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# Health Humanities and British Romanticism

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## Abstract

This article gives an overview of health humanities (HH) scholarship within British Romanticism as a literary historical field. Romantic literary studies has a peculiar relationship to HH work—one that justifies examining it separately from its adjacent fields, 18th-century and Victorian studies. The article surveys HH work from the past 20 years of Romantic scholarship, drawing some conclusions about how the field's history has informed its current shape, before offering some tentative predictions about the future.

## 1 INTRODUCTION

In this article, I offer an overview of health humanities (HH) scholarship within British Romanticism as a literary historical field.<sup>1</sup> I will begin with a brief introduction to the HH as they are currently understood by scholars who practice them. Then, I will turn to Romanticism. Romantic literary studies, I will argue, has a peculiar relationship to HH work—one that justifies examining it separately from its adjacent fields, 18th-century and Victorian studies. After recounting this relationship, I will survey HH work from the past 20 years of Romantic scholarship, drawing some conclusions about how the field's history has informed its current shape. Finally, I will offer some tentative predictions about the future.

## 2 THE HH AND METHODOLOGICAL PROXIMITY

As a deliberate scholarly project, the health humanities have existed since at least the mid-20th century, when US medical schools like Penn State began hiring humanities faculty. Around the same time, interdisciplinary groups like the Society for Health and Human Values formed. Both dedicated themselves to humanizing medical care through nonmedical partnerships (Trautmann, **1981**). I call HH a “project” and not a “field” because over the past 30 years, it has expanded to include a range of scholarly disciplines and approaches. These are united by a shared object of study—health—rather than by a particular methodology. “Health humanists” are sociologists and nurses; historians and literary scholars; and disability theorists and practitioners of Narrative Medicine. Partly because of this heterogeneity, scholars working in HH find the project difficult to define. Ongoing conversations in HH's two major journals and recent anthologies debate what HH is and what it should do.<sup>2</sup> Moreover, in the past 2 decades, disagreements about what to call the project—medical humanities, critical medical humanities, and HH—have become proxies for its most urgent questions: What relationship should exist between HH and professional medicine? How should health humanists critique medicine's structural problems, like institutionalized racism and ableism? In addition, how wide is HH's mandate, given that everything effects health and health matters to everyone? I do not have space to address these debates in this article. However, and for reasons that will become clear when I turn to Romanticism, I use the phrase “health humanities” rather than “medical humanities” and consider HH to encompass any study of the lived experience of health, illness, or embodiment, whether that study's relationship to professional medicine is trusting or critical. As Andrea Charise explains, “I prefer *Health Humanities*: as a matter of accuracy and as a statement of commitment to this field's broader inter-professional and non-expert applications” (Charise, **2017**, p. 436).<sup>3</sup> We do not experience health or illness exclusively in relationship to medicine. The HH's purview thus comprehends any structure or situation that affects human well-being. For example, the *Edinburgh companion to critical medical humanities* includes discussions of migration, genomics, labor, citizenship, and the death penalty (Whitehead et al., **2016**). Because these topics have profound consequences for people's health, they are as plausible foci for HH scholarship as analyses of doctors' bedside manner.

Literature has a unique place in this varied scholarly landscape. In the 1970s and 1980s, “literature and medicine” was one of the first interdisciplinary fields that coalesced in response to calls for humanist help in addressing biomedicine's perceived problems (Peterson et al., **2008**). Literature still serves as a flagship discipline within HH, partially because its offshoot, Narrative Medicine, gained recognition and some financial success in the 2000s. Health humanities initiatives that secure funding tend to be those with the most scientifically legible results, and Narrative Medicine is among the most praxis-based and institutionally friendly HH subfields.<sup>4</sup> But HH's relationship to medico-scientific legibility remains vexed for more traditional literary scholars, perhaps because they have been arguing since at least the 1800s about whether literature is, or should be, useful. When engaged in HH work, they face the additional hurdle of being judged via scientific criteria even Narrative Medicine sometimes has trouble fulfilling—a new version of the old complaint that “poetry makes nothing happen.”<sup>5</sup>

This problem becomes even more acute for Romanticists, whose field history includes a decades-long faith in poetry's healing power and a strong new historicist rejection of that faith in the 1980s.<sup>6</sup> Yet that faith was circuitously instrumental in shaping HH itself, giving Romanticism's relationship to the project some eerie family resemblances. I tell the full story of Romanticism's role in HH's development in my book, *The poetics of palliation* (**2019**). For now I will simply note that Romanticists tend not to classify their work as HH or even “literature and medicine,” despite a large body of Romantic scholarship on health, illness, and embodiment. This peculiarity caused me some challenges in compiling research for this article. In response, I developed a system for assessing Romantic scholarship's relevance to HH, via a factor I will call *methodological proximity*. By this, I mean a study's awareness of its ramifications for bodyminds in the world—in other words, how closely it keeps

in view the consequences of its object or outcomes on the well-being of actual people (“bodymind,” a term coined by Margaret Price, acknowledges how the mind and body's experiences are never separate).<sup>7</sup> Such concern with consequences is what distinguishes HH from interdisciplinary humanities-and-life-science scholarship. “Health” is experiential, contextual, and subjective. It is about how people feel. Therefore, HH foregrounds lived experience, whether considered individually or collectively, historically or contemporaneously. Below, I explain my criteria for evaluating methodological proximity with a hope that my framework might be useful to others.

I see two axes of methodological proximity in HH work. First is the spectrum between individual and collective experience: the difference between a study of one disabled woman's experience navigating her health insurance and a study of how US health insurance policies affect disabled people as a group. Second is the spectrum between concrete and abstract: the difference between a specific study of miners' unhealthy working conditions in Victorian Britain and a study of the general consequences of capitalism on the health of working-class people in the 19th century.<sup>8</sup> These axes are fuzzy tools, not rules or firm distinctions. They also overlap in various ways. For example, an individual-abstract study might show how predatory capitalism hurts an individual worker, while a concrete-group study might show how a particular labor law harms trans people generally. When combined, however, these axes describe a rough position of methodological proximity or distance that can gauge the visibility of a study's relevance to HH concerns. To wit: this relevance is easier to see the more *individual* and *concrete* a study is. Studies that are more distant—*collective* and *abstract*—are not less health humanistic. However, it might be harder to see (without explanation) why they are. To combine my examples above, more explanation is required to show why a history of the insurance industry in relation to British labor conditions is HH than a study of a diary of a woman injured in a 19th-century workhouse accident. This is because we tend to think of health and illness as discrete events that happen to individual bodyminds. As destructive as systems like capitalism, sexism, or ableism are for many groups of people, readers do not automatically register studies about them as studies about health, per se. It takes additional explanation, or individual examples, to show why they have concrete consequences for well-being.<sup>9</sup>

While I hope that these criteria are useful beyond this article, I developed them as a way of grappling with the quality of Romantic scholarship on health and medicine I mentioned earlier: a surprising amount of it is either collective or abstract or both, for reasons I believe stem from the field's unique history. Equally surprising, few studies take the additional steps I mention above to clarify whether their subject matter has concrete consequences for bodyminds in the world. However, I should stress that in my discussion below, when I call scholarship more or less methodologically proximate, I am not calling it more or less *valuable*. Medically inclined literary research need not be health humanistic to matter, just as all HH work need not be as institutionally legible as Narrative Medicine to be “useful.”

### 3 ROMANTICISM AND THE HH

First, a note on my own methods. My conclusions are based on a survey of Romantic scholarship broadly concerned with health, medicine, or the life sciences from several major journals (*Studies in Romanticism*, *European Romantic Review*, *Literature and Medicine*, *Disability Studies Quarterly*, *Medical Humanities*, and *the Journal of Medical Humanities*) and about 20 monographs and edited collections published since 2005. All surveys are necessarily incomplete, and I acknowledge that there are gaps in mine. Time and COVID-related access problems especially restricted the breadth of my research.

Since 2005, Romantic literary scholars have addressed a wide spectrum of health-related topics from a range of methodological perspectives. Some work centers on Romantic figures involved in medicine or whose experiences of embodiment were notable, most frequently the Shelleys, John Keats, Joanna Baillie, S. T. Coleridge, Erasmus Darwin, or Thomas Beddoes. Other work engages a secondary field like disability studies

(DS), animal studies, or ecocriticism. Most frequent, however, are studies that focus on a particular health condition, medical debate, or concept from life science and read that idea alongside the era's literature. Recurrent themes include vitalism/organicism (by far the most popular), anatomy, sensation, "scientific" experimentation, cognition, contagion, and vaccination, along with a host of individual studies of diseases like consumption. Among these are a handful of studies devoted to the rise of professional medicine during the Romantic era and explorations of some Romantics' faith in poetry's healing power.<sup>10</sup> A parallel vein of scholarship considers the early development of psychology, whose relationship to Romantic medicine is complex—especially because, as James Whitehead notes, Romantic "madness" has a fraught literary history.<sup>11</sup>

Curiously, many of the topical studies are what I would describe as methodologically distant from the HH. Even if they concern obvious medical practices like anatomy, their point is not usually those practices' effect on bodyminds in the world. For a representative example from *European Romantic Review*, Richard C. Sha's reading of the Romantics' "physiological understanding of the imagination" touches on nerve science, anatomy, and vitalism to outline a fascinating "aesthetics of embodiment." This aesthetics is less interested in how physiology or the imagination affects well-being than in their epistemological implications (Sha, **2013**, pp. 405, 416). On the axis I outlined above, this article is both collective and abstract. It is also typical of Romantic scholarship on health or medical topics. Exceptions do exist: recent work in Romantic DS (e.g., Emily B. Stanback's *The Wordsworth-Coleridge circle and the aesthetics of disability*, **2016**) and some older studies of Romanticism's role in the rise of professional medicine (e.g., James Allard's *Romanticism, medicine, and the poet's body*, **2007**) place the health of bodyminds front and center. I will discuss both at the end of this article. However, within Romantic scholarship published since 2005, their methodological proximity is not the rule. Why? I will offer three potential explanations, all grounded in Romanticism's peculiarity as a historical field: first, Romantic scholars' lingering new historicist baggage and the field's consequent embrace of organicism as its favored life-science; second, Romanticism's unusual place in the rise of professional medicine; and finally and most importantly, Romantics' tendency to *not* see medicine as methodologically distinct from science.

In her introduction to a 2007 special section of *European Romantic Review*, Geraldine Friedman calls "the science of life" the "dominant science in the Romantic century" (Friedman, **2007**, p. 205). Although the essays Friedman surveys cover botany, population studies, and organicism, it is the final topic that has received the lion's share of attention from Romantic scholars interested in medicine. Since the early 2000s, multiple monographs and dozens of essays have centered on organicism, a wide-ranging Romantic-era concept with complex biological, metaphysical, and aesthetic implications. Charles Armstrong calls organicism "a grounding systemics for understanding all holistic structures" (Armstrong, **2003**, p. 2). In medical terms, its major consequence was a faith that life and health could be recognized through their organized unity (Beiser, **2003**, p. 138). As Goethe puts it in one of his morphological treatises, "We ourselves are conscious of such a unity: for we are conscious of being in a perfect state of health when we sense the whole and not its parts."<sup>12</sup>

Significantly, the rise of organicism in medically interested Romantic scholarship since 2000 marked the end of the field's prolonged tumble with new historicism. High Romantic new historicism—inaugurated by Jerome McGann's *The romantic ideology* (**1983**) and Marjorie Levinson's *Wordsworth's great period poems* (**1986**)—rejected an influential vein of Romantic scholarship that had defined itself by a twinned faith in the immaterial self and the power of transcendent experience to heal that self (as in the conclusion of Wordsworth's 13-book *Prelude* and its well-known reading by Geoffrey Hartman as a *remedia intellectus* [Hartman, **1962**]). This rejection cast a long shadow. Even after the 1990s had passed, Romantic historicists were still turning outward to recover the era's material and collective commitments in an effort to qualify its typecasting as an age of therapeutic solipsism—a reputation it still holds among many scholars as well as beyond the academy. For Romantics interested in literature and medicine, this meant exploring topics that established Romantic thinkers' investment in the "real" world, whether understood materially or collectively. Somewhat surprisingly,

these topics favored Romantic medicine's theoretical discoveries over its practical role in patients' lives. Alan Richardson's *British Romanticism and the science of the mind* (2001) and Noel Jackson's *Science and sensation in romantic poetry* (2008) are classic examples of this genre.<sup>13</sup> Both are rich, field-defining books, and elegant proof that one way to avoid charges of therapeutic solipsism is to dismiss therapy altogether. For the same reason, until the 2010s, Romanticists mostly avoided medical topics that would have centered individual, interior, subjective experiences of healing.

It is telling that many turned, instead, to organicism—a topic in medical science that concerns life, but at a deliberately general level. For example, Robert Mitchell's *Experimental life*, about the “vitalist turn” in Romantic medicine, opens by insisting that the book concerns not “living beings” but rather “life in general” (Mitchell, 2013, p. 6). It keeps its methodological distance from bodyminds in the world. Accordingly, so do many studies that heavily engage Romantic organicism, including Sharon Ruston's *Shelley and vitality* (2005), David Fairer's *Organising poetry* (2009), Denise Gigante's *Life* (2009), Amanda Jo Goldstein's *Sweet science* (2017), and two *ERR* special issues on “Romantic Organizations” (2015) and “Romantic Life” (2018).<sup>14</sup> The affective result is peculiar. On the axis I have described, these studies are largely collective and abstract. Even those with passionate ethical commitments seem relieved to have found a way of talking about *life* without talking, too directly, about *living beings*. Organicism is not the only topic of Romantic literature-and-medicine scholarship that is skittish in this way. But it offers the clearest illustration of a wider tendency: avoiding lived experiences of health and illness in favor of medical theory, for fear of endorsing ideas about healthy selfhood the field has, since the 1980s, dismissed as naïve and solipsistic. It is no accident that these ideas echo those that dominated HH in the late 1990s and early 2000s, including the “whole person,” literary therapy, the irreducibility of individual experience, and the faith that the humanities can heal fractures in the “two cultures” (Snow, 1959). All strongly echo the Romantic stereotype of an insular self fissured by analysis and remade by contact with transcendence, whether found in poetry or nature.<sup>15</sup> In other words, where HH had arrived by 2010 was a place many Romanticists had just left. They were in no hurry to return.

If Romanticism's recent history explains one aspect of its distance from HH concerns, medical history itself explains another. The Romantic era was a time of great transition for British medicine. The years between 1790 and 1832 saw British doctors attempt to professionalize, adopting licensing systems, regulating medical education, and drafting a code of formal ethics.<sup>16</sup> What we would now call medical expertise was not limited to doctors, nor was medical discovery confined to hospitals. Practice itself was not yet standardized in the way it would become by the mid-19th century. As a result, no Romantic analogue exists to those Victorian literary studies that examine medicine as an established institution, whose doctors populated marriage plots and provided models for eccentric detectives.<sup>17</sup> At the same time, Romantic medicine was shifting away from the comparatively decentralized medical knowledge that had characterized the 18th century, and which make 18th-century studies of literature-and-medicine more social and cultural in their orientation.<sup>18</sup> Fuson Wang noted in 2011 that because of this liminality of Romantic medicine, DS had heretofore “directed its attention to the eighteenth century, the Victorian era, and post-ICD medicine while skipping over the Romantic period” (Wang, 2011, p. 467). Perhaps for parallel reasons, Romanticists working on medical topics are rarely interested in medicine as a nascent institution or therapeutic praxis. Instead, they gravitate toward what Jonathan Sachs, in a 2014 review of three new interdisciplinary monographs, calls “the making of particular knowledge and the institutions that shape it” (Sachs, 2014, p. 483). The literally undisciplined fertility of Romantic-era medical epistemology seems to fascinate scholars. Consequently, and understandably, studies of it lean toward the conceptual—even when dealing directly with people's lived experience. For example, John Savarese's (2018) *ERR* article on Joanna Baillie claims she found the “medical gaze to be deeply humanizing” in service of an argument about how her ideas fit into Romantic theories of social epistemology (Savarese, 2018, p. 41). For another, Michelle Faubert's (2016) analysis of contagion rhetoric compares Romantic suspicion of vaccines to the “epidemic” of suicides surrounding the publication of Goethe's *Werther*, sourcing both in a wider

fear that the “Other could become the Self ... and destroy it from the inside” (Faubert, **2016**, p. 389). Both studies are HH but less visibly so, concerned not with the experience of bodyminds in the world but with types of knowing we would now label “medical.”

However, maybe the most important factor in Romantic scholars' methodological distance from HH concerns is the one I have mentioned at the start of this survey: few studies self-classify as health or medical humanities. Few even align themselves with “literature and medicine.” As far as I can tell, this is primarily because many Romantic scholars working in these areas do not consider *medicine* to be methodologically distinct from *science*. When I was researching this article, most of the metacriticism I found focused on Romanticism and science rather than Romanticism and health, or Romanticism and medicine. Of the monographs I surveyed, most described the field to which they were contributing as “literature and science,” even if they dealt with what we would now call “medical” topics. They framed their methodological contributions similarly. Almost every book identified its goal as troubling the distinction between “literature” and “science,” usually accompanied by a desire to demonstrate how in the Romantic era, these disciplines did not exist—that they fruitfully inhabited the same spaces, sharing methods, materials, and objectives. As Gigante's *Life* puts it, her work on vitalism shows how Romantic “science and aesthetics confronted the same formal problems” (Gigante, **2009**, p. 3). Almost every post-2000 study on Romantic medicine or life science I have encountered includes some version of this claim.<sup>19</sup> Yet most still see it as a contested point. As Amanda Jo Goldstein wrote in 2017, of a book published a decade earlier: “And though Romantic literature and science has become a robust subfield in its own right, too rare are the moments when we follow through on Noel Jackson's important suggestion that ‘literature might be construed in this period as a form of scientific practice’” (Goldstein, **2017**, p. 13). These moments are no longer rare. However, one consequence of Romanticists' need to reiterate this point has been a disinclination to see the “science” in “literature and science” more granularly. Many studies of what we would now call “medical science” position themselves as *scientific* but not *medical*, as if implying that medicine includes a distinct set of methodological, practical, and ethical considerations were an anachronistic concession to disciplinarity.

The result can be confusing, and occasionally anachronistic in very different ways. For example, Mitchell's *Experimental life* files both physicians and surgeons under the broader term “scientist,” downplaying a distinction that mattered to Romantic thinkers, albeit along lines of class and reputation rather than research and praxis. For another, Jon Klancher's *Transfiguring the arts and sciences* claims that the Romantic era was “not yet an age of specialist scientific journals” (Klancher, **2013**, p. 6). As far as medicine goes, this is inaccurate: a competitive ecosystem of specialist medical journals existed by 1830, including *The Lancet* (founded 1823).<sup>20</sup> Argumentatively, these are minor quirks that do not detract from Mitchell and Klancher's excellent work. However, they do illuminate an odd consequence of Romantic scholars' proclivity to collapse medicine into science. One of the most influential claims of 1990s HH was Kathryn Montgomery Hunter's assertion that “medicine is not a science” (Hunter, **1991**, p. 1). Rather, Hunter argued, medicine is a therapeutic praxis employing scientific knowledge. In response to calls like Hunter's, for the past two decades HH has been broadening its scope beyond the procedures of clinical biomedicine. If medicine is more than medical science, health (and HH) is more than medicine. Ironically, then, by reducing medicine to science, some Romantic scholars have replicated the definition of medicine against which early HH set itself. In doing so, they have sidestepped precisely those aspects of health—the nonscientific, nonclinical, and experiential—HH now considers central. As James Whitehead puts it, in recent scholarship, “the poet-scientist” has “drawn more comment than the Romantic poet as patient, notional or actual” (**2017**, p. 74). Here is perhaps the key reason so much Romantic scholarship on health and medicine seems methodologically distant from HH. It blurs its relevance to HH concerns by viewing itself through the telescoping lens of “science,” making that relevance, however real and legitimate, tough to see.

Exceptions to this trend do exist, although they are rare. A handful of recent monographs on medical topics focus on lived experiences of health and illness rather than (or in addition to) medical science. Although none self-classify as HH, of all the studies I surveyed for this article, it is easiest to see how they might. Intriguingly, most were published in the mid-to-late 2000s. After 2010, with the notable exception of DS (including “mad studies”), anxieties about the relationship between science and medicine seem to have nudged Romantic scholars increasingly toward “literature and science.”<sup>21</sup> For example, Sharon Ruston's astute 2013 book subtitled itself *Case studies in the literature, science, and medicine of the 1790s*. It is careful to maintain this order of importance even in its thesis, where it gives science pride of place: “this book contends that science and medicine should be recognized as playing a part in the creation of what we now, anachronistically, call ‘Romanticism’” (Ruston, 2013, p. 2). Likewise, Gavin Budge's (2013) monograph chronicles how writers like Coleridge fretted that their own “bodily spectres” of disease created specious feelings of transcendence (Budge, 2013, p. 8). Yet the book still centers on a fairly abstract idea from medical science: Brunonianism, a theory whose metaphors (stimulation, nerves, irritability, and energy) gained a life of their own during the 19th century. Earlier works seem less anxious about these distinctions. For example, James Allard's *Romanticism, medicine, and the poet's body* (2007) considers the history of professional medicine, approaching doctors as carers who can help or hurt the human body. At the opposite end of the spectrum, Paul Youngquist's *Monstrosities* (2003) chronicles the medical and cultural consequences of categorizing some bodies as “monstrous,” and Clark Lawlor's *Consumption and literature* (2007) reads the Romantic aesthetic of consumption alongside its painful embodied reality. However, all three studies take a concrete and individual approach to health. Their methodological proximity to HH is thus more obvious than the comparatively collective and abstract attitude of life-science-minded “literature and science” studies.

If the years after 2010 saw fewer monographs that could be easily aligned with HH, however, it also saw a surge in Romantic DS—the most important exception to the trend I have sketched above.<sup>22</sup> For all its heterogeneity as a field, DS keeps embodied experience front and center. As Michael Bradshaw and Essaka Joshua note in their introduction to *Disabling Romanticism* (2016), Romantic DS aims to bring literary readings, especially those that view bodies symbolically, “into contact with historical lived experience” (Bradshaw & Joshua, 2016, p. 33). Disability studies' methodological proximity to HH, while complex, is therefore evident. Both projects are concerned with the consequences of their objects of study for bodyminds in the world. In addition, recent studies in Romantic DS have offered excellent models of how scholars might balance the abstractions of medical science with the concreteness of embodied health and illness. For example, Emily B. Stanback's *The Wordsworth-Coleridge circle and the aesthetics of disability* (2016) deliberately “foreground[s] the insistent material reality of the body,” examining “how disability impacts the aesthetic relations between the human body and the various bodies with which it comes into contact.” The book's three-part structure moves from articulations of disability within Romantic medicine, to experiences of “the ill self,” and finally to “intersections of textual and corporeal form” (pp. 44–45). It also pairs literary readings with records of personal experience, like Tom Wedgewood's chronic pain (Stanback, 2016, pp. 44–45, 143). By acknowledging that such experience is always intersubjective, contextual, and non-dualist, this approach avoids relapsing into solipsistic models of Romantic selfhood and therapy. It also resists reducing medicine to science. For Stanback and other Romantic disability scholars, this distinction matters because DS's overarching mandate is ethical. As Essaka Joshua puts it, DS is part of “what has come to be known as the ‘ethical turn’ in literary studies” (Joshua, 2020, p. 35). The field therefore sees medicine as an actor that shapes how different bodyminds navigate the world. Medical science is the context and, often, justification for that action. DS retains a robust connection to its activist roots, and baked into its methodology is a concern with the effects of cultural institutions, including medicine, on actual people.

Perhaps the rise in Romantic DS illustrates not simply an exception to but a future direction for the trends I have been describing. Because DS offers a distinct model for analyzing topics in Romantic-era health and medicine, it is plausible that future scholars interested in these ideas might gravitate toward DS instead of the



methodologically broader literature and medicine or HH (even if DS and HH frequently overlap). If the bibliography of *Disabling Romanticism* is any augury, this tide is already turning. Several of the scholars mentioned in this article have begun to publish scholarship Bradshaw and Joshua consider DS-adjacent.<sup>23</sup> Alternately, perhaps Romantic DS will follow the usual course of new methodologies introduced into a historical field: a slow uptake of approaches by scholars who study health and medicine but do not necessarily align themselves with DS. Either outcome could allow Romanticism to finally expand beyond its long-standing but narrow affection for medical science. Grounded in the belief that health is complex, non-dualist, and intersubjective, DS offers a different starting point from the early 21st-century history of Romantic criticism, with its lingering fear of naïve ideas about self and therapy. Moreover, DS sidesteps the persistent Romanticist anxiety to prove the era's thinkers really did care about materiality—again, by insisting that being embodied at all automatically puts you in some relationship to it.<sup>24</sup>

This is comparatively new ground for Romantic studies. Scholars may take some time getting comfortable on it. However, once they do, the horizon of possibilities could prove as wide as that opened by the field's 20th-century turn to historicism. What does “Romanticism” mean when it no longer has to define itself either by or against immaterial transcendence? I suspect that a lot of very interesting answers will hail from Romantic DS and from scholarship that is more methodologically proximate to the HH.

## ENDNOTES

<sup>1</sup>My profound thanks to Jason S. Farr, Corey Goergen, Laura Kremmel, Travis Chi Wing Lau, Jared Richman, and Emily B. Stanback for their insightful feedback on an early draft of this article; to this article's two anonymous readers for their helpful comments; and to *Literature Compass's* “Nineteenth-Century Networks” section editors, Jacob Risinger and Daniel Williams, for their advice and support.

<sup>2</sup>For anthologies that offer useful definitions of health humanities (HH), see Crawford et al. (Eds.) (2020) and Bleakley (Ed.) (2019). For the debate occurring across the flagship journal *Medical Humanities*, see Evans and Greaves (2010) and Viney et al. (2015).

<sup>3</sup>Similarly, the editors of a special edition of *Journal of Medical Humanities* explicitly adopted “health humanities” as of 2017. See Berry et al. (2017).

<sup>4</sup>Narrative Medicine has become the preeminent HH field in part because it slots so easily into professional medicine's preexisting aims—so much so that some HH scholars see NM as metonymic of the field itself. As Sara Van den Berg writes, “The most important agenda in Medical Humanities is to explore how attention to these interrelated and competing narratives can improve health care” (Van den Berg, 2015, p. 628). This is troubling because it positions MH as a secondary project whose key task is to “improve” professional medicine. Many HH scholars reject such instrumentalist descriptions of their aims (Viney et al., 2015).

<sup>5</sup>In 2010, Rita Charon had to defend the value of Narrative Medicine in *Academic Medicine* from complaints that its efficacy could not be quantitatively measured. See Charon (2010). For a recent history of the HH in relation to literature scholarship, see Billington (2016).

<sup>6</sup>For an influential early version of Romantic poetry's healing power, see Hartman and the tradition of reading Romantic poetry, especially Wordsworth, in terms of “anti-self-consciousness” (Hartman, 1962). For a history of how the assignation of healing power to Romantic poetry influenced John Stuart Mill's liberalism, the New Critics, and eventually HH, see Pladek (2019), chapters 1 and 2. For the related psychoanalytic tradition of viewing Romantic poetry as therapeutic, see Darlington (1998) and Wu (2004). For the new historicist rejection of poetic therapy, see McGann (1983).

<sup>7</sup>At key points in this essay, I use the term “bodymind” in addition to “body” as per common practice in disability studies (DS). “Bodymind” resists the ableist dualism of the mind controlling the body, recognizing that mind and body are not separate entities and are not experienced as separate by most people. See Price (2015).

<sup>8</sup>My axes were influenced by Garden (2019).

- <sup>9</sup>Work in feminist DS has critiqued the idea that we endure illness as isolated individuals, showing how our experiences of embodiment are collective and interdependent (Kittay, 2002). However, we are still a long way from an academic publishing landscape in which a book on, for example, the transatlantic slave trade would be automatically seen as HH or concerned with health.
- <sup>10</sup>Unsurprisingly, Romantic journals like *Studies in Romanticism* and *European Romantic Review* contain far more pieces on health-related topics than health-related journals like *Literature and Medicine* contain articles on Romanticism. A representative sample of scholarship drawn from *ERR* since 2005, including book reviews, yields the following (these are rough estimates, since many of these categories overlap): over 30 articles on individual authors' relationships to medicine, including 6 on Joanna Baillie, 4 on Coleridge, and a special issue devoted to John Polidori; 7 on DS; 16 on organicism/vitalism, plus 2 special issues on "Organizing Romanticism" and "Romantic Life"; 3 on anatomy/dissection; 5 on brain science/cognition; 7 on embodiment and/or proprioception; 6 on mental health; 4 on professional medicine; 5 on the health of reading; 2 on contagion/vaccination; and over 12 on "science" generally but where "science" denotes "life science" or "medical science."
- <sup>11</sup>Whitehead's excellent study argues that the "mad poet" was constructed from "criticism, biography, and other discourse built around and over the remains of Romantic writers" (2017, pp. 2–3). In 2008, Joel Faflak claimed that a "definitive history of Romantic psychiatry and its relationship to literature" had not yet been written (2008, p. 5). See also Sedlmayr (2011), Richardson (2001), and Burwick (1996). Romantic psychology's medical connections have received somewhat more attention in studies of German Romanticism, enough to warrant their own chapter in the *Cambridge companion to German Romanticism* (Barkhoff, 2009).
- <sup>12</sup>Quoted in Richards (2002, p. 456).
- <sup>13</sup>Richardson writes to "remind us of an antidualistic, materialist register within Romantic writing that has ... been badly ignored" (Richardson, 2001, p. 36). See also Jackson (2008). Despite the proliferation of such scholarship, Romantic studies of medical science continue to set themselves against the same stereotype the new historicists were rejecting. As Sharon Ruston puts it in 2013, only recently does "the claim that Romantic writers were not necessarily anti-science no longer seem far-fetched" (Ruston, 2013, p. 2).
- <sup>14</sup>See Ruston (2005), Goldstein (2017), Gigante (2009), Fairer (2009), O'Malley and Sha (2015), and Gillingham and Murray (2018). The two *ERR* special issues were based on meetings of the North American Society for the Study of Romanticism (NASSR).
- <sup>15</sup>For characteristic examples of this era of HH work, see Frank (1995), and Charon (2006).
- <sup>16</sup>For an overview of the rise of professional medicine over the course of the 19th century, see Digby (1994) and Porter (2001).
- <sup>17</sup>For Victorian doctors in the marriage plot, see Sparks (2009). For an older but still useful overview of trends in Victorian literature and medicine, see Logan (2008).
- <sup>18</sup>For example, 18th-century HH monographs are more likely than Romantic ones to be concerned with intersections like gender (Jordanova, 1989) and disability (Farr, 2019; Mounsey, 2019) and with doctors as cultural figures—often satiric (Porter, 2001). For a notable exception, see Felluga (2006).
- <sup>19</sup>While these studies have broached an impressive number of topics—hypochondria (Grinnell, 2010), preventative medicine (Wallen, 2004), sensation (Jackson, 2008), Brunonianism (Budge, 2013), organicism/vitalism (Fairer, 2009; Gigante, 2009; Goldstein, 2017; Mitchell, 2013; Ruston, 2005), anatomy (Griffiths, 2016), and brain science (Richardson, 2001)—they have focused almost exclusively on medical science, often simply called "science." Several even make "science" titular. Whitehead's (2017) study of madness is a notable exception.
- <sup>20</sup>These journals were central in promoting nearly every medical reform of the 19th century, from public sanitation to educational standards. See Bynum et al. (Eds.) (1992) and Morton (1990).
- <sup>21</sup>For Romanticism and mad studies, see Whitehead (2017, p. 9).
- <sup>22</sup>Romantic DS easily precedes 2010—*European Romantic Review* published a DS issue in 2001—but it was only after 2010 that Romanticism began to see its first DS-focused monographs.

<sup>23</sup>Their introduction cites relevant work by Gigante, McGann, Sha, and Youngquist.

<sup>24</sup>Bradshaw and Joshua make this point explicit in their introduction to *Disabling Romanticism*, setting DS against Romantic poetry's "perceived claim or aspiration to transcendence beyond the material" (p. 4).

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