Going with ‘the crowd’: representations of unexplained illness and future diagnostic promises in Netflix’s diagnosis

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15

Going with 'the Crowd': Representations of Unexplained Illness and Future Diagnostic Promises in Netflix's *Diagnosis*

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It is not easy to start a story of unexplained illness – not least because a beginning is often difficult to identify, and the 'story' often does not follow the usual logics of a story. The onset of illness is usually placed at a first instance of pain, expressed in the body, yet can also be traced back to a seemingly unrelated event in a patient's past. For Ann, one might identify multiple beginnings. She has already seen dozens of doctors. Each time she tells her story anew. The right side of her jaw had been painful for a couple of months. Then one morning she woke with a headache at the back of her head, which extended into her right shoulder. When she tried to call her dentist because of the pain in her jaw that had now spread to her head and shoulder, she noticed it was difficult to speak. Rushing to the mirror to see what was wrong with her, she barely recognised the face she saw. The right side of her face drooped and did not move at all. Her paralysis, which developed slowly but steadily, caused not only her face but any part of the right side of her body to give out at any point in time. None of her doctors had an explanation for what was wrong with her, so Ann turned to another place to get answers.

This story, as I have outlined it, is based on a written account of Ann's first symptoms of paralysis by Lisa Sanders, a medical practitioner but also a writer with a popular column on medical mysteries in the *New York Times*. The burden of telling such a story lies with having to give an account of unexplained illness first-hand, when logical order is missing, medical explanation is lacking, and yet the body in its pain forces *something* to be told. When given no answers by the medical profession, Ann, a real-life patient who only wishes to be known by her first name,[1] turns to Sanders and the *New York Times* in search of a diagnosis to her illness. At this point, her account is turned into a story, written with the aim of helping her to get her strange symptoms diagnosed. The problem central to this chapter is the difference that emerges between the two. This is the difference between having to give an account of one's own experience of illness and having a story made out of it – the difference between having a problem to solve and of being, or becoming, the problem itself. This chapter stays close to the problem of their distinction, and close to the difficulty of Ann's unexplained symptoms, despite the narrative drive of the illness story, which pushes the experience of her symptoms towards explanations, both in a narratological and in a medical sense.

In Netflix's *Diagnosis* (2019), the documentary series that eventually comes to represent Ann's symptoms, the medical and the narratological intertwine to form a story of diagnostic intervention that is presented as a tool for the future: an experiment in online medical diagnostic crowdsourcing. The series emphasises the promising potential offered by global communication: the 'winning' diagnosis could come from anywhere on the planet. Sanders's column becomes the basis for this crowdsourcing experiment – explicitly open to lay people and personal experiences – where the general readership of the *New York Times* are invited to upload their diagnosis onto an online platform. The result is a seven-part US documentary series. Each episode follows a different patient along their diagnostic process, presenting responses from the crowd and filtering through different diagnostic options. The episodes are hosted by Sanders, who also functions as a patient-crowd 'mediator' throughout the episodes. The seventh and last episode of the documentary series centres around both Ann and Joe, two patients with mysterious paralyses.

The relationship between narrative and illness is central to many discussions in the medical humanities. The extent to which narrative and illness can be seen as mutually constitutive, and the different forms that narratives of illness assume, is foundationally explored in Arthur Frank's (2013) seminal work *The Wounded Storyteller*, in which he identifies three major types of illness narratives: restitution, chaos, and quest. The (over-)emphasis on narrative, such as in the work of Rita Charon, is critiqued in what has come to be known as the critical medical humanities, pointing out the problematic aspects of taking a person's narrative to be co-extensive with their subjective experience (Woods 2014: 114). In Charon's work, attention to narrative becomes a narrative-based clinical practice which is concerned with interpreting and working with the narrative aspects of patients' accounts to provide more 'humane, more ethical, and perhaps more effective care' (Charon 2006: vii). For Angela Woods, the idea that self-expression through narrative is fundamentally healthy is a 'foundational, normative' claim that should be open to contestation (Woods 2011: 75).

Bringing this discussion of narrative to the representation of Ann's unexplained symptoms, a different trend can be discerned, one which I take to be emblematic for the experience of unexplained symptoms, and for medical dealings with them. In the case of unexplained illness, it is not only the patient who is turned into a 'narrative wreck' (Frank 2013: 55), being unable to form a coherent account of their own illness. Such narrative and explanatory shortcomings occur just as much on the side of medical knowledge, which is unable to form a coherent and clear version of the patient's symptoms. However, rather than simply constituting a lacuna in current medical knowledge, this narrative lack is offloaded onto the patient, who comes to bear a double burden: the pain of their illness and the burden of being an undiagnosed and therefore 'problematic' patient.

I have used 'unexplained illness' to refer to symptoms with no found organic cause. The appropriate terminology is contested, and names used vary from 'medically unexplained (physical) symptoms', also abbreviated as MUPS or MUS (Greco 2012: 2363), to 'functional disorder' or 'functional somatic syndromes' (Barsky and Borus 1999; Henningsen et al. 2007) or 'somatoform disorder' in psychiatry (Brown 2007: 772). In the twentieth century, a wide range of symptoms were still often referred to as 'hysteria', or Briquet's syndrome. At present, 'conversion disorder' is used to denote what was previously called hysteria (American Psychiatric Association 2013: 208). Yet, the

concept of hysteria itself has historically been imbued with cultural value and meaning, similar to that still encountered in research on unexplained illness, such as in the work of Elaine Showalter, who characterises syndromes like chronic fatigue syndrome or Gulf War syndrome as 'modern hysterias' (Showalter 1997). Depending on field or context, syndromes with no found organic cause, like irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, or Gulf War syndrome can be referred to as 'psychosomatic', 'psychogenic', or 'nonorganic'. In order to avoid a medical vocabulary that stresses the need for known organic aetiology, and to steer clear of the negative connotations and stigma associated with psychosomatic or psychogenic illness,[2] I refer to these various conditions as *unexplained illnesses*. I refer to patients as the *unexplainedly ill* – a term that, much like 'crip' for crip theory, has the potential to be reappropriated as an affirmative term by patient groups and advocates.[3] Precisely because the burden of the unexplained nature of these illnesses is often offloaded onto the patient, the term *unexplainedly ill* can be reappropriated, and carries the potential for resituating this burden within medical science itself.

To further understand this burden of being a problematic undiagnosed patient, I first need to make a distinction between what is presented by the series and what can be seen as medical knowledge. In the following analysis, focusing on one particular episode of *Diagnosis*, I attend to the series as a popularisation of medical knowledge which aims to entertain and inform. At the same time, I treat this popularisation as part and parcel of what David Kirby has referred to as the technoscientific imaginary: the narrative, representational framing of scientific knowledge which is at the same time an agent in its construction (Kirby 2011: 15). Although the Netflix series does not present grand visions of a new, fictional future world, and instead brings a dramatised, fictionalised version of a 'real' state of affairs situated in the present, the future is constantly invoked. As part of a representation of medical science, the series presents medical crowdsourcing as a diagnostic innovation of the future, which will open up medical knowledge on a scale previously unknown. Insofar as the documentary series is part of a technoscientific imaginary, it can be seen to produce a type of scientific fiction – a story which describes a possible though (as yet) unreal state of affairs. Possible, because the technology used by the crowdsourcing experiment – an online publication platform, global connectedness, and an interactive website interface – already exists. Yet the experiment functions as a prototype for a social technology that can be seen as a real-time mobilisation of the future, a rhetorical construction of it in terms of promise and innovation (Brown & Michael 2003: 4).

The critical potential of science fiction for complex social and political engagement with the present is noted by Gavin Miller and Anna McFarlane (2016). They emphasise how science fiction's extrapolations of possible future technological innovations can function to enter 'into a critical dialogue with the troubling ideologies of progress offered by the technoscientific imaginary' (Miller & McFarlane 2016: 215). In my analysis of *Diagnosis*, which presents itself not as science fiction, but as a real-time development of a future medical diagnostic innovation, my engagement with the notion of science fiction is located in the critical potential of the term 'science fiction' itself, when it is coupled with the series. *Diagnosis* contains a strong *scientific fiction*. Its offered innovation presents medical science as the inevitable producer of definite answers on the body, which will enable it to eventually solve every 'medical mystery' it encounters – the fiction of ultimate explicability. However, this fiction is only exposed

as such via the figure of the unexplainedly ill. Only when symptoms cannot fit into the mould of medical diagnosis does the scientific fiction of complete explicability appear. Eventually this fiction comes at the cost of the patient whose symptoms do not fit.

The 'crowd' involved in *Diagnosis* adds another layer to this representational two-way street. Not only does the series attempt to diagnose different 'medical mysteries', it attempts to do so by moving beyond the confinements of strict medical knowledge and professionals alone, explicitly inviting lay people and/or people speaking from personal experience to upload their 'out-of-the-box' diagnosis. While the future of ever-expanding explicability through diagnostic innovation in medicine is placed in a hopeful invocation of the future, this chapter aims to show that this 'future' remains shackled by the present. Unsurprisingly, the series does not stray from the normalising tendencies inherent to massive entertainment platforms. The overall narrative arc of the series is one in which the patients' stories are made into stories of restitution, treating health as 'the normal condition that people ought to have restored' (Frank 2013: 77). However, the narrative strategies employed by the series fail to account for those cases which escape the diagnostic reach of the crowd and thus remain unexplained. I take this failure to be especially interesting, as it exposes the process by which the series' representation of medical science works to transform a medical lack into a narrative wreck: leaving the patients themselves undiagnosed, and the experience of the symptoms unaccounted for.

The Problem and the Unexplained

Lisa Sanders's popular column in the *New York Times Magazine* had run since 2002. In the column, called 'Diagnosis', Sanders presented various cases of medical mysteries collected from patients and colleagues she encountered in her medical practice as an internist at Yale New Haven Hospital. The column always presented only 'solved' cases – that is, cases that had eventually received successful diagnosis by a doctor. In 2018, Sanders tried something new, and started writing about unsolved cases, asking 'the crowd' for possible diagnoses. These columns and the reactions to them would form the basis for a simultaneously produced Netflix documentary series, *Diagnosis*. Sanders, whose column also inspired the long-running series *House MD* (2004–12), and who was a consultant on that series, published two books on the search for medical diagnoses. The cynical and Sherlock-Holmes-like approach that *House MD*'s main character, physician Gregory House, maintains towards his patients was characterised by Leigh et al. (2008) as the epitome of the modern approach to medicine that 'involves an effort to communicate directly with disease' (221). This approach to medical diagnosis as a detective-like quest that emphasises objective signs of illness is also maintained in Netflix's *Diagnosis*, whose first episode is titled 'Detective Work'. In film, the moment of diagnosis is often used as a moment of transformation, or as a device to construct a narrative (Jutel & Jutel 2017).[4] In the Netflix series, the quest for a diagnosis has become the central theme.

Ann's case is presented in the last episode of the series, titled 'Paralysed'. While the six previous episodes centred around one particular patient, this episode is staged on the differences between Ann and Joe. Both from the state of Connecticut, they have very different approaches to their unexplained paralyses. Joe is described by Netflix as the textbook 'good patient'. He is a white, middle-aged male dentist, a

part of the medical community who stays positive and in good spirits while treated by his doctors. Ann, on the other hand, is described as being 'more sceptical' and is seen struggling with the medical community. In the first scenes, Joe, self-proclaimed 'firm believer in Western medicine', praises the 'brilliant doctors' who are helping him ('Paralysed' 04.45), while Ann is shown expressing frustration about having seen over thirty medical specialists who do not know what is wrong with her. Ann expresses a fear of doctors, and explicitly frames her position as a woman of colour as having a negative influence on the measure in which she is being taken seriously by medical science. Throughout the episode, Ann herself hints at the difference that exists between her, as a woman of colour, and a hypothetical patient like Joe, whom she is presented next to. She states that, as a person of colour, people tend to take her less seriously ('Paralysed' 09.34).

Scholarly work on medical racism in the US has shed light on both the fraught history of Ann's claim (Washington 2006; Cooper-Owens 2017) and the ongoing present-day health disparities experienced by Black Americans (Roberts 2012; Hatch 2016), which has only increased during the Covid-19 pandemic (Laurencin & Walker 2020), and on the specific racism experienced by Black women in medicine today (Davis 2019; Spears et al. 2021). While including her comments on racial bias against women of colour and therefore acknowledging them, the series presents Ann's issues with the medical community as an individual problem, without giving attention to the complex social and political hierarchies between doctor and patient or the history of medical racism that makes her position towards the medical community different from Joe's.

While Joe's search for diagnosis is not without trouble, as he struggles with his positive attitude and grapples with all the things he is increasingly unable to do, my analysis will focus on the story of Ann, whose unexplained paralysis eventually turns out to be more contested than Joe's. While there are no definite answers found to Joe's paralysis by the end of the episode and no diagnosis is given, a possible connection is made to the medication that he takes to cure his blood cancer, and the audience watches him as feeling slowly returns to his feet. By contrast, Ann's paralysis remains unexplained, and the epilogue reveals that Ann 'continues to look for answers on her own' ('Paralysed' 44.54). This is by then a disappointing note for the viewer, who has seen Ann being handed a possible diagnosis of functional disorder, which she has rejected, and on which she has not acted in the course of the episode. I analyse Ann's search for clarity by focusing on this pending diagnosis with functional disorder, and on the consequences of the blurring of patient–doctor hierarchies of the crowdsourcing experiment. In both aspects, I emphasise how Ann's position as a woman of colour plays a decisive and concerning role.

Two years before filming the episode, Ann experienced a pain in her chest. A month after, she noticed her face was changing. When she talked to her doctor she was sent to the ER because they suspected a stroke. As Ann's voice-over recounts how her right eye involuntarily shut while she was driving and on her way to the ER, the audience is shown a first person's perspective of a driver's view of the highway. The right side of the view darkens as Ann tells the viewer of how she was unable to open her eye, 'even to save her life' ('Paralysed' 08.44), encouraging identification with Ann's disconcerting experience. At the hospital she got a CAT scan and MRI, which both came up negative. As she recounts what happened next, Ann raises her eyebrows and mimics the words of the neurologist who came in and said: 'well you know I think you're just

stressed [pauses] I think all of this is just stress, you're just, it's just psychosomatic' ('Paralysed' 09.18). Then she continues:

> Really, being a person of colour people tend not to take you seriously. In fact, I feel like every woman in this country knows what it's like to be pooh-poohed by a doctor, cause it's happened to I would say . . . and I don't think I am exaggerating when I say every woman in this country at least once. This is the reason why I don't trust doctors. (09.34)

After Ann speaks these words, the episode switches to a suburban surrounding, showing the façade of a big house in which Sanders is getting ready for work. The image cuts to an image of her sitting in front of a camera and saying that when she came to know Ann and Joe, it was very clear to her that their attitudes about the medical community were very different (10.12). Sanders broaches carefully the possibility 'that Ann's distrust of the medical community would affect her ability to accept observations from that community' (10.40), effectively glossing over the structural role of Ann's race and gender, pointed out by Ann herself.

Having presented the dramatic onset of Ann's symptoms, the episode moves on to the quest for possible diagnoses. In the optimal situation, these solutions present themselves as concrete names of diseases, which relate to a physical structure in the body – for instance carnitine palmitoyl transferase type 2, or CPT2-deficiency, in the case presented in the first episode ('Detective Work' 40.48). Of the eight cases presented in the series, there are two cases – Ann's presented in episode seven, and Lashay, whose story features in episode five – where patients resist their given diagnoses ('A Question of Trust'; 'Paralysed'). In these episodes, both Ann and Lashay are presented not with a clear-cut physical explanation for their symptoms, but with a 'functional disorder' instead – a medically vague term for illness that is characterised 'more by symptoms, suffering and disability than by consistently demonstrable tissue abnormality' (Barsky & Borus 1999: 910).

Conflict emerges when Ann feels that what she is handed by the crowd is contrary to institutionalised medicine's own beliefs. Here, the scientific fiction of complete explicability emerges in the contested status of functional disorder in medicine. Ann's refusal to accept functional disorder comes down to the expectation that the medical profession itself will think she is crazy. In a sense, this view is confirmed in a study by Stone et al. (2002), who conducted interviews with patients on different terms used in diagnosis prior to their healthcare visit, and concluded that, while patients did not perceive it as such, the term 'functional disorder' is found 'pejorative' by doctors (1450). For both Ann and Lashay, the term is difficult to accept: they feel the implication is that, because their symptoms are not strictly physically explainable, they are dismissed as being 'all in their heads'.

Ann expresses her concern in a conversation with Sanders, when they go over the possible diagnoses offered by the crowd: 'I have issue with functional disorder, and the reason why is because [pauses] functional disorder, the term functional disorder is still associated with a psychological condition, and they are both interchanged' ('Paralysed' 34.06). At this point, she is interrupted by Sanders, who proposes to separate psychological conditions and functional disorders ''cause it's not actually the same thing' (34.23). Ann continues: 'and it's just like, there is going to be an awful

lot of medical people who come in and they look at that and they just think: Nutty. Crazy. Hysterical' (34.29). Ann directly links her reservations towards functional disorder to a tradition of the oppression of women and minority groups in medicine by referring to the fear of being called hysterical. Placing functional disorder in a direct line with this highly gendered historically contested condition, Ann's remarks show how cultural traditions attached to certain illnesses are not easily shed. David Edelberg (2012) describes functional disorder as 'the contemporary term for what was "psychosomatic" 50 years ago and "hysterical" a century ago' (306). Monica Greco (2012) notes that, while the term '"functional" literally refers to disturbance in function, [. . .] the term has a long history of being used among doctors as code for "psychogenic"' (2366). While names might have changed, the meaning of functional disorder as having no known physiology continues to result in similar stigmatisation as is attached to the notion of hysteria, and 'hysterical' at present.

Ann's reservations towards functional disorder as explanation for her physical symptoms shows a wish for her symptoms to have a place in medical knowledge, as well as the wish that her symptoms would fall within the dominant range of organic explicability. Her reservation is not a resistance to medical science – on the contrary, she fears being excluded from it as a result of accepting the diagnosis of functional disorder. Ann's resistance is directed towards the notion of functional disorder itself, precisely because it disrupts the clear boundaries between physical and mental symptoms. The crossing of these boundaries, and the lacuna of knowledge connected to the term conveys to Ann that what is actually being said is that she behaves in a way in which she should not, by normative standards, and that she can be held, in some way, accountable for the creation of her own symptoms.

In what is arguably the most emotional scene of Ann's story in the episode, both from Ann's and the audience's perspective, Ann has just returned from seeing another specialist, who told her that her paralysis could not be explained as Lyme disease. Sitting on her couch at home, Ann says:

> Once again, no answers. [. . .] If you don't have a diagnosis [pause] I can't go into a hospital if something goes wrong, like it did before. 'oh and they don't know what it is' [pause]. They automatically assume that you're just crazy and trying to seek attention. It makes me afraid to go to the doctor. I don't want to see a new doctor. I don't want to have to justify myself to somebody else. I'm tired of it. ('Paralysed' 26:30)

When it is suggested to her that her symptoms are not merely physical, but can be explained as a functional disorder, this does not offer Ann any more understanding. It only makes her feel she has to justify herself. For Ann, the level of explicability of her symptoms is inevitably bound up with the way she feels she is perceived by her doctors.

The conflictual dimension of the term is already present in the scenes in which functional disorder is first introduced by Sanders. Here I move back in the episode's chronology, before Ann has heard that Lyme was ruled out as her diagnosis by the Lyme specialist. When first going over the results of the crowd, Lyme disease and functional disorder emerge as the two remaining diagnoses that Ann's doctors had not already eliminated. Presenting the results, the scene cuts between Sanders, explaining

the possible diagnoses to the viewers, and Ann and her husband, sitting at their living room table at night, hunched over pages with statistics, which presumably show the results from the crowd. A voiceover by Sanders states:

> The other possibility is that Ann has a functional neurological disorder. That is, it is not an infection, not a tumour, it's not some pathology, which comes from the outside to attack you, it is instead something that your body is doing wrong. (24.11)

As Sanders's voiceover speaks, the viewer sees the images of Ann and her husband. At the moment where Sanders speaks the word 'wrong', Ann directs her gaze upwards, looking up at her husband as if she is alarmed by something. Immediately after Sanders's voiceover has finished, Ann says 'it's not functional disorder. That's not it. It's not [pauses] that's not it. So . . .'. Leaving the viewer ignorant of whether the sentence was finished, the view switches back to Sanders, who explains to the audience that 'when some patients hear the diagnosis: a functional disorder, it has a really bad connotation. What they hear, is that it's all in your head, that they are crazy. But of course, that is not what it means' (24.41). Next, the camera switches back to Ann's home, where she says to her husband that she has been saying it from the beginning, and that she thinks it is Lyme (24.48).

The sequence's switching back and forth between Ann and Sanders presents an alternation between explanations from the medical community, here represented by Sanders as the series' host, and Ann's individual feelings and intuitions. Sanders speaks from a position of knowledge, and speaks clear sentences which explain what she thinks is going on medically. Ann stutters. Although Sanders tries to refute the notion that functional disorder is similar to being 'crazy', what she effectively does is to invoke the possibility by repudiating it without providing justification or an alternative explanation. Both of Sanders's quotes given here imply that it is Ann who is wrong: firstly, her body is doing something wrong, and secondly, she wrongly takes functional disorder to be something which it simply 'is not'.

This interchange shows that, although the traditional, strictly hierarchical patient–doctor relationship is changed, it is far from voided in the series' diagnostic innovation. In the diagnostic negotiation between Ann and Sanders, Ann's options seem limited: either she obediently accepts the diagnosis being handed to her by the crowd or, by refusing, she is framed as a deviant individual. In focusing on the representation of her reservations towards functional disorder, and by staying close to the different sequences in which it is described, I have wanted to show how, for Ann, the notion of functional disorder itself implies a risk. In doing so I have shown how this particular popularised version of medical diagnostics situates the lack of medical explanation on the side of the patient, who now becomes the problem.

The Crowd, the Future, and the Present

The extension of medical diagnostics beyond closed disciplinary practice complicates and blurs the relationality of the diagnostic situation. Diagnosis, and especially the role of medical (in)explicability within it, has historically been confined to specific hierarchies and relations of power, concentrated in the examination room. This room, in which the medical doctor and the patient negotiate a discursive translation of the

patient's symptoms into a name for disease, is described by Whitehead and Woods (2016) as the background for what they call the 'primal scene' of the medical humanities (2). This scene is made up of the clinical encounter between the doctor and the patient, most characteristically in the 'scene that unfolds the diagnosis of cancer' (2). According to Whitehead and Woods, the emphasis that the medical humanities have laid on the individual encounter between patient and doctor needs to be enriched with critical attention to the various structural, cultural, and institutional settings determining the dynamics of this encounter. In the first episode of *Diagnosis*, Sanders explains that finding the right diagnosis is not an easy matter, and that the question of which diagnosis is eventually given is very much dependent on who is present in 'the room'. For Sanders, the crowdedness of the room in which a diagnosis is given becomes a 'tool' for doctors – the more people present, the more symptoms might be recognised, understood, or identified ('Detective Work' 8.54). Crowdsourcing medical diagnoses is presented by Sanders as 'Making the room just that much bigger' ('Detective Work' 9.04). However, in the widened online 'room' of the series, the encounter itself becomes dispersed, unable to account for different relations of power. With the encounter now no longer taking place solely between doctor and patient, but also between patient and patient, or between patient and a person otherwise interested, these power relations are displaced by the experiment, but certainly not voided, or removed. In theory, such a dispersal of power might attenuate the inequality of the relationship, but it might simultaneously intensify the danger of any kind of bias against the person being diagnosed.

In episode five of the series, this danger clearly emerges in the responses coming in for the case of Lashay, a teenage girl from Utah who cannot hold down anything she eats or drinks. She regurgitates after each meal, making her stomach so upset that she cannot stand straight or walk, which results in her being hunched over most of the time, and unable to go to school. In the opening scenes of this episode, Sanders says that 'on the surface, you might think this is classic teenage bulimia', and then continues to state that she is 'pretty sure this is not the case', as Lashay does not have the nutritional abnormalities that you see in self-induced vomiting ('A Matter of Trust' 4.40). Even so, the reactions from the crowd show what Sanders calls 'the darker side' of the crowdsourcing experiment (19.38). Many of the responses to the case, presented in the episode as a collage of tweets and online reactions, state she is either 'fake' or 'mental' or that her condition is due to 'picky kid syndrome' (19.11).

On online fora like Reddit or Twitter, the airing of Ann's episode met with a similar response, doubting the legitimacy of her symptoms. Confirming Ann's fear of racial bias, one comment refers to Ann as an '[a]bsolute moron who refuses reality just to keep being a complete bitch who get to be the "woman of colour" victim' (Goeffyerself 2019). Other users mention being 'frustrated with her' (Aebbae 2019) or say that they 'noticed that as she was explaining her symptoms she started manifesting them . . . [as if] she has trained herself to do that' (Rodgerdodger44 2019), effectively doubting the reality of her symptoms and suggesting she 'did this to herself'. In their cases, the expansion of the diagnostic space beyond the clinical room seemed not to engender out-of-the box diagnoses, but rather to reinforce positionalities – teenage girl, or woman of colour – which negatively influence diagnosis on the basis of normative, sexist, and racist ideas.

While the opening up of medical diagnosis beyond the medical profession offers the possibility for more people to contribute with different diagnoses, it simultaneously runs

the risk of eliminating hierarchies of power between doctor and patient which normally structure the diagnostic situation, and of filling up this vacuum with dominant cultural hierarchies that are already there – dismissing women's symptoms as being 'all in their head', and ignoring the racial structures at play. On first glance, the notion of medical inexplicability itself might be seen to hold a destabilising, critical potential with regard to medical discourse and technology, exposing existing gaps in the medical authority over the body. Not only does medical explanation obviously fail, but because no concrete medical fact is produced at the end of the diagnostic process, the entanglement of scientific medical practice and the structural vectors making up its 'room' remain in suspense. In the episode, however, this suspense is eventually solved not by presenting a solution to Ann's symptoms or by exposing the existing gaps within medical science, but by turning Ann into a problem herself.

Conclusion

Recent years have seen a surge of female authors who address the debilitating consequences of unexplained illnesses that challenge medical authority over the body, and who expose where medicine has failed them. In *Tender Points*, Amy Berkowitz (2019) writes that it is not just 'ignorant doctors and invisible-illness sceptics who object to the validity of psychosomatic pain', for this sentiment is shared by a substantial segment of people who live with chronic pain (91). 'You don't need to be fixed, my queens – It's the world that needs the fixing,' writes Johanna Hedva (2020) in their influential 'Sick Woman Theory' in response to these sentiments. Connecting the lack of attention to and knowledge about their symptoms to a capitalist patriarchy in which sexist or racist institutionalised healthcare has marginalised their experiences, Hedva centralises the 'un-cared for, the secondary, the oppressed, the non-, the un, the less-than' (2020). In a similar vein, Alice Hattrick's *Ill Feelings* (2021) blends memoir with medical history to expose the ways in which certain bodies have been neglected in present-day medical knowledge and to complicate the many relationalities that are involved when illness is contested.

Contrary however to such critical works, the Netflix documentary series keeps patients within the system of medical explicability. Different also from *Afflicted* (2018), another Netflix production following patients with undiagnosed and chronic illnesses,[5] *Diagnosis* aims to positively impact the presented patients' lives by way of the crowdsourcing experiment. This crowd, however, inhabits the same cultural condition described by Berkowitz, Hedva, and Hattrick, one that is oppressive, especially to women who are experiencing symptoms for which medical science has no answer.

The obverse of the series' emphasis on ultimate, shared explicability is presented by those cases in which a diagnosis remains absent, Ann's being the most prominent. Staying close to the representation of Ann in episode seven of *Diagnosis*, I have pointed to the ways in which the inexplicability of her symptoms goes hand in hand with her representation as a difficult, deviant individual. At the same time, the widening of the space for diagnosis by way of the crowdsourcing experiment is a tricky endeavour at the very best, and at worst a dangerous reinforcement of normative disciplinary exclusion. The people excluded turn out to be those people whose ailments are not merely mysterious, but persistently unexplained.

On a more abstract level, the notion of the 'unexplained' within this analysis can be construed quite literally as itself a science or scientific fiction. Insofar as it has a place within the representation of medical science, it forms a disruption of the technoscientific imaginary in which explicability is the norm. However, this place is never actually occupied, because the disruptive force is offloaded onto the patient. The inherently vague diagnosis 'functional disorder' does not destabilise the authority of medical diagnostician, but only enlarges the burden and insecurity of the patient. Attending to the dramatised, representational framing of medical diagnostics by Netflix, my focus on one particular representation of medical inexplicability aims to produce concrete points of departure for giving the problem a physical and truly problematic reality, a reality in which the promised future marvel of ever-expanding medical explicability is withheld for certain patients whose symptoms do not fit a medical mould.

Notes

1. In the original article in which Sanders introduced Ann to the crowd, she states that Ann 'asked that we use an abbreviated version of her name to protect her privacy' (Sanders 2018).
2. I refer to the way in which Ann narrates her doctor's comment that her pain was 'just psychosomatic' ('Paralysed' 09.18). In Ann's rephrasing of her doctor's words, psychosomatic becomes a condescending term with which she expresses that she is not being taken seriously. On Betterhelp.com, the world's largest commercial online therapy service, the entry on psychosomatic symptoms opens with saying that 'No one likes to be told their symptoms are psychosomatic. That's because, for many people, the term has come to mean imaginary. Being told your symptoms aren't real makes you feel brushed off and disrespected' (Faubion 2022). In a study on the terms that patients themselves prefer for unexplained illness, the term 'psychosomatic' was not included in the questionnaire, and it was found that patients preferred terms that included the word 'physical': the most popular term being 'Persistent Physical Symptoms' (Picariello et al. 2015: 423). A study on preferred terms amongst lay and otherwise healthy people done by Marks and Hunter (2015) included the term 'psychosomatic/psychogenic' which scored low, whereas 'Persistent Physical Symptoms' was also found most popular (111–12).
3. In his monograph titled *Crip Theory: Cultural Signs of Queerness and Disability*, Robert McRuer (2006) defined 'crip' for crip theory as the coming together of queer theory and disability studies. Crip is used to focus attention to the way in which disability intersects with race, class, or gender. In itself, crip can be seen as an example of a way in which language is reappropriated to better match the experience of the body and to explore its radical potential. In their essay, published online as 'Sick Woman Theory', which became hugely influential in queer and crip collectives around the world, Johanna Hedva (2020) made a similar gesture in appropriating the term 'sick woman'. They note that illness, disability, and vulnerability feminise any person who requires care and comment that '[t]hough the identity of "woman" has erased and excluded many (especially women of color and trans/nonbinary/genderfluid people), I choose to use it because it still represents the un-cared for, the secondary, the oppressed, the non-, the un-, the less-than'.
4. Jutel and Jutel here refer to cinema in general, as they state that '[d]iagnosis is the topic and the narrative tool of fiction, mémoire and poetry, TV series, greeting cards and films. It is a moment of rare emotional and personal intensity and therefore a potent source of drama in narratives' (2017: 185). In reference to film, they also give specific examples, like *Still Alice* (Glatzer & Westmoreland 2014) or *A Late Quartet* (Zilberman 2012).

5. In August 2019, four of the participants of the series sued Netflix for its representation of them in *Afflicted*, which aired in 2018. Bekah Fly, one of the patients who participated in the documentary series, told the *Huffington Post* that 'this is a community that's already marginalized, and [*Afflicted*] further marginalized us to the world because Netflix has so many viewers' (Flynn 2018).

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