Violence, Care, Cure

Self/perceptions within the Medical Encounter

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Introduction

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Introduction

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In the desktop documentary 'Watching *The Pain of Others*' (2018), French researcher and filmmaker Chloé Galibert-Laîné tries to make sense of their uncomfortable experience watching Penny Lane's *The Pain of Others* (2018), a documentary film that assembles footage about Morgellons disease. The latter is a 'perplexing' and 'poorly understood' skin condition involving the spontaneous appearance of 'ulcerative skin lesions that contain unusual filaments lying under, embedded in, or projecting from the skin' (Middelveen et al. 2018, 71). In the film, Lane makes use of fragments from videos by three famous YouTubers with Morgellons, to which she interposes excerpts with medical experts. As Galibert-Laîné remarks, the film seems to be built around two parallel narrative arcs: the first one is that of the three YouTubers – Carrie, Tasha, and Marcia – whose stories, initially believable, become more and more improbable as the film advances and the camera obsessively moves closer and closer to the skin's pores; conversely, the second narrative includes excerpts in which doctors' statements lead the viewer from doubting the reality of the illness towards starting to take the patients seriously. The ambivalence of the disease is further increased by the nature of its peculiar alleged means of contagion, since the women purportedly developed their symptoms when exposed to images of the skin lesions on social media. Galibert-Laîné themselves, at the end of the video essay, suspiciously looks at a little wound on their leg, critically interrogating the power of empathy, which is far from neutral. Reflecting on their own experience as a viewer, Galibert-Laîné posits that Lane's film invites spectators to 'formulate their own diagnostic' and to either believe 'the disembodied voice of Science' or the intimate evidence provided by the women, whose only expertise is their bodily experience and self-observation. As the video essay progresses, and with it also Galibert-Laîné's meta-reflexive investigation, viewers are compelled to ponder the legitimacy of lived experience, the supposed objectivity of medicine as well as its gender bias, the scrutiny to which we subject our bodies as 'other' from us, the limits of empathy, and the exhibitionist, voyeuristic drive that morphs illness into a social encounter(/experience).

'Watching *The Pain of Others*' was of great inspiration when we started conceiving the conference 'Violence, Care, Cure: (Self-)perceptions within the medical encounter' (ICI Berlin 2022), which is at the basis of this collected volume (Figure 0.1). As we were reasoning on the ambivalence between violence and care,

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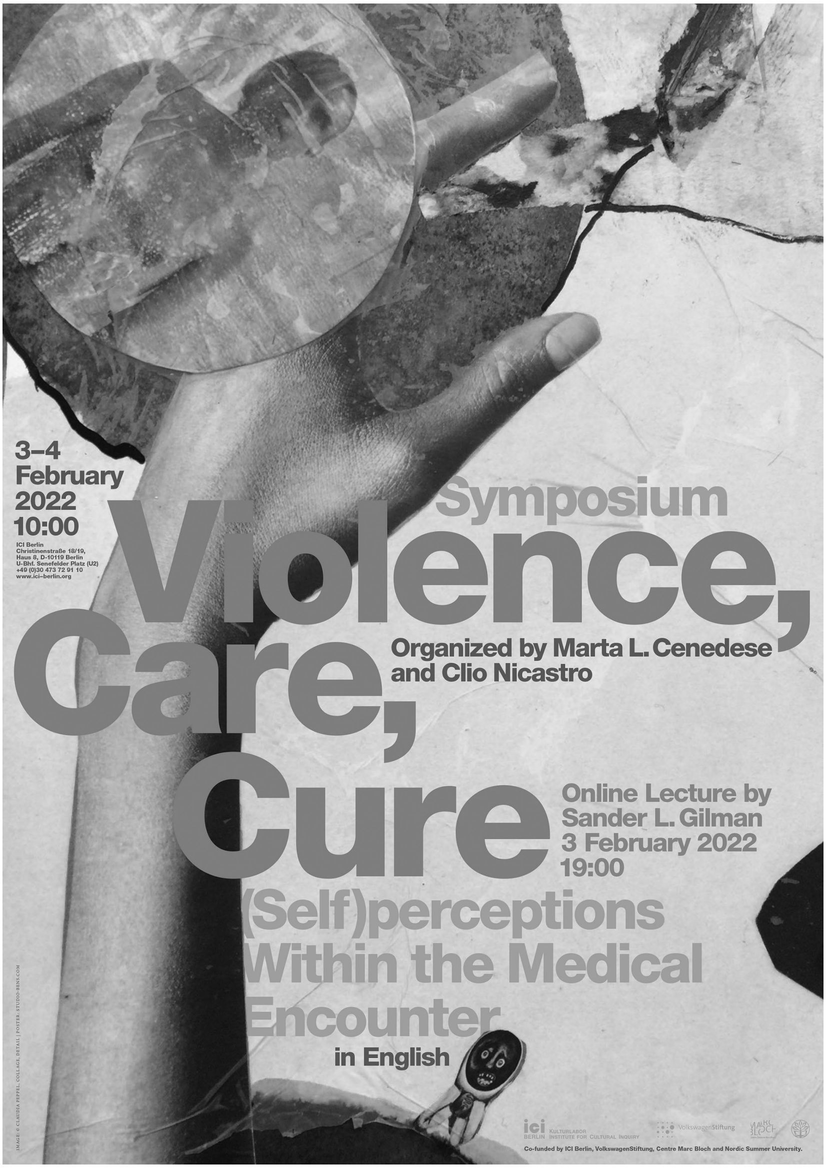

Figure 0.1 Poster of the conference *Violence, Care, Cure*. Image credit © Claudia Peppel, 'Who's afraid of…?', paper collage, 2013 (detail), poster design: Studio BENS.

and care and cure, in stories of illness and medicine *tout court*, Galibert-Laîné's video essay helped us to reflect in more complex ways and consider possible ramifications outside of our own disciplinary fields (philosophy and literary/cultural studies). It also provided us with an anchor to the most immediate socio-political event of the early 2020s, the COVID-19 pandemic, which inevitably influenced our need to confront the polarising climate, between conspiracy and security, and life and death, that we were living through. Aside from one contribution, however, we have chosen to let the pandemic take a backseat in the volume, in order to privilege other *cases* that illuminate the intersections between violence, care, and cure. Here, we borrow Lauren Berlant's (2007, 633) description of 'a case', which is not necessarily and not merely an illustrative example of an already existing more general issue but 'a problem-event that has animated some kind of judgement'.[1] Indeed, Berlant (2007, 633) makes a long and heterogeneous list of cases – from symptoms to crimes – that recognise as their common denominator 'an irritating obstacle to clarity'. The variety of fields and approaches included in this volume mirrors Berlant's idea of 'a case' in exploring the several forms and situations in which violence, care, and cure can intersect within the medical realm. In this respect, Galibert-Laîné's 'Watching *The Pain of Others*' encapsulates several of the themes that are discussed in this book: besides the three main concepts that give the collection its title, it deals with bodily experience, medical neglect or scepticism, biopolitics, ethics, pain and suffering, diagnosis and recovery, gender medicine, epistemic injustice, and the role of images and other narratives, including social media platforms.

Where the three concepts meet: A glossary

Violence: Lacking a preconceived definition in order to remain receptive and open to complexity, the volume suggests a conceptualisation of violence that is necessarily broad and that, significantly, views violence as an instrument of power (see, e.g., Bourdieu 1977, 2001; Foucault 1982; Žižek 2008; Dorlin 2019; Vergès 2020). In this volume, violence stands not only as the act of inflicting harm or injury on an individual or a group (physical and psychological violence), but also as a mode of constructing individuals, communities, and the world (symbolic and systemic violence). We do not posit that violence is inherent to science and/or to the medical encounter but rather that it emerges from the intersection of the social relations, performative activities, and structures of power (both symbolic and material) that permeate such institutions. While we acknowledge arguments about the inherent potential of violence within language, narratives, and sense-making practices (e.g., Bourdieu 1991; Levinas 1987; Derrida 1997), we contend that to name, to tell, and to make visible are essential for 'finding nonviolent ways of understanding subject formation and embodied life' (Fareld 2022, 189). The potential violence of language and scientific discourse is at the centre of Lisa Schmidt-Herzog's contribution (Chapter 7), in which she questions the neglect of Frantz Fanon's work in the medical and psy disciplines. According to Schmidt-Herzog, this effacement is due to the rigid relation between language and epistemic structures, which Fanon's work – uniting the poetic, the scientific, and the political – subverts and dismantles. The recent heated debate surrounding Giorgio Agamben's (2020) position against the restrictive measures adopted during the COVID-19 pandemic – especially in Italy where the philosopher lives – has reignited scrutiny of the role of 'biopolitics'. Foucauldian scholar Daniele Lorenzini (2021a, 2021b) argues that 'biopolitics' primarily functions as a descriptive tool for grasping the present and does not inherently imply an obscure or necessarily dangerous form of power. What is especially relevant for this volume is what Lorenzini (2021b, 42) terms the '(bio)politics of differential vulnerability', which highlights how the unprecedented exacerbation of social inequalities intensified by the pandemic is much more urgent to observe and to fight than a health dictatorship. In this sense, the health crisis has produced a range of new vulnerabilities and new social inequalities as a way of governing people; according to Lorenzini, this phenomenon is not limited to instances where the statistical impact of the coronavirus (and associated deaths) correlates with variables such as social class, salary, and race but extends globally, with the distribution of vaccinations following geopolitical logics. Xenia Chiaramonte (Chapter 3) shares the same concern in wanting to retrace the original meaning of biopolitics as used by Foucault to find a valuable analytical framework for a cogent approach to the relationship between medicine and power dynamics.

The above considerations shed light upon the different scales that appear when mapping the points of juncture between violence, care, and cure. In a volume concerned with 'medical encounters', it comes as no surprise that the micro dimension[2] coincides with the *body* as, to use a contentious metaphor, the 'battlefield' where wounding and caring occur:

> The body implies mortality, vulnerability, agency: the skin and the flesh expose us to the gaze of others, but also to touch, and to violence, and bodies put us at risk of becoming the agency and instrument of all these as well.
> (Butler 2004, 26)

In his seminal work on migraines, Oliver Sacks navigates the different explanations and remedies for one of the most mysterious yet common disorders of the nervous system – one that afflicts millions of people.[3] After a thorough examination of the main types of migraines and the prevalent treatments against them, Sacks (1995, 234) concludes that there is only one cardinal rule to deal with the diagnostic challenges of migraines: 'one must always listen to the patient'. At least at the time Sacks completed his research, migraine patients had a frequent second complaint beside their pain, namely, that of not being listened to by physicians: 'Looked at, investigated, drugged, charged: but not listened to' (Sacks 1995, 234). Novalis has famously and poignantly considered disease as a musical problem, whose cure is a musical solution,[4] which definitely offers a generative metaphor to move away from the visual fields of the medical gaze. Since the 1970s, when Sacks published his above-mentioned book, significant changes have undeniably occurred in the interaction between doctors and patients. These have undoubtedly been aided by the work of authors such as French-Canadian doctor Martin Winckler (1989, 1998, 2004, 2009, 2016, 2019) as well as by over two decades of research and dissemination of narrative medicine (Charon 2006; Charon et al. 2017), the recent yet long history of which is the focus of Sander L. Gilman's afterword to this volume. Nonetheless, in many countries, the recent implementation of healthcare cuts (as well as inflation) has impeded the practical application of awareness regarding the importance of listening: despite the ‘lessons’ of the COVID-19 pandemic, in the public sector healthcare workers are poorly paid, overworked, and understaffed.[5] We, of course, do not want to oversimplify or idealise the dialogical dimension of the medical encounter; instead, we have sought to compile various instances that consider intentional, unintentional, systemic, and/or individual forms of misunderstanding. The latter plays a crucial role in a study by German medical historian and scholar of Gender Studies, Barbara Duden, which productively resonates with Galibert-Laîné’s video essay. Another medium, another land, another time in history—yet the question remains similar: what does it mean within the medical encounter to take someone at their word? This is a question that is also behind Maria Morata’s ‘performative text’ (Chapter 12), where she confronts the absence of visual indicators for pain – especially chronic pain – and the power structures behind vision machines used by medical imaging technology.

By delving into the records of eighteenth-century German gynaecologist Johann Storch, who carefully transcribed how his female patients described their symptoms, Duden (1991) aims to understand how women from another time perceived their bodies and talked about their different bodily manifestations before anatomy reconfigured and remapped sensations, as Foucault notably discusses in *The Birth of the Clinic* (1963). Duden praises women’s organic metaphors for allowing access to a richer and painful intertwining between bodily symptoms, feelings, and (often abusive) relationships with men. Defining herself as the first ‘historian of the body’ in the early 1990s, Duden wished to overcome the opposition between the body as a series of natural, biological, stable, and unchanging phenomena, and the socio-historical dimensions of ever-changing life. An example of this would be the fear of solidification of blood, the movement and flow of which comprise a central element in women’s complaints and therefore became a key concept for Duden’s study. The fixation on expulsion to cure a disease reflected the theory that emotions can get trapped inside the organs; for instance, a heavy stomach was considered to be the consequence of anger, which could be released and cleansed by rhubarb. Duden is here fascinated by the connection between the mental and the physical, which together constituted the fabric of experiences and sensations, and by the role of Storch’s patients in apprehending the origin of the interpretative power of the natural sciences and medicine (Duden and Schminke 2019). Hannah Parlett’s addition to this volume (Chapter 10) is, in this respect, a fascinating travel into the director Pedro Almodóvar’s obsession of the body, showing anatomy as both a medical practice and a fantasy about the inner lives of organs and tissues. Parlett analyses salient scenes of Almodóvar’s films that depict the encounter between patient and physician, while at the same time revealing the historical interconnection between the cinematic and medical gaze.

Care: We understand *care* as a concept that holds ethico-political import – both as tangible labour and as a political and cultural construction. We are aware that over the last years the term ‘care’ has been widely circulating in academia and in the art field, almost becoming a buzzword that can easily fit the neoliberal discourse. Yet, not only do we want to follow German filmmaker Harun Farocki’s suggestion that one should not hand a notion over to the enemy but rather reclaim it (Farocki 2008, 21–22), we also wish to add a new perspective on care by reading it in constellation with violence and cure. In doing so, we want to call into question the neutrality of caring. Therefore, we hold simultaneously broad definitions, such as ‘a species activity that includes everything that we do to maintain, continue, and repair our “world” so that we can live in it as well as possible’ (Tronto and Fisher, in Tronto 1993, 103) and ‘a critical theory that denounces and exposes the processes through which caring for the most vulnerable has become marginalized, and through which the recognition of care-related practices, people, and institutions has been undermined’ (Brugère 2019, 59). As a notion and a praxis, care precedes Western academic interest; however, theories of care originate within the North American feminist, civil rights, and liberation movements of the 1960s and 1970s (Fine and Tronto 2020, 302). Foundational in the field are Carol Gilligan’s *In a* Different Voice (1982) and Joan Tronto’s *Moral Boundaries: A Political Argument for an Ethic of* Care (1993), which brought subaltern voices to matter for moral and political theory, and thus turned *care* into a critical political concept (Laugier 2011, 185). In *Moral Boundaries*, Tronto (1993, 136) argues that care has a role in our everyday life as a *practice*; in this regard, she identifies four phases, each of which defines a particular quality of what caring entails: ‘attentiveness, responsibility, competence, and responsiveness’. To these qualities of an ethics of care, in *Who Cares? How to Reshape a Democratic Politics*, Tronto (2015, 14) subsequently adds a fifth element, ‘caring with’, which she sees as essential for building a caring democracy that ‘imagines the entire polity of citizens engaged in a lifetime of commitment to and benefiting from these principles’. The ethical tension between the personal and political dimensions of care are thematised in this volume by Rachel Pafe (Chapter 9), who looks at how Hungarian-American writer and thinker Susan Taubes engages with Simone Weil, whose critique of modern violence she appreciates while at the same time still challenging the idea of a total solution to suffering. This chapter contends that the unresolved tension between Taubes and Weil raises crucial questions about the communal dimensions of an ethics to address suffering within the realm of political life. Taking a cue from Tronto’s encompassing understanding of care as ‘not restricted to human interactions’ (see Tronto 1993, 103 ff.), María Puig de la Bellacasa (2017, 1) has more recently explored the relevance of care ‘for thinking and living in more than human worlds’. In this volume, Nora Heidorn’s thinking with and about historical objects (Chapter 1) is framed in terms of Puig de la Bellacasa’s ethics of care. As Heidorn (35) writes, ‘all kinds of objects and artefacts – “things” – could become Matters of Care through caring and critical attention to what they represent and what they do in the world’. Puig de la Bellacasa’s (2017, 5–12) conception of care retains the tension between its ontological dimensions (affective, practical, ethico-political) in order to stay with its potential to disrupt and displace.

As these feminist thinkers, among many others, show, an ethics of care stresses relationality, vulnerability, and interdependence, and therefore is ‘always about power’ (Tronto 2020, 185), yet it is also about imagination (Fleury 2019, 11). Imagination is at the core of Myriam Sauer’s contribution (Chapter 13), where, by blending fiction and theory, she emphasises the fantasies (in their psychoanalytical sense) produced by gender dysphoria, a wound that can never be completely sutured. Within a medical context, Cynthia Fleury observes, ‘Care is a shared function, arising from the dialectical, creative alliance of caregivers and care-receivers, who, together, open up to a unique dynamic that is woven thanks to the specificity of their own subjectivity’.[6] And Annemarie Mol (2008, 6) reminds that care is ‘not opposed to, but includes, technology’.

Cure: As we have seen above, the concepts of both violence and care have been amply discussed from a variety of disciplinary fields, and several prominent scholars have written about them. Yet, what motivates this volume is the lack of scholarship engaging with both at the same time – that is, with the ambiguities of care and its overlaps with different forms of violence. Even more profoundly, these works overlook a space that, we believe, marks a primary stage for their conflicting intersections: the medical setting and encounter. By these terms, we do not mean solely the doctor–patient encounter at the hospital/clinical space; instead, we refer to a variety of spatio-temporal contact zones that, beyond the consulting room, also include bureaucratic systems, artistic venues, and the discursive space or the digital sphere – as well as all the in/corporeal agents involved. In this respect, we follow Anne Whitehead and Angela Woods (2016, 2), who call to expand and ‘re-envisage’ the ‘primal scene’ of the medical humanities to include the exploration of ‘new scenes and sites’ outside of medical institutions – those that are potentially ‘occluded from view’ and that may prompt ‘more critical questions’.

Two important notions that emerge within this encounter, and that underscore the mismatch that often arises between the medical gaze (Foucault 1963) and the individual’s gaze in the face of the same event, are those of ‘disease’ and ‘illness’. Once established, the distinction between the two shifted the focus from the official descriptions and definitions of syndromes (their scientific/medical classification) to the individual’s experiences and articulations of them (see, e.g., Kleinman 1988; Toombs 1992; Frank 1995). Particularly salient for this volume is Sander L. Gilman’s (1995) work, whereby he distinguishes between ‘illness’ as the subjective experience of a condition that affects (to a greater or lesser extent) the physical and mental health of an individual, and ‘disease’ as a medical category that emerges within a given historical and cultural context and offers a model for understanding and treating a certain constellation of symptoms. The latter, therefore, corresponds to a social construction and not to a mere label, thus suggesting an approach that seeks to take distance from both dogmatic scientism and relativism. The perception of a symptom is not necessarily ‘truer’ than its scientific description because symptoms are, most often, an expression of the psychosomatic relationship between the physical and the psychic. Aware of the inevitable interaction between the two dimensions of illness, as an experience (‘illness’) and as a category (‘disease’), Gilman is particularly interested in their distinction when he investigates the relationship between images and medical science, which, in his opinion, the history of medicine has long underestimated and not fully understood in all its complexity. For Gilman, the presence of such images throughout history suggests a tension between the real and the imagined, and therefore tells us about the social construction of diseases, especially chronic and contagious ones (1988). As shown above in our discussion of Duden's work, the ways diseases have been portrayed with words and images have also affected the (self-)perception of the body through history.

At the same time, however, the distinction between 'illness' and 'disease' has also highlighted the gulf (and incommunicability) between the patient's experience and the physician's understanding of it (see Toombs 1992, 11). This aspect, in particular, is concerned with the flawed equivalence between cure and care (see Mol 2008, 1–2), and especially cracks open the prescriptive and linear assumption that after 'diagnosis', a cure will channel a 'recovery' towards 'health'. Phenomenologist S. Kay Toombs (1992, 112) explains, 'If the end of the medical encounter is defined solely in terms of diagnosis and cure of the "disease," the suffering of those with chronic illness seems intractable. The focus on "cure" suggests that the physician has little to offer the person who is incurably ill'. Toombs (1992, 114) goes on to add that

> If "cure" is perceived to be the goal, disease is the enemy and the patient's body the battlefield. The emphasis is on winning the war, whatever the cost. The "disease" is confronted as an abstract entity residing in, but in some way separate from the one who is ill.

The 'curing function' of medicine is thus opposed to its 'healing function'. Here, cure implies a normative expectation of recovery as returning to the original healthy body (i.e., prior the disease derailed its normative functioning); on the contrary, healing encompasses an understanding of the body as lived. The former, normative conception of 'cure' has also been challenged by disability studies scholars: Alison Kafer (2013, 27–28), for instance, speaks of 'curative time' and 'curative imaginary' to designate a temporal framing that, by normalising 'the dominant narrative of progress', casts disabled people aside, leaves out addictions and chronic diseases, eliminates any form of impairment, and assumes the imperative of treatment. Instead, recovery is not a linear return to a pre-fixed state of absolute and universal health (i.e., identical to a 'before' comparable for everybody and which, according to Kafer (2013, 27), is concerned with 'compulsory able-bodiedness/able-mindedness') and health is commensurate to one's temporally fluctuating abilities (Woods et al. 2022; Cheston et al. 2025). Healing implies the 'mourning' of recovery identified as a return to a prior state (Canguilhem 1966) and the shift towards a perspective of continuum between living with and without illness (Fleury 2019, 29, 31). As Xenia Chiaramonte writes in this volume, 'illness is not measured as a deviation from pre-established norms; it is a change in the quality of life' (69).

Individuals and communities: The privileged perspective of the patient's experience has contributed to the rise of prominence of scholarship on stories of illness, which the 'narrative turn' of the 1990s certainly nurtured. Anne Hunsaker Hawkins (1999), for instance, coined the term *pathographies* to address discrete illness narratives. Narratives, broadly construed, allow the ill person to reconfigure and reorganise their experience at a time of, as Silvia Pierosara writes in this volume, 'loss of personal and moral autonomy' (152). Such loss, Pierosara notes in her contribution (Chapter 8), can become an incentive to reconstruct meaning and, therefore, it calls for a different kind of autonomy – *narrative autonomy* – through a process of mutual reliance between the patient and care network which demands acting with 'narrative humility' (DasGupta 2008). In this volume, we continue to foster the production of individual stories of 'medical encounters'; however, their forms challenge canonical tropes of linearity and coherence and instead offer new, performative, episodic narrations interlaced with rigorous critical, theoretical, and reflective examination. For instance, in this book – besides Sauer's previously mentioned exploration of the lived experience of gender dysphoria through an exchange between poetic and theoretic modes of expression and Maria Morata's attempt to represent on the written page her performative account of her life with chronic pain – we find Claude Kempen's praxiographic autoethnography, which, drawing on their personal experience of transitioning in Germany as a non-binary person and making use of their own insurance-purposed medical records, theorises 'trans as gap' and revels in its vastness and multiplicity (Chapter 11).

Nonetheless, we are also cognisant of the criticism towards an emphasis on the individual, which oftentimes is not fully integrated into the larger structures and contexts that accompany illness and medical practice in general (see, e.g., Woods 2011; Wasson 2018). In her book *The Logic of Care. Health and the Problem of Patient Choice*, Annemarie Mol (2008) explores how the 'individual' and the 'collective' are related in the context of healthcare, and suggests that a logic of care starts with collectives. Individuals do not aggregate into a collective based on already present, fixed categories; rather, they first belong to collectives that, within a 'logic of care' (as opposed to a 'logic of choice'), are horizontally categorised and differentiated (Mol 2008, 66–83). And indeed, the above-mentioned chapters are not mere individual accounts but rather stories entangled with social phenomena and structures. They are 'collective narratives' in a double sense: they are inextricable from their context, made up of more than the simple individual, embedded in institutional and social interdependence, as well as aided and upheld by different groups and communities (see, e.g., Kempen; Morata); they are shared here as part of a communal practice of making visible. This attention – turned towards the peripheral to spotlight who and what the institutions discard and communities marginalise, and the loss entailed by this exclusionary logic – is present in Janina Klement's (Chapter 5) and Sophia Rohwetter's (Chapter 6) contributions, which aim to broaden the frame of anti-psychiatry. Whereas Klement thoroughly digs into R.D. Laing's practice as a psychiatrist who created new therapeutic strategies and considered schizophrenia a social event, Rohwetter's chapter delves into the Italian radical psychiatry movement of the late 1970s, revealing how, in its encounter with proletarian struggles, feminist politics of sexual difference, and avant-garde counterculture, the psychiatric scene underwent a transformation, becoming a contested social site that was amplified and mediated by audio-visual media.

Invoking shared experiences, however, does not imply the existence of a universal 'we' that, similarly to Mol's (2008) 'logic of choice', entails 'inclusion in some already constituted thing or entity' (Mbembe 2019, 40). Whereas 'universal' stands in as a vague synonym for a (Eurocentric) exclusionary system that, de facto, ideologically serves the superior position of the enlightened Western world (Suaudeau and Niang 2022), here we privilege a 'we' that fosters what is 'in-common', which, according to Achille Mbembe (2019, 40), 'presupposes a relation of co-belonging and sharing'. At the opening of her video essay 'Watching *The Pain of Others*' (2018), Chloé Galibert-Laîné includes a quotation from Susan Sontag's *Regarding the Pain of Others* (2003, 7): 'No "we" should be taken for granted when the subject is looking at other people's pain'. Similarly, and without denying its own subjectivity and positionality, 'we' in this book is not taken for granted but seen as fluid and flawed, relational and variegated, always in-the-making, and subject to question. Still, we are witness to how collective positionings are easily taken up in public discourse in order to separate between 'us' and 'them' in simplistic, essentialist, preconceived ways.

These issues have gained momentum with the outbreak of the COVID-19 pandemic. Yet, although the pandemic itself is referred to by only one of the volume's contributors (Dal Bo), the peculiar and often extreme ways in which it has been approached, and in which it has propelled categorical debates about violence, care, and cure, linger over the volume. Such a black-and-white opposition between internal/external, care/neglect, and cure/violence may seem reductionist; however, to engage with these seemingly contrasting attitudes reveals the genesis and features of a number of scientific dogmatic drifts, social and racial inequalities within healthcare systems, and idiosyncratic projections of individual and collective fears that often lead to stigmatising certain collectivities for the origin or transmission of a contagious disease. For instance, in this volume, Federico Dal Bo (Chapter 2) proposes a rich biopolitical analysis of a racist comment that a right-wing Italian politician made just before the pandemic hit Italy and Europe. In his chapter's incipit, Dal Bo refers to Sander L. Gilman's (2021) recent work about the COVID-19 pandemic and the resurgence of historical and sociological stereotypes in the naming and blaming of specific groups for the origin and transmission of infectious diseases. Looking at case studies of Ultra-Orthodox Jewish (Haredi) communities and the Chinese in the Popular Republic of China, Zhou Xun and Gilman (2021) explore the symbolic value of health and illness defined by the community and in defining the boundaries of communities, which are both impermeable and flexible. Public health measures, they write, may be necessary, but they also reinforce existing boundaries that provoke placing the blame on others: 'They may indeed save lives, but what kind of life? and whose life?' (Xun and Gilman 2021, 43).

Critical: Diving deep into a variety of case studies – such as the Black maternal mortality crisis (Banerjee), the blaming of a racialised group (Dal Bo), the anti-psychiatry movement (Klement and Rohwetter), gender dysphoria (Sauer), chronic pain (Morata), the collaboration between researchers and patients/health practitioners (Punzi et al., Woods), etc. – in this volume we address continuities among episodes of violence that highlight the structural rather than the exceptional, which confute claims of stability in favour of a long global history that reaches back to the early twentieth century. Thus, this volume is also a critical response to the COVID/post-COVID peak in violence – including within the medical setting.

Our wish is that, after reading the different contributions, readers will have better critical tools to understand the nuances at stake in the medical encounter, and be less inclined to take polarised positions – something that often happens when this topic is discussed in the public arena.

Finally, by examining the state of the art and testing its methodological boundaries, the volume also aims to provide, both directly and indirectly, a meta-reflection on the disciplines that fall under the umbrella of 'medical and health humanities'. Although not all contributors recognise their work as belonging to this field, several chapters (e.g. Banerjee, Heidorn, Punzi et al., Pierosara, Woods) directly interrogate certain approaches (whether established or emerging) at the core of the medical humanities – such as narrative medicine, visual medical humanities, engaged research, and collaborative research with non-academic partners – for their potentiality to unearth systemic bias, to open different possibilities of existence, and to make visible the complexity of objects and artefacts, as well as to caution against their possible pitfalls. In his afterword to the volume (Chapter 14), Sander L. Gilman offers an overview of the status of moral education and the role of the humanities in fulfilling this mission. As he argues, as the fortunes of the humanities slowly dwindled and collapsed, and skill-based education (i.e., STEM) took over, the medical humanities came to fill the moral gap of professional education. Gilman criticises the early naiveté of a field, especially in its declination as 'narrative medicine' (Charon 2001), for claiming that 'literature can teach empathy and that empathy is what was lacking in the training of physicians' (234). Similarly to Gilman's critique, the claim today that the humanities shape better people and thus better professionals would be disputed by many medical humanities scholars, including proponents of narrative medicine, whose development includes a heightened attention to the issue of social justice and, indeed, to forms of violence within the discipline (see, e.g., DasGupta 2017). For Gilman, the humanities act 'as a sort of contra-factual universe, the "as if" world' (241) that better serves as a means of orienting ourselves within the reality we inhabit, to test (and perhaps reinforce) 'our own blind spot and presupposition' (241):

> The humanities can add another dimension to the study and practice of medicine and vice versa. No stronger sense of moral virtue is implied unless we embed this moral goal in one or the other ways of imagining and shaping the world.
>
> (243)

All in all, we wish to offer a 'critical' lens on the discipline (as is the case for the *critical* medical humanities) to account for a field that is inherently fluid, mobile, ever-developing, and, in our opinion, critically attuned to fostering new avenues for research – whether thematic, theoretical, or methodological – that do not fear to reflect on and challenge its own forms and practices. In this regard, by including novel and provocative ideas and objects of analysis as well as forms of expression, the volume's chapters contribute to the growing scholarship concerned with a variety of non/narrative and non/linguistic forms that interrogate and convey the embodied experience of medical matters but also different methods, geographies, and territories of knowledge.

Coda

Overall, this edited volume addresses the notions of ‘violence’, ‘care’, and ‘cure’ within the medical encounter and seeks to foreground how, as a triad as well as individually, they are prone to ambiguous interpretations. Altogether, the book’s chapters – which are organised around four sections – attend to the complex interlacing of these three key terms and what to make of their entanglement by offering historical, practical, philosophical, personal, and aesthetic analyses of different medical scenes, objects, and concepts. As the book’s title infers, we argue that a hermeneutic of violence, care, and cure is inseparable from individual and collective perceptions of the medical encounter; that is, it is inextricable from an understanding of the tensions and consensus that surge among perceptions orchestrated by both internal (subjective) and external (social, cultural, political) ‘gazes’. In this book, we invite the reader to observe medical encounters that take place in and are shaped by a variety of both material and ‘immaterial’ spaces, from the consulting room to the antechamber of medical bureaucracy, and from artistic venues to biopolitical discourses. We engage here not only with the most apparent forms of medical violence but also with those hidden forms of aggression that circulate in everyday medical/health/care practices and settings, and which affect predominantly marginalised and minority groups. What individuals experience, at either end of the consultation room, is a complex intertwinement of personal vicissitudes, global structures, and community practices, a prismatic network in which ‘care’ and ‘violence’ are reflected and refracted in a variety of often overlapping and divergent interpretative modes. The interlacing of personal experience and critical reflection that the book engages with eschews the confessional mode and instead creates a productive distance that turns even more personal experiences into something worth sharing, and thus it allows readers to apprehend their own bodily and medical experiences in a new light.

As mentioned, the book is divided into four sections punctuated by four ‘musings’. These are short, thought-provoking pieces by established scholars in the field, which encapsulate the main ideas and questions this volume wishes to tackle – namely, the ambiguous, thorny, productive intertwinement of violence, care, and cure.[7] After this introduction, Mita Banerjee’s musing on colour-blindness in healthcare, and specifically within childbirth, leads us to the first part of the book, where Heidorn’s, Dal Bo’s, and Chiaramonte’s contributions engage with ‘Medical histories and biopolitics’. The following section, ‘Unsettling and working through practices and languages of cure’, brings together four contributions by Lena Ditte Nissen, Janina Klement, Sophia Rohwetter, and Lisa Schmidt-Herzog, which address different forms of therapeutic encounters for coping with social, historical, or psychological forms of violence. This part is introduced by Elisabeth Punzi, Helen Johansson, and Annica Engström, who reflect on how critical heritage studies and cooperation can serve as important means to counteract psychiatric violence. Drawing from Frantz Fanon's critique of objectification within the medical encounter in the colonial context, Daniele Lorenzini's musing builds a generative bridge from the second to the third section, 'Agency in illness and ethics of suffering', where Silvia Pierosara, Rachel Pafe, and Hannah Parlett inquire into how one can actively make sense of and react to conditions that generate overwhelming (physical and psychological) pain and loss of meaning. This part is concluded by Angela Woods' musing on her experience in co-directing the project 'Hearing the Voice' (University of Durham), where care emerges in terms of attention, investment, and ethical practice. To encourage a transformative approach to the issues we have tackled in this volume, we dedicate the last section, 'Anatomy of a transformation', to three contributions – by Claude Kempen, Maria Morata, and Myriam Sauer – that use imagination and performative practises of (self-)expression to overcome narrative and material gaps in the medical sphere. The book concludes with Sander L. Gilman's afterword where, as previously detailed, he takes a broader view to interrogate the role of the humanities within professional education, particularly when it pertains to physicians and healthcare workers.[8]

Overall, we hope that, in bringing together different methodological approaches, this volume will provide its readers with conceptual resources for thinking about the intersections of violence, care, and cure. By providing a space where the voices of both emerging and established scholars mingle and respond to one another, we hope to also encourage future scholars – highlighting novel areas of investigation; nurturing interdisciplinary thinking on the intersections between medicine and critical thinking; developing a medical understanding of the human at both individual and collective levels; and showcasing marginal creative and intellectual practices.

Notes

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1 Clio Nicastro is grateful to Tom Holert for bringing to her attention Berlant's concept in the context of the project *Terms and Conditions* (Harun Farocki Institut Berlin 2024–2025).
2 Here we refer to Asia Bazdyrieva's (2023) poignant reflection on scales of violence, divided into the macro, the meso, and the micro.
3 See https://www.who.int/news-room/fact-sheets/detail/headache-disorders.
4 Novalis, *Das allgemeine Brouillon*, entry 386, HKA 3, 310 (2007, 58).
5 See, e.g., https://www.lastampa.it/cronaca/2023/10/10/news/tagli_sanita_inflazione-13774265/; https://www.linkiesta.it/2023/08/sanita-italia-tagli-investimenti/ in the case of Italy. For the UK, see, for example, https://nhscuts.org.uk/about/; https://www.theguardian.com/society/article/2024/jul/23/nhs-finances-so-dire-that-whole-service-may-collapse-says-spending-watchdog.
6 'Le soin est une fonction en partage, relevant de l'alliance dialectique, créative, des soignants et soignés, qui, ensemble, font éclore une dynamique singulière, notamment tissée grâce à la spécificité des sujets qu'ils sont' (2019, 20). Translation from the French by Marta-Laura Cenedese.
7 At the conference held at ICI Berlin in February 2022, the authors of the four musings took part in a roundtable discussion that was conceived as a collective moment

to reflect on the main themes of the conference, as seen from the different disciplinary perspectives and experiences of the panelists.

8 At the conference, Sander L. Gilman gave the keynote lecture ‘Let’s Talk about Vaccination’ (3 February 2022). A recording is available on the ICI Berlin website: https://www.ici-berlin.org/events/lets-talk-about-vaccination/.

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