“When the dreadful steel was plunged into the breast”: Teaching Romantic Surgeons, Anatomists, and Bodysnatchers to Students in Health Sciences

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**Context, Demographics, and Structure**

At Duquesne University, I regularly teach a 300-level writing-intensive “Healthcare and Literature” class populated almost exclusively by sophomores and juniors enrolled in a Doctorate in Physical Therapy (DPT) program, which awards them a bachelor’s degree after 4 years and a doctorate after 6. My primary goal is for these students to articulate practical, professional takeaways from studying literary representations of illness and medical intervention. Thus, I prioritize relevance, foregrounding it on the first day of class and throughout the semester, frequently asking students, “What does this mean for you as future physical therapists?” I let them know that I have worked to align the class’s goals and their needs by considering their program’s outcomes. And I require them to reflect on how experiences of illness and expectations for healthcare professionals have changed over time. We extend our discussion into how wellbeing coexists with illness on separate yet parallel tracks. We read a narrative of illness, and we ask, “Despite how sick the patient was, what made that patient’s experience terrible? What made that patient’s experience uplifting? How did the healthcare provider affect that experience? How can the healthcare provider manage their own wellbeing to subsequently increase patient wellbeing?” These things are interconnected.

My “Healthcare and Literature” class is part of a trend in higher education: students majoring in health sciences are increasingly offered liberal arts courses designed to address humanistic issues that arise in their fields. Though at times the gap between literary studies and my students’ study of physical therapy has yawned wide, outcomes for the physical therapy program dovetail with literary and cultural studies’ investments in social justice, intersectionality, and careful reading. Indeed, this overlap is a hallmark of the medical humanities, which uses an interdisciplinary framework to bridge that imagined gap between medicine and literature. When we take a medical humanities approach, we draw from literature and art as well the social sciences to critically examine representations of medical education and medical practices. The college’s vision for the physical therapy program is outlined in their “Strategic Statements” document, which harmonizes with studies in the medical humanities by asking students to be “compassionate, culturally competent, and socially responsible reflective practitioners,” and “critical thinkers, life-long learners, healthcare educators … critical consumers of pertinent literature, and leaders in the profession” (“Strategic Statements”). In addition, the program’s learning outcomes emphasize “practic[ing] … in a competent, safe, ethical … reflective and professional manner,” “perform[ing] effective patient examination [and] evaluation,” “provid[ing] healthcare education to patients, clients, families, peers, and society, using culturally appropriate teaching methods,” and “demonstrate[ing] social responsibility and altruism” (“Outcomes”).

Clearly, the program stresses empathy and reflection. It also links textual literacy to interpersonal literacy. Professional acumen flows from the ability to interpret patients’ individual needs. Students are expected to understand that patients *and* practitioners are influenced by socio-cultural contexts and power-privilege dynamics; there is additionally an investment in holistic patient-centered care. My pedagogy, drawn from the medical humanities and narrative medicine, facilitates developing professional-personal critical reflection, altruism, interpersonal communication skills, and an awareness of the factors that affect hearing, telling, and developing care plans. Under the umbrella of the medical humanities, narrative medicine draws attention to the narratives that patients and practitioners construct. It also teaches students to interpret those narratives by thinking about things like word choice, mind-body relations, point of view, power, and context. I emphasize that skills in textual analysis are a personal-professional asset that will help students to hear patients and, by meeting them where they are, ensure that they are administering effective care.

In “Healthcare and Literature,” the classroom becomes a space of conceptualizing wellbeing. Our medical humanities approach invites students to imagine themselves as future practitioners, but more importantly, it requires students to consider the relevance of their emotions in the present. We confront difficult scenarios together as a class. We discuss and process those feelings to create emotional resilience, a *preparedness* that equips them to lean into hard emotions now, which may prevent burnout later. The class—capped at 18—is discussion driven and thematically organized, and transhistorical. Focusing on North American and Western European medicine and culture, students complete reading, in-class writing, and process-writing with individual guidance.[[1]](#footnote-1) I explain to students that our discussions will facilitate their awareness of humanistic issues in medical contexts past and present; improve literary analysis and close reading skills across genres; enable them to articulate their professional goals and values; and finally, set them up to write informal and formal essays.

Although I teach texts from many historical periods, there is good reason in “Healthcare and Literature” to discuss Romantic texts as a foundation and starting point because the Romantic era is an especially rich moment in medical history. At the time, for example, surgery suffered from low status as manual craft (i.e., the “sawbones”) compared to the more “cerebral” work of physicians. Pairing Romantic texts with contemporary ones also shows how medical attitudes change across time. Clusters of texts allow us to study how anatomy has been taught and learned; shifting attitudes towards mental illness and disability; different conceptualizations of pain and attitudes towards pain management; and individual articulations of how treatment can traumatize patients. In this vein, our texts include long and short fiction and medical texts, poetry and visual art. We end the semester with contemporary nonfiction written by medical professionals and a visit to the campus cadaver lab where students will perform a dissection during their fourth year.

Romantic texts that address medical topics are diverse, but I have found two texts especially useful for helping my students develop compassion and cultural awareness: Frances Burney’s journal letter, “Account from Paris of a Terrible Operation – 1812,” and an anonymous 1831 short story “The Victim” from *The New Monthly Magazine,* in which a medical student finds his friend’s fiancée on his dissection table. These works enable us to discuss aspects of healthcare that many students typically take for granted: that surgeons embody the pinnacle of expertise and manual dexterity, and that dissection and human anatomy are foundations for medical knowledge. As we engage both of these texts, historical distance allows students to safely express shock or anger and to openly criticize the practitioners as well as the “barbarism” of medicine. Students begin to probe their assumptions about professionalism, patients’ rights, and even the construction of the body in medical study.

As I will demonstrate, when taught using principles of narrative medicine, including the concepts of logotherapy and pathography, Burney’s letter and “The Victim” provide an opportunity to connect literary study to the physical therapy program’s goals. The texts present relatable healthcare situations, such as receiving a cancer diagnosis or studying for an anatomy exam, with a striking strangeness that engages students’ emotional and intellectual interest. Ultimately, the texts often lead students to not only question the history of the medical professions, but also to assess their own personal and professional values and learn how to use emotions to facilitate care. As is characteristic of Romantic texts, Burney’s letter and “The Victim” stage and elicit powerful sentiment. The sexualized cadaver in “The Victim” disgusts students and opens a conversation about clinical distance as the story’s own medical students fail to balance clinical distance with empathy. Burney’s letter invites students to explain how they might communicate with their own patients differently from Burney’s surgical team in order to better support patient quality of life.

**Narrative Medicine, Logotherapy, and Pathography**

Narrative medicine emphasizes the transportability of close reading skills and the importance of language to the medical practitioner (Charon et al, “Close Reading” np). Narrative medicine also considers forms and effects through two concepts, pathography and logotherapy, which are a key focus of my “Healthcare and Literature” course.[[2]](#footnote-2) Pathographies, or patient-produced narratives, provide audiences with the deeply subjective “extra-clinical” details of illness that resonate poignantly and build empathetic connections. As a philosophy, logotherapy affirms that narratives have the power to validate experiences of illness and can promote recovery.

Narrative medicine uses literary texts to increase provider effectiveness by fostering skills in listening, critical thinking, and interpretation. Together, these skills are known as “narrative competence, that is, the competence that human beings use to absorb, interpret, and respond to stories … it enables the physician to practice medicine with empathy, reflection, professionalism, and trustworthiness”(Charon, “Narrative Medicine” 1897). Working with diverse kinds of texts ultimately equips the practitioner to avoid any one-size-fits-all assumptions, because “[e]valuating patients requires the skills that are exercised by the careful reader” (Charon et al ,“Literature and Medicine” 601). Much like literary scholars, the healthcare provider listens, collates, and interprets metaphors, point of view, and repetition. Narrative medicine fundamentally values patients’ stories, whether filled with overwhelming detail or loaded with meaningful silences, and views each story as much more than an index of symptoms. Narrative competence ensures that the practitioner meets the patient where they are (Charon, “Narrative Medicine” 1898). Patients can feel compelled to narrate their histories into coherence (Torney 37), and they know when they are being heard.

Broadly speaking, writing about traumatic illness or treatment can promote wellbeing. Trauma-focused therapy frequently requires patients to write, read, and re-read narratives of their trauma because repeated exposures decrease episodes of physiological distress (Gurak et al). Pathographies prioritize the patient’s point of view within their socio-cultural moment: “in the full, rich, nuanced particularity seldom if ever available elsewhere, literary accounts of illness widen physician-readers’ knowledge of the concrete realities of being sick and enable these readers to appreciate their own patients’ stories of sickness” (Charon et al, “Literature and Medicine” 600). Pathographies tap into readers’ emotions. Healthcare providers who believe that clinical detachment keeps them unbiased while emotions distract from caregiving can benefit from using pathography to discuss how emotions can be appropriately leveraged into caregiving.

Clinical detachment, though at times necessary, can become dangerous when practitioners are burned out. Yet suffering and illness cannot be ignored, nor can narratives in which medical professionals fail to practice effective care. Narrative medicine offers safeguards against the exhaustion deadly to careful interactions, and against the weariness born of bearing constant witness to suffering. The design of my “Healthcare and Literature” course follows a logical chain. Students read pathographies to encounter difficult patient experiences. Discussing these pathographies together as a class, we share our own strong emotions. In sharing these emotions, the emotions are in turn validated. Through such discussions, students can therefore begin to see emotions as a meaningful guide to patient care and to self care. When students can trust their emotions in this way, their wellbeing is preserved.

**Burney’s Mastectomy Letter**

I use Burney’s letter early in the semester to foreground the value of transhistorical analysis and reading medicine “across history.” Students usually expect that surgeons will explain to patients what kind of operation they need and what will be done to them. It is difficult for students to imagine surgeons lying – deliberately or through omission – because they believe that patients are entitled to transparency. However, by reading Burney’s letter they realize that their assumptions about surgical professionalism are historically constructed. Ultimately, I want students to consider how and why Burney’s surgeons fail to communicate honestly with her and what kinds of emotions drive their interactions. Before reading Burney’s letter, I have students watch “Being Mortal” (2015), an episode of *Frontline* in which Atul Gawande addresses how difficult it is for oncologists to discuss end-of-life priorities with terminal patients, often because they fear hurting a patient’s feelings or being perceived as a failure. After discussing Gawande, the class reads Burney’s letter to study the ways in which Burney’s surgical team compounds her suffering by avoiding hard conversations. Finally, we read Mary Roberts Reinhart’s 1947 interview with Greta Palmer for *Ladies Home Journal*, “I Had Cancer,” about her experience with breast cancer. We discuss these three texts over three class periods. I offer framing questions or comments, but most of my time is spent reading passages aloud, moderating discussion, and synthesizing students’ comments. They then submit a two-page reflection in which they may respond to a single text or the triad overall.

The thematic focus on cancer allows us to confront a troubling topic head-on while also inviting us to consider what kinds of things are said about cancer at different moments in history. What kinds of assumptions surround the symptoms, diagnosis, and treatment plan? What must be communicated? What is at stake? Many of these questions lead us to close examinations of language: the words used to describe disease reflect social attitudes towards that disease. After watching “Being Mortal,” we typically discuss the belief that patients need their doctors to communicate openly, even if doctors are worried about arousing strong emotions or coming across as failures. Only when doctors manage their own negative emotions can they venture into conversations that, though painful, can spare a patient long-term suffering.

While students have not yet read secondary materials on logotherapy or pathography, I introduce these terms to them during our discussion on Burney’s writing. Given the letter’s vivid and sometimes gruesome details, it is perfect for linking emotions to wellbeing via logotherapy. In addition, Burney’s literary skill infuses her pathography, enabling students to emotionally connect with her. I begin class by asking students how they felt about the reading: Was the letter hard to understand? What feelings did they have about Burney’s experience? They usually confess that they had difficulty sustaining attention up to the surgery. Student recall of the surgery is very high because of the feelings it elicits, while the “build up” takes more work to unpack. I lean into their discomfort with the earlier part of the text by having students recount Burney’s experience before the surgery. What results is a discussion about the meandering process of illness and treatment, and what students expect doctors will do when a patient needs help.

Students react especially strongly to the way that Burney’s surgical team treats her, and they empathize with her. We linger over passages where Burney describes her shock and terror. When I ask why Burney feels so terrified, students blame the surgeons. The students believe that Burney’s doctors prioritize their own fears and concerns over her wellbeing, and also that Burney’s male doctors treat her with a destructive delicacy because she is a woman. Moreover, they perceive the surgeons as inappropriately emoting. In their eyes, medical professionals should inspire confidence in their patients instead of expressing fear and anxiety. When Burney is told that a surgery is unavoidable, Dr. Larrey has tears in his eyes: “All were silent, and Dr. Larrey, I saw, hid himself nearly behind my Sofa… I saw all hope was over. I called upon them to speak. M. Dubois then, after a long and unintelligible harangue, from his own disturbance, pronounced my doom” (435-436). Students interpret Larrey’s hiding as childish, and Dubois’s “long and unintelligible harangue” as an inadequate effort to communicate clearly. In this respect, students see Burney’s doctors as incompetent because they cannot balance appropriate empathy with confidence. The surgeons’ poor communication compounds Burney’s helplessness and disempowerment.

The disempowerment escalates as Burney must fully submit to the surgeons. While Burney does not mention embarrassment at baring her breast to a male doctor, she comes close to expressing humiliation: “I was compelled, however, to submit to taking off my long robe de Chambre, which I had meant to retain – ah, then, how did I think of My Sisters! – not one, at so dreadful an instant, at hand, to protect – adjust—guard me” (440). Students interpret this passage as a commentary on gender. Burney realizes that only a woman could understand what she feels, yet her surgery is spearheaded by men who have demonstrated little interest in her wellbeing. A particularly poignant endorsement once came from a student who had experienced breast biopsy. She said that Burney’s account collapsed historical distance and made a Romantic text accessible. She knew the rawness. She knew the pull of modesty during disrobing and the helplessness in relinquishing it. She felt affirmed in her connection to Burney. It was like a shared triumph. This is an example of how the upsetting emotions elicited by pathography can lead a student to an insight about caregiving. Burney’s narrative allowed a student to think of herself as both patient and practitioner. By powerfully empathizing with Burney she could ask herself what responsibilities the surgeons abdicated and appreciate Burney’s fortitude. Difficult emotions thus become a gateway to assessing patient care.

Taken together, Burney’s letter and Gawande’s “Being Mortal” bring students to recognize that communication issues have long plagued medical interactions and that a fear of emotions is at the root of the problem. But while Gawande emphasizes including patients in conversation, making sure they understand their disease and asking about their goals and priorities, Burney’s doctors bowl her over, and in the end they don’t protect her from any suffering. Patients expect doctors to take the lead, but doctors may be unprepared for the emotional nature of conversations about critical illnesses. What is the patient’s understanding of their disease? What are their priorities? Gawande insists that medical professionals should avoid instilling false hope. He advises allowing patients to emote in whatever way they need to, since patient personalities differ. I ask students, as future physical therapists, what kinds of difficult conversations they may have to have with patients and how Gawande’s claims and Burney’s experience help them to think about what they should take into consideration when talking to patients.

**“The Victim”**

After discussing Burney and Gawande, I transition students into texts on anatomy and surgical education during the Romantic period, focusing on Ruth Richardson’s historical analysis of the 1832 Anatomy Act called *Death, Dissection, and the Destitute* and the short story “The Victim” (1831). What were surgeons taught? How were they taught? Can we find in other texts examples of emotions interfering with patient care? While Burney’s doctors emoted in uncontrolled ways, Richardson’s *Death, Dissection and the Destitute* shows how clinical detachment, or emotionlessness, could be taken to such an extreme that patients were treated as objects. She argues that during the nineteenth century, the emotional distance that medical professionals adopted in order to dissect human beings took on new stakes.[[3]](#footnote-3)

The dark fictional landscape of “The Victim” presents the dangers of clinical detachment when medical study overshadows the main characters’ social awareness. Dudley, the narrator, is a medical student. He and his roommate St. Clare order a cadaver from a resurrectionist to study for an examination on the arteries of the neck. Passing this exam has high stakes for St. Clare: once he receives his certification, he will be able to marry his fiancée Emily and receive a significant sum of money. Dudley receives the cadaver late one evening and directs the resurrectionists to take it to the closet in his bedroom. Upon unwrapping the body, he is astounded to see the most beautiful woman he’s ever encountered. Rather than dissecting her, he kisses her, sketches her, and falls asleep on her exposed “inanimate breast, which had been deprived too soon of existence to know the pure joy of pillowing a fellow-heart it loved” (190). When St. Clare arrives home, he is devastated to learn that the cadaver is Emily. Time passes, St. Clare dies, and Dudley ends up treating a man who confesses to the murder of Emily. The story’s somewhat heavy-handed moral comes with the horrifying revelation that St. Clare’s love interest had been abducted and murdered because resurrectionists found it more convenient than digging up a dead body. Once Dudley realizes his complicity in the trafficking of the dead he “renounc[es] the scalpel for ever” (193).

Students invariably discuss the irreplaceable importance of hands-on dissection. Students in the DPT program have the privilege of completing a yearlong cadaver lab on campus during their undergraduate curriculum. They know that dissection is a vital privilege. Some anticipate it with anxiety, while others look forward to it for years, but most have not thought about it critically. “The Victim” provides us with an opportunity to talk about students’ emotional experiences by using the characters in the story as our case study.

Before we begin discussing the story, we analyze images from John Bell’s and Govard Bidloo’s Romantic-era anatomical atlases so that they can get a sense of what anatomical study looked like before the historical development of the clinical gaze. I ask them what they could learn from these images and what their reactions are. They find them frightening and compelling, but not scientific. When I show them these images, they even more deeply understand why Dudley and St. Clare feel the *need* to dissect to prepare. Illustrations from John Bell’s 1810 *Engravings of the Bones, Muscles, and Joints*, for example, do not meet their criteria for a didactic anatomy textbook. They marvel that students learned anything at all when textbooks were so encumbered with emotional valences and chaotic excesses.[[4]](#footnote-4) Through these images my students also speculate on how anatomists felt when dissecting and sketching their cadavers. John Bell’s images especially communicate a horror and sadness that students believe has no place in the dissecting room, even if they anticipate feeling fear or sadness when it is their turn in the lab. Even Dudley calls dissection a “necessary, but revolting, part of the profession” (189). Most importantly, “The Victim” gives a sexual torque to dissection’s insult. The sight of Emily’s cadaver stirs up erotic feelings in Dudley. He feels dissection will dishonor her, but he cannot resist her beauty. He experiences a warping of his ethical and erotic drives:

never till that instant had I seen aught that came so near to my most ideal picture of female loveliness; even though the last touches had been painted by the hand of Death … I had almost brought myself to meet with indifference the objects which are found on the dissecting table, [but] I could not gaze on one so young, so very fair, without feeling the springs of pity dissolve within me. (189)

Dudley is stirred away from clinical distance toward more altruistic thinking. But his activated emotions lead him to a series of activities that starkly emphasizes his masculinity, agency, and dominance in contrast to her feminine and unresisting vulnerability. Receiving Emily’s body, unwrapping it, examining it, opening her eye, kissing her, sketching her, cutting off her hair, then finally dissecting her: these acts show Emily’s sexual undoing as a drawn-out process culminating in dissection.

While students do not interpret this as a rape scene, I read out loud Dudley’s description of Emily’s body and his behaviors to push them to see the eroticized power dynamics at play in “The Victim.” I also show them anatomist Robert Knox’s 1828 nude sketch of Mary Paterson’s cadaver.[[5]](#footnote-5) This allows them to imagine that Dudley’s sketch of Emily may have looked to them more like an eroticized image of a nude, consenting, living woman than like a dead body. I also remind them that in the early nineteenth century, anatomists were viewed with disgust and distrust because they meddled in guts, and their affiliation with surgeons linked them to manual craft and butchery—not intellect. Excess of clinical distance, thinking of humans as inert material, facilitates the cavalier ordering and receiving of Emily’s remains. The ensuing objectification enables Dudley’s Robert Knox-esque abuse, even as it is masked as a misdirection of socially appropriate chivalrous emotion. We take time to identify the thoughts Dudley has, the emotions he feels, and the behaviors that follow from these.

While students cannot imagine admiring the beauty of a cadaver, they *can* imagine feeling exhilarated to see anatomical structures. They can also imagine being unable to “turn off” their feelings to achieve the clinical distance they need to dissect. None of them, I certainly hope, are at risk of sexualizing their cadavers, but I ask them what kinds of behaviors might be similar to Dudley’s behavior, such as making a joke about a cadaver’s appearance or taking photos. Most students share that they are afraid of what they will think and feel in the lab. They believe that to be studious, they must be *somber*. This is where we really hit on appropriate emotions and coping. They can feel sad, frightened, excited, nervous, and even silly. But there are ways to experience all of these feelings, to accept them, and to use them as guides to engage their learning. If they are sad, they can talk about it. If they are excited, they can express it. If they are afraid, that’s okay, too. As narrative medicine can teach us, registering and exploring these emotions can make my students more compassionate and more effective medical professionals. I often share my own thoughts and feelings about the cadaver lab and how I have coped.

We come back to the dissecting experience twice more in the last three weeks of class. First, we read Pauline Chen’s 2012 work of creative nonfiction, “Resurrectionist,” in which Chen describes her first dissection as a med student. The essay allows us to discuss what a current-day student thinks, feels, and experiences before, during, and after dissecting. I again ask students how they feel about their upcoming dissection – are they anxious, excited, worried? This discussion is usually animated, and it’s clear that students are relieved to hear their peers’ concerns. Then, I collaborate with the Anatomy I lab professor who meets us in the cadaver lab where students will eventually be doing their dissections. My students have the opportunity to meet students who are currently dissecting. We give students time to experience their sensations and talk about their feelings first. Then, we open the body bags and let the students talk through their thoughts and feelings. Anatomy I students share what they thought and felt about dissecting, and how they coped. They show my students their cadavers and dissections. This has been an enormously fruitful collaboration. The Anatomy I professor knew that his students at times had struggled emotionally, and we both anticipate that the collaboration will equip future anatomy students with more resources for addressing these struggles. My students report great appreciation for the experience in written reflections, in the class discussion following the lab, and in their course evaluations. They feel that when it will be their turn to dissect, they will be able to fully engage intellectually instead of worrying about getting sick or crying. Organizing this collaboration has required emotional labor on my part, but supporting students during a difficult confrontation with a cadaver has afforded me another opportunity to validate their difficult emotions. It also has allowed me to show students how we can work through sadness or fear. For example, one semester I sat in the hallway with a sobbing student. I listened to her, and we developed a plan to walk into the lab together. She asked me to walk ahead of her, to keep up a steady stream of chatter, and to lead her to a table where a few of her friends were. Students know that they need to work through the discomfort of seeing cadavers but have few guided opportunities to do so. Visiting the cadaver lab has also given me a chance to really communicate to students that I care about their wellbeing, and I am able to welcome and withstand their feelings. I am, in other words, modeling how I accept emotions as part of my profession.

**Student Reactions**

The medical worlds of literary texts like Burney’s letter and “The Victim” are unimaginable to students pursuing degrees in health science—a world in which a mastectomy is performed on an inadequately informed, fully conscious woman by a clutch of terrified and silent surgeons, and a world in which anatomy students become sexual predators complicit in murder. My students’ world is one in which cancer is openly discussed, where cadaver lab is part of their undergraduate curriculum, and where surgeons are stereotypically the apotheosis of efficient protocol. My students are not ready for the butchery, for the emotionally labile surgical team, for the woman who holds her own breast on a pile of old mattresses. Nor are they ready for the student falling weeping onto and kissing his study-cadaver in his bedroom the night before an exam. The strength of these texts, then, is their medical uncanniness. They are familiar enough to comprehend and alien enough to shock students into engaged reflection. They bring to the surface students’ assumptions about appropriate study and care and thus embed them more mindfully in the present. Burney’s letter and “The Victim” invite conversations about clinical detachment as both necessary to practice surgery and dissection and also something that can be taken to a dangerous extreme. By reading these nineteenth-century texts, students come to the conclusion that empathy cannot be sacrificed in medical care. Even though medical professionals face complicated emotional challenges that can make effective care difficult, the patient’s experience must always be weighed and appreciated. Narrative medicine makes it clear that this leads to better outcomes for patients and can prevent other negative effects for medical professionals.

My “Healthcare and Literature” students connect to the texts in three significant ways: as learners with professional aspirations, as erstwhile and future patients, and as individuals who want to change lives. Official Student Evaluation Surveys have confirmed that students find the texts relevant to their future professions. They appreciate being introduced to communication challenges, and they can express the importance of language when working with patients. Students have stated that they appreciate discussing difficult medical scenarios. They know that they will have hard conversations when they ask a patient why they aren’t completing their prescribed exercises or when they resist instilling false hope in a postoperative athlete who will likely not comfortably play their sport again. Part of my joy in working with future physical therapists is their belief in recovery and triumph. They are optimistic and excited to help future patients. My ancillary joy is mediating their journey, even if in a small way, to becoming comfortable with situations where they may feel powerless, overwhelmed, angry, or frustrated—and being able to persist in the midst of those feelings. By normalizing difficult conversations, they can, I hope, take comfort, feel prepared, and know they are not alone.

Works Cited

Anonymous. “The Victim.” (1831) *Gothic Evolutions: Poetry, Tales, Context, Theory*. Ed. Corinna Wagner. Peterborough, Ontario: Broadview, 2014. 186-193.

Bell, John. *Engraving of the Bones, Muscles, and Joints, Illustrating the first volume of the anatomy of the human body.* 3rd ed. London: Longman, Hurst, Reese, and Orme, 1810. *HathiTrust.* Accessed 28 July 2011.

Burney, Frances. *Journals and Letters.* Introduction by Peter Sabor and Lars E. Troide. New York: Penguin, 2001.

Caldwell, Janis McLarren. “The Strange Death of the Animated Cadaver: Changing Conventions in Nineteenth-Century British Anatomical Illustration.” *Literature and Medicine* 25.2 (2006): 325-357. *Project Muse*. Accessed 30 November 2016.

Charon, Rita. “Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust.”  
 *Journal of the American Medical Association* 286.15 (2001): 1897-1902. Web. 30 August 2016.

Charon, Rita, Joanne Trautmann Banks, Julia E. Connelly, Anne Hunsaker Hawkins, Kathryn Montgomery Hunter, Anne Hudson Jones, Martha Montello, Suzanne Poirer. “Literature and Medicine: Contributions to Clinical Practice.” *Annals of Internal Medicine* 122 (1995): 599-606.

Charon, Rita, Nellie Hermann, and Michael J. Devlin. “Close Reading and Creative Writing in Clinical Education: Teaching Attention, Representation, and Affiliation.” *Academic Medicine* 91.3 (2016): 345-350. *Ovid*. Web. 1 September 2016.

Epstein, Julia L. “Writing the Unspeakable: Fanny Burney’s Mastectomy and the Fictive Body.” *Representations* 16 (1986): 131-166. *JSTOR.* Accessed 1December 2016.

Gurak, Kayla K., Blanche Freund, and Gail Ironson. “The Use of Both Prolonged Exposure and Cognitive Processing Therapy in the Treatment of a Person With PTSD, Multiple Traumas, Depression, and Suicidality.” *Clinical Case Studies* 15.4 (2016): 295-312. *SAGE*. Accessed 29 November 2016.

“Outcomes.” *Physical Therapy*. John G. Rangos, Sr. School of Health Sciences. Duquesne U.

duq.edu/academics/schools/health-sciences/academic-programs/physical-therapy/outcomes. Accessed 29 November 2016.

Richardson, Ruth. *Death, Dissection, and the Destitute*. 2nd ed. U Chicago P, 2000.

---. *The Making of Mr. Gray’s Anatomy.* Oxford UP, 2008.

Roach, Joseph and Shelby Richardson. “Writing the Breast, Performing the Trace: Madame d’Arblay’s Radical Prosthesis.” *Acting on the Past: Historical Performances Across Disciplines*. Ed. Mark Franko and Annette Richards. Wesleyan UP, 2000. 52-66.

Souter, Kay Torney. “Narrating the Body: Disease as Interpersonal Event.” *Health and History* 1.1 (1998): 35-42. *JSTOR*. Accessed 29 November 2016.

“Strategic Statements.” *Physical Therapy.* John G. Rangos, Sr. School of Health Sciences. Duquesne U. duq.edu/academics/schools/health-sciences/academic-programs/physical-therapy/strategic-statements. Accessed 29 November 2016.

1. Process writing involves assisting students with planning, drafting, and revising. I dedicate class time to each stage of the process, including workshopping student drafts. During workshop we discuss how the student might revise their paper to meet the assignment’s guidelines. It also allows me to demonstrate to them what an “A” thesis looks like, for example. [↑](#footnote-ref-1)
2. Anne Hunsaker Hawkins coined the term “pathography” in *Reconstructing Illness: Studies in Pathography.* Purdue UP, 1993. [↑](#footnote-ref-2)
3. Britain’s 1832 Anatomy Act dictated that “people too poor to pay for their own funerals” could be used for dissection (Richardson 50). This abuse of the dependent poor showed how Romantic surgeons’ clinical detachment could encourage a callous attitude towards patients. [↑](#footnote-ref-3)
4. Janis McLarren Caldwell’s essay “The Strange Death of the Animated Cadaver” could be taught in tandem with J. Bell and “The Victim.” To extend discussion into the Victorian period, Ruth Richardson’s *The Making of Mr. Gray’s Anatomy* provides an outstanding analysis of what made Gray *the* game-changer in anatomical textbook illustration and design. [↑](#footnote-ref-4)
5. Richardson details Knox’s treatment of Paterson’s body: “men had come to draw her body, comments had been made upon her physical attributes and Knox had even had her body preserved in spirits so that he could continue to indulge in necrophiliac voyeurism” (96). [↑](#footnote-ref-5)