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Thinking regionally: narrative, the medical humanities and region

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ABSTRACT

Drawing on multiple literatures from history, geography, anthropology, sociology and literature, this essay asks questions about what we mean by region and why narratives of region should matter to the Medical Humanities. The essay surveys how region can be used as a lens of analysis, exploring the various academic approaches to region and their limitations. It argues that regions are dynamic but also unstable as a category of analysis and are often used uncritically by scholars. In encouraging scholars working in the Medical Humanities to be aware that regions are not simple objective or analytical boxes, the essay shows how an awareness of region helps challenge metropolitan whiggism and ideas of core and periphery to give a more prominent place to hinterlands, market towns, and rural environments. Furthermore, the essay considers how incorporating region into our understanding of illness can offer new insights. It demonstrates the need for scholars to be attuned to the narratives constructed around regions, suggesting that regions can be viewed as discursive formations which provide a frame for understanding both collective and personal ideas of, and responses to health and illness, disease and healing, to create what Megan Davies calls a more nuanced ‘intellectual cartography’.

Over the last thirty years regions and regional identities have proved to be an area of increasing interest to social scientists and historians, encouraged by political initiatives to promote region as an important layer of government. What might be seen as a ‘regional turn’

can be detected in work on the history of healthcare, hospitals, asylums, and professionalization, with research on the medical marketplace inherently favouring a regional analysis,[1-7]. Such work has produced important insights that challenge conventional paradigms, while more recently questions surrounding how, why, and whether place matters when it comes to health and healthcare have highlighted the need for new ways of thinking about region,[8]. However, as region has become more central to inquiry in a wide range of humanities disciplines, we need to be more precise about how we think about the term and more aware of the problems of thinking regionally. In exploring region as a lens of analysis for the Medical Humanities, this essay focuses on Britain in the last 300 years and draws on multiple literatures from history, geography, anthropology, sociology, and literature to ask questions about what we mean by region and why the narratives that framed regions should matter to the Medical Humanities. The first part of the essay broadly examines the importance of region to medicine before turning to how region might be used as a way of exploring interconnections. The essay then considers why incorporating region into studies of illness narratives can offer new insights before addressing the role narrative has had over the last 300 hundred years in constructing region and ideas of health and illness to explore how regions can be viewed as discursive formations shaped by the narratives associated with them.

THE IMPORTANCE OF REGION

For any scholar of twentieth-century healthcare, region looms large in their accounts, particularly in relation to the National Health Service (NHS). The complex debates about how to organise the new service focused on contested questions of region and subsequent NHS reforms repeatedly rewrote regional boundaries,[9]. But region was important to twentieth-century healthcare in other ways. For example, Marguerite Dupree reveals how the Highlands and Islands Medical Service in the 1920s and 1930s was an important regional

driver of health improvements in a region characterised by poverty, limited medical care, and isolation,[10]. As the 1980 Black Report and 2010 Marmot Review have shown, regional inequalities and structures in health remain recurrent and crucial questions for the NHS,[11-12]. But it is not just in the twentieth century that region mattered to the organisation of healthcare. In the nineteenth century, Poor Law medical services had a strong regional dimension. Just as with the NHS, regional boundaries proved controversial with regions responded differently to the 1834 Act, resulting in discrete regional regimes,[13]. Region mattered to health and medicine in other ways. Eighteenth- and nineteenth-century voluntary hospitals may have been distinctly urban institutions, but they had, as the history of the Derbyshire Infirmary demonstrates, strong regional identities and relied on regional networks of charity. Region also informed ideas about health and disease. From the time of Hippocrates' *On Airs, Waters, and Places* to the nineteenth century the qualities of place were incorporated into notions of health, often with a regional focus to create what Charles Rosenberg has referred to as an 'epidemiology of place',[14]. Medical practitioners were attuned to regional differences in how disease was influenced by place, climate, and topography. As Jonathan Reinarz demonstrates, eighteenth- and nineteenth-century medical practitioners asserted a regional understanding of disease, citing the example of Edward Jenner's work on cowpox, with this regional approach equally marked in how ague (or fever) was framed in the Fens. Such regional ideas affected how local practitioners and institutions treated disease,[15]. Different regions equally saw different medical cultures become associated with them as evident, for example, in the ideas eighteenth-century antiquarians associated with the Physicians of Myddfai in the Brecon Beacons, or in the rise of medical botany in the industrial regions of northern England in the mid-nineteenth century.

If region was important to medicine, as Megan Davies explains in her examination of British Columbia, considering region fundamentally helps us 'understand the whole in a more

nuanced way',[16]. A regional focus is by its nature comparative, while at the same time placing emphasis on interconnections. It encourages us to historize and revisit existing paradigms and chronologies, while providing a way to incorporate both the 'spatial turn' into our research and the emphasis the 'culturalist turn' has placed on specificity. After all, human interactions around illness and medicine took place in locales and regions while, as David Livingstone's important book *Putting Science in its Place* reminds us, scientific knowledge is inherently geographical in terms of how it was produced, transmitted, and consumed,[17]. Rather than subsuming place with other issues, it should be added to more familiar categories of class, gender, and race. One way of re-placing health is to employ a regional perspective to examine the links between health and place especially as, until the 1870s, a large body of writing on illness was informed by local and regional concepts of disease. Equally, a regional approach reveals the diverse textures of experience that illness acquired in different places; for example, showing how rising levels of tuberculosis in northeast Ireland into the twentieth century produced different patterns of responses to the disease and different experiences of institutionalisation from the rest of Britain. It forces us to consider how the social epidemiology of many diseases and the response to them varied from region to region, an acknowledgement which is just as important to conceptualising experiences of sickness in the past as it is to understanding cardiovascular disease or cancer now.

Yet a sensitivity to region is not just an exercise in medical geography or social epidemiology. By shifting the focus from those urban centres like London, Edinburgh, Dublin or Manchester that dominated medical consciousness in the past, a regional perspective allows scholars working in the Medical Humanities to incorporate those areas remote from the metropole and the interplay of national and transnational forces with the regional and local. Thinking regionally can challenge the urban focus of much existing scholarship, shifting the focus to allow a consideration of medicine in those market towns and

rural communities that ‘affected the activities and attitudes of very large numbers of people’,[18]. But a regional approach does far more than encourage research into hitherto neglected areas, medicine beyond familiar urban centres, or the remote and the rural. Sensitivity to regional environments, medical cultures and organisations, and the social, cultural, economic, and political formations associated with them, encourages us to explore medical networks, as well as ideas of diffusion, to examine how medical ideas, practices, and policies were adopted or contested in different places and among different populations. Considering region then helps challenge the notion of core and periphery, offering a focus that enables a better understanding of how relationships between those areas viewed as core or periphery were negotiated. It equally allows us to interrogate how regions considered periphery influenced the core, a process evident in eighteenth- and nineteenth-century patterns of professionalisation as seen in the work of provincial medical societies such as North of England Medical Association and their campaigns for medical reform. We are familiar with such an approach through scholarship on colonial medical encounters that challenged the idea of the inherently passive periphery,[19]. But if scholars working in the Medical Humanities are to continue to avoid metropolitan whiggism they need to employ the same sensitivity to agency, the diffusion of ideas, and the importance of local providers of healthcare and the rivalries between them, when thinking about British regions, so that they can better understand how medical practices and policies were adapted to regional needs and cultures.

A regional approach has other benefits. Whereas work in the Medical Humanities has tended to privilege the immaterial – texts, symbols, and images – over the material, a regional focus means that material objects, such as medical equipment, or material factors, such as topography or transport networks, and how these affected, for example, professional networks, access to medicine or health policy, can be better integrated into research,[20-21].

After all, a region was not only a collection of places but also a collection of environmental facts and landscapes. In concentrating on the urban, scholars appear to assume that the past is flat, whereas as a regional focus reveals how landscape could be important to health and healthcare. For example, in the eighteenth century, topography and the nature of the roads ensured that only four to five miles an hour could be travelled on horseback, which limited the size of most practitioners' practices,[22]. Landscape also influenced regional patterns of health and illness, as well as the nature of health services. Speaking about one parish in Glamorgan in 1901, the medical officer of health explained how it was located in a 'most mountainous and thinly populated part' of his region where 'the roads to this wild mountain waste... are very difficult to travel'. This made disease in the parish and region 'difficult to deal with' and perhaps explains levels of poor health there,[23-24]. Doctors working in the Scottish Highlands or the Lake District would have encountered similar problems. Considering region helps move us beyond the mental or cultural to consider the physical.

Thinking regionally then gives us access to more nuanced ways of addressing the interactions between practitioners and the people they treated; how regional patterns of medical care or policy reflected cultural negotiations, administrative limitations, geography, and political agendas, as well as the host of social and economic factors that affected health, healthcare, and health practices. Rather than viewing region as simply a network of sites, those working in the Medical Humanities need to think of regions as places where values, beliefs, codes, and practices associated with particular locations are visible to consider what the geography Doreen Massey sees as the 'dynamic simultaneity of multiple locations in which people perform their interactions',[25]. Such an approach might counter the tendency to think in phenomenological terms where histories or our objects of study happen nowhere or everywhere.

REGIONAL v REGIONS?

If we accept the advantages of studying regions like the South West, Wales or the Midlands what do we mean by region? While notions of regionalism can be traced back to Frederick Jackson Turner's work on the US, in the last ten years, questions related to geography and spatiality have pre-occupied those who have tried to theorise region,[26]. As Sulevi Riukukehto has explained, various dichotomies have been employed -- simple/complex, static/evolutionary, administrative/discursive -- to understand regions in sub-national, supranational or cross-national terms,[27]. If we accept that regions are the largest intermediary collective between the individual and nation how should the boundaries between regions be understood?

A simple definition of region would see them linked by geography. Regions are perceived to be bounded by place, space, and land so that they become 'geographical areas having distinctive cultural, social and economic identities',[28]. Such a definition makes it possible to think about, for example, Yorkshire medicine. This more geographical approach often merges the regional and the local, but defining region is more tricky than this as scholars have, probably too easily, slipped between seeing region in geographical, socio-cultural, economic terms or administrative terms,[29]. While Charles Phythian-Adams has identified seven key characteristics for defining a region -- demographic concentration, hierarchical structures, intra-dependence, self-identification, provincial interests, concentration of indigenous families, and a sense of belonging -- as the historian Keith Robbins reminds us, 'Whether any given space coheres into a locality, a region or a nation has been... differently perceived by historians who, after all, have themselves to be located somewhere',[30-31]. The result is that many scholars use region both confidently and imprecisely, assuming the existence of some thing or things in the region they are studying that bounded people together.

Just as the move away from grand narratives encourages those working in the humanities and social sciences to consider multiple sites of belonging, regions, it seems, are equally unstable and subject to multiple configurations. While various organisations in the nineteenth and twentieth century employed region as a category, the problem of thinking about region in the past is that they seldom existed in a clearly defined fashion, making them contingent upon time, place, and their interactions with local, national, and global political and economic units. For many contemporaries in the eighteenth and nineteenth century, region was essentially a question of the provinces as ‘an aggregate of all that was not London’,[31]. In the history of medicine there has been the same metropolitan whiggism, and even if scholars have come to reject this attitude, recent work continues to refer to ‘studies of provincial medicine’ when discussing medicine beyond London, reflecting a wider sense that Britain had core and peripheral regions,[32]. Of course, we can now turn to a growing body of writing that shows how ‘countries typically consist of multiple domestic cores and peripheries’, but the idea that Britain had core and periphery regions remains enduring in scholarship,[33]. Inferior characteristics are frequently attached to regions associated with the periphery, such as Ireland, which are often framed through notions of backwardness, while the core / periphery model privileges antagonisms. As the history of Poor Law medicine or public health demonstrates, regions did resist central government initiatives or adapted them to their own needs as evident in regional responses to the ‘crusade’ against outdoor relief in the 1880s and 1890s,[34]. While such resistance saw such regions characterised in negative ways by metropolitan commentators, recognising tensions between core and periphery, and the shifting geography of these tensions, can illuminate the fluidity of core and periphery in different medical contexts. There are clearly different hierarchies between various core and peripheries: in our work we must be attuned to how a region could be ‘core’ in relation to one area or region, but ‘peripheral’ to medicine elsewhere.

If the core / periphery model can be too blunt a tool for thinking about region or the dynamics between regions, how many regions are there? One answer would be draw on scholarship that points to a more pluralistic conception of 'British' history that has adopted a 'four nations' – England, Ireland, Scotland, and Wales – perspective,[35-36]. It, along with the 'New British History' with its emphasis on transnationalism, challenged the distortions of 'anglocentricity' and drew attention to relations among the peripheries themselves to highlight the complex interactions of different cultures as seen in writing on medicine and the Enlightenment. In this framework, Britain can be viewed as 'a multiplicity of overlapping, interlinked yet distinct nations, regions and localities',[37]. England and London might have set the tone of medicine in the nineteenth and twentieth century, but thinking of Britain as 'four nations' allows differences and commonalities -- for example about the nature of the medical marketplace -- between regions to be considered. Yet a 'four nations' approach often lumps experiences together, missing significant differences within areas that make up one of the territorial regions: for example, Teesside in the Northeast had a different medical culture from the East Anglian Fens, while as Smout's work on Scotland shows there are many 'Scotlands' each with a distinctive history,[38].

How else might we understand region? Should we subdivide our 'four nations' to get at regional or intra-regional differences? When this is done there is a tendency to resort to binaries, such as North v South Wales or Highlands v Lowlands in Scotland, and to stress the antagonisms between them. Yet regions seldom neatly fitted these binaries: for example, in debates about Scottish health policy the Highlands and Islands Medical Service received positive support throughout the 1930s and 1940s,[10]. Further geographical, political or economic regions can be identified within these 'four nations', and scholars must remain sensitive to the fact that, as the case of Monmouthshire illustrates, political borders between regions could be unstable. One way round this problem is to draw on early-modern

scholarship and think in terms of ‘cultural provinces’ based around a dominant urban metropolis, such as Bristol for the South West in the seventeenth century, to equate regions with economic, social or medical networks,[39]. For example, the Yorkshire Philosophical Society linked practitioners together in what Michael Brown describes as a ‘provincial scientific movement’ which provided doctors in the region with opportunities to assert a medical culture and identity,[40]. While the idea of ‘cultural provinces’ places cities or towns at the centre of regions, regions can also be mapped onto administrative units, such as counties or Poor Law unions. County histories have shown how counties constituted ‘communities’, yet as Christopher Lewis explains, ‘few counties are sensible regions for the purposes other than the study of local government’ because the regional boundaries identified by central government often had no public profile, bringing us back to the problem of where to draw the boundaries between regions,[41]. Furthermore, as Steven King and Alan Weaver’s work on eighteenth-century Lancashire illustrates, counties had their own regions of medical heritage that created multiple and distinct medical cultures at a county level,[42].

Notwithstanding the analytical advantages of a regional approach, region is therefore inherently problematic to define especially when we consider whether health or illness was ‘of’ a region or ‘in’ a region. Regions were functional and formal, core and periphery, plastic and ephemeral, places of similarities and differences. Never simply defined by geography or administrative units, a region could be linked by climate, topography, culture, economics, politics or language; by professional bodies, medical practices, and medical policy; or by the networks that resulted from them. All too often the boundaries between regions were complex and porous as suggested by how medical ideas and practices flowed across them as demonstrated by Alun Withey’s work on early-modern Wales,[43]. Regions, it seems, are durable in scholarship but essentially mutable in practice and we need to be sensitive to this in our writing.

MEDICAL HUMANITIES, REGION AND NARRATIVE

What can the Medical Humanities add to our understanding of region? While medical historians have provided the essential tools for historization so central to our understanding of the production of medical knowledge, scholars in the Medical Humanities have shown the value and importance of exploring the role of narrative in health and medicine. Responding to the growing dominance of biomedicine, interest in illness narratives has reminded scholars of the need to re-inscribe the patient's perspective and voice across a range of disciplines. While scholars have become increasingly sensitive to questions of authenticity, integrity, and believability in patient's writings about illness, work on illness narratives has exposed how, rather than the patient being irrational or passive, they are valuable first-person actors with their stories giving both meaning and context to the conditions of illness. This approach counters what has been seen as the totality of the clinical gaze with its objectification of the body. For Michel Foucault the emergence of this clinical gaze at end of the eighteenth century saw a rejection of a 'visionary space' around illness evoked through an often fantastical and myth-making language in favour of a gaze that encapsulated disease not within the patient's words but their body. For Foucault and subsequent scholars the rejection of such 'imaginary investments' was 'both tiny and total',[44].

Responding to criticisms that work on illness narratives has not always paid sufficient attention to their historical or cultural contexts, my work with Martin Willis on narratives of families' encounters with hospital medicine suggests that rather than being a 'total' shift, the difference was 'tiny'. It revealed how 'imaginary investments' continued to be made in illness and how illness writing and the stories told about illness can be examined as individual acts of the imagination,[45]. Given the role of the imagination in how social groups conceive of themselves and others, patients and family members writing about illness often continue to articulate a 'visionary space' and make imaginative connections to existing

histories or fictions or both. For example, one family member of a patient with a chronic disorder of consciousness made sense of finding his son 'laying on this bed with this bolt in his head' by creating a Gothic narrative reminiscent of Shelley's *Frankenstein*,[46]. Illness narratives read with a sensitivity to history and fictions can move our understanding of the stories constructed by patients and their families around illness beyond the boundaries of the clinical encounter to explore a different kind of textual community where history, memory, mythologies, and fictional representations meet. Thinking about illness narratives in this way reveals how narratives about and around illness were and can be imaginative acts of history making that embody interconnections between geography, memory, emotion, and identity. To give one example of this process at work, when her mother was transferred first from a hospital over thirty kilometres away to 'our own district hospital' and finally to a community hospital nearby, her daughter wrote:

Maybe it's a [Welsh] Valleys thing, perhaps we share a humour that binds us and sees us through such times or maybe it was just because it's a smaller hospital and I was known there, whatever the reason our experiences here could not have been more different,[47].

Rather than seeing the above as an expression of 'banal' nationalism expressed through an understanding of region -- the Welsh Valleys -- this quote highlights the social embeddedness of illness narratives linked to a wider sense of region and belonging. Here the Welsh Valleys are imagined through a particular notion of region associated with a different sense of community and understanding that is not felt to exist elsewhere,[48]. Illness experiences, how they were constructed, and remembered can be just as tied to the region in which they occur as they are to their medical, social or cultural contexts. Region needs to be viewed as one of the contexts that informs and structures narratives about illness. We therefore need to extend our understanding of illness narratives to incorporate a sensitivity to the imagination, place

and region, and move beyond individual accounts to address how notions of region and place informed the illness narratives produced by patients, families, and communities. Analysing illness narratives in this way also helps us think about how regions were discursive formations that influenced ideas and perceptions of health and illness.

NARRATIVES OF REGION AND HEALTH

After all regions are associated with particular notions that are framed through narratives -- by which I mean accounts and representations of a particular situation or place -- that evoke identities, myths, and particular images, which include those connected to health and illness. For example, the Highlands and Islands of Scotland can be seen as belonging to a 'remote north' where the maintenance of health and responses to illness has been associated with notions of 'human resilience and sustainability' in a region characterised by isolation, cold, hardship and, as Visit Scotland claims, with 'magnificent mountains, enchanting lochs and sandy beaches',[33, 49]. But how might region be imagined through the narratives constructed around them, and what role do such narratives have in understanding medicine and disease?

As Alastair Bonnett explores in *Off the Map* we are naturally terracentric and construct narratives around the places we live and visit to create a sense of belonging,[50]. While such narratives often defy a simple label, Benedict Anderson's paradigmatic concept of 'imagined communities' as a way of thinking about nation might provide a starting point for understanding these narratives as knowledge from human activities or experiences are read into or onto particular regions,[51]. As cultural geographers remind us, places had performative and cultural aspects,[52]. The same is true of regions. Regions can therefore be read as discursive formations that give meaning and representation to 'imagined communities' of experience, identity, emotion, and history. Such an approach emphasises the

formative role narratives had in constructing notions about particular regions, and helps focus attention on how various narrative forms served to mediate experiences in order to fashion identities and meanings. People do not pull their narratives of illness out of the nowhere, and we need to be sensitive to wider structures and frames of reference that different types and acts of writing about region provided.

Some of these narratives about region were explicitly medical as medical texts and medicalised accounts produced an understanding of region based around notions of health and disease. Around the start of the sixteenth century, Hippocratic ideas of health and place gained importance in medical discourse as specific regions were presented as healthy through a blending of the medical with historical accounts and landscape descriptions,[53]. Such works created narratives about the health properties of particular regions. The connections between regions and health was replicated in the eighteenth century by medical topographies and in Victorian explanations for epidemics as practitioners, patients, and writers made real and imagined links between regions and disease. Other notions of region and health were produced imaginatively: they were pieced together out of personal and community experiences, verbal and written, and from memories, and could be further mythologised through historical discourse. For example, travel writing and travel guides made imaginative investments in regions that included ideas about health. Rather than being simply transparently factual or interesting only in offering contextual validation for other accounts, nineteenth-century travel guides generated narratives of region that were invested with meanings to create what John Urry refers to as the ‘tourist gaze’,[54]. Travel guides created an imaginative portrayal of place, history, and health. For example, one 1911 Welsh travel guide explained how ‘almost every hill and mound in the district, has its legends, its romance, which lives in the hearts of an intensely patriotic and imaginative people, and blends the past and the present into one’, while guidebooks for Tenby presented a narrative that stressed the

health-giving properties of the region and the Pembrokeshire coast,[55-56]. Such representations may well have created a dissonance with lived experiences but they shaped visitor perceptions of health and medicine at a regional level.

While such works reinforced an understanding of region that might not always be to the advantage of the inhabitants -- for example, public health legislation was not initially seen as relevant to Birmingham because the surrounding region was imagined as healthy -- contemporaries made imaginary investments in particular regions through acts of writing, representation and discourse that associated regions with qualities, illnesses, or states of health. For example, if individual places could be the subject of competing and plural accounts, as demonstrated by the existence of ‘two Bristols’ around the turn of the nineteenth century, or villages could be described as insanitary, rural regions were imagined and understood through a discursive model that asserted their health-giving qualities notwithstanding evidence of insanitary conditions in particular places, [57]. In medical and non-medical works, rural regions were imagined as ‘a “medicine” for the soul suffering from the effects of weariness, doubt, and the pressures of an increasingly urbanised society’,[58]. These accounts drew on history and comparison and encouraged early forms of health tourism as evident in the nineteenth century by wealthy tuberculous patients travelling to mountain retreats, dry climates, and seaside resorts. Whether the narratives presented in these writings matched-up with lived experiences of health did not appear to matter. What was important was that they presented a plausible scenario that drew on cultural, historical, and material interpretations of the region.

This process can be seen at work in how Wales was imagined as a region in a range of medical and non-medical accounts that generated a particular narrative about the region. After 1750, accounts describing Wales shifted from representing the Principality as a wild and dangerous place to one imagined through a Romantic vision of untamed uplands close to

nature,[59]. In these accounts, the Welsh landscapes, rivers and lakes became associated with myths, legends, and notions of purity. The result was a narrative that marginalised industrial Wales in favour of scripting the region through its history and landscape to associate Wales with a narrative of timelessness characterised by moral and physical renewal. Wales was hence imagined as a region untouched by the impurity of modern life. This notion of Wales was repeated in travel writing and guidebooks, in the press, and in the annual reports of medical officers of health. The latter might have presented a ‘woeful tae’ of ‘all manner of foul insanitation’ at a parish level, but they also made imaginative investments in their regions as naturally healthy,[60]. For example, the region covered by Gelligaer Rural District Council in South Wales could be imagined as healthy because of the ‘wild upland[s]’ that surrounded it,[61]. Because ‘the way we see things is affected by what we know or what we believe’, individuals equally made imaginary investments in an idea of Wales as healthy,[62]. For example, George Burrow in his popular *Wild Wales* not only explained how in Wales ‘Nature displays herself in her wildest, boldest, and occasionally loveliest forms’ but also described how the people he encountered considered where they lived the healthiest place in the region,[63]. Individuals also appeared surprised when their health experiences did not match the dominant meta-narrative of rural Wales as the healthy place presented in accounts about the region. For example, James Russell of Llandaff was surprised in 1885 when his family fell repeatedly ill because he imagined that ‘This should be quite the reverse in [a] place like this’,[64]. Notwithstanding research on tuberculosis and the sanatorium movement, we know little at present about how such imaginary investments in region influenced health perspectives, practices or policies. However, what is clear is that practitioners, government bodies, tourists, and individuals made imaginative investments that informed the narratives they constructed around regions in terms of health and disease.

CONCLUSIONS

If regions could be invested with notions about health and illness, they remain dynamic but also unstable as a category of analysis. Scholars working in the Medical Humanities need to be aware of this instability. They need to think of regions not as objective or analytical boxes, but as unstable, functional and formal, and a relational category that generates meaning and reveals interconnections. By being sensitive to region it is possible to move beyond superficial contextualisation by rejecting generic qualities and give a more prominent place to hinterlands, borderlands, market towns, and rural environments to use region as a lens of analysis to deepen our understanding of the diversity of transactions, negotiations and interconnections that were played out in different regional settings. Thinking regionally encourages a consideration of material factors, such as geography and landscape, and how they influenced medical practices and policies, medical identities, and medical institutions, while being attuned to how the narratives constructed around region offers a frame for understanding both collective and personal ideas of, and responses to health and illness, disease and healing. It is important to both highlight what is unique about the region under examination and place regions in their national or transnational contexts as we work towards what Megan Davies refers to as a more nuanced ‘intellectual cartography’,[65]. It is not an easy approach. There is a risk of simply multiplying studies that point to the sameness or distinctiveness of regions. But by adding region to our methodological framework scholars in the Medical Humanities can anchor their studies in the discursive and imaginary investments about regions that formed essential components of lived experiences of health and disease especially as beliefs about health care’s past shape current practices and attitudes,[66].

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