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Recommended Citation
Sauceda, Sebastian, "Medical Horror: Authority and History in Medical Spaces" (2024). WWU Honors College Senior Projects. 814.
https://cedar.wwu.edu/wwu_honors/814

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Medical Horror: Authority and History in Medical Spaces

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9 June 2024
Of all of the subgenres of horror, medical horror is one that obviously and inherently makes sense. While medical spaces frequently exist as spaces of healing and relief, they are just as often places of pain and fear. They are spaces inherently invested with high levels of emotion from across the spectrum of what can result from something as intimate as the mortality and health of ourselves and our loved ones. This fact, in combination with the relative frequency in which the average person visits a healthcare space, make it one of the most understandable settings for horror fiction. Few of us will ever visit a haunted mansion, let alone an ordinary one, but practically every person will have some type of experience with a medical institution in their life.

In her “Mad Medicine: Disability in the Mad-Doctor Films,” Angela Smith draws from Michel Foucault’s *Birth of the Clinic* to discuss the concept of the medical gaze as a historical development in which the authority of medical professionals began to be harnessed from the visual examination of patients and their symptoms (165). Initially this may seem an overexplanation of something that is already painfully obvious; of course medical professionals derive their authority from their ability to recognize the symptoms of disease. Any professional in any field derives authority from their ability to recognize issues they are trained to address. However, despite this apparently obvious observation, this understanding is not evenly applied. Many people distrust car manufacturers or repair professionals because they recognize the inherent imbalance in the distribution of power and interest in transactions with these professionals. When people go to mechanics to get their cars fixed, there is an understanding that the mechanic has authority over us because of their specialized skills and understandings. Because this authority is derived from our lack of knowledge, it is both possible for us to be taken advantage of and in the interest of these professionals to maintain the knowledge gap that
gives them their status. Obviously not every individual, or even the majority of individuals who are specialized professionals abuse their authority, but it is important to examine and understand the epistemological structures of these professional/non-professional relationships. If medical professionals derive authority from their ability to recognize and define the physical symptoms of disease and injury, then their authority is inherently derived and continuously strengthened when colloquial conceptions of sickness and medicine are rooted in their understandings. In other words, the medical field’s authority is predicated on its ability to create consensus on what a broken body is. Exploring other historical, present, or possible medical paradigms is beyond the scope of this paper; instead I will focus on exploring the ways in which the current systems of medical authority incentivize visual consensus-making, the ways that these practices have harmed marginalized communities, and the ways that these visual constructions of sickness affect popular conceptions and media representations of medical spaces.

With access to healthcare being a major issue that marginalized communities face, it would seem as if these groups suffered from a lack of attention from the medical establishment. I instead argue that the issues these groups face in relation to health care stem from over exposure to the medical gaze. While disparities of health care access are often understood and framed as blind spots in social and legal systems, things simply not considered or predicted by their original constructors, I argue that instead these are signs of deliberate exclusion. After all, in systems that are human constructions, such as the United States healthcare system, one must be able to see something in order to build around or on top of it.

A prevalent example of this is the discussion that surrounds disparities in healthcare access and quality for women and assigned female at birth (AFAB) queer people. Going forward, when discussing women and AFAB queer people broadly, I will use the term female for the sake
of brevity and clarity. I want to acknowledge that simplifying this large and diverse demographic into a single term does a disservice to representing the vast range of historical and personal experiences, especially for transgender and intersex people. However, given that I will largely be discussing women and AFAB queer people in historical contexts or in relation to things such as reproductive health care, using this singular term may be the best available option. In national discussions surrounding legality and access to abortion in the United States, a common sentiment is that male opposition to abortion results from an inability to fully understand the lived experiences of female people surrounding reproductive health and rights. This sentiment is an immensely reasonable observation and frustration at the massive disparities between the population of the United States and the demographics of its government, and at the broader issues with gender roles that result in unequal distributions of empathy and emotional education. However, while it does point to ways that a lack of knowing fuels these issues, it overlooks the larger ways that comprehension and visual fixation drive violence in medical spaces. Banning abortions after six weeks of pregnancy does not reflect a lack of knowledge that it often takes at least six weeks for a pregnancy to even be detected, but rather a hyper-awareness of it. If a medical system could ever be theoretically blind, not that would necessarily be a more equitable alternative to what exists now, it would be unable to distinguish differences between demographics and would apply treatment equally. Instead, the hyper-precision with which the current medical system identifies and targets the weak points of different marginalized groups indicates that medical disparities are rooted in the power dynamics of visibility.

Returning to “Mad Medicine,” while examining the nineteenth-century practices of neurologist Jean-Martin Charcot, Smith discusses a well-known painting of him giving a lecture on female hysteria, Andre Brouillet’s Charcot at the Salpetriere (1887).
The image depicts Charcot and his assistants holding up their subject, Blanche Wittman (labeled as #1 in figure 2). Though simplistically depicted as a sufferer of hysteria and a subject of these medical professionals, this was likely to some extent a performance given as part of the lecture: “scholars suggest that Wittman was an apt pupil, ‘as she learned from the representations of the hysteric how to appear as a hysteric’” (167). The rest of the room features an audience of
medical students, many of whom are identifiable and would later become prominent figures in the field. Behind the crowd is another visual depiction of a female person suffering from hysteria (labeled as #2 in figure 2), as well as the painting’s artist, Paul Richer (labeled as #3 in figure 2), sitting among the crowd. Together these three elements create an unintended cyclical relationship; with Wittman enacting a physical, visual performance based upon depictions such as Richer’s, and Richer creating another depiction that serves as a copy of a copy (166-167). While obviously not every visual record of illnesses was as deeply and ironically drenched in the developing canon of medical visuals, it becomes easy to see how quickly depictions of illness could move away from the lived realities of patients and become filtered through the constructions of doctors.

For many people, their conceptualizations of the history of medicine is characterized into two broad stages: first medicine was bad because people did not know any better, and then it was good because they figured it out. This is not an entirely unfair way to chart the history of medicine, given the sharp decline in many of the more obviously brutal practices, such as bloodletting, and the improvement of tools that helped to make treatment more bearable, such as developments in sanitation and anesthetics. However, what this conception lacks is consideration of the transition period between these two stages of medical history. Before moving forward, it is important to acknowledge that this conception of medical history as being split into a ‘before and after’ structure is inherently problematic. To frame medical or scientific history as exclusively or continually linear is to perpetuate the destruction of the histories and contributions of non-wealthy and non-Western people and cultures to humankind’s collective medical history. However, given that the focus of this paper is on the ways that the construction of medical narratives and epistemologies affect understandings of and experiences in medical spaces within
the United States, it is necessary that to some extent these narratives be engaged with as they are and in the cultural places that they occupy. The transition between pre-modern and modern Western medicine was not seamless, for as much as the contemporary medical establishment wields a strong authority, that was not always the case. As the example of Charcot demonstrates, there was a period in which medical authority had to be established, as it often was through such visual demonstrations.

Smith argues that this “stage-managing of medical performance and photographic sessions suggest both the exploitation and objectification of his female subjects and the ‘theatrical labor’ that produces their bodies as ‘visual evidence’” (167). During the process in which the modern medical and scientific apparatus was beginning to develop, medical professionals were able to generate trust and authority from their ability to present visual displays of their knowledge. However, because of the aforementioned knowledge gap in the professional/non-professional relationship, issues arose due to the general inability of the audiences of these medical presentations to consider the context and perspective of the medical professional. Returning to the example of the car mechanic, when a professional explains an issue with a car to someone without knowledge of the subject, it is difficult or impossible for them to consider the biases that the mechanic may be bringing into their understanding. A completely uninformed person could bring an issue to an American, European, or Japanese mechanic and view all three as being the same type of professional, as without knowledge of this field they lack the ability to detect how differences in automotive and technological culture would affect how each of these professionals diagnose and approach issues. In the same manner, if you were observing a medical display such as Charcot’s and lacked a background of medical knowledge, it would be difficult to perceive the ways in which this presentation was influenced
by the biases and goals of the presenter. A hierarchical distribution of knowledge like this inherently compounds into a decreased likelihood of facing detection or accountability. This lack of restraining factors, when combined with the prospect of acquiring social capital, inevitably created a system where this practice of medical stage making was highly incentivized. This is not to claim that every medical professional during this time period engaged in practices like these, or that even everyone who did so did so consciously. But given that there is clear evidence that some level of sensationalizing of medical imagery occurred during this transition and that the systems of incentivization surrounding this process would have made this practice incredibly easy, it is almost certain that the purposeful construction of medical imagery played a role in the development of the modern medical field. The prevalence of the images that resulted from this practice are part of the historical foundation of medical authority, and as a result medical authorities have a vested interest in maintaining these conceptions of illness, even at the expense of the groups for which these images are most harmful.

Similar to how the power dynamics of knowledge during the development of the modern medical field incentivized performative medical displays, the social power dynamics that underlaid this period of transition deeply affected the choice of subjects. If we continue from the understanding that a non-professional consumer of medical imagery is often unable to analyze the ways in which their gaze is endowed with bias and manipulation, then it is also clear how a separation of lived experience can prevent an understanding of the ways that social hierarchy may affect the construction and presentation of medical imagery. When one lacks a solid understanding of the body and illness, it may be difficult to consider the epistemological relationship between the illness and the doctor. Having to also add the patient and their individual and collective relationship to illness and medical professionals into that equation
would make critical analysis of medical imagery incredibly difficult. As exemplified by Charcot’s presentation, medical imagery is often derived from the objectification of marginalized groups. Considering how the depiction of this event showcases an audience of men gazing upon a seemingly vulnerable woman, who is also being held by men, it is not difficult to consider the ways in which the power dynamics of gender play a role in this imagery, and resulting on the wider understanding of hysteria and women’s health. This is prior to even considering that the audiences and consumers of medical performance and care have historically been and currently are disproportionately skewed towards demographics with more social power. By the time a large proportion of medical recipients are exposed to medical imagery, they are already at least three layers removed from the lived experiences of the subjects of these images.

In *Medical Apartheid*, Harriet Washington writes about the history of medical exploitation of and violence towards African American communities. Throughout the book, Washington discusses the history of medical stage-making and authority building practices performed at the expense of Black bodies and communities. Specifically, when discussing the infamous Tuskegee Syphilis Study, she states that, “After the first clinics enabled doctors to identify syphilitics, they selected study participants. They wanted only [Black] men, whose signs and symptoms were on the exterior genitalia and therefore easier to identify” (162). While this practice does not as obviously display the type of showmanship present in Charcot’s demonstration and other similar displays, the manipulation of data is an equally malicious construction. It is undeniable that logistical practicalities make the visual and medical objectification of marginalized communities common. If an imbalance of power creates avenues of exploitation that would not exist in a non-hierarchical society, then it is inherent that these paths will be more commonly trodden. However, it is undeniable that this type of visual objectification of Black bodies reflects deeper
layers of how power operates within medical spaces. As previously discussed, the types of medical violence that oppressed groups face often reflects an intense level of study and specification. The history of the objectification of Black bodies by formal medical establishment in the post-slavery era is not coincidental or merely a side effect of the more obvious types of marginalization that Black communities faced. Enslavement, as a cultural system, was more than the physical realities of ownership and objectification of people. It was also an epistemological delineation of value, continuously creating and reinforcing understandings that certain bodies existed for the purpose of physical utility. The Black body has not been objectified so commonly throughout the history of medical research because of some secret underlying sense of inferiority by White doctors, but rather because these White doctors come from an epistemological background where understandings of the supposed perfection of White bodies exist deeply interdependently with understandings that Black bodies exist as tools. The medical gaze so often falls upon people from marginalized identities not simply because it is easier and more acceptable to objectify them, but because the ultimate purpose of that gaze, to establish and reinforce the authority of White medical instructions, is best accomplished by showcases of the ability to manipulate and control marginalized bodies.

Siddhartha Mukherjee’s *The Emperor of All Maladies* documents the history and development of understandings and treatments of cancer. In a section titled, “A Radical Idea,” Mukherjee details a period in the history of cancer treatment where American and European doctors had an obsessive fascination with extensive surgical removal. The chapter largely focuses on American surgeon William Halsted and his exploits in breast cancer treatment. Following in the steps of European surgical practices that he studied, Halsted advocated for and helped to popularize a type of surgery called a radical mastectomy. Rather than removing breast
tissue, surgeons who performed radical mastectomies would dig into the outer and inner layers of the patient’s chest muscles. Some were even recorded as removing and cutting through collarbones, deep chest lymph nodes, neck tissue, chin glands, and ribs (64-65). This violent operation was performed with the goal of removing all of the patient’s cancer and preventing remission; however, Mukherjee points out that this strategy was deeply flawed. Localized breast cancer can be sufficiently treated with a standard mastectomy, but if the cancer has already spread into other parts of the body, then surgical removal, no matter how aggressive, is not an effective treatment (67). This conceptual fallacy with radical surgery as a treatment for cancer was understood and vocalized by contemporary critics of the operation (see page 68).

While radical mastectomies could easily be filed with the plethora of brutal medical practices throughout history, the culture behind the practice makes it distinct. Mukherjee described the subculture of radical surgery as “a discipline so swooningly self-impressed with its technical abilities that great surgeons unabashedly imagined themselves as showmen. The operating room was called an operating theater, and surgery was an elaborate performance often watched by a tense, hushed audience of observers” (66). The stage-making involved with this process extended to the surgery’s results on the patients, “With the pectoralis major cut off, the shoulders caved inward as if in a perpetual shrug. . . Removing the lymph nodes under the armpit often disrupted the flow of lymph, causing the arm to swell up with accumulated fluid” (65). The discussion of the dramatic physical effects of radical mastectomies on its recipients is in no way meant to make any assertions about what constitutes a healthy or normal body or to make value judgments about those who fall outside of the narrow scope of what is colloquially understood to be a healthy or normal body. Rather, it is the sheer brutality and the absolute lack of necessity of radical mastectomies that makes this conversation necessary. In the same way that
defining disabled bodies as lesser is a statement on what is considered a healthy and normal body, unnecessarily altering a body (especially in a violently and likely often unconsensual manner) is also a statement on what a healthy and acceptable body is, as well as one on who has the power to define and create these bodies.

This historical subculture surrounding radical mastectomies is an example of how the medium of medical power is visual. It showcases how medical professionals use visual demonstrations of their technical ability to establish and reenforce their authority and position. By presenting a visually stark solution, the butchered bodies of those who underwent these surgeries, to an audience that lacked a strong understanding of cancer, these medical professionals create an extravagant display that showcased the supposedly equal extravagancy of their skills and expertise. This type of extractive showmanship was performed to great effect, giving medical professionals the power to define a healthy body, and to include bodies harmed by them within that definition.

As examined earlier, this process of performative authority building is often deeply connected with underlying social power dynamics. The Emperor of All Maladies features the following two images (figures 3 and 4), which Mukherjee describes as:

“‘The patient was a young lady whom I was loath to disfigure’ Halsted wrote. In this etching, Halsted presented an idealized patient. Real cancer patients tended to be older women . . . far less able to withstand this radical attack” (301).
The goal of these physical presentations was to create a display so visually pompous that it provoked a shock in audiences and the public that faded into a sense of awe at the ability to create such displays. The use of younger women in these displays of radical mastectomies aided in this shock by increasing the contrast between the objectified image of this group and the brutal
results of these operations. While deviations from objectified conceptions of the female body are never truly accepted, a certain level of leniency comes with age. There is a general acceptance and expectation that older bodies inherently contain certain amounts of supposed brokenness. If these dramatic displays of radical mastectomies were performed on older people, there would be a lesser distance between the results of these surgeries and what audiences already expected of an older, female person’s body. Younger female people provide a stronger contrast, and additionally come with extra amounts of already existing social objectification and sexualization. It is no coincidence that such a violent and violating surgery would be centered around a part of the female body so strongly associated with the visual objectification of the female body.

While the ideology behind radical removal was present throughout the cancer treatment field during this period, it was not evenly applied throughout hierarchies of power, “Although called the radical prostatectomy in the tradition of Halsted, Hampton’s surgery was rather conservative by comparison. He did not remove muscles, lymph nodes, or bone . . . stopped short of evacuating the entire pelvis or extirpating the urethra or the bladder” (71). It is admittedly difficult to call a conservative approach to excessive organ removal a privilege of power, however, it is clear why a group with more social power would face less intense medical abuse. If the female people who had access to professional health care during this time (a group that, while marginalized, was still largely skewed towards more White and wealthier demographics) were practically butchered as a form of treatment, one can only imagine what even more marginalized groups faced.

Returning to the subgenre of medical horror, what first needs to be addressed are the sources within the modern medical apparatus from which horror is drawn. Given some of the brutal practices used in the construction of medical authority, it may seem obvious why medical
figures and spaces are so commonly subjects of horror media. However, even considering that practices of authority-building are not and can never be fully comprehensive, it seems strange that the aftermath of a historical movement so focused on establishing trust and confidence, and remarkably successful in achieving this, would still contain such distrust and fear. While much of this paper is critical of narratives that define the history of medical progress as strictly linear, it is impossible to deny that the average quality and quantity of care, as well as the highs of care possible, have risen dramatically since the mid- to late-nineteenth century. From a purely public relations perspective, the jump from practices such as bloodletting to the comparative extent that the modern public health apparatus insulates the average person from disease should have resulted in nothing less than a rhetorical slam dunk. Yet despite this, medical horror not only sustains the more innate fears of bodily harm, but also now has layers of opposition to modern medical authorities and epistemologies.

In “Medical Horror Story: Realism, Reality, and the Real on Television,” Catherine Belling argues:

Representations of the content of health care – disease, disfigurement, death, and the scary gross stuff we all have inside of use – tend to generate horror…Yet such representations, when situated in a realist clinical diegesis, temper that response with credulity: this is happening in a hospital not a horror movie (No vampires here.)…A question of plausibility disturbs the viewer here more than in, say, an overtly gruesome horror movie [setting] that makes no claims that this shocking sight could be integrated into the routine work. (275)

Medical horror is unique among horror subgenres in the fact that it has to work against social efforts to remove horror from its setting. Many other horror settings only need to introduce a
horrifying element, such as a ghost to a mansion or a serial killer to a motel, in order to create tension. The platonic version of a medical space is already invested with the tension and emotion inherent to any place that deals with health and mortality, and it takes large amounts of work, both logistical and epistemological, to make these spaces palatable. The balancing act that goes into counteracting the horror inherent to medical spaces means that these spaces have so much momentum for horror to be drawn from. Beyond how medical spaces serve as fertile soil for horror, it is also important to consider the role that the foundations of medical authority play in medical horror. In “‘And Send Her Well-Dos’d to the Grave’: Literary Medical Horror,” Laura Kremmel argues that:

Medical horror draws from and heightens not just the fears of the body…but also, more prominently, the fears of the larger medical institutions and authorities that claim absolute power over the body in their promise to care for and cure it. As such, medical authorities intrude on the body in its most vulnerable state, one in which it is easily entrapped and manipulated. (314)

As effectively as medical authority has been able to use visual documentations and constructions of illness to establish and maintain itself, this also had the additional adverse effect of creating clear associations of control in medical audiences. Demonstrations of knowledge and authority such as radical surgery clearly showcased medical ability, but also inversely revealed to patients what possibilities could await them under the medical gaze.

When discussing the development of modern hospitals in the United States, Washington notes that, “the hospital was less an institution for healing than a physician-centered venue for learning, training, and experimental approaches” (105). As medical modern authority is so deeply rooted in epistemologies of power and control, hospitals and other physical spaces of
authority are bastions of the extraction that accompanies this. This type of control is so strongly associated with medical spaces that even medical horror media set outside of traditional facilities still relies on these understandings of control and extraction. Ira Levin’s 1967 novel, *Rosemary’s Baby*, concerns a woman whose life is taken over by a satanic cult that her husband and many of her neighbors are a part of, and who is forced to become pregnant with and give birth to the Antichrist. Kremmel emphasizes in their summary of the novel, that despite Rosemary spending much of the story isolated from traditional medical authorities and spaces, what she experiences with the medical gaze of the cult is eerily similar to traditional medical surveillance (see page 319). The theme of extraction becomes plainly apparent when Rosemary’s titular baby is born, “bedridden by the medications . . . she is directed to pump her milk in order to relieve her pain, falsely told that her baby has died: ‘She drew from each breast an ounce or two of thin faintly-green fluid’” (321). Not only is her body hijacked by cultist, medical authorities for the purpose of producing the Antichrist, the creation of which is something fundamental to the construction of this group’s power, but after its birth, Rosemary remains imprisoned by implements of medical authority in order to be continuously used as an object of production, or as Kremmel phrased it, “trapped in a contaminated body that is both inseparable from herself yet no longer her own, medically altered and occupied” (321).

Medical horror explicitly set in professional spaces is able to explore how the contrast between the presentation of medical authority and its realities creates horror. *12 Hour Shift*, written and directed by Brea Grant, is a 2020 horror comedy film about a nurse, Mandy (played by Angela Bettis), who suffers from addiction and is involved in a black market, organ trading scheme. In a scene early in the film, Mandy enters the room of an unconscious patient and their adult daughter. The patient’s daughter pleads for information about her mother’s condition,
including personal information about herself and her mother, to which Mandy replies with short apathetic answers. After seeing the patient’s suitcase in the corner, Mandy rushes the daughter out of the room and steals some of the unconscious patient’s medication, rummages through her belongings, and eats a granola bar that was packed in the suitcase (0:06:50-0:08:48). This type of predatory treatment of patients also appears in several scenes later in the movie, notably in one scene where Mandy sets up an older male patient onto a dialysis machine. After walking to a cabinet and pulling out some bleach, Mandy stands looking at the patient, with the camera looking down, past her hand holding the bottle, and at the man through a predatory gaze (0:09:52-0:11:23). In these scenes we see a type of medical exploitation similar to that in *Rosemary’s Baby*: the limitations that sickness and care often place on the body serve as opportunities for medical professionals to take from patients.

In addition to the ways that the scene where Mandy steals from the unconscious patient discusses medical extraction, it also reflects a conflict between the desire for medical instructions to operate as on demand machines and the reality that they are operated by people with human needs. The premise of medical authority in some ways can be understood as a promise of omnipotence; if you are able to see and understand all within my body and illness, why wouldn’t you be able to see and comprehend all that takes place within the physical spaces within which you operate? As much as an all-encompassing and exploitative form of medical authority and gaze can generate horror, the places where the limitations of those promises of authority become visible can also be powerful sources of horror. This occurs again later in the film, when Mandy, suffering from a disorientation caused by her drug use, walks in front of a crowd of concerned patients, led by the women Mandy dismissed earlier in the film, but is unable to see clearly or even speak comprehensively to them (0:56:53-0:57:19). Throughout the film, Mandy’s addiction
is implied to have been the result of some type of abuse from her brother, so while it would be
difficult to call Mandy a sympathetic character overall, amongst the chaos of the second half of
film, this moment serves as a sobering reminder that Mandy’s actions are driven by her deeply
human emotions and problems. As much as current structures of medical authority can be
harmful, it is important to acknowledge that medical professionals serve as essential public
servants and that they are deeply depended on in what are often the worst and most dangerous
moments of people’s lives. In many ways, all-encompassing presentations of medical authority
can be deeply harmful to medical professionals themselves, especially those who occupy a lower
status within societal power dynamics or in institutional structures, who are more likely to face
the brunt of the frustration that patients feel as a result of this disconnect between promises and
realities.

An additional element of medical epistemologies that *12 Hour Shift* explores with its mix of
horror and comedy are the inherent flaws that accompany a reliance on visual mediums of
communicating authority. Part way through the film, Mandy’s hand-off contact, Regina (played
by Chloe Farnworth) sneaks into and moves throughout the hospital by wearing a set of scrubs,
being assumed a nurse by both patients and other medical staff. Within this time period she
discovers the dialysis patient and kills him with bleach in an attempt to get his organs (0:28:52-
0:31:08). By simply donning a visual symbol of medical authority, Regina taps deep into larger
cultural understandings of what constitutes authority within medical spaces. Ironically, when
empowered by this symbol of medical authority, she also attempts to commit a similar act of
exploitation associated with the fundamentals of visual medical authority. The extent to which
this disguise works exceeds what would be reasonable for simply wearing a uniform, as in
another scene later in the film, after having attacked a nurse and patient, Regina attempts to
escape the hospital barefoot and covered in blood and vomit. While she is waiting at an elevator, another nurse walks by Regina, but because she is looking down at a clip board the entire time, the nurse sees nothing wrong with Regina’s appearance and walks away after a quick discussion. (1:00:12-1:00:35). The comedy and tension of this scene attests to the reality of how often internal, self-reflective medical gaze lacks the intensity of its external face. The film expands this argument to include the ways that this internal visual neglect extends to patients in these spaces, such as when it presents a scene where Mandy and another nurse named Karen (played by Nikea Gamby-Turner), while trying to find Regina in the hospital, walk past a patient who is wandering around with a loose bag of organs (0:50:14-0:50:18). The film’s framing of authoritative gaze as so exclusively outwardly facing also extends to the ways in which other forms of instructional power interact with medical authority. In a scene near the midpoint of the film, a police officer walks in on Mandy, covered in blood, performing an organ removal on a corpse on the floor of a morgue. Because she is a nurse in a hospital, the officer is not suspicious and helps Mandy lift the body off of the floor and even offers her a soda (0:45:25-0:47:50). As harmful as an excess of medical, visual objectivation can be, 12 Hour Shift, by positioning so much of its violence within the unseen spaces of medical facilities, argues that a lack of internal medical gaze and self-accountability are also dangers.

This relationship between the medical and the visual is also deeply carried into the ways that violence is structured in the film. While Mandy has directly carried out murders and Karen is at the very least actively involved in planning them, the only times we ever see a medical professional commit on screen acts of violence, is in terms of the visual. While being held hostage by one of the men involved with the other side of their organ harvesting scheme, Mandy pretends to grab some medicine and then stabs the man in the eye with a needle (1:12:17-
A few moments later, when Mandy and Regina attempt to flee the hospital, Karen runs up from behind that same man, where he cannot see her, and hits him in the head with a bedpan. This action sequence represents a major shift in gendered power dynamics in the story, as throughout the rest of the film, the two nurses and Regina were largely in control of the situation, and when they did run into trouble it was from other female nurses or female patients. At this point in the film, the hospital has turned into a hostile environment where the female characters are being hunted by police, an escaped serial killer, and the goon of an organized crime boss, all represented by male characters. By making it so that this situation, which was immensely imbalanced in terms of structural power, was resolved in the favor of the marginalized group using a medical medium of power and attack, the visual, *12 Hour Shift* blatantly showcases the strength that visual, medical authority has, even in comparison to other institutional systems of power.

Medical spaces hold a special place within the horror genre. The broad range of emotions and treatment outcomes possible within these spaces endows them with a level of volatility not common in other everyday spaces. This disparity in possibilities covers a range all the way from benevolent protection from suffering and death, to deeply violent exploitation. As much as it is easier and more comfortable to believe in historical framings that describe medical progress as completely holistic and linear, this is a grave oversimplification that does far more harm than good. Medical horror is a difficult genre for many to engage with, who after all wants to be reminded of or introduced to some of the darkest things that can be found within a space they frequent. However, despite the difficulty that can come with examining medical horror and the history that informs it, doing so is a valuable method for gaining understandings of the foundations of the issues found within the modern medical establishment.
Works Cited


