Chapter Six

Disease, Prophylaxis and the Narrative Society

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*I argue that the medical documentary, by medicalizing the body, at once depersonalizes it and renders it more “situated”, through references to filial and professional networks of care. This is achieved through a visualizing, as argued earlier in this section, of spaces where the ailing body is “cared” for and “rehabilitated”, like the space of the “home” and “family”, the medical institution/the clinician’s office. Films like Controlling Leprosy, Sanctuary of the Ostracized (A film narrating the story of the setting up of Anandwan or Maharogi Seva Samiti, a nonprofit organization founded for leprosy patients but now a rehabilitation center for persons with disabilities) and There is
Life for Selvi (which chronicles the efforts of the Community Health Education Society in Chennai towards rehabilitating AIDS patients) for instance, continually stress the importance of “restoring” self-esteem to patients once they have been treated, through a “return” to practicing a vocation. The narrator of Controlling Leprosy notes that one of the features of the State’s efforts at controlling leprosy (National Leprosy Control Programme), is the drive to isolate “potential” leprosy patients at their “homes”. This ensures, he adds, that not only can the incidence and spread of the disease be curtailed, but most importantly, patients do not have to leave their “homes” and “families” and travel to seek treatment. This is indicative of the importance laid on the local containment of disease, but also the relative “normalcy” afforded to patients who can be treated “at home”, and can avoid the unfortunate consequences that befall those who need to be restituted by the efforts of the State and other agencies. Controlling Leprosy further describes the advantages of seeking treatment early, by noting instances of patients who have not only been cured, the documentary emphasizes, but continue to work and take care of their families. They are not only cured of the disease, but are now productive members of their families.

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

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

Diagnosis of the illness is often spectacularly visualized in the documentary narrative – the viewer is taken literally “through” the patient’s body (with the help of a seamless interspersing in the documentary of X-rays, animated sequences and slides magnified under microscopes) and follow medical practitioners and researchers as they isolate and then “study” these otherwise invisible pathogens inside laboratories and hospitals. These “invisible” agents of destruction, thus isolated, are then “conquered” in the narrative, through a visualizing of the various medical interventions that are available for “normalizing” those deviant bodies that house them. It is significant to note that these medical images of disease are often employed in the service of an omniscient narrator (invisible to the viewer and may thus not belong to the ranks of medical “experts” who comprise the source of these “image-texts” within the narrative) and are thus removed from the context of the hospital or laboratory. The voice-over in several of these
documentaries provides the contexts within which viewers can interpret the medically imaged body. For instance, Figure 4 is from the opening sequences of the documentary *Conquest of Cancer*.

The documentary opens with the above image (Figure 4), while eerie music plays in the background. A voice-over begins after a few moments by saying, “This is not a work of modern art. This is us. The basis of our life – human cells”. The “cells” thus identified, continue the work of normal division on screen, while the narrator introduces the deadly menace of cancer – a condition that affects this “basis of life” not from the outside, but from within these so-far “normally” functioning cells. As Belling argues, viewers find meanings in such medical images, because of the text constructed around them that contextualize and break them down for the viewer and are also crucial in investing them with objectivity and “naturalness” (14). However, the text that surrounds this particular image in *Conquest of Cancer* is provided by a disembodied narrator, located outside the confines of the medical apparatus and institution.

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

(a) Ascertaining Disease

The medical documentary enables the viewer to participate, at a distance, in the medical “diagnosis” of illness. This “participatory” diagnostic narrative in the documentary, utilizes the visual and aural strategies described above, to draw the viewer into a domain that is otherwise out-of-bounds for a lay person. The participatory diagnostic narrative is crucial for the development of the viewer’s “sensibility” of disease, but is also important for establishing the medical institution as “redemptive” and implicating the viewer in a moral imperative to identify and seek treatment for a lapse in health. As Talcott Parsons has argued, illness allows an individual to take recourse to a “dependent relation”, where the temporary disability brought on by illness forms the basis of a legitimate claim to be “taken care of” (285). Moreover, the conditional legitimacy available to an individual’s “deviant” pattern like a period of illness automatically shifts to a collective – this individual’s dependency on other non-sick individuals like the medical institution/professional and the family and personal circle who collectively constitute a sub-system within the social system. What is significant about Parson’s sick role is that it is “institutionally categorized” and “socially recognized”, the individual’s status as “patient”, defined by being sick or sick enough to seek treatment is defined by persons other than the patient himself. The patient’s status as such, is thus sanctioned socially and institutionally, thereby extending control over the definition, care and restitution of illness. The “patient” is controlled by the “moral imperative” to return to a state of health and activity.
(i) The Moral Imperative: The documentary titled *Cancer* begins with the image of a man smoking, framed against the backdrop of a reddening sun (Figure 5). The narrator speaks as the man continues to smoke and notes, “The choice lies with you. He is in the prime of his life, not at the end. Could he be responsible if he dies, one wonders?” What is interesting about this image, is the conflation of temporal ambiguity with the ambiguity inherent at this stage in the man’s smoking and his apparent state of ill-health (he is closer to death as the narrator has contextualized, though this is not “visible” right away).

The viewer is directly addressed with the words “The choice lies with you” – the choice referred to here works at various levels. First, the viewer can “choose” to see the man as being in the “prime” of his life, thereby heightening the stigma attached to his smoking habit, which draws him “prematurely” to his imminent death. Second, the temporal ambiguity of the scene – the sun could here be the rising or the setting sun – contributes further to the viewer’s choice. The man’s “choice” to smoke is framed against what the viewer could “choose” to see as the “start” or the “end” of a day, with each such passing day steadily moving towards inevitable illness (specifically cancer in this documentary) and certain death. This ambiguity in situating the smoker somewhere between the prime and end of his life is significant at this stage in the documentary. The documentary will proceed after this initial sequence to provide affirmative evidence of the “scientific” links established between smoking and contracting cancer and will effectively negate the initial “choice” offered to the viewer. Smokers are more prone to cancer than others, the narrator who “wonders” at the start later asserts and the “choice” initially offered to the viewer is now limited to the “choice” of not smoking in order to enjoy a risk-free, healthy life. Moreover, the documentary here offers a veiled definition of this particular man being in the “prime” of his life, since this visualizing of the habit of “smoking” (as in
other cases where alcoholics, drug users, tobacco chewers, sex workers whose lifestyles are explicitly linked with the presence of illness) makes visible “risky” behavior, but simultaneously elides any “invisible” problems the body may carry in its “prime”. The medical documentary frequently calls to the viewer to “choose” health through an active participation in medical surveillance for disease. The alternative can be fatal, as many of these documentary narratives testify and moreover, this would involve the crossing over of the body from the established limits of medical science.

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

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

The documentary narrative thus interprets for the viewer, the function that this viewing as assimilation/dissemination of information performs for the viewer. Several other documentaries like *Gita Ki Kahani, H1N1: A New Influenza Virus, There is Life for Selvi, H1N1 – Few Facts*(see Figure 6), *Conquest of Cancer* and *Cancer* enfold within their narrative, groups of people being addressed by a medical professional who provides information and advisory about the spread and control of disease. The medical professional, the doctor and the healthcare worker, are portrayed within the narrative as a ready source of information for patients’ questions. Their “instructions” to groups of people or individual patients on screen, implicates the viewer of the documentary, himself/herself similarly at the receiving end of information and advisory from the documentary narrative. The documentary thus foregrounds its potential for enhancing literacy and knowledge and draws in the viewer through the metaphoric association of the “staged” or “reenacted” process of acquiring knowledge on screen.
The sooner the “diagnosis” of illness, the narrator informs the viewer, the better the chances of cure and improvement. Many diagnostic narratives in the medical documentary are particularized to individual “real-life” cases of illness. In *Your Enemy - TB*, for instance, the diagnostic narrative is particularized through the telling of the story of a young couple, Mala and Gopal. Gopal is urged by Mala, the narrator informs us, to visit the doctor about a persistent cough. Though Gopal is himself reluctant, he visits the doctor on account of Mala’s insistence. At the doctor’s office, we see that Gopal is examined and then referred to the TB Institute because his symptoms are suspected to resemble TB. Gopal, however, is seen to visit the TB Institute, only once his symptoms continue without respite and he is himself convinced that all is not well. Upon entering the TB Institute, we are informed that Gopal is subjected to a “thorough” medical examination – his sputum is tested and “reveals” the presence of tubercular bacilli. When the medical expert announces his prognosis to Gopal, the narrator echoes the viewers’ possible anxiety at this juncture, when the “presence” of illness has been ascertained beyond a doubt, by asking whether this was the end of Gopal and Mala’s life together. To this question, the doctor responds with an emphatic “No!” and proceeds to assure Mala and Gopal as well as the viewer, that “TB is completely curable today thanks to modern medicine and the progress of medical science”. Most importantly however, the doctor adds, “Luckily, you have come here well in time”. The TB infection inside Gopal’s lungs, we are led to believe, is still “in the initial stages” and can thus be completely cured. Indeed, the documentary does go on to show Gopal’s full recovery and return to a “normal” life, thereby underscoring the importance not only of medical intervention, but a timely diagnosis. The particular “story” of Mala and Gopal, is also instructive in its definitions of sickness and the sick role. Gopal’s decision to visit the TB institute is
spurred not by his increasing symptoms, but on account of their interference with his “work”. Before he visits the TB Institute, Gopal is seen at his office, seated at his desk but visibly uncomfortable. The narrator informs the viewer that this is another day for Gopal at the office, but he is “feeling listless” and has no motivation to work. It is at this point that Gopal is seen leaving his office (presumably earlier than usual), to visit the TB Institute. It is important to note at this juncture, that the “surveillance” of the self is an “imperative” or personal standard that has to be adhered to, even prior to seeking medical assistance. Self-surveillance is constructed in the medical documentary as a “moral” to be upheld, even prior to “entering” the professionally managed systems of monitoring within the medical institution.

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

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

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

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

As already argued in this section, the medical documentary foregrounds its “potential” in enhancing literacy and knowledge, through the “staging” on screen of the process of “learning” and “being educated” by watching film/video and being cautioned/instructed by medical/health experts. This process attempts, through a metaphoric association, to instill in the viewer the “ability” to recognize similar avenues for learning, presented by the format of the medical documentary itself. The medical documentary is thus presented as an “educational tool” that functions as a “source” of knowledge and brings together the attempts to eradicate disease made by multiple actors – doctors, health care workers, medical/research institutions, individuals who have experienced illness and treatment, public servants, among others. Foucault has demonstrated that there was an increasing medical coloration and thus “institutionalizing” of the practice of “improving” or cultivating the soul in Greek culture, where even the Philosophers’ School espoused the interconnectedness of education and caring for oneself (55). “Caring” for one’s “self” thus needs to be “instilled”, through systems of education that mandate and underscore the sustenance of “health” through a continued monitoring of “afflictions” of the body. Self-surveillance is espoused in the medical documentary, as a prerequisite or moral imperative to sustaining health, even outside medical/institutional systems of assisting/reinstating ailing bodies.
(ii) The Spectacle of the Ailing Body: As argued in the Introduction, public health discourse is affected by a crisis and anxiety about “visibility”. Ostherr has argued that public health cinema thus relies on indexical and artificial modes of representation, on account of the difficulty in “visualizing” pathogenic invaders that are “invisible” (180). Public health cinema moreover, to dispel the fear of an “invisible” threat to bodily and national borders, visualizes this threat as being embodied by a racially and sexually marked body that originates in spatially and temporally distant locations. The Films Division documentaries frequently rely on indexical and artificial modes of representation, to “visualize” the entry and presence of invisible pathogens within the body. Figure 7 to Figure 10 illustrate the visualizing of the break-down of the body’s immune system, on account of the AIDS virus and the consequent “populating” of the body with various other opportunistic infections. The figures illustrate a significant reduction and then complete absence of white blood cells, explained by the narrator to be the “fighter cells”, responsible fortifying the body against invasion. With the entry of a retrovirus like AIDS however, the narrator explains, (seen in figures 7 to 10 as “A”) the white blood cells quickly diminish, leaving the body open to other invaders. In figure 10, the body is seen to be teeming with infection.

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

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

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

(b) Social Restitution/Rehabilitation

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

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

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

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

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

Section III: The Sentimental Narrative in the Medical Documentary

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

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

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

While instances of the ostracization of those that suffer from contagious diseases may be showcased in the documentary as an erroneous practice, it nonetheless functions, along with the inevitable “awareness” the individual is shown to have of a lapse in health, as the condition of the individual’s existence. He/she is made aware, more than the physical pain of illness, of the disruption caused by this illness to what is portrayed in the documentary as “normal”, everyday existence. Disease is seen to disrupt the fundamental situatedness of the individual body, thus requiring immediate medical intervention to restore this body to its earlier place. Medical intervention is seen to redress the changes brought about by a lapse in health, to the relationship this body has with its socio-material contexts. The medical documentary thus negotiates the movement and position of its subjects, through what is produced as the “normal” and “healthy” spaces of everyday life. The individual’s entry into the medical establishment for instance, is contingent upon a declaration by this individual of his suspected status as “ailing”. In Sexually Transmitted
Diseases for instance, individuals are seen to “confess” to “high-risk” behaviour, like indulging multiple sexual partners or having visited sex workers. These individuals seek medical attention, both on account of an observed change in physical appearance and functionality, but also upon recognizing the “threat” they now pose to their families.

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

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

(a) The Individual: The Microgeography of the Body

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

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

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

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

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

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

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

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

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

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

(b) Community

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

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

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

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

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

(c) The City

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

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

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

*Space is thus reconfigured in the medical documentary at the level of the individual, the family, community and city to reveal hidden geographies of disease that expose and make evident the vulnerability of these levels of space.* The documentary narrative makes evident for the viewer, what Wald has termed “spatial promiscuity” (94). The possibility and potential of infection is thus located in the permeable boundaries between the levels of space visualized in the medical documentary.
This chapter has argued that the doctor-narrator in the medical *Bildungsroman* constructs a “narrative society” with an emphasis on individual patients as “stories”. The doctor-narrator foregrounds the therapeutic power of narrating “stories” and integrates them in his/her own “story”, to present a unified, social “self” that is attentive to the ethical dimensions of the medical narrative. This “self” created in the medical *Bildungsroman*, is able to attain “fixity” through the articulation of a particular kind of voice that emphasizes the social and draws upon the textual and cultural authority of the author. This chapter has also argued that the “story” of illness in an individual body narrated in the medical documentary visualizes for the viewer, a “potential” for violation by disease that exists in all bodies. The politics of the medical documentary, this chapter has argued, moves between scientific and affective poles. The scientific end is aimed at anchoring an “objective” and “factual” truth behind the instance of disease depicted on screen and relies on indexical modes of visualizing the inner landscape of the body. The affective sentimentalizes the embeddedness of the body and relies upon the viewer’s identification with the “familiar” modes of personalizing/particularizing the ailing individual as “story” on screen.
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