent upon an emotional response and calls upon the viewer to identify with the particular instance being presented on screen. These two poles in the medical documentary are enmeshed and are together responsible for implicating the viewer in its narrative. As Dave Saunders has argued, a film becomes a “documentary” in the manner in which its viewers/spectators perceive, anticipate and react to it (14).

These medical documentaries, I argue, while striving for factual accuracy through the use of an evidentiary narrative, replete with visual and aural strategies of representation, enlist these very strategies to produce and encode normative structures that work to pathologize particular bodies and lifestyles within these narratives. The “normative” structures encoded by the medical documentary, in addition to the indexical representations of the anatomically correct bodies, include the “situating” of care and cure within the family and/or the medical institution. The narrative organization of the "story" of illness emphasizes the importance of the "early" detection of disease. However, this "storying" of an illness experience suggests that the "normal" course of events following such an identification of "pathology", is seeking medical expertise and assistance and the eventual "restitution" of the sick body within the family and the return to "active" labor. It is significant that the body is visualized in the medical documentary as body-in-treatment or body-in-medical examination or as a body-in-labor. The individual "victim", once identified as such, is always framed within the medical institution (on a hospital bed, in a medical/physical exam, seated inside medical camps/hospital lounges, undergoing surgery).Most importantly, the movement of this victim-body is traced through its entry into the medical institution and subsequent re-entry into normal family and social life. This is especially true of diseases that are spectacularly visible and are known to be a source of stigma, where the emphasis in the documentary narrative is on complete restitution to enable firstly, a re-entry into the family and secondly, a re-integration into society by the return to "work".

I argue that the medical documentary, by medicalizing the body, at once depersonalizes it and renders it more "situated", through references to filial and professional networks of care. This is achieved through a visualizing, as argued earlier in this section, of spaces where the ailing body is "cared" for and "rehabilitated", like the space of the "home" and "family", the medical institution/the clinician's office. Films like *Controlling Leprosy*, *Sanctuary of the Ostracized* (A film narrating the story of the setting up of Anandwan or Maharogi Seva Samiti, a nonprofit organization founded for leprosy patients but now a rehabilitation center for persons with disabilities) and *There is*

Life for Selvi (which chronicles the efforts of the Community Health Education Society in Chennai towards rehabilitating AIDS patients) for instance, continually stress the importance of "restoring" self-esteem to patients once they have been treated, through a "return" to practicing a vocation. The narrator of *Controlling Leprosy* notes that one of the features of the State's efforts at controlling leprosy (National Leprosy Control Programme), is the drive to isolate "potential" leprosy patients at their "homes". This ensures, he adds, that not only can the incidence and spread of the disease be curtailed, but most importantly, patients do not have to leave their "homes" and "families" and travel to seek treatment. This is indicative of the importance laid on the local containment of disease, but also the relative "normalcy" afforded to patients who can be treated "at home", and can avoid the unfortunate consequences that befall those who need to be restituted by the efforts of the State and other agencies. *Controlling Leprosy* further describes the advantages of seeking treatment early, by noting instances of patients who have not only been cured, the documentary emphasizes, but continue to work and take care of their families. They are not only cured of the disease, but are now productive members of their families.

These "particular" cases/stories of individuals narrated in the medical documentary, are instances of "situated" bodies that exist in conflict with "medicalized" or "institutionalized" bodies. "Medicalized" or "institutionalized" bodies arevisualized through the "study" of microscopic pathogens in laboratories and as neutral anatomically "correct" models. There exists thus, a dialectic between "individuation" and "institutionalization" in the medical documentary. Here, the "individual" or "personal" story of illness is narrated through an emphasis on the individual's "situatedness" in filial and social networks, through a visualizing of the "monitoring" of symptoms by family members, the voluntary "seeking" of medical intervention and the return to financial and social "productivity". However, this "individual" is then simultaneously "depersonalized", to make visible the presence of "disease" through a process of "medicalization" or "institutionalization". This "medicalized" or "institutionalized" body, visualized through neutral criteria like an X-ray or the magnified microscopic image of a pathogenic invader, can be accessed only as synecdoche, shorn of all "individuality". The medical documentary relies on the "dialectic" between the story of "this" particular person and the depersonalization of "this" person in a "medicalized" or "institutional" setting, to visualize the incontrovertible "potential" for disease in *all* bodies. Viewers associate affectively with "individual" stories of illness experienced by *aparticular* body and this provides the basis for *identification* with the "depersonalized" and "medicalized" visualizing of *any* body.

In Singh and Bharadwaj's study of the government of India's communication strategies since the launch of the Universal Immunization Programme (for the eradication of Polio), an attempt to both define and constitute the family can be seen (670). These communication strategies defined an "ideal" healthy family (images of small, single child families who were seen participating in Pulse Polio Immunization), which was able to simultaneously communicate messages of family planning and naturalize this "model" family as a commonplace one, thereby generalizing this definition of the "ideal" family. Like Singh and Bharadwaj's "model" families in the government's communication strategies for immunization, the Films Division documentaries visualize particular instances of families that are "ideal" in their "responses" to local health initiatives and "actively" monitor their family's "health". As argued earlier in this section, bodies represented in these documentaries are predominantly bodies-at-work or bodies-in-treatment. This level of characterization in the narrative of "normalcy" serves to "other" those bodies that are marked as "deviant" not on account of the presence of illness, but on account of being framed as they are in the narrative, outside the confines of "family" as well as the medical institution. Viewers are thus instructed in the advantages (to their families and by extension, the social sphere) of the medical surveillance of the pathologized body and are implicated in the documentary narrative's moral imperative to identify and drive out "the enemy within". This "enemy", lurking as it does quite often silently and imperceptibly, requires the "exposure" effected through the visual techniques employed by the documentary narrative, to become "real" for the viewer.

Diagnosis of the illness is often spectacularly visualized in the documentary narrative – the viewer is taken literally "through" the patient's body (with the help of a seamless interspersing in the documentary of X-rays, animated sequences and slides magnified under microscopes) and follow medical practitioners and researchers as they isolate and then "study" these otherwise invisible pathogens inside laboratories and hospitals. These "invisible" agents of destruction, thus isolated, are then "conquered" in the narrative, through a visualizing of the various medical interventions that are available for "normalizing" those deviant bodies that house them. It is significant to note that these medical images of disease are often employed in the service of an omniscient narrator (invisible to the viewer and may thus not belong to the ranks of medical "experts" who comprise the source of these "image-texts" within the narrative) and are thus removed from the context of the hospital or laboratory. The voice-over in several of these documentaries provides the contexts within which viewers can interpret the medically imaged body. For instance, Figure4 is from the opening sequences of the documentary *Conquest of Cancer*.

The documentary opens with the above image (Figure4),while eerie music plays in the background. A voice-over begins after a few moments by saying, "This is not a work of modern art. This is us. The basis of our life – human cells". The "cells" thus identified, continue the work of normal division on screen, while the narrator introduces the deadly menace of cancer – a condition that affects this "basis of life" not from the outside, but from within these so-far "normally" functioning cells. As Belling argues, viewers find meanings in such medical images, because of the text constructed around them that contextualize and break them down for the viewer and are also crucial in investing them with objectivity and "naturalness"(14). However, the text that surrounds this particular image in *Conquest of Cancer* is provided by a disembodied narrator, located outside the confines of the medical apparatus and institution.

The "depersonalized" human cells are thus "naturalized" and with the help of a disembodied narrator, appear to "speak for themselves". The image of *any* human cell, coupled with a disembodied voice thus attains "objectivity", contextualized as it is as the "basis" of "our" life. The "warning" issued by the narrator's "voice", disengaged from his "body", naturalizes the body as synecdoche. The "cells" on screen thus represent *all* bodies and become a "sign", merging with the warning issued by the "voice", which also emanates without a visual material referent. This visual dismembering and disaggregation of the body emphasizes for the viewer, the multiple locations of "potential" vulnerability to disease present in the "individual" body on screen and by extension, all bodies. Here, the viewer only hears a “warning” voice, as opposed to other medical documentaries, where the “warning” is issued by a narrator in a doctor’s coat or can be seen speaking from inside a laboratory or himself/herself exhibits visual symptoms of disease and is thus contextualized as possessing professional/expert/experiential knowledge. The “voice” is here therefore disengaged from any visual/material “proof” of expertise and is thus further “naturalized” for the viewer. The “viewer” ought to know what he “hears” when he “sees” the cells on screen, rather than being a “passive” learner who is being “educated” or “instructed” by an “expert” about a subject that is not common knowledge. The narrator’s “voice” thus serves to remind the viewer of what he/she already “ought” to know about the “basis” for all “our” lives – the depersonalized and “medicalized” body on screen does not require visual corroboration by an “expert”. This depersonalized and “medicalized” body functions as a sign for *all* bodies and can thus speak for itself, relying on the viewer for a “personal” identification with the body and voice-as-synecdoche naturalized on screen. Thus, while the narrator’s address to the viewer works to contextualize the image on screen as the “basis of our life”, I argue that this address and the medical images disengaged from their original context used in its service, are part of the documentary’s larger project to inculcate in the viewer, a visual “sensibility” of disease and the vulnerability of the particular body visualized on screen. As argued earlier in this section, these indexical representations of “the” human body, function as a bridge that links “a” particular body to the larger context of the “us”, the “basis of *our* life”, that the narrator evokes. The medical documentary thus also teaches the viewer to “see” anew his own body – implicated scientifically and literally as being a “human” body and metaphorically and affectively as the particular instance of a suffering/ailing body, its vulnerability to disease. The viewer is consequently able to “see” the routes taken by invisible pathogens into a healthy body and by extension, into the community.

(a) Ascertaining Disease

The medical documentary enables the viewer to participate, at a distance, in the medical “diagnosis” of illness. This “participatory” diagnostic narrative in the documentary, utilizes the visual and aural strategies described above, to draw the viewer into a domain that is otherwise out-of-bounds for a lay person. The participatory diagnostic narrative is crucial for the development of the viewer’s “sensibility” of disease, but is also important for establishing the medical institution as “redemptive” and implicating the viewer in a moral imperative to identify and seek treatment for a lapse in health. As Talcott Parsons has argued, illness allows an individual to take recourse to a “dependent relation”, where the temporary disability brought on by illness forms the basis of a legitimate claim to be “taken care of” (285). Moreover, the conditional legitimacy available to an individual’s “deviant” pattern like a period of illness automatically shifts to a collective – this individual’s dependency on other non-sick individuals like the medical institution/professional and the family and personal circle who collectively constitute a sub-system within the social system. What is significant about Parson’s sick role is that it is “institutionally categorized” and “socially recognized”, the individual’s status as “patient”, defined by being sick or sick enough to seek treatment is defined by persons other than the patient himself. The patient’s status as such, is thus sanctioned socially and institutionally, thereby extending control over the definition, care and restitution of illness. The “patient” is controlled by the “moral imperative” to return to a state of health and activity.

(i) The Moral Imperative: The documentary titled *Cancer* begins with the image of a man smoking, framed against the backdrop of a reddening sun (Figure5). The narrator speaks as the man continues to smoke and notes, “The choice lies with you. He is in the prime of his life, not at the end. Could he be responsible if he dies, one wonders?” What is interesting about this image, is the conflation of temporal ambiguity with the ambiguity inherent at this stage in the man’s smoking and his apparent state of ill-health (he is closer to death as the narrator has contextualized, though this is not “visible” right away). The viewer is directly addressed with the words “The choice lies with you” – the choice referred to here works at various levels. First, the viewer can “choose” to see the man as being in the “prime” of his life, thereby heightening the stigma attached to his smoking habit, which draws him “prematurely” to his imminent death. Second, the temporal ambiguity of the scene – the sun could here be the rising or the setting sun – contributes further to the viewer’s choice. The man’s “choice” to smoke is framed against what the viewer could “choose” to see as the “start” or the “end” of a day, with each such passing day steadily moving towards inevitable illness (specifically cancer in this documentary) and certain death. This ambiguity in situating the smoker somewhere between the prime and end of his life is significant at this stage in the documentary. The documentary will proceed after this initial sequence to provide affirmative evidence of the “scientific” links established between smoking and contracting cancer and will effectively negate the initial “choice” offered to the viewer. Smokers are more prone to cancer than others, the narrator who “wonders” at the start later asserts and the “choice” initially offered to the viewer is now limited to the “choice” of not smoking in order to enjoy a risk-free, healthy life. Moreover, the documentary here offers a veiled definition of this particular man being in the “prime” of his life, since this visualizing of the habit of “smoking” (as in

other cases where alcoholics, drug users, tobacco chewers, sex workers whose lifestyles are explicitly linked with the presence of illness) makes visible “risky” behavior, but simultaneously elides any “invisible” problems the body may carry in its “prime”. The medical documentary frequently calls to the viewer to “choose” health through an active participation in medical surveillance for disease. The alternative can be fatal, as many of these documentary narratives testify and moreover, this would involve the crossing over of the body from the established limits of medical science.

The narrators of several of these medical documentaries (*Filariasis: An Ugly Disease*, *Cancer, Conquest of Cancer*, *Saying it Again* (AIDS), *Sexually Transmitted Diseases*, *Your Enemy - TB*), emphasize the need for timely diagnosis. While these narrators are quick to extol the virtues of modern medicine and its vast reach in terms of cure and restitution, they also periodically warn viewers of the need to monitor their bodies for tell-tale signs of illness and seek medical care immediately. The viewer of the medical documentary is also explicitly implicated as “viewer” within the documentary narrative. As argued earlier in this section, the medical documentary narrative moves from the particular instance of a victim of disease to a larger, general instance of the incidence and prevalence of disease in the population. Within several of these documentaries, for instance, the “story” of illness told by the documentary also incorporates the staging of being “instructed” and “taught” about one’s own body and the effects of illness. In *Controlling Leprosy*, for instance, the central protagonist, a tailor by profession, is persuaded by his young daughter to visit the doctor, after she watches an instructive video at school about the symptoms of leprosy. The film opens with this video that the young girl is watching along with her classmates and the viewer can then see, over the course of the film, the providential effect that this “viewing” had on the girl’s father’s life. To confirm this “educative” potential of film, the doctor who successfully treats the tailor for a case of non-contagious leprosy, informs him that he has his daughter to thank for the timely medical intervention that resulted in a complete cure in his case.

The film is replete with a “catalogue” of the bodies of other “patients”, whose case of leprosy has advanced to a degree that cannot be checked with medical intervention. The film also stages another “viewing”, when the local leprosy eradication program sponsored by the state pays a visit to the village in which the tailor and his young daughter reside. They, along with other members of their village, watch a film about the effects of leprosy on the body and the importance of early detection and the need to prevent social stigma.

The documentary narrative thus interprets for the viewer, the function that this viewing as assimilation/dissemination of information performs for the viewer. Several other documentaries like *Gita Ki Kahani*, *H1N1: A New Influenza Virus*, *There is Life for Selvi*, *H1N1 – Few Facts*(see Figure6), *Conquest of Cancer* and *Cancer* enfold within their narrative, groups of people being addressed by a medical professional who provides information and advisory about the spread and control of disease. The medical professional, the doctor and the healthcare worker, are portrayed within the narrative as a ready source of information for patients’ questions. Their “instructions” to groups of people or individual patients on screen, implicates the viewer of the documentary, himself/herself similarly at the receiving end of information and advisory from the documentary narrative. The documentary thus foregrounds its potential for enhancing literacy and knowledge and draws in the viewer through the metaphoric association of the “staged” or “reenacted” process of acquiring knowledge on screen.

The sooner the “diagnosis” of illness, the narrator informs the viewer, the better the chances of cure and improvement. Many diagnostic narratives in the medical documentary are particularized to individual “real-life” cases of illness. In *Your Enemy - TB,* for instance, the diagnostic narrative is particularized through the telling of the story of a young couple, Mala and Gopal. Gopal is urged by Mala, the narrator informs us, to visit the doctor about a persistent cough. Though Gopal is himself reluctant, he visits the doctor on account of Mala’s insistence. At the doctor’s office, we see that Gopal is examined and then referred to the TB Institute because his symptoms are suspected to resemble TB. Gopal, however, is seen to visit the TB Institute, only once his symptoms continue without respite and he is himself convinced that all is not well. Upon entering the TB Institute, we are informed that Gopal is subjected to a “thorough” medical examination – his sputum is tested and “reveals” the presence of tubercular bacilli. When the medical expert announces his prognosis to Gopal, the narrator echoes the viewers’ possible anxiety at this juncture, when the “presence” of illness has been ascertained beyond a doubt, by asking whether this was the end of Gopal and Mala’s life together. To this question, the doctor responds with an emphatic “No!” and proceeds to assure Mala and Gopal as well as the viewer, that “TB is completely curable today thanks to modern medicine and the progress of medical science”. Most importantly however, the doctor adds, “Luckily, you have come here well in time”. The TB infection inside Gopal’s lungs, we are led to believe, is still “in the initial stages” and can thus be completely cured. Indeed, the documentary does go on to show Gopal’s full recovery and return to a “normal” life, thereby underscoring the importance not only of medical intervention, but a timely diagnosis. The particular “story” of Mala and Gopal, is also instructive in its definitions of sickness and the sick role. Gopal’s decision to visit the TB institute is spurred not by his increasing symptoms, but on account of their interference with his "work". Before he visits the TB Institute, Gopal is seen at his office, seated at his desk but visibly uncomfortable. The narrator informs the viewer that this is another day for Gopal at the office, but he is "feeling listless" and has no motivation to work. It is at this point that Gopal is seen leaving his office (presumably earlier than usual), to visit the TB Institute. It is important to note at this juncture, that the "surveillance" of the self is an "imperative" or personal standard that has to be adhered to, even prior to seeking medical assistance. Self-surveillance is constructed in the medical documentary as a "moral" to be upheld, even prior to "entering" the professionally managed systems of monitoring within the medical institution.

Like the young girl in *Controlling Leprosy* who "learns" to identify the symptoms of the disease on her father's body and "identifies" his "need" for treatment, Mala, in *Your Enemy-TB*, "recognizes" that Gopal is ailing, by monitoring/observing his "persistent" cough. As mentioned earlier, Gopal himself "submits" to medical care only once he has determined/observed for himself, the persistence of his symptoms and their interference with his "productivity" at work. Interestingly, the tailor in *Controlling Leprosy* needs to "persuaded" by his daughter because his symptoms (patches of discoloration on his hands and back), as he informs his family and the viewer, do not interfere with his "work". The tailor is seen to express anger at being asked to submit to medical enquiry as he does not recognize himself as "unfit", seeing as how his economic/physical productivity to the home remains unchanged. His daughter however, has "learned" from the instructional video she has seen, that such "visible" marks of leprosy, though not capable of immediate harm/debilitation, are still "proof" of the presence of disease that will eventually run its course and lead to extreme consequences. The “knowledge” assimilated by the tailor’s daughter (who is seen as being “informed” not only by the instructional video, but also by the institutional apparatus of the “school” where she accesses this educational exercise), is contrasted in *Controlling Leprosy* with a “lack” or “ignorance” on the part of the tailor (who can be presumed as uneducated, given his “outburst” that his daughter’s “school” was responsible for her “unusual” insistence that he seek treatment for a condition that was not “interfering” with his work/productivity). The tailor is, however, eventually seen to “accede” to seeking treatment, when he sees the visible distress that his wife and daughter are in, once they have acknowledged the possibility that “harmless” symptoms could cause future debilitation. The “knowledge” about illness is brought into the home by the young daughter, who has now “infected” her mother with her own anxiety about her father’s health. The tailor in *Controlling Leprosy* thus agrees to seeking treatment, not on account of accepting his “symptoms” as the “signs” or “proof” of illness, but because he “recognizes” the significance of his health and “role” in the family. “Anxiety” or “doubt” about his “ability” to continue contributing to and sustaining his family is itself seen as “pathology”, requiring clarification through institutional channels/medical personnel.

Knowledge about the “potential” for disease within one’s own body, gained through a systematic self-surveillance, is thus seen as a preliminary “moral” imperative, a necessary pre-condition to the seeking of medical intervention. The individual body and the filial networks within which this body is embedded, are “responsible” for “recognizing” the signs of disease and debilitation. In his study of the evolution of practices of caring for the self, Foucault emphasizes the recognition of a condition of dependency and needing assistance. He stresses therefore, the importance of recognizing the self as "one who suffers from certain ills and who needs to have them treated, either by oneself or someone who has the necessary competence", rather than simply constructing an image of one who is imperfect and ignorant and therefore requires improvement, correction and training (57). As chapter two has demonstrated in the case of "self-improvement" performed by patient-narrators in the illness-memoir, an important aspect of "learning" new skills during the period of illness is the recognizing of a state of inability/unfamiliarity. The moral imperative in the medical documentary thus entails the "recognition" of inability/debilitation in one's own body and the "potential" inherent in this body for disrupting the filial/social networks within which this body is embedded.

Once Gopal has been diagnosed with TB and informed by the doctor that he can be cured, the narrator in *Your Enemy-TB* takes the viewer through the "conditions" that Gopal is now to submit to – "He is to stay away from office" and he is to convalesce "at home". Quite significantly, although Mala is seen to accompany Gopal on his visits to the doctor, in the scene where Gopal is presumably convalescing "at home", resting and taking medication, he is seen with an aged couple, "his family", but not Mala. Gopal is thus situated in a special relation with his "family", his designated caretakers at this time. Mala returns on screen only when Gopal has been declared as completely cured and the viewer then sees them together on Gopal's scooter, having returned to the state of domestic bliss portrayed at the start of the film, prior to intrusion by illness. A timely diagnosis saves Gopal's life and more importantly, is seen to preserve his domestic happiness with Mala. It is through "timely" diagnosis that the patient is expected to contribute, by becoming astute in the identification of symptoms and seeking “timely” medical attention.

In *Cancer* as well, for instance, while surveying the extensive medical facilities of a cancer treatment center and describing their role in the extermination of various types of cancer, the narrator exclaims that all of this advanced technology will be rendered impotent, if diagnosis is deferred on account of the *patient* delaying the seeking of treatment. Similar concerns are expressed by the doctor who informs the viewer in *Sexually Transmitted Diseases*, that several patients are too ashamed to seek treatment for STD’s as they are afraid of the resulting stigma and too embarrassed to relay their medical history. The doctor then promises confidentiality and more importantly, warns of the dangers of seeking treatment too late. The further the progress of illness in the body, he implies, the greater the chances of this ailing body moving outside the miraculous treatment possibilities offered by the medical institution. The moral imperative that implicates the viewer and patient to participate in the surveillance of their own bodies also extends to the surveillance of family members. In the documentary *Gita Ki Kahani* (The Story of Gita), Gita is seen to experience anxiety about infecting her son and husband with the Hepatitis B virus. She is then counseled by her doctor to bring them in for a medical examination as well. Patients depicted in *Sexually Transmitted Diseases* are prodded by their doctors to reveal the identities of their sexual partners and are also asked to bring them in for blood screening. *Sexually Transmitted Diseases* also enfolds within its narrative, the “confessions” of husbands who visit prostitutes and are then filled with remorse at the prospect of having infected their “innocent” families. The onus on the patient to “declare” his state of illness and the situating of stories of “confessions” and "timely interventions", serve to employ the ailing body in the service of "instructing" and "educating". The particular instance of a victim of illness is utilized in the documentary narrative as a warning and its status within the narrative is that of "instructive example". The particular diseased body is put to productive use within the documentary, in the service of "educating" and "reforming" the general viewers.

As already argued in this section, the medical documentary foregrounds its "potential" in enhancing literacy and knowledge, through the "staging" on screen of the process of "learning" and "being educated" by watching film/video and being cautioned/instructed by medical/health experts. This process attempts, through a metaphoric association, to instill in the viewer the "ability" to recognize similar avenues for learning, presented by the format of the medical documentary itself. The medical documentary is thus presented as an "educational tool" that functions as a "source" of knowledge and brings together the attempts to eradicate disease made by multiple actors – doctors, health care workers, medical/research institutions, individuals who have experienced illness and treatment, public servants, among others. Foucault has demonstrated that there was an increasing medical coloration and thus "institutionalizing" of the practice of "improving" or cultivating the soul in Greek culture, where even the Philosophers' School espoused the interconnectedness of education and caring for oneself (55). "Caring" for one's "self" thus needs to be "instilled", through systems of education that mandate and underscore the sustenance of "health" through a continued monitoring of "afflictions" of the body. Self-surveillance is espoused in the medical documentary, as a prerequisite or moral imperative to sustaining health, even outside medical/institutional systems of assisting/reinstating ailing bodies.

(ii) The Spectacle of the Ailing Body: As argued in the Introduction, public health discourse is affected by a crisis and anxiety about “visibility”. Ostherr has argued that public health cinema thus relies on indexical and artificial modes of representation, on account of the difficulty in “visualizing” pathogenic invaders that are “invisible” (180). Public health cinema moreover, to dispel the fear of an “invisible” threat to bodily and national borders, visualizes this threat as being embodied by a racially and sexually marked body that originates in spatially and temporally distant locations. The Films Division documentaries frequently rely on indexical and artificial modes of representation, to “visualize” the entry and presence of invisible pathogens within the body. Figure 7 to Figure 10 illustrate the visualizing of the break-down of the body’s immune system, on account of the AIDS virus and the consequent “populating” of the body with various other opportunistic infections. The figures illustrate a significant reduction and then complete absence of white blood cells, explained by the narrator to be the “fighter cells”, responsible fortifying the body against invasion. With the entry of a retrovirus like AIDS however, the narrator explains, (seen in figures 7 to 10 as “A”) the white blood cells quickly diminish, leaving the body open to other invaders. In figure 10, the body is seen to be teeming with infection.

As argued earlier in this section, the narrators of these documentaries insist on the timely diagnosis of illness and the frequent monitoring of the body for signs of illness. Advanced or terminal diagnosis of illness is seen to be outside the confines of medical science. I argue that these documentaries present the process of advancement of an illness (unchecked by medical intervention) as “spectacle”, enlisting the bodies of such patients in the service of the “instructive” goal of the documentary, that champions the necessity of periodic medical diagnosis and complete cure. The documentary narrative here presents two “stories” – that of the experiences of the human “host” body after the entry of disease into his/her life/body and that of the journey undertaken by the virus/pathogen inside the body of the human host. The documentary narrative thus also offers two orders of spectacle: the “visible”, literal spectacle of the manifestation on the body of the ailing patient, of the visible markings of the presence of the disease within, and the “invisible” and thus “metaphoric” spectacle of the virus or pathogen’s progress/invasion of the insides of the body. These spectacular visualizations of “advanced” stages of illness or cases of delayed diagnosis, where the invisible pathogens have taken complete hold of the body, are framed as “temporally” distant from those success stories in the narrative, where a speedy diagnosis resulted in a complete cure and restitution. In addition, an “additional layer of spectacle” is added with the help of computer graphic imaging to the overall aesthetic of the medical documentary (Hight and Coleborne 238). Cases of quick diagnosis do not hold the spectacle value of those bodies that, without medical intervention, have run amuck with disease. Examples of these abound in *Cancer*, where patients with malignant growths are seen to express remorse at having delayed seeking treatment and having lifestyles that were known to pose the risk of illness. Figure 11, from *Cancer* focuses on the cancerous tumor of this patient, described by the narrator to be a tobacco user. He has since stopped using tobacco, the narrator informs the viewer, after he experienced the effects of tobacco use. The “spectacle” of the advanced stages of illness is thus enlisted by the narrative, to demonstrate the effects of not receiving timely medical care and the lapse in continuous monitoring of the body.

The medical documentary thus enables the viewer to identify particular bodies and spaces as “anomalous” and requiring the normalizing intervention of medicine. Van Dijck (2002) and Catherine Myser and David L. Clark (1998) have argued that the televising of “normalizing” the bodies of conjoined twins, have replaced the nineteenth century freak show and illustrate our continued fascination with extraordinary bodies that continue to be objects of public spectacle. Within the medical documentary, professional and “expert” testimony combines with the “spectacle” of the diseased body, to remind viewers of the consequences of bodies that are beyond medical attention, while simultaneously “pronouncing” the presence of illness and validating the competence of medical science. Moreover, as Van Dijck has noted, viewers are unaware of the voyeurism inherent in the documentary’s examination of patients’ vulnerable, exposed bodies, since they are presented within medical scans that legitimize the spectacle (550). Specific norms and values about “deviant bodies” are constructed, through the format and content of what she terms as a popular genre of “hybridized spectacles” (552).

Saying it Again, for instance, while attempting to instruct the viewer in the importance of de-stigmatizing the AIDS patient, also foregrounds “risk groups” and “high-risk” behavior. The narrator says to the viewer, that it is important to know how AIDS does *not* spread and proceeds to debunk misconceptions or stereotypes about the spread of the illness. However, she emphasizes, it is also important to know how one can get AIDS and those sections of the population most at risk from the virus. The viewer is then taken through these “sections” – red light areas, scenes depicting the soliciting of sex workers, a crowded and filthy room where drug addicts share needles. It is important to note at this juncture that there is a relative “normalcy” accorded in the narrative to those who are believed to be “innocent” victims, like hemophiliacs, those who received the infection through blood transfusion, “unsuspecting” wives of men who frequent prostitutes and especially children. The relative “normalcy” of these “innocent victims” is also identified here as being “moral”. In *There is Life for Selvi*, for instance, the focus of the film, though essentially AIDS and its causes, is on the children of HIV infected mothers who pass it on to their children. These children, visualized in the documentary through an affective rendering of them playing, laughing and interacting with people at the Community Health Education Society, are also contextualized by the narrator as being victims of an unfortunate inheritance. The film opens with shots of several types of flowers in bloom and the narrator’s voice says subsequently, to frame these shots, “This is a blossoming childhood. Selvi.” Selvi is then seen on screen, smiling and not looking directly at the camera. The narrator continues, “Selvi. Unfazed by the vagaries of life” and the narrative thus moves from a metaphor for childhood to the individual story of Selvi (she was abandoned by her HIV positive mother, who, upon learning that Selvi is also infected, has no more use for her. Selvi is found and given shelter by CHES). The narrator then tells the viewer, “but there are several Selvis in our country, and everyone doesn’t find a mother once discarded by her own. Why should one be rejected by one’s own?” Selvi thus stands in for every HIV positive child abandoned by their families and the narrative implicates the viewer through this affective movement from the particular instance of Selvi’s early experience of tragedy to its widespread incidence. Their “obliviousness” to their condition as children is foregrounded in the narrative, to better establish their relative “innocence” in comparison to other particular “bodies” and instances that the documentary surveys. The viewer is thus instructed in the “identification” of particular bodies that need to be normalized through medical intervention to contain the spread of infection.

Moreover, the bodies that are subjected to medical intervention are acknowledged to require rehabilitative care. These bodies need to be further "normalized" in order to be reinstated socially. The moral imperative that implicates the viewer and the patient extends to the social restitution of the bodies that have been "normalized" by medicine.

(b) Social Restitution/Rehabilitation

Myser and Clark emphasize the correlation of power and knowledge in the medical documentary and argue that they function "in prescriptive ways, reproducing normative assumptions about what it means to be properly embodied and thus operating as agents for the medical regime" (46). It is significant that the Films Division medical documentaries encourage timely diagnosis and promote close personal surveillance of the body, but discourage attempts at self-treatment. In *Sexually Transmitted Diseases* the narrator repeatedly asserts, "Please don't try to treat your self. Don't fall for spurious remedies. See your doctor and get treated by him". However, what these documentaries do prescribe is the importance of community and family support, for the restitution of patients who have undergone medical treatment. To be properly embodied, these narrators imply, it is not enough to undergo medical treatment to excise disease, but it is necessary to be "able" and productive socially. At the end of *Your Enemy -TB*, for instance, the narrator informs the viewer that "Our Government and voluntary agencies are doing great work in this battle against TB. With your help, much more can be done". The narrator calls upon the viewer to purchase TB seals for a small price and explains that every small contribution can make a difference in the "battle against TB". The call to be socially productive and "able" may not however, always be as overt. The Films

Division documentaries often employ within their narrative structure, various other kinds of narratives.

Personal testimony is a narrative frequently employed in the service of the narrative "organizing" by the documentary, of the "story" of illness and the experience of being ill. Part of the affective dimension of the documentary narrative, individual testimonies also serve to heighten the "real" status of the documentary's subject. At the start of *Glaucoma – A Race to Blindness,* for instance, a Glaucoma "victim" speaks directly to the viewer from within an office. She appears to be employed, but is wearing dark glasses and appears on the screen immediately after the narrator questions the viewer about what it would be like to be unable to see the beauty of the world (this "beauty" has been briefly sampled for the viewer with intercuts of various scenes of nature, thereby proposing that "beauty" is somehow associated with nature) – some are, the narrator says, unfortunately blind at birth. The Glaucoma victim then addresses the viewer, to inform us that she was not blind from birth and is in fact, educated, has an MSc degree and lost her sight at the age of twenty two, to Glaucoma. She was unaware of the onset of Glaucoma and it progressively completely mars her vision and she shares with the viewer what the "medical" diagnosis of her condition is – "chronic Glaucoma".

Those "victims" who choose to narrate their story in the documentary, are always situates amidst their new vocational set-up (handicapped leprosy patients are seen working at looms specially designed for them in *Controlling Leprosy* and *Sanctuary of the Ostracized*, breast cancer survivors are seen making special innerwear that help women who have undergone radical mastectomy preserve a "normal" form) and their "stories" are utilized for their "reformative" potential. At the start of *Gita Ki Kahani* for instance, Gita expresses regret at not having experienced what the viewer is now experiencing with the telling of her story. Her “story” is coded as confession, one that will help the viewer and future viewers, to recognize their vulnerability to Hepatitis B and take necessary precautions. Gita is seen to struggle with “several questions” she has about her illness, with no one to answer them. She says at the start of the documentary, that she wishes she had known someone who would have said to her, the things that she is now narrating to us, the viewers. Moreover, the choice to film and narrate Gita’s story is also dictated by the fact that it is a story of “triumph”. She declares in the course of the documentary that she has decided to “fight” the illness inside her body. She says, “I decided to cast off this disease from my body and become the same Gita that diseases dread” and is successful in this endeavor, as the documentary testifies. She jubilantly records at the end that “she has won”, as the disease is no longer present in her body. Significantly, the entire “story” of Gita is framed within her “medical reports” (Figure 12).

The documentary begins with a close-up view of her medical reports, indicating the presence of Hepatitis B in her blood and ends with reports that indicate “normalcy”. The documentary has thus narrated the story of a “triumph” over illness, one that restores faith in medical intervention and the resuscitation of normal life, following this intervention. Similarly, *Conquest of Cancer* enfolds within its narrative, stories of women who testify to identifying themselves as “cancer victors”, rather than “cancer survivors”. In a display of its production of normative assumptions about being properly embodied, *Conquest of Cancer* testifies to the importance of rehabilitating women who have undergone breast surgery to help them “preserve their personality”. The medical documentary thus uses patient narratives to advocate the use of breast form (a breast prosthesis intended to mirror and restore the shape of the breast following mastectomy), to help “normalize” their now “deviant” bodies.

The following section will examine the forging of “affective” links through a sentimental narrative between the particular, pathologized body and the social networks within which this body is inevitably embedded.

Section III: The Sentimental Narrative in the Medical Documentary

The medical documentary narrates stories of the “presence” of disease in an individual body and its cure that moves from the documentation of a particularized instance, to a contextualizing of the relevance of this particularity for the general public. In narrating particulars of the “presence” of disease in the individual body, the medical documentary inevitably visualizes for the viewer, the many social and material contexts in which this body is embedded. The “story” of disease in the medical documentary is thus typically one of *locating* various aspects of the condition of being ill. As a part of this “story”, the viewer is taken through the various locations of disease or illness at the personal, familial and communal level. The medical documentary realizes these locations through a visual representation of the individual’s interrelatedness with the family, the community and city. Several of the Films Division documentaries on health and disease thus always portray their subjects within their particular socio-cultural milieu. This milieu is visualized in particular terms, with respect to the home, the office or place of work and personal interaction with the doctor and in general terms, with regard to modes of public transport in the city, crowded waiting rooms of hospitals and other places of social interaction. The subject of the medical documentary is thus seen to be embedded in spaces that are marked by the permeability of boundaries. When the particular context of the occurrence of disease in an individual's body (visualized through the observing of the individual himself/herself or their families of the onset of disease symptoms in the body) gives way to the general context of the presence of disease in the national population (visualized often through a map of the nation that reflects the statistics of disease occurrence in its various parts), the viewer learns to recognize that invading pathogens represent a threat to the individual, as well as the many interrelated spaces he/she is embedded in.

This visual representation produces specific identities for the individuals thus portrayed and simultaneously territorializes the locations or spaces with which he/she interacts. The medical documentary seeks to establish for the viewer, with the help of a diagnostic and evidentiary narrative, the "real" presence of disease within the individual and social body. As part of the evidentiary narrative, the medical documentary allows the viewer to participate in visualizing the interior of the body. This is done through a collapsing of the camera's view with that of the surgeon/doctor/laboratory researcher, who uses various technological devices like the X-ray, Ultrasound and the Microscope, that can "see through" the body. The camera's view of the individual subject moves to allow a deeper and more "real" appreciation of the inner dimensions of the body. The medical documentary depicts the individual's entry into the hospital/clinic/community health centre, only once he/she has established the need for such a journey. Once the individual recognizes that he/she is ailing, or when members of his/her family suggest medical intervention for what appears to them as a lapse in health, then the individual seeks medical counsel. The individual's own "diagnosis" of a lapse in health or the recognition of symptoms thus anticipates a "transformation" of identity, an establishment of the "reality" of disease. The individual's "diagnosis" anticipates his/her transformation into "patient" and thus "sends" him/her to the hospital/medical institution. The encounter with the doctor/community health worker/medical institution and the individual's subsequent transformation into a "patient" is often portrayed as an illuminating and life-saving experience. This encounter is constructed within the documentary as an example to be emulated – the "patient" is informed by the doctor that it was a timely recourse to medical intervention that saved him/her.

The individual's assessment or recognition of his/her condition is constructed through a foregrounding of social/material embeddedness. In *Your Enemy -TB*, for instance, one of the central characters, Gopal, is seen to visit the TB centre, only after he realizes that his symptoms affect his productivity at work. Similarly, in *Gita Ki Kahani*, Gita seeks medical attention when she is unable to discharge her domestic duties and more significantly, at the start of the film, she recognizes a difference between her current, ailing self and an earlier, active and productive self. Gita is seen in the documentary looking wistfully at an earlier photograph of herself, where she is wielding a tennis racquet, dressed in her playing gear. This earlier, visibly "athletic" self, is visualized in contrast with the constant fatigue, lack of appetite and listlessness that Gita confesses to be feeling and her recognition of a lapse in health and productivity is thus established. In *Controlling Leprosy*, similarly, a young schoolgirl is seen along with her classmates to be watching an educational film about leprosy and is then able to return home and suggest to her father, that he exhibits the very same symptoms she has recently "learned" to identify. It is on his daughter's insistence that the individual portrayed in the film undertakes a journey to the village health centre. The individual in the medical documentary is thus portrayed as inevitably “requiring” medical intervention for a “lapse in health”. This lapse is both recognized and required by the individual, as it is seen to affect his body in terms of its productivity and threatens its situatedness within the many interrelated spheres of workplace, the home and the city. A “lapse” in health is also visualized, especially with regard to a contagious disease, as the precursor to ostracization. Individuals are shown to be forcibly removed from their place of work and even their homes on account of harbouring a condition that comprises a threat to others. More significantly, “harbouring” or indicating complicity with an “infectious” invader is also seen as a mark of the failure to seek medical help and return to a state of “health”.

While instances of the ostracization of those that suffer from contagious diseases may be showcased in the documentary as an erroneous practice, it nonetheless functions, along with the inevitable “awareness” the individual is shown to have of a lapse in health, as the condition of the individual’s existence. He/she is made aware, more than the physical pain of illness, of the disruption caused by this illness to what is portrayed in the documentary as “normal”, everyday existence. Disease is seen to disrupt the fundamental situatedness of the individual body, thus requiring immediate medical intervention to restore this body to its earlier place. Medical intervention is seen to redress the changes brought about by a lapse in health, to the relationship this body has with its socio-material contexts. The medical documentary thus negotiates the movement and position of its subjects, through what is produced as the “normal” and “healthy” spaces of everyday life. The individual’s entry into the medical establishment for instance, is contingent upon a declaration by this individual of his suspected status as “ailing”. In *Sexually Transmitted*

Diseases for instance, individuals are seen to “confess” to “high-risk” behaviour, like indulging multiple sexual partners or having visited sex workers. These individuals seek medical attention, both on account of an observed change in physical appearance and functionality, but also upon recognizing the “threat” they now pose to their families.

Recognizing the “threat” posed by an unhealthy and “diseased” body, to what is consequently constructed as “uninfected”, “healthy”, but simultaneously vulnerable spaces is thus crucial in the establishment of the status of “patient”. The diagnostic and evidentiary narrative in the medical documentary works to tether particular bodies to particular spaces and practices and relies on viewers’ pre-existing cultural knowledge of such bodies and spaces. Though the “presence” of disease in the individual body is determined “scientifically” and objectively for the viewer through statistical and indexical modes of representation, it is also contingent upon an “emotional” response to how this body is “situated”. The viewer, like the on-screen subject, is implicated in the documentary’s narrative structures, through the affective links it forges between the diseased subject and the interrelated spheres within which this subject occupies a place. These affective links include the sense of “belonging” to the family, the community and the nation, the sense of “responsibility” for protecting the vulnerable health of these spheres, “fear” of losing this place/membership or “status” and the importance of being a “productive” member in these spheres.

The medical documentary forges affective links between the diseased subject and the spaces he/she occupies at the level of the individual, the family, the community and the city. *These affective links are visualized through a movement from the familiar to the unknown and a production of specific identities for the diseased subject and the spaces* *they occupy and a negotiation of their movement through these newly forged spaces, identities and their connections*.

(a) The Individual: The Microgeography of the Body

The “story” of the “presence” of disease narrated by the medical documentary is individualized or personalized, while simultaneously reminding the viewer of the larger structures within which this personal or individual case operates. *This is achieved first through an instantiation of unrest/rebellion within the body.* As argued earlier, the medical documentary allows the viewer to “see through” the body. Through this visualizing of the body’s inner landscape, I argue, the medical documentary unveils the “microgeography” of the body. In the individual case of the presence of “disease”, the viewer is taken through the individual’s life prior to the onset of disease. The viewer can see this individual going through the “familiar” motions of daily life – the individual body is “situated” at the place of work, amidst family members in the home and participating in designated social spaces (using public transport, playing at a public park, visiting a restaurant). The viewer is made “familiar” with this individual body and the membership he/she enjoys, on account of the role/function performed in each of the spaces through which the individual transitions over the course of the documentary narrative. Membership in the home and family for instance, as domestic worker/breadwinner, membership in the place of work as labourer and membership in spaces of trade and leisure as economic participant/consumer, among others. This “familiarity” is transformed with the unveiling of the microgeography of the body, as the viewer is suddenly made aware of an inner ecosystem that is at odds with the several outer networks within which the individual body is embedded. Through statistical and indexical modes of representation that function as scientific “evidence” of the presence of disease in the body, the viewer is made aware of the existence of parallel systems of existence at work within the individual. The anatomically correct model of the human body used as part of the indexical mode of representation in the documentary, works to animate the “harmonious” conditions presumed to be present under a condition of normalcy. “Normal” bodily processes are animated using the anatomically correct model and the viewer, yet again, is made familiar with the “work”/co-ordinated effort carried out inside the “normal” body. Documentaries about AIDS for instance, familiarize the viewer with the workings of the immune system and animate the white blood cells that “help” keep invading pathogens at bay. *Glaucoma – A Race to Blindness*, for instance, familiarizes viewers with the functions carried out by a healthy, normal human eye and its steady maintenance of excess fluid drainage and pressure. *Preventing Anaemia through Nutrition* teaches the viewer about the functions performed by “healthy” blood that is “rich” in its supply of nutrients and oxygen.

The presence of disease is seen to cause a break in these “normal” processes that until then carried on without intervention or surveillance. Similarly, the individual body, thus far “familiar” in its workings both in its internally visualized microsystems and external situatedness, is suddenly transformed and made unfamiliar by disease. The anatomically correct model is then “marked”, with locations that are vulnerable to the threat of invasion by pathogens. This unveiling of potentially “vulnerable” spaces in the newly mapped interiors of the body, transforms its familiar space into a hostile environment. AIDS destroys the body’s “natural” immunity to disease and opens up its borders to any lethal pathogen-invader, Glaucoma draws a halt to the eye’s “natural” fluid-draining mechanism and causes a vision-obstructing blockade and Anaemia limits the oxygen absorbing/carrying capability of blood. In each case, a new, “pathological” system is seen to be operating within the individual body, signalling the “start” of unrest and rebellion. This “pathological” system is presented to the viewer, by superimposing its workings on the indexical representation of the anatomically “correct” or healthy body. This body, made unfamiliar by disease, is seen to make its internal unrest apparent externally. The “internal” unfamiliarity of the diseased body, illustrated via the anatomically correct model marked by its diseased locales, transfers to an externally manifested unfamiliarity as well, in terms of decline in productivity, sexual performance and the ability to maintain an easy transition through the spaces one occupies. In *Preventing Anaemia through Nutrition*, for instance, an anaemic labourer is seen struggling with a heavy load that eventually collapses on him as he succumbs to exhaustion brought on by limited oxygen supply. The same documentary visualizes other “individual” instances of the discordance brought about by anaemia – a pregnant woman participating in a ritual household celebration suddenly collapses amidst her guests, bringing celebrations to a halt and a farmer tilling his fields suddenly falls to the ground, no longer able to guide his bullocks, as his vision begins to blur.

The individual’s decline in productivity is thus central to the visualization of the unrest brought on by illness. In addition, especially with regard to infectious diseases, the individual now poses a threat to his family and wider community. Diseases that are characterized by their power to transform physical appearance alter the relations shared by the individual with the several social spaces he/she is a member of. The medical documentary thus demonstrates the situated nature of the individual, through an instantiation of the unrest brought on by disease to the internal bodily processes of the individual and consequently, the external processes of which he forms an integral part. As the narrator of *Tobacco Habits and Oral Cancer* attests, a tobacco habit “starts a chain reaction over which you have no control”. The “situated” nature of the individual is also visualized in the documentary, through the “mediation” staged between the doctor and the “technological ascertainment” of disease.

While the individual’s entry into the medical institution or his/her desire for medical intervention is premised, as argued earlier in this section, on his/her own recognition of a lapse of health, the actual/verifiable presence of disease is established within the medical institution. It is only upon entry into the hospital/clinic/health care centre, that the individual obtains knowledge/advisory about his/her condition. It is here that the viewer is taken through, along with the individual portrayed in the documentary, the process by which the presence of disease within the body can be declared with certainty/authority. While it is the “doctor” or “health worker” within the documentary who generally pronounces the individual’s status as “patient”, the viewer is also always allowed to follow the progress of this individual body through the various stages of diagnosis. It is here that the viewer is made aware of the individual’s existence amid a network of actors within the medical institution,who negotiate his/her movement through the stages of illness. The individual is typically requested to perform “tests” to determine the presence of disease and the viewer is taken through the various spaces in the medical institution, where these diagnostic procedures are performed. As the viewer watches, the familiar individual/patient body slowly disperses into a series of bodily fluids and secretions, captured inside glass vials, test tubes and processed through various digital media. Biopsy procedures are often visualized for the viewer, especially in the documentaries that detail the removal and analysis of malignant growths, like *Conquest of Cancer*, *Tobacco Habits and Oral Cancer* and *Cancer*. Here, the body's dispersal is recorded from the collection of a tissue sample and its scrutiny under a microscope (visualized for the viewer as a magnified slide), to its conversion into data in the form of a medical "report". In addition to cataloguing the workings of the parallel "pathological" system of the disease in the individual body, this visualizing of the body's dispersal also works to establish the multiple medical networks within which the diseased body is embedded.

As argued earlier in this section, the doctor/health worker within the medical establishment, functions as the primary source of knowledge/advisory about the individual's ailing body. The figure of the doctor in *Conquest of Cancer, Gita Ki Kahani, AIDS* and *Controlling Leprosy*, is visualized as one who can not only rid the body of its suffering, but can allay fears and anxieties and dispel doubts and misconceptions about disease.The personalized nature of the individual's interaction with his/her doctor in the documentary narrative, attempts to "humanize" the disembodied nature of the individual's presence as "patient" within the medical institution. The unfamiliar and "dispersed" nature of the body in the stage of medical diagnosis is made familiar by the doctor's recognition of the individuality of his/her patients. The medical institution is similarly viewed as one that "individualizes" the care of its patients. The viewer is ensured in *Your Enemy - TB*, that each individual report is maintained at the TB Institute to track the progress of treatment in each individual case. Similarly, in *There is Life for Selvi*, the narrator explains that the CHES (Community Health Education Society) which works with AIDS patients, adopts an “individual” approach. This is because, the narrator explains, “An individual approach in counselling has been found to be the most effective method as each person is distinctly different”. Through an evocation of ideas of individualized or personalized care and attention and the recognition of the “individual” as such, the medical documentary forges affective connections between the individual body and its presence within the space of the medical institution. Via the figure of the health worker/doctor, the medical documentary is able to stage a personalized effort carried out by the state, to wipe out disease and restore health in the individual body. This is a significant manner in which the efforts of the state in eradicating disease are concretized in the medical documentary.

In addition to personalizing the encounter and subsequent relationship between the individual and the medical institution, the state is also incorporated in the documentary narrative, as an “ally” in the battle against a common enemy – the invading pathogen. The state-as-ally in the documentary narrative functions yet again to materialize the state’s role in the realm of public health and its affective relationship with the individual. In *Your Enemy -TB*, for instance, the narrator informs the viewer that “Our Government and several voluntary agencies are doing great work in this battle against TB”. In *Controlling Leprosy*, similarly, the narrator explains the narrowing of the gap, through state efforts, between health care centres and places of leprosy incidence and the viewer is shown a map of India the depicts the presence of governmental leprosy centres (See Figure 13).

The body-space of the individual is territorialized through a militant discourse, a call to arms against an illicit invader. The individual is encouraged in the medical documentary, to reclaim sovereignty of his/her body, by ousting the enemy that resides within him/her, orchestrating discordance and restructuring the familiar "normalcy" of the body's interior. Metaphors of war pervade, for instance, in the following description provided by the narrator of *Conquest of Cancer*. He says, "Totally unmindful of their healthy brothers, the normal cells, the cancer cells keep on multiplying, invading and destroying the healthy cells". Cancer, the narrator describes, "can arise in any part of the human body and like all traitors, it attacks surreptitiously, secures a foothold and keeps growing for months before the patient has any inkling". Significant in this description, are the qualities of ruthlessness and cunning that are ascribed to the cancer virus, who is seen to be a "traitor" to his healthy, normal family – the normal cells in the human body. *Your Enemy- TB, AIDS* and *Sexually Transmitted Diseases* are other instances where an invading pathogen is viewed as possessing characteristics of a wily intruder, whose unsuspected onset or "surprise" attack problematizes surveillance as well as cure. The individual's body in these cases is territorialized through the affective bond of "loyalty" and "responsibility", both to one's own body-space-system and by extension, the larger structures within which this body operates, that requires an immediate weeding out of the "treacherous" and "traitorous""enemy" represented by disease. An establishing of sovereignty, order and health to the body-space, is thus the individual's duty and his/her responsibility to the larger structures he/she occupies.

As argued earlier in this section, the medical documentary produces specific identities for the diseased subject and the spaces they occupy and negotiates their movement through these newly forged spaces, identities and their connections. The individual diseased body in the medical documentary is produced as a productive member of the nation, if he/she can set an instructive example. The depiction of the state-as-ally is contingent upon the individual and viewer's recognition of his/her own identity, as a fellow soldier in the fight against disease. This becomes "affective", through a sentimentalizing of the situated nature of the individual body. The individual's sense of "belonging", for instance and consequently, his/her identity, is premised upon a responsibility to the larger structures of which he/she forms a part. In *Controlling Leprosy*, for instance, the doctor reminds his patient on screen and the viewer, that they can become infected if they come in contact with an individual afflicted with the "contagious" variety of the leprosy virus. While he speaks, the camera isolates potentially "contagious" leprosy victims. The first case identified, is a local pan seller and the doctor emphasizes the degree of danger in the location of disease in "familiar" and "unfamiliar" bodies. The danger of contracting leprosy from the "familiar" or "known" local pan seller is not as great, the doctor informs his patient, as contracting leprosy "unwittingly", from a person you may not even know is contagious. The camera then isolates for the viewer, an innocuous passenger on a bus who is, as the doctor informs us, a contagious leprosy victim and moreover, is dangerous precisely on account of his innocuousness (See Figure 14).

The "responsible" citizen however, is contrasted with the "innocuous" carrier/spreader of contagion, as he/she is personalized in the medical documentary narrative. A "personalized" individual is "marked" as "citizen", through a performance of the responsibility owed to filial/social networks in which he/she is embedded. Such an "individual" is given personal features like a "name" and a "story" within the medical documentary, where he/she is seen to voluntarily give himself/herself over to medical examination/treatment. The process of “personalizing” the “responsible citizen”, who submits to medical care/investigation and regains “control” over his/her malfunctioning bodily and social functions, is achieved in an “affective” mode in the medical documentary. Such a person is seen to “care” for his/her family, worry about their vulnerability and visibly experiences “distress” at being unable to operate productively at work. A range of “affective” responses to the unrest caused by illness, is thus mapped on the “personalized” story of the “responsible citizen”, while the “innocuous” and infectious body is, in contrast, outside the narrative reach of the medical documentary. Potential “carriers” of a disease are isolated, but not personalized within the medical documentary narrative. The progress of disease in these bodies is “unknown” to medical science and the viewer. These bodies are seen outside the “bounds” of familiar social structures like the family and other normal disciplinary institutions like the workplace and the medical institution. These “carriers” are constructed within the narrative, as individuals who are unaware of their destructive power and who are, on account of their anonymity, beyond the narrative scope of the documentary and out of the normalizing reach of the medical institution. This “anonymous” carrier in the narrative functions as the errant citizen, one who, without knowledge or consciousness of the inner pathological workings of his body, causes destruction to himself and others among whom he is inevitably embedded. The medical documentary, thus, in contrast to the dangerous and anonymous carrier of disease, constructs a dutiful and responsible citizen who reclaims sovereignty of his/her body and engages in battle against disease, as a “loyal” subject of the larger national body he/she inhabits. The medical documentary thus “affectively” creates an anxiety about the porousness and embeddedness of the individual ailing body, which is then "alleviated" through the normalizing intervention of the state/medical institution.

In her study of accounts of the first known "healthy carrier" (Mary Mallon, an Irish immigrant cook in the United States christened "Typhoid Mary" in the popular press, on account of the widely held belief that she voluntarily spread typhoid germs) of the typhoid germ in the early twentieth century in America, Priscilla Wald argues that the impossibility of locating all such carriers meant that an individual's behaviour and social interactions had to undergo a change. Maintaining "cleanliness" was thus seen not only as a solution, but also a measure of citizenship (70). More significantly, the individual was responsible for social welfare and negligence or carelessness on his/her part, attained the status of a social crime or sin (72-3). This dutiful citizen removes himself into seclusion/the containing power of the medical facility, once he has gained consciousness of the inner landscape of his/her body. As the narrator of the *Conquest of Cancer* emphasizes, "consciousness of the disease" is crucial to win the "fight" against cancer. A responsible individual is one who seeks medical attention upon becoming "conscious" of the presence of disease in the body. His/her membership in the national body is contingent on "acting upon" this consciousness of disease, to restore order and sovereignty in the microgeography of the body.

(b) Community

The medical documentary constructs the individual's embeddedness in the community through a visualization of a "shared vulnerability" to disease. This is done through asserting, as argued earlier in this section, the importance of the containment and restitution of disease, and a lapse in health within the family and the medical institution. In addition to the threat posed by the individual to the "vulnerability" of the home however, the medical documentary also visualizes for the viewer, the condition of posing a threat to the community. The various social interactions carried out by an individual everyday are portrayed with the intent of making visible, the many points of contact individuals share with the communities they inhabit. These points of contact serve to make clear the individual's responsibility to the community. He/she can be safe and in turn protect the communal spaces he/she inhabits, through a responsible and model containment and prevention of "high risk" behaviour (See Figure 15).

The individual "performs" his role in what is constructed as the "national community" of which he/she forms a part, through setting of an "example". In *Health for All*, for instance, the narrator stresses for the audience, the "vital" link between health and the development of the nation. "In every sphere of physical and intellectual activity", the narrator says, "the health of the individual is of vital importance. Only a healthy people can make a nation wealthy". The documentary also features footage from a joint conference held by the central councils for health and family welfare, when Indira Gandhi was prime minister. In addition to stressing the importance of a balanced diet and nutrition for the maintenance of health, the prime minister reminds her audience and the viewer, that adults should set an "example" for their children with regard to the maintenance of hygiene. The footage of the conference is then replaced by a visualizing of a school, where children are playing and later eating, while Indira Gandhi's voice continues its address. The children are aided by attending adults at the school, who are shown to help them wash their hands after meals and playtime. In addition to "performing" the role of the responsible citizen, thus, the individual is also responsible for the transmission of ideas of "hygiene" and the maintenance of the health of the body, progeny and the community. The prime minister's address continues and adds that the provision of services of health is the first task of any government, but the onus is on the individual who, along with the state-as-ally, is responsible for the maintenance of his/her own health and by extension, that of the nation. As Wald has argued, the advent of bacteriology staged a coming together of "social responsibility" and "bacterial individualism", that focused on the individual as an agent responsible for his/her own health, as well as the health of anyone he/she may come into contact with (73).

Social responsibility is emphasized in *Alcohol-The Killer*, where alcoholism is portrayed as primarily a "social" evil/disease. The documentary begins with a cataloguing of alcohol-related crimes, where the alcoholic "criminal-victim" stands in a witness box of the court and the narrator declares their specific crime to the viewer (including a "society-woman" who kills her child in an incident of drunk driving). The significance of the alcohol induced crimes these "criminal-patients" commit is that they pose a threat to the social group as well as their own space within this group. Criminalizing their actions demonstrates their removal from the sphere of the "responsible" national community and places them instead, within a dangerous category of "deviants". The narrator of *Alcohol-The Killer* is himself a transformed alcoholic, as he confesses to the viewer with the words, "I used to be a social drinker". The relative harmlessness of "social drinking" is reconfigured in the context of the "criminal" acts recorded in the film, and a seemingly harmless "social activity" is thus demonstrated to wield a destructive power. The narrator subsequently introduces the viewer to a “doctor”, who instructs him/her about the effects of alcohol on various parts of the body. The “doctor” interestingly, focuses on the disruption caused by alcohol to the “sociability” of the body. He says, “The inhibitions we develop over the years due to formal education and social education are completely taken away under the effect of alcohol”. “Inhibitions” are thus a vital part of the “social education” an individual receives, the social inheritance that is transformed and rendered irrelevant by the effects of alcohol.

The pathologization effected by alcohol, is thus constructed via its disruption of the individual’s “social education”, the cultural transmission of appropriate codes of conduct and the consciousness of the individual’s responsibility to his/her social group. The documentary then goes on to visualize for the viewer, the geographic distribution of alcohol inside the body. Alcohol’s absorption into the bloodstream and its dangerous reach into the various parts of the body are represented on an anatomical model. This scene immediately shifts to a depiction of the “spread” or reach of the “practice” of drinking alcohol in various parts of society, with a shot of a local bar, whose patrons drink in close proximity with each other. At this juncture, while the camera stays focused on the bar’s patrons, the narrator’s voice intervenes, to remind the viewer of the “internal” pathological processes that he/she viewed just a moment ago. “About 2.5 percent of alcohol”, the narrator says, “is eliminated through urine, breath, saliva and sweat”, thus visualizing for the viewer, the otherwise imperceptible transmission of the pathological contents of the body to its surroundings. Similar routes of transmission are evoked in *Cancer* and *Conquest of Cancer*, where the viewer is reminded of the dangers of “passive” smoking. The “smoker” is pathologized not only on account of the potential risk/harm caused to his/her own body, but to the wider social group of which he/she forms a part (Figure 16).

In *Controlling Leprosy,* the individual story of the treatment of a non-contagious leprosy patient that is interspersed in the narrative is contextualized at the time of a governmental leprosy eradication drive, being carried out in the village where the patient resides. During the course of his treatment, this patient befriends the local health worker, with whom he travels to visit the only “contagious” patient in the village (treated within the documentary as being a greater social concern in comparison with the non-contagious forms of leprosy), a worker named Ramesh. The health worker explains to the non-contagious patient who accompanies him, that he has tested every other member of the village, all of whom were either uninfected or had early stages of non-contagious leprosy, for which they were now being treated. He then mentions that only one patient remains, who works in the home of the village headman, and the main protagonist immediately recognizes him as “Ramesh”. Speaking of Ramesh to the health worker, he remarks (building on knowledge of being a victim of non-contagious leprosy and having been warned by his doctor of the dangers of the contagious variety), that this would mean that Ramesh’s family is also now infected with leprosy. The health worker clarifies for the protagonist, that Ramesh’s family was in fact uninfected when he tested them earlier. Explaining the miraculous escape made by Ramesh’s family from the contagious disease to the bewildered protagonist, the health worker explains, that Ramesh spends all his time at his place of work rather than at his home. While the routes of transmission of leprosy from Ramesh’s body are not explored further, it is significant that here, the threat of contagion is contextualized with regard to the community. The space of the family is here constructed as relatively safe from the threat of disease, in comparison to the space of work and the larger social interactions of the individual.

(c) The City

The city space is constructed in the medical documentary, through a visualization of the individual’s interactions with this space, in the context of the everyday. Public means of transportation, places of trade and work in the city, frequently form the visual subtext of the “situatedness” of the individual demonstrated in the medical documentary. The unrest brought on by disease at the level of the body and family, are often visualized as an inevitable part of the “experience” of living in the city. The city suggests a cosmopolitan condition for the individual, where he/she is rooted by the responsibility to the home and immediate social group, but is also simultaneously implicated in the interconnectedness of the city, with various potentially unsafe locations. The city’s borders are seen to be permeable and the growing numbers of the population and an increase in travel and migration are instantiated in the medical documentary via scenes of crowded bus stations and city roads. The city space is territorialized through the individual’s professional interactions with this space. The engagement in a profession and the consequent “movement” outside the home (either on account of commuting to the workplace or working in a different place from where the “home” is located or even travelling to several places *as* work), makes evident a “cosmopolitan” engagement with/exposure to several places and people. The "engagement" with the city necessitated by "work", makes the "home" and the "city" vulnerable/threatening to the individual, who is simultaneously embedded in these spaces he/she inhabits. In *Sexually Transmitted Diseases* for instance, a man is seen "confessing" to the doctor, his recent "breach" in responsibility by visiting a sex worker. The doctor questions this man about why he looked for sexual release in a dangerous location, when he was already married. The man proceeds to explain to the doctor, that his wife lives away from him in their village and on account of high living costs in the city where he is employed, he is forced to share his small room with three other tenants and cannot afford to bring his family to the city. Sexual promiscuity and its association with disease is here represented as an inevitable condition of inhabiting the city space, where one may come in contact with potentially unsafe spaces and persons.

Similarly, in *AIDS*, when the patient suffering from syphilis is being diagnosed by his doctor, he is asked as part of the medical exam, what kind of profession he practices. After he presents his symptoms (genital discomfort) to the doctor, his means of occupation is the first question the doctor asks him, as part of ascertaining the "history" of his illness. When he responds that he is a salesman, the doctor immediately asks if this means that he is required to travel a great deal. When the patient does not offer a specific job title, the doctor himself offers "touring salesman", as what he understands the man's occupation to be. The doctor has here appropriated the man's profession (the label of "touring salesman" itself inspired by prevalent discourses that stereotype lifestyles and professions prone to disease),to explore its links with the entry of disease into his individual body. He then proceeds to capture the wider network within which this professional occupation is embedded and asks whether or not the man remembers visiting any "unknown" woman during his travel to the city. The man now admits to meeting a different girl every time he travels to the city, thereby making evident what the doctor had been leading towards during the history and medical exam.

As a member who participates in the city, the "touring salesman" is implicated in its interconnectedness with spaces of disease and infection. What this exchange with the doctor also designates, however, is the reprehensible nature of associating with the "unknown" woman. The "unknown" woman or sex worker, a frequent character in the city, is an instance of the gendered representation of the practice of professions in the city space. While addressing the job of sex workers, though documentaries like *There is Life for Selvi* and *Saying it Again* focus on the socio-economic factors that lead women into the profession, they also highlight what are seen as the "peculiarities" of these professions. With sex workers in particular, the practice of unsafe sex is deemed to be rampant, precisely on account of the "behavioural peculiarities" of those who practice and participate in these professions. These behavioural peculiarities include an avoidance of prophylactics, and the consequent committing of the unforgivable social crime of negligence. Workers in this profession and its participants are seen to be willing agents of biological disaster. The emphasis on "unknown" also marks the fear of the "mobile" woman inhabiting the city space. These sex workers, often portrayed in isolation, are a mark of social degeneration not only on account of their profession, but on account of being perhaps unmarried and working away from their families and living alone or in unrecognizable groups in the city. The image of the sex worker, like that of the unidentifiable "healthy" carrier of disease, represents the break-down of the family and the social as they are typically characterized in isolation. In other words, they are not surrounded by the "normative" trappings of a wife/husband, a child and located within the sanitized space of the home. These professions, through a visualization of the travel routes of disease in and through the bodies of human hosts, are conflated with the city space, thus rendering it a situation or condition that represents the break-down of familial and social ties. Writing about the anxiety generated by "mobile" women who were single and pursued professions in the city away from their homes, Wald argues that the prostitute came to be regarded as one such "mobile" woman, whose movements and practices were imagined as causing biological and social destruction. "The definition of the prostitute", she argues, "was clearly expanding to encompass women who ventured into anonymous spaces and who abjured the marriage bond" (91-2). While the city-dwelling male's contact with the sex worker is redeemed in the documentary narrative through his "confession" and repentance, the "unknown" sex worker is marked by her "deviant" mobility and existence outside the space of the home. The city is thus reconfigured through the individual's professional interactions with this space that demonstrate yet again, the mutual interconnectedness of the city with the individual, the family and the community.

Space is thus reconfigured in the medical documentary at the level of the individual, the family, community and city to reveal hidden geographies of disease that expose and make evident the vulnerability of these levels of space. The documentary narrative makes evident for the viewer, what Wald has termed "spatial promiscuity" (94). The possibility and potential of infection is thus located in the permeable boundaries between the levels of space visualized in the medical documentary.

This chapter has argued that the doctor-narrator in the medical *Bildungsroman* constructs a “narrative society” with an emphasis on individual patients as “stories”. The doctor-narrator foregrounds the therapeutic power of narrating “stories” and integrates them in his/her own “story”, to present a unified, social “self” that is attentive to the ethical dimensions of the medical narrative. This “self” created in the medical *Bildungsroman*, is able to attain “fixity” through the articulation of a particular kind of voice that emphasizes the social and draws upon the textual and cultural authority of the author. This chapter has also argued that the “story” of illness in an individual body narrated in the medical documentary visualizes for the viewer, a “potential” for violation by disease that exists in all bodies. The politics of the medical documentary, this chapter has argued, moves between scientific and affective poles. The scientific end is aimed at anchoring an “objective” and “factual” truth behind the instance of disease depicted on screen and relies on indexical modes of visualizing the inner landscape of the body. The affective sentimentalizes the embeddedness of the body and relies upon the viewer’s identification with the “familiar” modes of personalizing/particularizing the ailing individual as “story” on screen.

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Chapter Seven

Conclusion

This dissertation has examined patient, doctor and public health narratives in late twentieth century India. I have demonstrated that disease is performed *in* narrative, and may be read as organized around interventions in two key domains – the individual and the social. Moving from an analysis of the performance of disease and healing at the level of the individual to performances of disease and healing at the level of the collective, I traced the emergence of a "socialized" identity for the narrators of illness "accounts". The doctor memoir and the patient memoir, this dissertation argued, in their plotting of an individualized experience of illness and healing, take the form of the medical *Bildungsroman* in the late twentieth century. This cultural variant of the classical *Bildungsroman* maps the "growth" and eventual "social integration" of an individual (patient or doctor) through the condition of illness and healing. Medical documentaries produced by the Films Division, India, visualize for the viewer the presence of disease in an individual body and locate this body socially via a sentimental narrative. This sentimental narrative forges affective links between the "individual" visualized on screen and the viewer, thereby emphasizing the shared vulnerability to disease at the level of the individual, the family and the community.

The first chapter of this dissertation, the Introduction, theoretically contextualized the study of non-fictional narratives of disease. I argued here that these narratives can be read productively via theories surrounding various genres/modes of articulating a story of the "self", theories of "narrating" or "storying" an experience of illness and healing and theories of "voice" and "agency" that underpin the arguments made in this dissertation about the concretizing of "agency" in the acquiring of a particular kind of "voice" by narrators in the medical *Bildungsroman*. The introduction also delineated theories of social and public "identity" formation that contextualize the "development/transformation" and eventual "socialization" performed by narrators in the medical *Bildungsroman* and visualized in the medical documentary. The Introduction proposed that studying the medical *Bildungsroman* and other non-fictional modes of narrating illness and healing in India in the late twentieth century is significant on account of their *functional* attributes, namely, ensuring "fixity", "agency" or the ability to narrate/direct the plot of one's life in our contemporary era of chronic illness and embodied biographies.

The second chapter on the patient memoir argued that the patient-memoir presents a voluntary "diagnosis" of a life that integrates accounts of the material effects of illness but is not subsumed by it. This chapter studied Anita Jayadevan's *Malicious Medicine*, Anup Kumar's *The Joy of Cancer* and *Smiles and Tears: A Salute to Cancer*, Lata Mani's *Interleaves: Ruminations on Illness and Spiritual Life* and R. M. Lala's *Celebration of the Cells: Letters from a Cancer Survivor* to trace a "social" narrative of disease origin. This "social" narrative imaginatively reconstructs the onset of illness and its consequences through affective modes that serve to destabilize the "universal" and precise biomedical narrative of illness. This chapter proposed that this "social" or "particularized" narrative of the onset of illness anticipates a recovery narrative where the "improvement" of the ailing self is performed for the reader. The narrator of the patient memoir, this chapter demonstrated, performs the "acquisition" of certain skills, firstly, "learning" to manage affective/medical responses to his/her illness. Secondly, the patient in his/her particularized account of surviving/experiencing illness learns to "focalize" this account via "selective" narratives of improvement.

The third chapter on the doctor memoir examined the symbolic physical transformations "performed" by the doctor-body to mark his/her "growth" from "novice" to "expert" self. This chapter looked at several doctor memoirs, Atul Gawande's *Complications*, Abraham Verghese's *My Own Country*, Sandeep Jauhar's *Intern: A Doctor's Initiation* and Noshir H. Antia's *A Life of Change: The Autobiography of a Doctor* to map the transcending of "youth" in the journey towards "expertise" and "professionalism". This chapter thus examined the various modes through which the doctor memoir or the *Bildungsroman* of healing circumscribes "youth", seen as symbolic of the period of medical education and personal standards of professionalism. In addition to marking "symbolic" physical transformations to distinguish the "novice" and "expert" self of the physician, the doctor memoir also improvises an "editorial self" that establishes interpretative authority over individual "cases", presented initially by patients in their own words. This chapter argued that the doctor body is substitutable with the sign/value of medical education and expertise and is as such able to carve out a space from which to articulate or "voice" a particular experience of medical education and practice. This chapter demonstrated how the doctor-narrator in the *Bildungsroman* of healing is able to construct a particular voice/self that is able to harness particular discourses of patients and generate transformative, agential discourses of improvement/perfection/critique that sustain the "fixity" of this doctor-narrator's "self".

Chapter four on Filiation and Affiliation dealt with the filial networks within which the narrating "self" in doctor and patient memoirs is inevitably embedded. This chapter studied the doctor's "filial self" in Atul Gawande's *Complications* and Abraham

Verghese's *My Own Country*and the patient's "filial self" in Jayadevan's *Malicious Medicine*, Kumar's *The Joy of Cancer* and *Smiles and Tears: A Salute to Cancer*, Lata Mani's *Interleaves: Ruminations on Illness and Spiritual Life*, R. M. Lala's *Celebration of the Cells: Letters from a Cancer Survivor* and Yuvraj Singh's recent memoir, *The Test of My Life*. This chapter demonstrated that the overcoming of an "inherited" form of the "self" to present a seamless route from "individual" to "professional" (in the doctor memoir) or "ailment" to "recovery" and "improvement" (in the patient memoir) is a significant aspect of narrating "growth" and "development" in the medical *Bildungsroman*. In the case of the doctor memoir, this chapter argued, the doctor-narrator's engagement with plural and globalized cultural contexts of disease sets his "professional" self above the "filial", thereby charting "growth" and a move towards the social. In addition, this chapter demonstrated that "filial" interests are seen in the doctor memoir to be either on par with or as located "outside" his "professional" engagement with medicine.

Chapter four also examined the construction of a caregiver *Bildungsroman* in the patient memoir which emphasizes the "mutuality" inherent in patient and caregiver relations. In addition, this chapter demonstrated that the patient's recounting of "acts" of caregiving and the experience of illness are mutually constitutive and through a system of parasitic relations, mutually "communicate" and are transformed by normative "ideals" of "caring" and "improvement". This chapter revisited the "filial" aspects of "self-improvement" performed by the patient-narrator, namely recognizing their embeddedness in and dependence on, "filial" networks of care. This chapter also examined the visualization of a "filial body" in the medical documentary through a study of *AIDS*, *Sexually Transmitted Diseases*, *Alcohol-The Killer*, *Preventing Anaemia through*

Nutrition, *There is Life for Selvi*, *Saying it Again* and *Conquest of Cancer*, among others. This chapter argued that the medical documentary localizes the "filial body" within the "home" and the "family" and simultaneously designates these spaces as the socially sanctioned location of reproductive and sexual activity. The "filial body" is thus also gendered, as the medical documentary conflates biological and social roles and enables the superseding of individual rights by "future" members of the family, embodied by progeny. This chapter demonstrated how the "filial body" is situated within the "family" and the "home" as embodying both "threat" and "vulnerability" through a visual imagining of affective ties of belonging, productivity and concern.

Chapter five on Community and the doctor memoir argued that patients' "stories" are rendered stable, mobile and combinable by the doctor-narrator's "informational labour" to allow for the creation of an "ethos community". This chapter studied the "ethos community" in Atul Gawande's *Complications*, Abraham Verghese's *My Own Country*, Sandeep Jauhar's *Intern: A Doctor's Initiation* and Noshir H. Antia's *A Life of Change: The Autobiography of a Doctor* and argued via Christian Pentzold that this community is organized around a shared understanding of normative behavioural criteria during an experience of illness. This chapter demonstrated how the doctor-narrator selectively reconstructs certain aspects of his/her patients' illness experience to inscribe normative criteria like "productivity" and the "will" to survive on the patient's body. This chapter also illustrated how the narrator in the doctor memoir is able to carve out a space from which he/she articulates a critique of medical practice. The doctor-narrator transcends his "filial" context by circumscribing the "naïve" wonder with which he regarded medical science/knowledge during the period of medical education/training. As an "expert" self, the doctor-narrator performs his/her "expertise" by emphasizing situations in which medical practice is flawed and fails to deliver care and cure. This chapter argued that the doctor-narrator acquires agency in his/her memoir through the voicing of a critique of medical practice and by simultaneously engaging global and local contexts of medical science/knowledge. The doctor is thus insinuated in a "community" by emphasizing his/her continuing viability in terms of emphasizing the ethical dimensions of medical practice and its shortcomings while engaging closely with a "localized" and "intimate" practice of healing patients.

Chapter six on "Narrative Society" studied the construction of such a society via Gawande's *Complications*, Verghese's *My Own Country*, Sandeep Jauhar's *Intern: A Doctor's Initiation* and Noshir H. Antia's *A Life of Change: The Autobiography of a Doctor*. In addition this chapter examined the use of "particular" narratives of disease/illness in several medical documentaries - *AIDS, Sexually Transmitted Diseases, Alcohol-The Killer, Preventing Anaemia through Nutrition, There is Life for Selvi, Sanctuary of the Ostracized, Controlling Leprosy, H1N1 Swine Flu: Few Facts, Saying it Again* and *Conquest of Cancer* among others. This chapter argued that the "narrative society" constructed by the doctor-narrator in the medical *Bildungsroman* with a view of individual patients *as* "stories" emphasizes the therapeutic value of narrating "stories". These "individuals" or "stories" are integrated, this chapter illustrated, in a particularized "story" of healing narrated by the doctor, to present a unified, social "self" that is attentive to the ethical dimensions of medical narrative. This chapter also demonstrated that the politics of visualizing particular instances of disease in the medical documentary moves between two poles – the scientific and the affective. The "particular" accounts of disease visualized in the medical documentary constructs a "pathological" lens with which to view *all* bodies as vulnerable to disease. This is achieved, this chapter argued, through a reliance on scientific, indexical modes of representing disease and their seamless integration with a sentimental or affective narrative that visualizes the individual's social embeddedness.

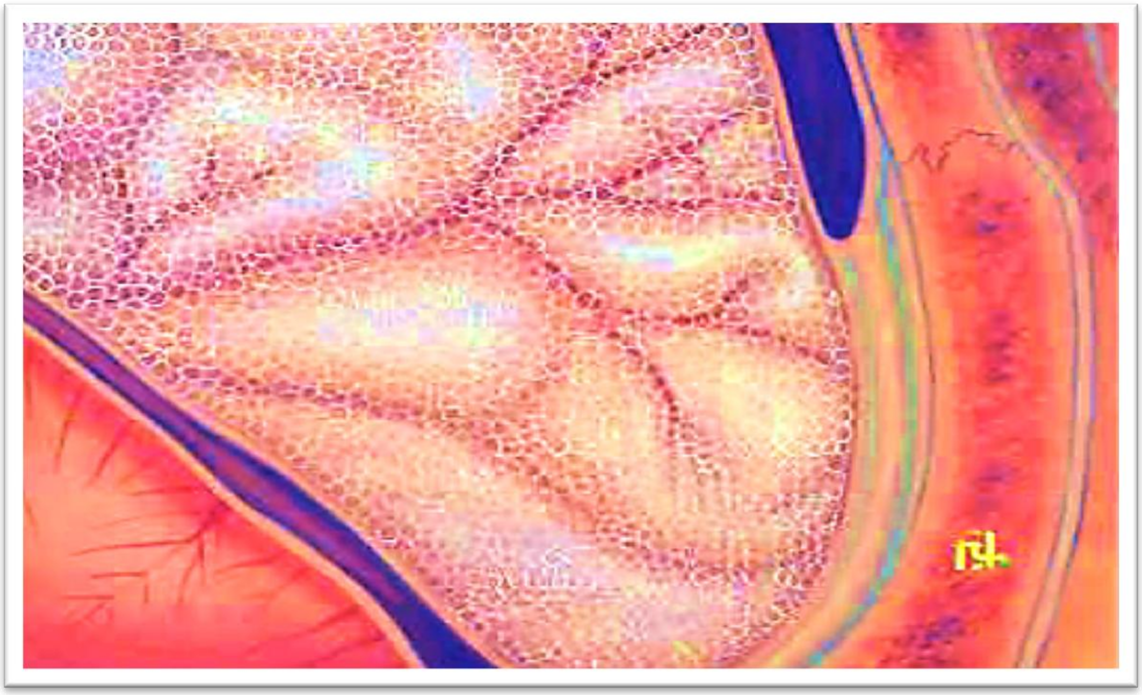


Fig. 1. Illustration of anatomically correct (normal) brain cells in *Alcohol-The Killer*.

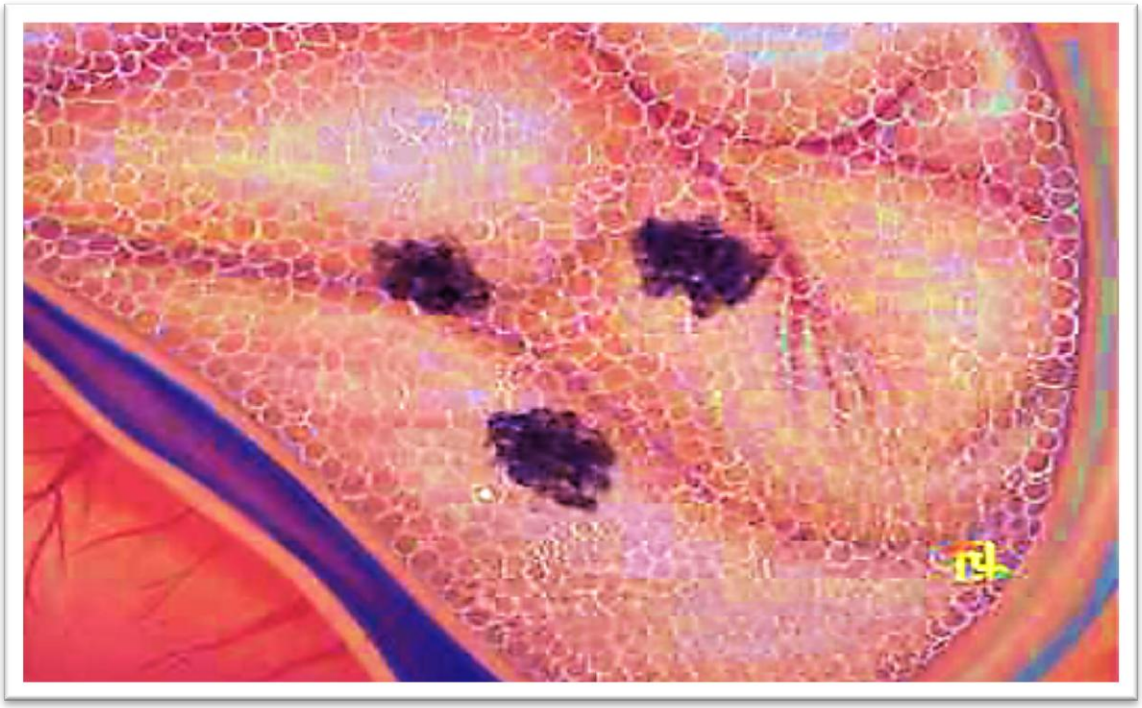


Fig. 2. Demonstration of the effects of alcohol on normal brain cells in *Alcohol-The Killer*.

Fig. 3. One of several images of the incidence of alcohol consumption in the population, in *Alcohol-The Killer*.

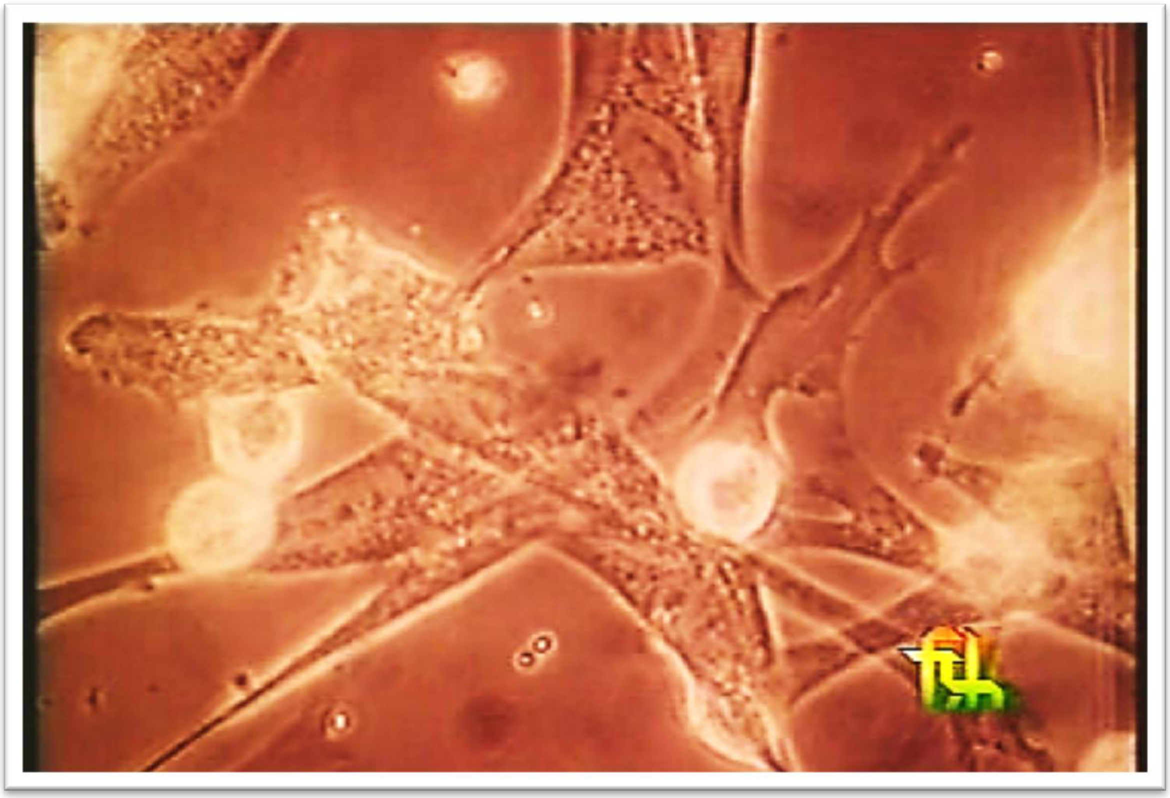


Fig. 4. Microscopic visualization of normal cell division in *Conquest of Cancer*.

Fig. 5. Visualizing the risks of tobacco use in *Cancer*.

Fig. 6. A medical professional explains the spread of and precautionary measures to be undertaken for the H1N1 virus in *H1N1 Flu – Few Facts*.

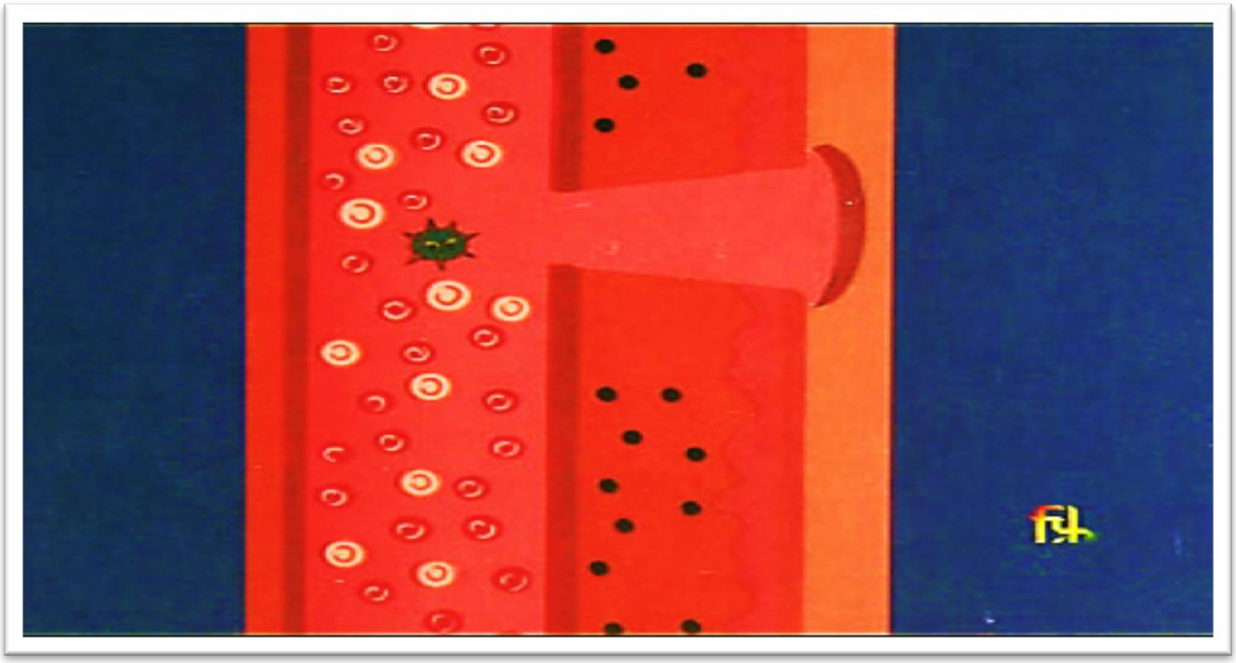


Fig. 7. Animated sequence illustrating the entry of the AIDS virus into the body in *Saying it Again*. Seen here is an illustration of the otherwise "invisible" AIDS virus, outnumbered by "fighter" white blood cells.

Fig. 8. Here, the white blood cells are seen to be rapidly diminishing, with the identity of the "unknown" invader being established with the letter "A" that signifies AIDS, in *Saying it Again*.

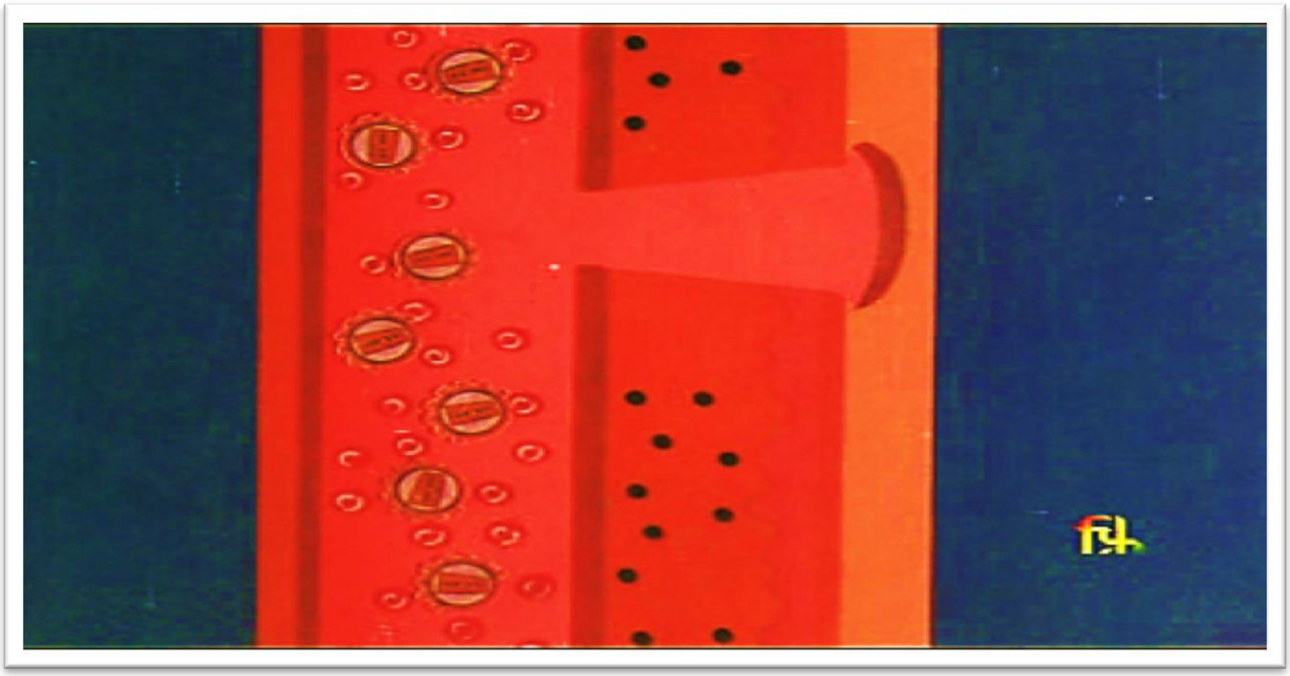


Fig. 9. White blood cells are completely absent here and the virus "A" rapidly proliferates in *Saying it Again*.

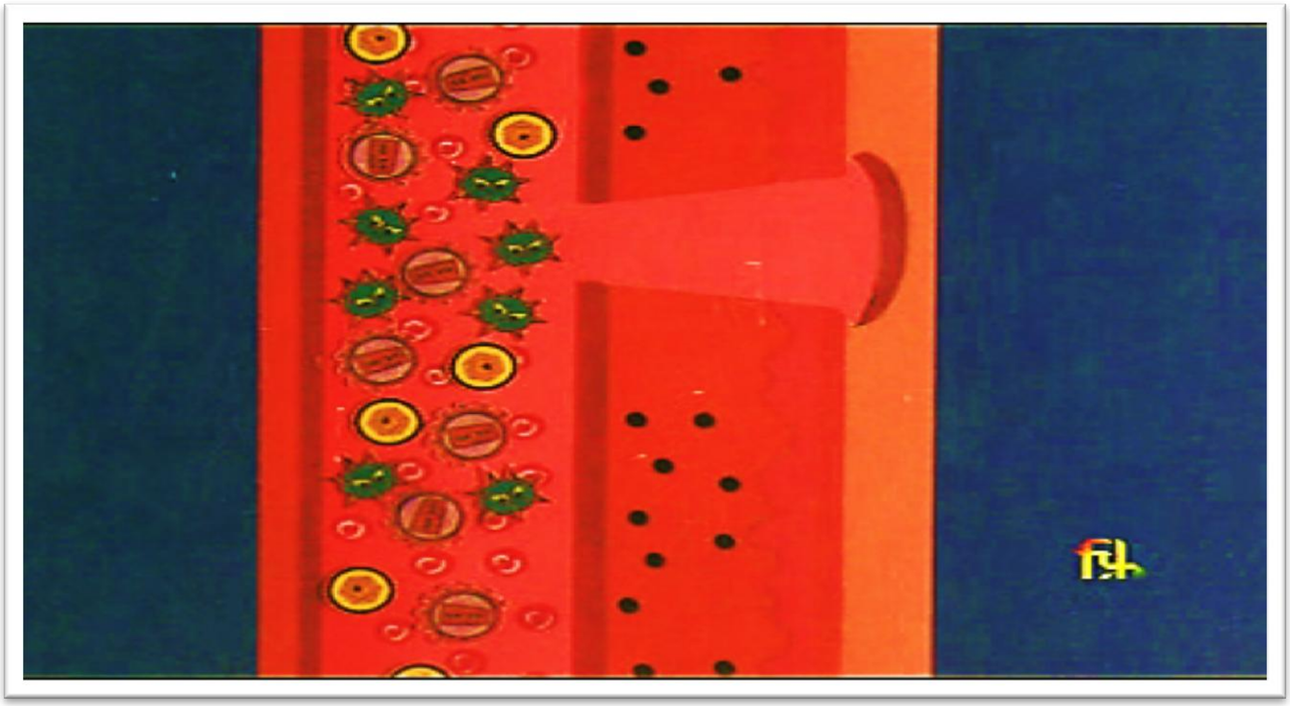
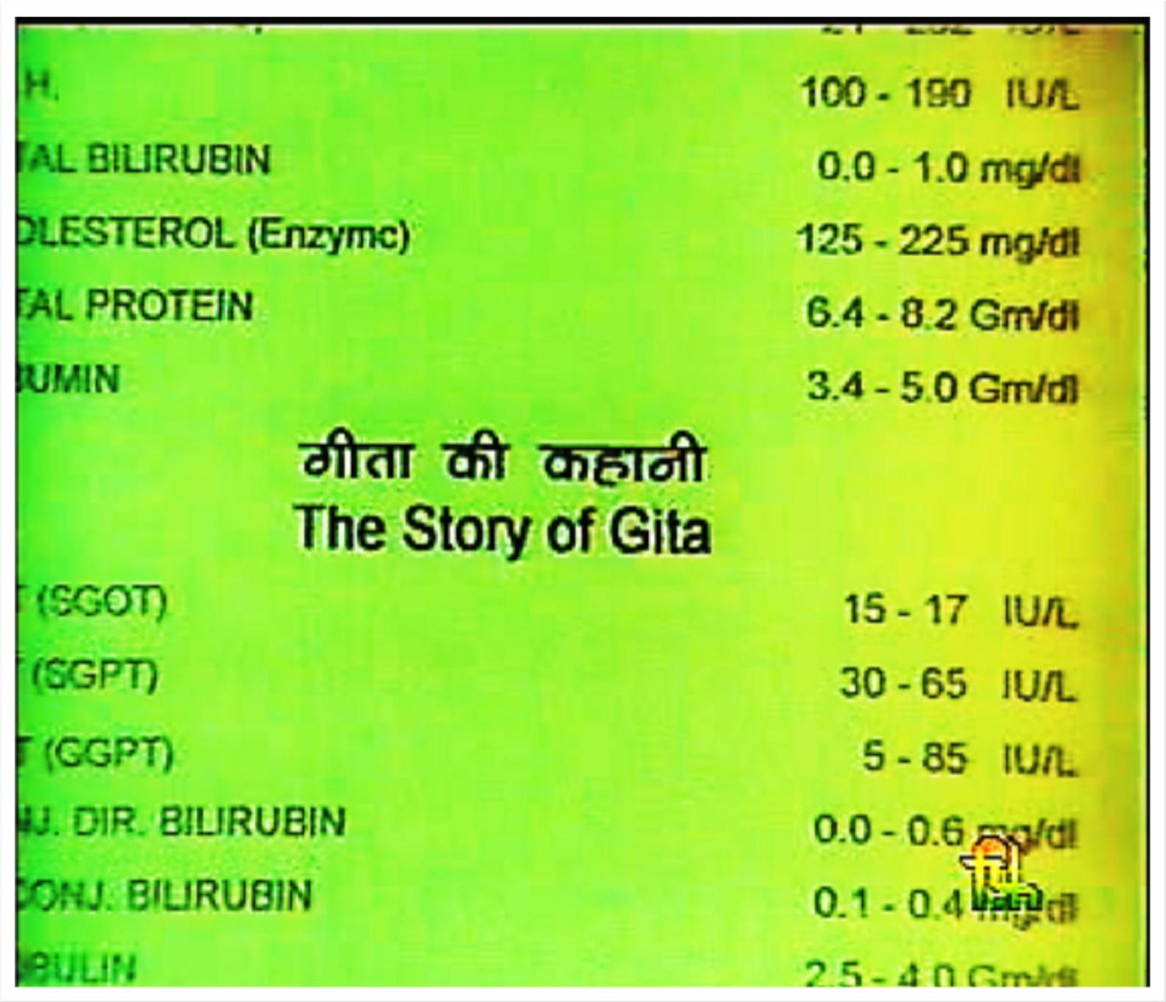


Fig. 10. The body, now rendered defenseless by the entry of AIDS, is teeming with various opportunistic pathogenic invaders in *Saying it Again*.

Fig. 11. The "spectacle" of the ailing body in *Cancer*.



H.	100 - 190 IU/L
AL BILIRUBIN	0.0 - 1.0 mg/dl
LESTEROL (Enzymc)	125 - 225 mg/dl
AL PROTEIN	6.4 - 8.2 Gm/dl
UMIN	3.4 - 5.0 Gm/dl

गीता की कहानी
The Story of Gita

(SGOT)	15 - 17 IU/L
(SGPT)	30 - 65 IU/L
(GGPT)	5 - 85 IU/L
J. DIR. BILIRUBIN	0.0 - 0.6 mg/dl
ONJ. BILIRUBIN	0.1 - 0.4 mg/dl
BULIN	2.5 - 4.0 Gm/dl

Fig. 12. ***The Story of Gita*** **visualized in the title credits as being encapsulated by the medical report.**

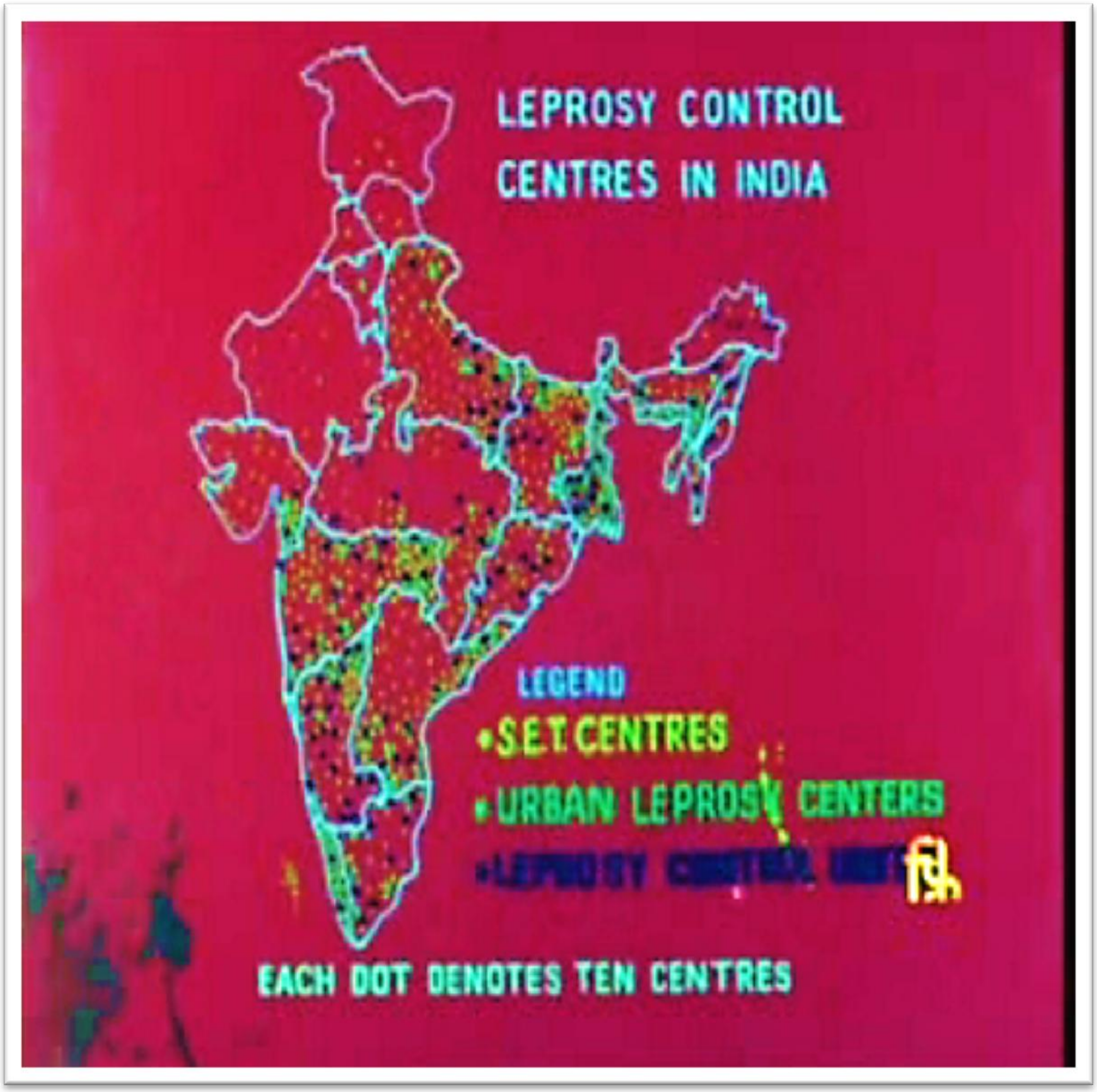


Fig. 13. ***Controlling Leprosy*: Visualizing and materializing the state's efforts in leprosy management and cure.**

Fig. 14. Visualizing the dangerous, contagious carrier of leprosy, in *Controlling Leprosy*. The danger in an accidental encounter with him is exacerbated by his relative anonymity.

Fig. 15. ***Mask: A Protection*****: The “performance” of responsible citizenship in the face of the Swine Flu epidemic.**

Fig. 16. ***Cancer*****: Tobacco habits harming the health of others. Here, rather than the smoker himself, it is the "passive" smoker in the vicinity who appears in great distress.**

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