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The Semiotics of Western Hospitals: From a Stone Boat in Rome to Reconstructing the Self in Montreal

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Abstract

In this article I analyze the symbolic role of the hospital in its social context, from its creation in Rome in the 2nd century BCE to contemporary Montreal hospitals. I trace the change from its original role as a site to isolate the sick to limit the symbolic pollution of the allegedly perfect social body of the Roman state, a trope that became an important vector of unity as Rome expanded and incorporated greater numbers of foreigners and slaves. Today, however, western hospitals have become a semiotic engine where patients construct a new biography to counter the depersonalisation of contemporary medical practices. I propose that today patients use the hospital as raw material to construct a temporal framework that substitutes the rhythms of everyday life that illness and the institutional culture of the hospital have interrupted. These narratives adhere to the same basic structure: the entrance scenario is always admission to the hospital; the plot structure is built with the non-medical details of the daily hospital routine. Surrounded by a neoliberal ethos that insists on the autonomy of the self but silenced by the mechanisation of illness, contemporary patients transform hospitals into semiotic engines where patients use their immediate environment to re-engineer new voices of the self.

Keywords: hospitals; patient narratives; Rome; Montreal

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1. Introduction

It is almost banal to state that State-sponsored notions of space and time are hegemonic tools that operate at both extremes of the social pyramid. On the one hand, they are a manifestation of elite power that can draw a macro-portrait of history that crudely and brutally frames individual identity (we are all 'Italian', 'American', or 'Hungarian' and thus allegedly share the same putative inherited genetic and cultural traits). On the other hand, shared notions of time impose daily schedules whose repetitive nature creates matrices that normalize how space is used in daily life.

From the individual's point of view, however, the crushing temporality of history and the micro-rhythms of quotidian space operate within very different interpretative frameworks, leaving intact the illusion that each person has the freedom to act and choose despite the repeated subtexts behind homogeneous schedules and historical hegemony that push people to conformity in thought and deed. One difference between the macro and micro is that each time frame is attached to a different set of signs: one, a shared but imaginary public space, the other, the empirical, personal intimacy of work and home. It therefore becomes important to identify how tropes of time emerge and how they become attached to place, whether the history of the nation or the intimacy of local spaces such as the home or hospitals, whose double overdetermination as sites of shared identity

and individual activity transforms them into polysemic vehicles that give rise to complex imaginaries whose components can often contradict one another. Paradoxically, this creates interstitial spaces where people can exploit the polysemic quality of signs to create their own identity tales.

Western hospitals have long been places were the ill were isolated, either to protect the social body (at its foundation in ancient Rome) or, much later, to provide more efficient use of resources to treat the sick. I argue that today they are also a neuralgic point where illness disrupts the rhythms of daily life and brings the individual's temporary (hopefully!) helplessness into sharp focus, which is exacerbated by the hospital's institutional culture of medicalization and depersonalization, thus pushing already-threatened biographies and senses of agency into full-blown crises. Isolated bodies are thus targeted by medical practices that temporarily interrupt and annihilate the patient's power to act and thus their ability to add episodes to their autobiography or act out the accumulated baggage of their past. I argue that patients react by creating new biographies cobbled together from the very hospital spaces that depersonalise them. Critically, I found that the biographies I collected ignored the symptoms of illness and focussed on the hospital environment, possibly because the temporal progression of illness moves the patient to a either a dark terminus or at best an uncertain timeline of healing, or that illness has been medicalised and treatment mechanised such that the patient's body belongs to the medical professionals. Both these outcomes would be inconsistent with the desire to express the patient's desire to exercise some control over their lives.

Here, I propose to analyse the semiotics of two hospital settings: the first western hospital of which we have documented and archeological evidence, established in Rome in the first century BCE, and contemporary hospitals in Montreal. I will argue that tropes of space and time intersect with and mirror the dominant social dynamics of each epoch, and these have defined the ways in which authorities see hospital mandates. The first hospital was a place that isolated the sick, whose emaciated bodies threatened the symbolic purity of the trope of the social body that purported to embody the strength of the Roman State. As the social effects of modernity increasingly transformed western societies in the 17th and 18th centuries, the culture of hospitals followed. Increased surveillance and a ward system that segregated patients according to their physical symptoms meant that illness as a condition became defined by medical professionals. Patients' life trajectories and their personal stories mattered less and less in determining treatment and care. The 20th century trend towards total medicalization of illnesses and their subsequent depersonalization puts pressure on patients to develop their own biographies of the self to counter their irrelevance. In other words, from its birthplace in Rome where sick slaves were isolated so their deformed bodies could not symbolically contaminate the perfect social body of the State, the hospital in the West has become a semiotic storehouse of signs with which patients can rebuild their timelines interrupted by illness and by institutional biomedicalization. To contextualize this transformation and its significance, I will refer to notions of illness and healing that draw from the works of Claude Lévi-Strauss, Byron Good and Arthur Kleinman, who launch their investigations from the same starting point, the idea that severe illness weakens the patient's normalized spatial and temporal semiotic matrices. Unlike these latter two researchers, however, I believe like Lévi-Strauss that patients seek psychic equilibrium. They are not necessarily seeking a psychosomatic cure but want to create personalized temporal matrices to counter the continual surveillance and powerlessness imposed by contemporary biomedical culture that has completely appropriated or ignored the patients' personal experience of illness and possible collaborative contributions to treatment. In particular, I will take as my starting point Claude Lévi-Strauss's article on the efficacy of the shaman, then analyze the creation of the first Western hospital in Rome.

Finally, I will discuss the experience of some long-term patients in three major Montreal hospitals: Saint-Luc, Notre-Dame and the Jewish General Hospital.

The data from Rome are archeological and historical analyses of the social body trope and Roman notions of illness. The data from Montreal are based on spontaneous narratives that approximately 50 patients offered to me over several long term stays in three Montreal hospitals between 2008 and 2012, and again in 2021. At the time, I was not interested in research, since these were episodes in which I was seriously ill and just another patient. After I healed, I had tried with some success to put the earlier episodes out of my mind, but the latest (2021) made me rethink my earlier interactions with my fellow sufferers. I realised that there was a pattern to our spontaneous conversations. Hence, my findings in the second part of this essay, on three hospitals in Montreal, are not based on formal interviews but on realising that the spontaneous conversations with fellow patients followed a pattern. Since patients were all encouraged to walk as therapy, we would often meet in the corridors. It is impossible to quantify the number or total length of these conversations. Nonetheless, their similarity is suggestive and warrants further research.

There are limits on what I can extrapolate from these conversations, since another person in the same hospitals at the same time might have elicited different reactions from patients, or I might have had different observations depending on the composition of the cohorts of patients who were hospitalized at the same time as I was My status as a patient and fellow sufferer rather than as a professor or researcher (I did identify myself, of course, but since there was no research strategy involved there were no ethical considerations) placed us on an equal footing and bypassed the inherent biases of researchers interacting with patients in an institutional setting, whatever their claims to methodological rigour. I am thus convinced that no formal research methodologies could have elicited these conversations and avoided the inherent biases of doctor-elicited narratives that I will discuss below. Finally, I am not suggesting that these mini biographies of the banal express the totality of patients' thoughts and emotions. Serious and chronic illnesses give rise to feelings of fear, panic, depression and anxiety (Strauss et al., 1985, p. 129). I am not suggesting that the desire for a coherent biography of the self that validates a person's claim to respect and dignity (Taylor, 1989; Cardoso de Oliveira, 2020) is more important than the stressful feelings mentioned by Strauss et al. Nonetheless, I argue that the content, regularity and repetitiveness of the Montreal narratives are significant clues of how patients may feel when the impersonality of biomedical culture adds to their illness-induced apprehensions.

2. Alone in a Shared Space

According to Lévi-Strauss, who based his analyses on the practices of the Amazonian peoples he studied in the 1930s, extreme illness removes the individual from the community and places them in a special space. Sick individuals cannot adequately communicate their psychic conditions of isolation and fear, because the homogeneity of tribal societies offers them a very restricted range of socially validated responses to interpret and to describe their sense of temporary, illness-induced isolation (Lévi-Strauss, 1949, pp. 285–306). Alone in their bubble, those closest to them have no idea how to reintegrate them into the relatively homogenous community: no one has had a similar, culturally validated experience of separation unless it is the imminence of death. Then comes the shaman, whose incomprehensible antics, triggered either by hallucinogens, by the incessant beating of a drum that drowns out other sensory inputs, or by symbolic blindness when he fixes his gaze on a mirror or the sun (which also cancels other inputs), also detach him from the community. He too is temporarily 'sick' and can join the isolated patient. The patient is no longer alone, and when the effects of their shock mechanism wear off and the shaman finally calms down, the patient can accompany him back into the communal fold.

The patient is not physically cured but is no longer in an unspeakable psychic space of isolation. He is not alone and has a guide. The important thing is not the psychosomatic effect of the shamanic performance but the gesture of symbolically detaching oneself from the homogenous community, reaching out to the isolated patient, and rejoining the community when the effects of the shamanic trance have worn off. In the case of a tribal community where individual achievement is not the cornerstone of personal identity, cultural homogeneity and a person's extreme illness define two unique spaces separated by a normally impassable boundary.[1] The shaman's tools and his status as a person who is already considered abnormal and potentially dangerous allow him (they are normally male) to join the patient and bring them back into the community.[2]

Williams (1984), Kleinman (1988), Good (1994) and Hyden (1997) have also noted that sufferers must rebuild their identity frameworks that have been thrown off balance by illness. They too examine the relationship between the patient's normal environment and the isolation caused by serious illness, except that in the Western context identity is normally framed by a culture that normalizes and validates heterogeneity, with shared imaginaries alleged composed of autonomous individuals each acting according to their self-interest. While homogeneous Amazonians 'detach' a shaman from the social body to reach out and bring the alienated patient back to normality, Williams, Good and Kleinman propose that the contemporary Western patient must, alone, reconstruct an individual narrative journey that explains the abnormal bubble in which they find themselves and which is normalized by the insistent and intrusive practices of the hospital that only acknowledge a patient's physical distress. In fact, the reconstructed narrative is personalized, as it is intended for the patients themselves, like the patient who exclaimed to Williams, "…your mind's going all the time, you're reflecting … 'how the hell have I come to be like this?' … because it isn't me" (Williams, 1984, p. 175).

Hyden, for his part, shares the same orientation as Williams, Good and Kleinman but points out that the patient does not produce a single narrative to reconstruct their fractured identity. Patients may offer several depending on the circumstances that frame their relationship with the researcher. Hyden emphasizes the integrity of the temporal dimension interrupted by illness: "In other words, narratives recreate a temporal context that had been lost, and thereby takes on meaning as part of a life process" (Hyden, 1997, p. 53). Hyden seems to be inspired by Ricoeur (1981), who insists that narrative logic rests on a matrix of temporality, whether or not the sequence of its components adheres to a standard model of progression through time. In other words, he recognizes that there may be several definitions of temporality, and that individual narratives need not conform to a single, rigid model. I concur but add that Hyden did not comment on the banality of daily hospital schedules in these narratives, as I do, and seems to accept that these narratives focus on the body.

In other words, it is the act of constructing an individual, explanatory framework that stabilizes the contemporary Western patient and puts them on the path of psychic healing, even if the framework is totally idiosyncratic and not seen as 'normal' or shared with others. In brief, unlike these researchers who propose that illness narratives are about regaining control of the damaged body,[3] I suggest that they are also attempts to reconstruct temporal autobiographies. Bodies damaged by illness and by medicalisation are on a negative, downward temporal spiral, even if healing is possible or likely. This Unlike Amazonian tribes, normative discourse in the West emphasizes individuality, insisting that the Self is a unique set of experiences and that shared identities are mostly superficial facades that are unaffected by illness because they come from ('are imposed by') the community—whether nation, gender, religion, work environment or the like. It is, however, the individual core that is compromised by illness and its medicalization. In response, patients use the

hospital environment to cobble together a sequential temporal journey to recreate their autobiographies, no matter how detached these may be from the patient's past or expected future. Most narratives I collected contain no references to illness; if there are references to the sick body, it is only because the patient has a limited palette of semiotic components at their disposal. The subject of the spontaneous narratives I collected is not the body but the autonomous Self threatened by the homogeneous, sterile hospital environment. The sameness of hospital routines is the symbolic antithesis of the diversity of experiences that normally nurtures a person's feelings of individuality. Unlike health professionals who take it for granted that the body is sacrosanct and is therefore the primordial subject of these narratives, I believe that patients tell tales to reconstruct their lost temporal baggage.

I propose that hospitals that I describe here occupy two different imaginaries, each conditioned by their respective political dynamics. At a time when class tensions threatened Rome's survival, elites sought to reinforce political solidarity by invoking the metaphor of the social body. A sick body represented semiotic contamination that had to be materially isolated, whereas the contemporary Western patient, already accustomed to the psychic and emotional isolation of postmodern over-individuality, seeks to exploit the hospital as raw material to weave together a narrative aimed at constructing a new temporal matrix to replace the one crushed by the subtexts of biomedical institutions that devalue the patient's subjectivity. In this way, they can reintegrate themselves into the rhythms of the new everyday life and, more importantly, they can produce a standardized performance but with a diversity of content, based on each patient's individual hospital experiences. The patient, then, follows a symbolic path dictated by his environment: involuntary spatial exile in one case, temporal rebirth in another. In sum, there are hospitals and hospitals, and their similar role attributed to them in contemporary biomedical culture can hide very different subtexts.

3. The Isolated Body

The Romans were not the first to introduce practices to isolate the sick. For example, lepers are mentioned several times in the Bible, usually on the margins of the community.[4] Their exile removed them from the collective imagination. Cancelled, they became the walking dead. Transformed into roadside beggars, they no longer participated in the community's moral economy. They depended entirely on charity, which is a one-way relationship totally under the control of the giver and a sign that the sick are unable to participate in the exchanges that define community life.

The Romans had a different idea of illness. True, the ill were isolated, but they were always present in the collective imagination and in the social contract. In fact, it is fitting that the place of isolation was at the geographical and symbolic heart of the Roman universe. The first hospital in our sense was founded in the 1st century BCE on the Tiberian island in the middle of Rome's sacred river, the Tiber. Legend has it that an epidemic struck the city in 292 BCE. A delegation was sent to the sanctuary of Aesculapius in Greece, a hero and semi-god associated with healing pilgrims. A snake emerged from the base of his statue and lodged itself in the Romans' boat, where it had wrapped itself around the mast on the return voyage (which is why the snake appears on the doctors' symbol).[5] Once back in Rome, the snake jumped ship and fled to the island. Convinced that this was an augury, the Romans built a sanctuary dedicated to the god of healing, and the epidemic ended.

Around the middle of the 1st century BCE, the island was formally converted into a hospital: "A later phase must date back to the middle of the first century BCE, when the whole island was undergoing a monumental layout, which involved the renovation of the sanitary structures, subjecting them to restoration and equipping them with the essential infrastructures for a large hospital center, which was renowned" (Nunziata, 2008, p. 59;

my translation). Contemporary Romans attribute this creation to Emperor Claudius, who reigned half a century later. According to archaeological evidence, however, he simply exploited the Tiberian island's existing status as a hospital to declare it a refuge to prevent sick slaves from being killed by their masters.[6] By Claudius' time, economic conditions in the empire may have inspired a change in attitudes towards slaves, as they seem to have become more valuable by the 1st century CE. There is evidence that by this time the practice of taking care of slaves by creating special dormitories (*valetudenarium*) where they could be treated and healed had spread to at least some parts of the empire (Risse, 1999, pp. 47–48). Nonetheless, the evidence suggests that practice of isolating ailing slaves at least in Rome itself seems to predate this later practice by at least 150 years.

There may have been a dimension of pity towards these unfortunates, as the Romans believed that the waters of the sacred river possessed healing powers, but there was above all a Durkheimian social fact that encapsulated class dynamics. Sick slaves were triply marginalized: by their illness, by their low-caste status and by their ethnicity, since they were generally captives of war and therefore foreigners. They did not have Roman citizenship, which was, for the Romans, an identity not linked to the fact of being born in Rome but a symbolic token that allowed them to participate in the political life of the community. Nonetheless, by the 1st century AD the Roman economy completely depended on these non-citizens.

For the Romans, the body was the main symbol of this community made up of distinct but interdependent social classes. The Romans adopted the trope of the social body a century before the first sanctuary for the sick was founded. This, as far as I can tell, was the first recorded use of the metaphor as a means of creating an image of an integrated, functioning society in popular discourse. Titus Livius in *The History of Rome from its Foundation* describes (vol. 1, tome II, chap. xxxii)[7] the first instance of this metaphor being used. According to the author, in 494 BCE (not a notation Livy would have used!), Rome suffered a strike by the Plebs, the working classes, who refused to serve their Patrician masters and left the city. The Senate, realizing that Rome was vulnerable without its workers and soldiers, sent a representative to convince them to return. Livy describes word for word the speech of this delegate, Agrippa Menenius Lanatus, "an eloquent man, acceptable to the people, because he was once part of their body". His cognomen *Lanatus* suggests he was associated with wool, probably a rich merchant. The senate would hardly have named a shepherd, a carder or a weaver to the task. Again according to Livy, Lanatus' exhortation recounts a revolt of the body's parts against the stomach, because they thought they were constantly working to feed it, forgetting that the stomach feeds them all. The stomach reacts and stops digesting the food, and the other parts of the body understand their mistake. Lanatus concludes: "Thus the senate and the people, as one body, perish in discord [but] are strong in harmony" (my translation).

The speech allegedly reproduced by Titus Livius is obviously a fiction, as no trace of a verbal exchange could have survived for almost 500 years to reach Livy's ear around the year 20 BCE. This means that the historian was sure that his audience would not have challenged the metaphor of society as a body, even if it were presented in the form of a fairy tale set centuries in the past.[8] The metaphor of the social body was thus a powerful vehicle for calling citizens to solidarity despite the almost insurmountable class tensions symbolized by the complementary relationships that exist between the body's organs. It is no coincidence that classical Rome provided 600 L of water per person per day, while the United States averages 250, including industrial consumption (Bruun, 1991). In the public baths for which ancient Rome is justly famous, water purified the individual body so that it was ready to receive the message of the social body, which was conveyed in many allusions in public discourses and affirmed by political rituals; like later Catholic

baptism, instead repeated daily. Roman representations of the body advocated a perfect, standardized model, and any deviation from the ideal signaled an imbalance of humors that governed nature and was seen as a threat to the social order:

> What this ideological standardization of body types means is that any variation in the shape or proportion of bodies represented in art is particularly striking: fleshy cheeks, double chins, flabby arms, love handles, excessive musculature, skin rolls and protruding bellies, as well as sunken eyes, bony cheeks and skeletal torsos, represented a conspicuous differentiation from the idealized norm, and these features brought with them various sets of political and moral associations that distinguished the subject-matter socially, economically and ethnically from the vast majority of somatic representations. (Bradley, 2011, p. 4).

There is more: the Roman state was fragile, according to its politicians and ideologues. They were aware that the city depended on the appropriation of agricultural surpluses from the countryside, and later, from abroad. The political system of exploitation that guaranteed the uninterrupted appropriation of grain from the subaltern classes and the transfer of the spoils to Rome required a strong hand that had to be continually validated by state ideology and its ritualized public dramas such as gladiatorial combats. Why else invent a founding myth that Romans were the descendants of a bastard (Romulus) adopted by a landless shepherd (Faustulus) and his prostitute wife (Acca Larantia), who killed his twin (Remus), whose biological father (a descendant of Aeneas) was of oriental lineage, a citizen of a city (Troy) that even the 'effeminate' Greeks had the strength to conquer, only to be conquered in turn by the 'masculine' Romans? Why did they baptize their strongly patriarchal civilization with the name of a relatively unknown goddess (Rome had no temple dedicated to Roma)? Why were their cities characterized as feminine and adorned with gates whose symbolism embodied sexual penetration?[9] It seems that foreign, feminine and weak traits were projected onto Rome to emphasize that it had to be supported by decisive, warlike, masculine interventions. The body, then, was a good symbol to represent the interdependence of its social classes but was nevertheless fragile and easily compromised by 'infections', 'penetrations' that threatened its fragile harmony, either from outside by invaders or by their own subaltern classes. The sick, therefore, and especially sick slaves triply marked by their status as slaves from abroad had to be isolated like Douglas's (1966) out-of-place matter could not be expelled but had to be hidden until they got better or died.

There was another dimension, too, for a sick person in extremis was probably emaciated, which for the Romans was a sign of weakness:

> Latin terms for 'thin' normally implied, like Greek terms, a state of poverty and a lack of strength and substance: as Ovid shows, *gracilis* could put a more positive spin on thin bodies but still denoted weakness and meagreness, and could describe a plain, scanty style of life or speech. *Tenuis* and its derivatives were closer to the bone, and described feeble-bodied individuals who typically belonged to the poor underclasses. At the extremes, there was a category for emaciated (*macer*) and bodily emaciation (*macies*): such bodies were normally on the fringes of life and civilization. (Bradley, 2011, p. 8)

In the classical world, the end of life was often represented by emaciated bodies (Grmek & Gourevitch, 1998). Sick slaves, probably undernourished for years, would certainly have conformed to this trope. Their emaciated condition was a visible sign that the body was on the verge of disappearing. Gravely ill, their emaciated condition signaled the weakness of the otherwise perfect and idealized social body. Unlike lepers, the Romans recognized that slaves were protagonists of the social fabric, as they could marry, buy

their freedom and even start small businesses. The hospital on the Tiberian Island was the perfect place for these deformed bodies that belied the political fiction that Rome was a healthy, united entity. The island was indelibly linked to Rome by the fact that the founders Romulus and Remus had been abandoned by their mother in a wicker basket in the sacred waters of the Tiber that floated to the site that became Rome.[10] The first hospital as we know the term was therefore a unique site, whose purpose was not to cure the sick but to protect the health of the social organism by isolating individuals marginalised by illness, foreign ethnicity and low status.

4. Telling Time

Hospitals in the West never lost the function of isolating the sick. As their social mandates evolved at least from the 18th century onwards, ward systems were developed so patients with similar illnesses were placed together in the name of efficient use of resources (Kisacky, 2017, p. 18). Fewer personnel could watch over larger numbers of patients, and it made teaching easier: "...thereby providing a spatial structure that contributed to an ongoing transformation of medical focus from seeing the patient to seeing the disease" (ibid, p. 18). According to Michel Foucault, this tendency was first documented in Paris hospitals in the 18th century. Hospitals acquired a new temporal dimension thanks to the emerging vision of the relationship of individuals and states, whose increasing complexity of class and economic relations urged their elites to innovate ways of surveying and controlling their citizens by means more sophisticated than the mere threat of force. In the hospital context, this new policy of patient surveillance was not the result of the advancement of knowledge or new theories of the body. Foucault's arguments suggest that this policy emerged from the same sensibility and at the same time that had led to the idea of Jeremy Bentham's Panopticon (1780s–1790s), the cornerstone of Foucault's *Surveiller et Punir*, where prisoners never know whether they are being observed and therefore behave and self-censor as if under incessant surveillance.

It seems that this new vision that the growing sense that people had to be watched like specimens on a microscope slide had prompted the Paris City Council to adopt the same system for hospitals, except that unlike the Panopticon, which was in fact never built, hospitals did begin paying more attention to their patients. Physician visits, once hasty and sporadic, were transformed into continuous surveillance:

> In 1661, a doctor at the Hôtel-Dieu hospital in Paris was responsible for one visit a day; in 1687, an 'expectant' doctor was required to examine some of the more seriously ill patients in the afternoon. The regulations of the eighteenth century specified the times and duration of these visits (a minimum of two hours); they insisted on a rota system to ensure that they were carried out every day, 'even on Easter Sunday'; finally, in 1771, a resident doctor was appointed, who was required to 'render all services appropriate to his position, both by night and by day', in the intervals between visits by an outside doctor. (Foucault, 1975, p. 218; my translation).

An individual's normal interaction with the events unfolding around them was now rendered irrelevant by the routines of institutional surveillance. Time in hospital was no longer marked by the anticipation of doctors' sporadic visits, nor, later, by the intervals between regularly scheduled visits.

There was another factor. Hospital patients no longer suffered at home surrounded by family who had to maintain their normal schedules despite caring for their sick family member (Kisacky, 2017). This normalcy of the group was structurally akin to the Amazonian shaman's normalising the patient's abnormal state by entering the patient's space and signaling that the patient was not alone in an unstructured environment. Likewise,

the European patient's family's uninterrupted schedule also underlined normalcy that by proxy included the patient, and in effect signalled to the patient that normal activities were not disturbed.

Under the new regime, hospitals removed the patient from the reassuring rhythms of family life. Once doctors became permanent fixtures of the hospital, social isolation and constant surveying of the patient became a component of the healing process. Suffering no longer belonged to the patient, since it was subject to the constant possibility of intervention by omnipresent doctors without the compensating warmth of family support. The only markers of time were those that signaled the progression of disease or, more rarely, healing. These processes, however, were identified, labeled and appropriated by doctors, who took credit for all treatments, whether the patient (rarely) healed or if they actually managed to ease the patient's suffering. Constant surveillance meant patients were forced to use other markers to measure the progression of time. These, I suggest, were akin to the modern illness narratives I observed, in which patients measure time by their ego-centered events. Indeed, it is arguable that all narratives in the modern sense are temporal narratives, since they begin with *something* and end with a coda, a resolution (Labov, 2007, summarizing Labov & Waletzky, 1967). There are implicit beginning and end points, in other words, and in the narratives I collected, these are within the walls of the hospital itself. Being in a hospital meant that a person was no longer able to function in the social body, since many people in the 18th and 19th centuries in western Europe might have been sick but continued with their daily lives as long as possible (Withey, 2011, p. 124). The dividing line between wellness and sickness in the 18th century was probably not so well-marked (Withey, 2011, p. 126), since small scale farmers, peasants and the majority of poorer urban artisans probably did not go to hospitals except in extremis, and so would have not produced illness narratives in our modern sense. The true dividing line was between inside and outside the hospital. Lying in a sickbed at home, patients were not subject to the enforced impotence of the hospital routine and to the loss of their intimate relation to their own bodies.

Initially, the few narratives that were recorded tended to concentrate on the patient's ailing body. Gradually, however, narratives evolved: "While seventeenth-century sickness depictions in letters often mentioned symptoms and often something of the state or condition of the sufferer, the eighteenth-century sufferer presented their sickness effectively as a story, complete with plot, dramatisation and even serialisation" (Withey, 2011, p. 134). It seems descriptions were moving away from a straightforward description of symptoms and pleas for relief to a truly narrative structure intended to present a grand overview of the crisis and re-establish the patient's voice in describing their condition.

If the increasingly complex division of labour in the17th and 18th centuries led to a culture of surveying, which triggered people to create their own versions of the world by the spoken and the written word, certainly it would have taken some time for this phenomenon to have trickled down from the larger European centres to margins such as 18th century Wales described by Withey. It seems, though, that as long as people avoided hospital (except as places where the indigent went to die), narratives continued to be about the body and its ailments. By the 19th century, in another Western margin (Ontario, Canada), patient narratives were supplanted by standardised medical records in jargon (Niburski, 2019). Jewson (1976) was one of the first to enunciate that by the 19th century doctors categorized patients by their symptoms. First-person accounts of illness in hospitals became the exception. Wealthier and presumably better-educated patients probably opted for home care rather than hospitalization, and so patient narratives from hospitals were rare (Carpenter, 2012). Modern illness narratives have become a recognized genre which, by framing the patient in his or her local environment, can be used by sympathetic medical professionals to gauge the patient's sense of alienation, isolation

and suffering.[11] These narratives form a counterweight that establishes and reinforces the legitimacy of the individual experience of suffering that is ignored or suppressed by the biomedical machinery to which the patient is subjected (Riessman, 2002), which is probably the reason why illness narratives are generally not elicited by the majority of medical professionals.

5. In Search of Lost Time

During my many stays totalling five months in three Montreal hospitals in the 2010s and again in 2021, I had many opportunities to participate in conversations with my fellow sufferers. These were not recorded, nor were they elicited as part of a research project. They were spontaneous. Most were prompted (reciprocally—I was not acting as a researcher) by a banal, 'How are you doing?' I quickly came to see that these narratives adhered to a rather rigid and particular structure. They contained few details of their ailments apart from a few general words ('I have stomach cancer'; with a ward system, any patient I encountered was likely to be a fellow sufferer),[12] almost no details of their previous lives or of their hoped-for future ('I am/was/work as an accountant/teacher', etc., or, 'I can't wait to get back to my job, walking my dog'... etc.). No one mentioned missing pets, family and friends. Instead, they presented a somewhat detailed picture of their daily hospital routines. It is as if these narratives described lives that had been suspended in a time bubble stuck in an eternal present. In fact, almost all the verbs used were in the present, even those describing past events in the hospital. In hindsight, this alerted me to the implied importance of the time frame that was being interrupted by the hospital stay.

The narratives I collected adhered to a standard plan.[13] The alpha point of the story is the entry into hospital. Certain details of the illness sometimes emerged, but it was striking how much these accounts ignored the medical details of their illness. This was surprising, as I thought the stories would have expressed a desire to return to a time when people were healthy. Yet this was rarely manifested. Some patients had absorbed some professional jargon but these ostensibly biomedical details enabled patients to reinforce and concretize their mini-biographies of their experience in the hospital. Narratives shared an emphasis on constructing an individual imaginary, on appropriating the alienating conditions of the hospital and making them their own; in other words, of how the hospital's specific services and conditions impacted them. In general, the stories related the treatments undergone and the conditions of confinement experienced.[14] These biographies sometimes fused together several episodes of hospitalization, as if the norm had become the hospital and 'real' life outside the institution no longer played a role in the construction and presentation of the Self. Conversations are rarely reproduced in the narratives (e.g., no "My doctor says..."), which take on the flavour of soliloquys, again suggesting that patients are not concerned with their biomedical diagnoses.

Narratives usually start by a description of the entry process, bureaucratic registration, the number of nurses or doctors who initially attended, questions asked by ambulance drivers or triage nurses, and sometimes, the various locales they occupied (e.g., window orientation, outside noise level) but rarely some medical details such as their blood pressure, etc., the discomfort of the stretcher, how long they waited in the ER before seeing a doctor. Of course, the details vary, as not everyone has followed the same path, but in general, the patient surrounds themselves with details that signal that they are moving from one world to another. Finally come the details of a miraculous or dramatic medical intervention: surgery, the start of radio- or chemotherapy treatments, sometimes physiotherapy (in the cases mentioned in note 12). The same attention is paid to the details of the intervention or first treatment: preparations are noted—travel to the intervention or chemo- or radiotherapy room, intubation, injection, descriptions of the medical personnel and of the intensive care

room (not a ward as such, so more likely to encounter people experiencing a variety of reactions to anesthesia, including one-way conversations or weird accusations that the medical personnel are CIA operatives, etc.). Not all patients include all of these details, but all accounts select from this range.

No patient mentioned missing family, friends or work. The past does not apparently offer any comfort of a happier time. Not only was the past rarely mentioned, it was also rare for a patient to mention the future: a trip to celebrate recovery, a favorite restaurant to revisit, and so on. In short, the tales were set in an eternal present.[15] It was also remarkable to me that the stories seemed to adhere to the same structure despite differences in the patients' length of stay. One woman had been there for nearly a year and a half, yet her story as she told it to me was no more elaborate than those of patients who had been in the ward for a week or two. Indeed, I found it relatively sketchy as far as details were concerned, but after a year and a half in the same ward her new biography was probably already well-polished.

It should come as no surprise that narratives somewhat resemble each other, no matter if they come from Wales or Ontario. The similarities are deeper, however. I was surprised that the narratives I heard traced a journey, with hospitalization as a starting point rather than the earlier events or conditions that led to illness. In other words, the narratives I heard have a very distinct temporal structure compared to the corpus of narratives cited in the scholarly literature, which take it for granted that patients want to talk about the body.[16] These, however, are narratives elicited by medical professionals, unlike the ones I collected spontaneously. It is not surprising that in elicited narratives patients respond with stories that target the body and talk about the past, about how the body became ill, since they are being asked pointed questions about their biomedical condition or prior lifestyle choices that may have triggered their illness. In spontaneous narratives, however, the patient weaves together the events of his or her stay: the blood sample or temperature check at 6 a.m.; injections and medication; breakfast; the sponge bath; the nurse's aide's visit to transfer to the chair; the five-minute visit from the doctor and their team of students; lunch; reading or television (afternoons are quieter); visitors; supper at 5 p.m., interspersed with unscheduled treatments or tests as equipment slots become available; the wards were usually quiet by 8 p.m. Most of the day's scheduled activities turn the patient into a passive subject, interposed and reinforced by boredom: apart from reading, the choice of television channel and walking the corridors if they are able, there is no activity controlled by the patient. In such circumstances, narrating one's interaction with the medical environment becomes an act of appropriation, taking back the dominant discourse from the medical staff. This is the context in which of the stories I heard.

The fact that these narratives have a coherent temporal dimension at their core has also been noted by other researchers, but more in the context of its connection to the body rather than to the hospital. For example, Rier notes (2000) that his experience of severe illness that landed him in intensive care for three weeks cancelled out the sensation of the normal passage of time, as the patient (he generalizes from his personal experience) is placed in an environment devoid of clues to his previous life. Rier is one of the few researchers to have noted the loss of temporal framing in the hospital setting. The struggle to survive from one minute to the next creates an eternal present in which the patient no longer has any sense of the unfolding of events outside his own body, an experience Rier calls "immediacy". In my case, however, I am not referring to patients in intensive care but to patients in the general population. People in intensive care usually are isolated and do not or cannot interact with other patients. In other words, it is certainly possible that patients in ICU create new time narratives that frame their experience based on what is happening to their body, as Rier suggests, but they have no one with which to share nor do they have outside events with

which to build a narrative. In contrast, nearly all the narratives I heard were offered when sharing a room, or when patients encountered one another while walking in the corridors or, in a few cases, in small lounges that Montreal hospitals offer so patients can meet their visitors (patient rooms usually have only one chair, so multiple visitors have to use the lounge—assuming the patient is mobile—or sit creatively on beds, radiators or window sills or hunt for chairs in the ward). Patients would often use these lounges even without visitors, just to get out of their rooms. They became chat rooms in the flesh.

Most analyses note that patients and doctors speak two different registers, one based on the patient's desired notions of care, the other on the healing precepts that the educational pathway has inculcated into the doctors' culture. For example, Charon writes:

> The parallax gaps that occur between doctor and patient are not simple misunderstandings or lack of knowledge—scientific knowledge for the patient, knowledge about the patient's lived experience for the doctor. Rather, the deep and conflictual *positions* of the two are exposed. The sick person faces, in the doctor, a person who sees sickness fundamentally as something to be fixed and managed, a person whose training and clinical responsibility have spoiled his or her capacity to understand what living with sickness must be like. The doctor faces, in the patient, a person who sees sickness fundamentally as something to be undergone and made meaning of, a person whose very existence throws down a challenge to knowledge, a leering at powerlessness, a mute accusation that all cannot be cured. (Charon, 2011, p. 35)

The emphasis here (the author is a doctor) is that the difference in the two positions can lead to an impasse in healing, as the patient does not share the doctor's unshakeable confidence that illnesses can be cured. But, as Sylvie Fortin (pers. comm.) suggested, the patient may have an expectation of care from the doctor, whereas this is no longer the doctor's role in current hospital practice. It is the contemporary status of medicine that is at stake—a status that is inseparable from the institutional context, where roles are increasingly specialized and defined more by technical issues than by human needs. Yet institutions and their practices have been created and managed by doctors, and so it is hardly surprising that the powerful doctor (Rier) transformed into the vulnerable patient should have an epiphany when she realizes that patients are totally helpless.

Note that Charon (also a doctor) adopts a personalized tone but when presenting the patient's position she uses the impersonal 3rd-person voice. This discrepancy is certainly plausible, but the subtext is that the patient's narration is somehow depersonalized and therefore less convincing ('the patient') rather than the doctor's 'I', since health professionals who solicit patient narratives are convinced that the patient's words cannot balance the unequal relationship between doctor and patient to set them on the road to recovery (see, for example, Carle, 2013). Even if they demonstrate a sensitivity to the patient's suffering, these professionals take it for granted that the patient's stories focus on the ailing and failing body, while they, the professionals, embody the healthy hospital whose healing power is a central trope in their culture. This dichotomy is partly empirically true, but most if not all healthcare professionals seem unaware that patient narratives do not necessarily seek to diminish the gap between patient and doctor by mirroring in a diminished form the doctor's professional register. In other words, patient narratives are not dumbed down versions of the 'real' thing as defined by medical professionals. It is not that patients lack the jargon or expertise to meet medical professionals' expectations of a narrative; it is that they target a completely different audience: the self, not the doctor.

Indeed, most analyses of patient narratives accept that patients' elicited narratives see illness either as a biological phenomenon (the medical position) or as an incomprehensible event that must be absorbed and contextualised within the patient's idiosyncratic experien-

tial and biographical matrix. Many professionals insist that both formats, the medical and the personal, share the same goal: to heal the patient. They seem unwilling to understand the sense of isolation expressed in these narratives as caused by contemporary medical culture that mirrors the neoliberal depersonalization that dominates contemporary discourse.[17] In brief, most professionals are only interested in the prior details that may have caused the patient's illness.[18] In the relatively rare instances in which researchers explicitly ask the patient about their hospital stay, it is not surprising that the patient may complain about their conditions—understaffing, dirtiness, bad food, etc. (Holmes & Stephenson, 2010). Frustrated by their illness and surrounded by ever-hurried staff whose professional formality depersonalises the patient's voice, patient complaints may seem to be directed at the medical professionals themselves, which does not encourage the professionals to go beyond the surface. In fact, it may encourage them to conclude that the patient's narrative is not a useful guide for treatment.

Finally, the political context can also condition narratives. In the American medical system, "... health care in the United States operates as a marketplace within which (at least some) patients can leave their current clinician if care does not meet their needs, [so] providers have long had some incentive to use patient experience surveys to understand consumers' perspectives" (Grob et al., 2019, p. 178), whereas Canadian patients with a public health care system have far less choice as to their doctor or even where they are treated. In this case, American professionals elicit narratives with pointed questions that target patient satisfaction and thus their performance as vendors of medical services. This, however, only reinforces the depersonalisation of the patient, who is reduced to being a mere consumer and the hospital just another Walmart. The illusion of contractual equality in the relationship—I sell, you buy—in fact masks the desperate plea for help by the patient, who is asking for structured inequality—you give, I take.

6. Conclusions

Hospitals mirror the hegemonic practices of their respective eras: the first hospitals in the West were places for isolating sick bodies at a time when the cultural apparatus of the modern nation-state was emerging. Rome perfected the governance of its heterogenous lands by using the metaphor of the social body to create a bridge between the everyday life of the individual and political reproduction in a context of profoundly antagonistic class relations. The practice of isolating the sick body on Rome's sacred island worked on two levels, by removing the visible threat of symbolic infection of the social body and by reinforcing the importance of the spatial dimension in political equilibrium, an apt addition to the tools of governance in the context of Rome's dependence on foreign labour, foreign tribute and foreign foodstuffs.

I suggest that today's oppressive hospital culture pushes patients to construct personal narratives that concentrate on the minutiae of their environment, weaving these details into a coherent temporal matrix, a temporary autobiography. They could have constructed narratives that traced the emergence of the symptoms of their illness (which they do only when prompted by medical professionals), but their spontaneous testimonials avoid this, as this would clash directly with the competence of healthcare professionals and thus have the effect of increasing the agency of these professionals on whom they depend but who contribute (involuntarily, it must be said) to the patient's malaise. Although it might seem that hospitals are symbolically part of the medical professional's world, patients focus on banal details of the working of the hospital rather than on illness. Their narratives are thus personalized and help them reclaim their voice that has been silenced by medical culture. The patient becomes a protagonist in the drama of their existence. Unlike the sick Amazonians described by Lévi-Strauss who are rescued from their illness-induced extreme

isolation by the shaman when he temporarily joins the patient in their disturbed condition, the contemporary patient has no shaman to help them and no community to which they seek to return. Living in a context that values individuality above all, they must rebuild the self weakened by the medical culture that does not acknowledge his or her individuality. Even their illness is appropriated by the medical culture that treats patients as technical puzzles to be solved. Hospitals have become time machines—not the science-fictional kind that allow people to slip between the past and future but devices that use the present to allow the patient to construct a simulacrum of a biography in which they emerge from passive victim to once again become an active agent.

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Notes

1 This is perhaps the origin of North American Indigenous stories of shamans being able to visit the netherworld. See Lanoue (1993).

2 This idea of a barrier isolating the patient is mentioned by Carle (2013) in the context of his analysis of a Montreal hospital, where patient resistance is seen as irrational, and the role of medical staff (especially nurses, who have more intimate contact with patients) is to 'bring' the patient to accept 'rationally' the treatment plan desired by the doctor. This, however, is not bringing a patient back into the community but detaching them from their normal frame in order to bring them into the specialised and alien community of medical professionals.

3 See, for example, Hawkins (1999); Couser (2009).

4 For example, Luke 17:12–24 describes the moment when ten men with leprosy came to Jesus asking to be healed, which Jesus did.

5 This is the Roman version (in Ovid, Metamorphoses (multiple editions), vol. XV:622–745), which 'Romanised' the Greek original, where the snake is in a tree, according to a Greek votive plaque "of uncertain provenance", which shows a snake, a sacred animal-god, in a tree. At the foot of the tree is a sick man on a litter who begs the animal-god by lifting his sick leg towards the tree and the snake (Grmek & Gourevitch, 1998, pp. 296–297). The symbolic importance of the snake is attested to in Sumerian legends more than 1000 years before it emerged in the biblical Garden of Paradise: a snake stole the gift that Gilgamesh received on his visit to the Garden of Wonders that would have enabled him to regain his youthful appearance. According to the Epic of Gilgamesh (Volume XI), this is why the snakes can moult and remain young. The popular legend that a hospital for sick slaves was founded by the Emperor Claudius can be traced in Suetonius, The Lives of the Twelve Caesars (multiple editions), "The Life of Claudius", vol. 25, verse 2. The work was written c.121 CE, i.e., c.70 years after the death of Claudius and c.400 years after the foundation of the Tiberian hospital. Indeed, Suetonius writes that the sick slaves who were abandoned by their masters on the "island of Aesculapius" because the latter did not want to take on the responsibility of caring for them were freed if they recovered, and that a citizen who killed a sick slave could be accused of murder.

6 The island is still the site of a major hospital, Fatebenefratelli, founded in 1585 and still run by the Hospitaller Order of St John of God, dedicated to caring for the poor. In Montreal, they founded two hospitals, Notre-Dame de la Merci, and the Hôpital Général, which became the Centre d'hébergement Paul Émile Leger.

7 *Ab Urbe condita libri*, in 142 books (rather, chapters) that he wrote from the year 32 BCE until his death in the year 17.

8 It is impossible to specify the first use of the metaphor of the social body, but the trope was fairly well known in Cicero's time at the beginning of the 1st century BCE (he was Consul in the year 63 BCE.), as he used it frequently in his speeches (Crawford, 1978, p. 162); therefore, approximately 100 years after the creation of the hospital on the Tiber island.

9 Unlike popular Hollywood images of gates in walled cities, Roman gates had no doors to close against enemies.

10 So much so that Emperor Augustus in 7 A.D. recognized the island as an official neighbourhood (*Vicus Censori*) in his reform of the old system of *regiones* (pl. 'regions', colloquially 'neighbourhoods'; Moreau, 2017). Note that '*vicus*' designates a village

and not a neighborhood (sing. *regio*) as such, and therefore the island had an urban status, but an ambiguous one. According to Moreau (2017, p. 434), archaeological excavations of the island revealed no prior traces of habitation, which supports the hypothesis that the island had a special status and not that of a normal *regio*, although Moreau, on the basis of other data, believes that the island had residents.

[11] See the discussion in Fraser (2004). The same point is made by Waddington and Willis (2013, p. iv) in their introduction to a thematic issue on *Rethinking Approaches to Illness Narratives.*

[12] There were of course a few exceptions: one man had had both lower limbs amputated below the knee from diabetes; another had lost large parts of his thigh to flesh eating bacteria.

[13] Unlike patients whose symptoms have no obvious biomedical explanation and who produce, in the jargon adopted by one author, 'chaos narratives' which, from the professional's point of view, make no sense but which may still reveal ways of diagnosing the patient; see Sowińska (2018).

[14] See, for example, Hawkins (1999, pp. 33–60 passim), where, in the context of a literary analysis, she proposes that these narratives resemble myths of self-transformation ('rebirth'), and that their components are structured according to a model of selective forgetting and invention to put forward the idea that severe illness is only the first stage in a process of personal transformation and growth.

[15] Rier (2000) was surprised at the discrepancy between his memory of the facts a few weeks after his stay in intensive care and the reality he recorded in his diary during his illness. The phenomenon of selective forgetting of details of the hospital stay is mentioned by Petersson et al. (2015) in the context that diaries help patients to remember their journey. The authors assume that trauma leads to forgetting. Radley and Taylor (2003) suggest that patients forget details of their stay. According to the authors, photographs help people to remember. Note that the hypothesis is based on the experience of a single patient, and that they explicitly asked the patient to recall the details of her stay.

[16] Köiva (2014) presents a case of patient-to-patient narratives in which they main content of the exchanges is about the body and patients' medical conditions, but these discussions occurred on internet blogs, not person to person spontaneous narratives in a hospital context.

[17] See, for example (to cite only a few): Grob et al. (2019); White and Shriver (2002); Locock et al. (2014).

[18] See Schleifer et al. (2013). Aull (2015, p. 287) mentions that there is a tendency for professionals to adopt a register that implicitly questions patients' competence to self-diagnose. For example, the medical report uses neutral constructions when it comes to verifiable empirical data ("the patient is 46 years old, weighs 83 kilos, is 1m81 tall"), but adopts dubious constructions when it comes to quoting patients' statements when they talk about factors that could have affected their illness ("the patient states that he does not smoke", rather than "the patient does not smoke").

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