THINK PIECES

Ghosts in the health machine
Visits from the dead in hospital

Victoria Hume

Abstract

Ill health and hospitalisation can conjure up both benign and threatening visits from the dead. This piece is an exploratory attempt to understand these visits in the context of a long cultural history of the relationship between the ill and dying, and those already dead. It looks, too, at the role played by the machine of the hospital, with all its constituent parts, in both this cultural history and manifestation of figures of the dead during illness today. The article uses evidence from two narrative studies of delirium conducted by the author in the United Kingdom and South Africa in 2013 and 2017 respectively, as well as brief reflections on experiences within the author's family.

Keywords

ghosts, hospital, delirium, intensive care, hallucination

> I was having a tea party with dead people. It was so strange – it was like my uncle who'd passed away, my two granddads . . . and my cousin, who had a car crash. So, you know, we just had this great big tea party and they were people that had passed on – I was like 'what's going on here?' Perhaps it was time to think, 'Well, am I ready to go?' (UK interviewee, 2012–2013 research)

The dead may have been visiting those in fragile health for some centuries. Lisa Morton's (2015, 16–17) survey of the history of ghosts tells us that the 'thirteenth-century nun Gertrude of Helfta . . . described meeting deceased sisters of the cloth, lay brothers and even a knight during her extensive and excruciating physical suffering'. In late fourteenth-/early fifteenth-century Western/Christian society, 'Ghosts, in particular, were believed to be drawn to humans during times of crisis or to be produced through the unresolved tensions of those crises' (Edwards 2015, 84). Another two or three centuries later, and Voltaire's *Philosophical Dictionary* ([1764] 1901, 175) states that 'Fantastic visions are very frequent in hot fevers', referring in part to Charles IX's visions of 'hideous and bloody faces' after the Massacre of St Bartholomew. Indeed by the eighteenth century, the sceptic Charles Ollier suspected that ghosts were merely symptoms of illness: 'It may be laid down as a general maxim, that anyone who thinks he has seen a ghost, may take the vision as a symptom that his bodily health is deranged. Let him, therefore, seek medical advice, and, ten to one, the spectre will no more haunt him. To see a ghost, is, *ipso facto*, to be a subject for the physician' (quoted in McCorristine 2010, 75).

Hospitals are of course houses of fever, trauma, and crisis. These states – exacerbated by treatment itself (surgery, drugs, immobility and so on) – can in turn cause a multitude of different delusions and paranoias. In clinical terms, this experience is called various things depending on the context, but perhaps most often 'delirium' (see for example Adamis et al. 2007; Bélanger and Ducharme 2011). Broadly speaking, the more extreme our state of health or the greater our vulnerability, the greater the likelihood that we will be subject to delirium in hospital. Thus, in a 'normal' hospital ward, about one in five people are likely to be delirious at any given time (Peter 2012; Ryan et al. 2013). In intensive care, this figure rises to over 80 per cent (Maldonado 2008).

One possible characteristic of this experience – the one I focus on in this essay – is a conjuring up of the dead, particularly when mortality looms. A 2014 study in the United States, for example, suggested that the bulk of the hospice patients surveyed were engaging with the dead in the later stages of their illnesses (Nosek et al. 2014). During my own research on delirium in hospitals, a South African intensive care unit (ICU) nurse of many years' experience told me that patients 'will often see family members, sometimes deceased family members'.

I hope to give some substance in this essay to these figures of the dead, in particular by looking at how the architectural space of the hospital – already haunted by prejudice, expectation, and dread – appears in delirium, and by prising apart two types of spectre – which I call for now 'friendly' and 'unfriendly'.

Most of the evidence I provide derives from two narrative studies of delirium in hospitals, the first conducted in the United Kingdom between 2012 and 2013 and the second in South Africa

between 2015 and 2017. Between the two studies I interviewed a total of thirty-one people – fifteen with direct experience of delirium in hospital, five family members, and eleven health care professionals. Interviewees varied in age between their early twenties to their late sixties. For those with direct experience of delirium, hospitalisation had resulted from a huge variety of causes, including major surgery, organ failure, a car crash, and unexpected postsurgical complications. At the time of our conversations, interviewees were at different distances from their delirious experiences – the closest being three months prior to the interview, the farthest twenty years before.[1] I have not included the biographical details of each person I mention below, but like their hospitalisations, their biographies are enormously varied; what is often more striking is the commonality across delirious experience.

I should note, however, that only a proportion of my interviewees saw figures of the dead. While the narrative studies resulted in explorations of the more dominant themes elsewhere (Hume 2017), this think piece explores an issue that was peripheral to these themes, but collided with my personal experience of my mother's recent ill health and hospitalisation.

The hospital as a house of ghosts

> The tulips are too excitable, it is winter here.
> Look how white everything is, how quiet, how snowed-in.
> I am learning peacefulness, lying by myself quietly
> As the light lies on these white walls, this bed, these hands.
> I am nobody; I have nothing to do with explosions.
> I have given my name and my day-clothes up to the nurses
> And my history to the anesthetist and my body to the surgeons.
>   – 'Tulips', Sylvia Plath

What Plath describes is the epitome of one kind of literary hospital: white and blank; the patient passive, inert, silent. Emotion is condensed in the single threatening object of the vase of tulips, which communes telepathically with the reluctant patient. Plath (1960) writes: 'Their redness talks to my wound, it corresponds'.

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[1] In an interview during my research in the United Kingdom, Melanie Gager, an ICU nursing sister, noted that distance does not diminish the vividness of the experience: 'That never ceases to amaze me – how somebody ten years ago can recall their hallucination and get just as teary today as they first retold it ten years ago. They're very powerful, very deep, very emotive'.

Hospitals are spaces in which a certain kind of control is exercised to make our biomedical health care possible, a control that extends from the 'white walls' to the implicit need for quiet, to sedation. The volume of need is managed to an extent through suppression.[2] There is also a certain etiquette required of being in intimate proximity with strangers, the psychic equivalent of those flimsy hospital curtains. In relation to this etiquette, during my 2015–2017 research in South Africa I was struck by the frequent use of the word 'inappropriate' by health care professionals to describe delirious behaviours of various kinds: saying 'inappropriate' things, doing 'inappropriate' things – acting out. Indeed as people become sicker, and the intrusions on their bodies and minds greater, those who cannot restrain *themselves* may be subjected to chemical or physical restraint.[3] The more intense the care, the longer the stay, the greater the pressure, the harsher the restraint. 'Tulips' speaks to this essential hospital contradiction between controlled space and the violence that constantly threatens to burst through its surface.

And when this violence does erupt, an equally powerful literary image arises: the gothic asylum, a space epitomised by our ideas about Bedlam,[4] which echoes through every history of medical abuse, from Richer and Charcot's nineteenth-century images of 'L'Hystero-Epilepsie' at Saltpetriere[5] to Morton's (2015, 85) description of the island of Poveglia, which she calls 'the most haunted island in the world'. Morton (2015, 86) continues:

Poveglia has a perfect history: before the twentieth century the 7-hectare (17-acre) island served as a quarantine point for plague victims, a refuge against barbarian invasions and a fortified lookout. In 1922 the existing buildings – some dating back to the twelfth century – were converted into a mental institution, and rumours circulated that the facility's director conducted cruel experiments on many of the inmates. According to legend, he was driven mad by ghosts and threw himself from one of the towers.

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[2] In the context of managing delirium, one clinician I interviewed during the South African research asserted, 'I don't think we medicate them to relieve their distress, I think we medicate them to make them manageable'.

[3] Restraint is used in intensive and in general acute care if the patient is deemed to present a danger to themselves or others. Some parts of the world favour chemical restraint (Langley, Schmollgruber, and Egan 2011); in others, physical restraint remains widespread. Langley and colleagues (2011) found that almost half of the patients admitted to a South African public ICU over two months were restrained during their stay, and for a surprisingly high average of nine days.

[4] 'Bedlam' is a variation of 'Bethlem' (from Royal Bethlem Hospital, also called St Mary Bethlehem, in London, once an asylum for the insane).

[5] An exploration of Charcot's photography of 'hysteria', created by Susan Hawes, a professor of clinical psychology, can be found at http://www.slideshare.net/suhawes/charcots-photographic-icongraphy-of-hysteria.

When I worked in a National Health Service hospital I remember being approached periodically by artists and film crews eager to work in empty wards (an impossible luxury) for the 'atmosphere'. Indeed a whole industry is built on this quasi-clinical space, wherein medical museums and 'ghost tourism' thrive on the frisson generated by countless iterations in popular culture.

The hospital in delirium

So how does this already loaded space appear to someone who is lying inside it, delirious? In hospital – and particularly in intensive care – our capacity to understand our surroundings may be compromised both by our illness and by our treatment. We might not know exactly where we are, or why we are there. One interviewee explained that 'you use part of your surroundings, and then your mind makes things up'. At one point he felt that he was a projector in a cinema, an apt image to describe how we (as patients) seem to project our emotional landscape onto a partial perception of our surroundings, and to write a new narrative that brings the two together.[6] The art critic Robert Hughes (2006, 17), for example, describes his delirium after a near-fatal car crash thus: 'Something weird had been fixed to my right arm, driven into the flesh, immobilizing me. I realized (in the dream) that it had been surgically implanted there by two fiendish Chinese doctors. . . . Their gadget (in the dream) was a broadcasting unit. In reality . . . it was an "external fixator" . . . its purpose was to immobilize or fixate my right arm, whose elbow had been smashed into a mosaic of bone fragments'.

An external fixator is a substantial metal structure that sits outside the body and is fixed to a fractured bone with metal rods and screws to ensure that the bone is kept in place as it heals. To see one is to understand why it might be associated with both entrapment and antennae in the mind of the person experiencing it. Like the interviewee who felt he was a projector, Hughes is riffing on the reality of his situation with an emotional overlay. This is just an extreme example, however, of perceiving medical devices attached to the body as having nefarious properties, misprisions typical of hospital-induced delirium. Other interviewees spoke of drips that contained poison, bedside monitors that counted down to bombs, televisions that were spy cameras, and beds that were coffins.

Indeed the hospital itself could be understood as a macrocosm of such medical devices. Inside the architectural shell, its constituent moving parts – whether beds, lights, or health care professionals – interact to conduct the business of preserving life. This larger medical machine,

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[6] Voltaire ([1764] 1901, 175), defining the 'apparition', says that 'Fear, love, grief, remorse are the painters who trace the pictures before unsettled imaginations'.

too, is subject to misinterpretation. Several interviewees felt themselves to be not in hospitals but in vehicles of various kinds: a spaceship, a 'naval vessel', a ferry. Several spoke of feeling that they were in a 4x4 or an aeroplane. Sarah, a senior ICU nurse, described the frequency of deliriums featuring 'being at sea' (Hughes similarly mentions a pirate ship).[7] Several interviewees described being underground in some way, often alone; one described being at the bottom of a lift shaft, where he had been for 'hundreds of years'. My mother experienced the same thing, experiencing herself as trapped in an underground garage. Hospitals are generally notorious for their lack of darkness; people describe overstimulation, constant disturbance. Yet even in the bright lights of ICU people often dive underground into these occluded, limbo-like spaces, where time seems to stretch almost to infinity.

And as with all the other machine parts, the people also change. Three interviewees reported that people had been transformed into skeletons, for example (see below for more detailed descriptions); one young woman saw the nursing staff as pigs; another saw her mother as the devil. One man experienced a Capgras delusion, in which both he and his wife became clones of themselves.[8] He said: 'I could tell that this was a clone, because she had a microchip in her neck. . . . The real [wife's name] was supposed to rescue me and take me away from – from that subjugation'.

He continued, describing his efforts to escape: 'I wanted to be out of there. . . . I was becoming very physically agitated, and trying to remove all the lines from my arms. . . . It was like being shackled'. Under the circumstances it is not surprising that people will (often repeatedly) try to escape, sometimes at great risk to themselves. This tendency to remove drips, cuffs, intravenous lines, even breathing tubes[9] was mentioned in more than half of the interviews I conducted in the South African study.

Two kinds of ghost

> It is as difficult too to determine whether the Spirits that appear are good or evil, or both; the only Conclusion upon that Point is to be made from the Errand they come

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[7] Two interviewees attributed this to being moved around the hospital, for example, being taken for scans whilst semi/unconscious, or to lying on a mattress that moves in a wavelike pattern to prevent bedsores. One nurse felt that this together with dryness of mouth could lead to the delusion of being on a ship.

[8] See for example Blom 2009, 84–85. The Capgras delusion consists in perceiving the self or a loved one to be a clone or imposter.

[9] One nurse explained that 'with their tongue, they'll push the tube out, even if they're restrained, they'll push that tube out'.

about; and it is a very just Conclusion, I think; for if a Spirit or Apparition comes to or haunts us only to terrify and affright, to fill the Mind with Horror, and the House with Disorder, we cannot reasonably suppose that to be a good Spirit; and on the other hand, if it comes to direct to any Good, or to forewarn and preserve from any approaching Evil, it cannot then be reasonable to suppose 'tis an evil Spirit.

– Essays on the History and Reality of Apparitions, Daniel Defoe

Not everyone I interviewed mentioned figures of the dead. Amongst the fifteen who had had direct experience of delirium, six spoke of seeing the dead; and amongst the eleven health care professionals, three.[10] I would not ascribe the religious and moral overtones of Defoe's 'good' and 'evil' to these stories, but the ghosts these nine people described could nonetheless be divided into two polarised groups – friendly and unfriendly – which I describe further below. I begin, though, with an example from my own mother's experience.

Felt presences and friendly ghosts

In the weeks while she waited for an operation that seemed constantly to be receding into the ungraspable horizon, my mother told me that she was living with another person. At first she turned around when she sensed them. She thought it might be my father (who died in 2008). Or a combination of me and my father.[11] My father himself saw a ghost once, during a difficult phase of his life, a former mentor who appeared to him as he laid in bed. And in turn I saw my father's ghost when he died. It was in fact a classic amorphous white shape, waiting in the house I grew up in; I could see it in the mirror from my bedroom. Then it passed on and away. Not frightening at all; reassuring, in fact, in a way. As is my mother's companion. She has realised now that there is no one there, and has stopped turning around, but when she is feeling weaker, she tells me it is as if she is 'seeing it from somebody else's point of view all the time; it's very odd'.

Ben Alderson-Day, a psychologist working with the interdisciplinary Hearing the Voice project at Durham University,[12] explores this world of felt presences, which often appear at times of crisis. In his 2015 *Guardian* article with David Smailes, he tells us that Ernest Shackleton and his

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[10] The interviews were not structured with these figures in mind. People mentioned what they could recall or felt was important in their experience, so the absence of these figures does not necessarily mean they did not appear, only that they were not mentioned in the interview.

[11] In traditional Scottish folklore terms I could have been a 'wraith' or 'fetch', essentially a living person appearing 'to warn a loved one or friend' (Morton 2015, 18).

[12] http://hearingthevoice.org/.

companions 'reported an uncanny experience during their trek in the Antarctic: a feeling that "often there were four, not three" men on their journey'. The authors suggest that 'Extreme physical conditions, threat to life, and social isolation all seem to trigger the feeling of a presence' (Alderson-Day and Smailes 2015). I note in passing that simple, everyday things like age and solitude may take us to the same place as Ernest Shackleton in the Antarctic. But, between us, my mother and I consider that it may be her own sense of her body being disrupted, escaping its bounds, that is leading to this splitting off of a part of herself into an other. The coherent self has revealed itself to be a lie; but there is a guardian-like quality to these presences, and in themselves they don't especially trouble her.

I would suggest that these felt presences are similar to other examples from my interviews, like these two from 2013. One person described the appearance of their dead grandfather, saying, 'I see a lot of him now . . . watching me all the time and having a go at me: "Get out of here!" You know, "you don't need to be in here – you've got your daughter to get home to"'. Another talked of her friend's long-dead mother: 'A friend of mine, her mum died twenty years ago and I can remember her talking to me and saying, "oh P—, you've got to go back". . . . I just felt as if I was in a deep sleep… and I can just remember her saying "oh you've got to go back"'.

For the interviewees above, the role of these figures seems to have been to bring people back from the brink of death. In another instance, however, an interviewee described her grandfather, who had passed away, 'trying to get me to go with him. I just didn't want to go'.

A series of three recently deceased figures appeared to one young woman who was herself extremely close to death, from complications relating to the very difficult birth of her child. Her husband video-recorded her time in ICU, and during our conversation in 2013 she suggested we watch this video together. In the quote below, she is partly describing what the viewer can see on the video, and partly what she remembered of the experience:

> My most comforting hallucination – cause they weren't all frightening . . . I'm actually communicating with my partner, and . . . my voice is very childlike, I recognize that. . . .

> Two weeks before I was admitted here, my nan died . . . and I couldn't visit her, just leading up to her death. . . . When she died . . . I had gone overdue for my pregnancy, so I couldn't go to the funeral, which was really upsetting.

> The week before I was admitted, one of my best friends suddenly died. . . . I was convinced I was going to die, because this had happened to two very special people to me. And I didn't get to say goodbye to them. . . .

> And there was another girl there. . . . She died a few years ago from sudden adult death syndrome[13] . . . so I was waving goodbye to her, so the three people I'd lost recently, I'm sort of seeing them go to this light.

The three figures this interviewee described were benign, but none of them had been properly buried – in the speaker's terms, she had been unable to 'say goodbye'.

There are ample cross-cultural precedents of the dead reaching across to the living to resolve their deaths. The historian Lisa Morton (2015, 25, 29–30, 112) writes about the *ataphoi* in Greek theatre and the Hindi *Bhuta*, who appear in response to a lack of respectful ritual surrounding their deaths. Kathryn Edwards (2015, 92) discusses late medieval Christian notions of Purgatory, epitomised in a story from Cologne of Arndt Buschmann and his dead grandfather Heinrich, who in November 1437 returns 'to ask Arndt's help in fulfilling vows and righting wrongs so that he could ascend from purgatory to heaven'. In late eighteenth-century England, Sasha Handley (2016, 120) writes, 'it was widely accepted that ghosts were the souls of the dead who returned to confess their sins to the living to speed their passage through the fires of purgatory'. More broadly, the idea of 'unfinished business' informs many ghost stories, from Banquo's quest for vengeance for the murder of his family to Oscar Wilde's early story *The Canterville Ghost*, in which Sir Simon de Canterville is trapped in a sleepless limbo for the murder of his wife.

The unfinished business of the ghosts in the brief examples above could perhaps be read as a metaphor for the unfinished business of the living: even the grandfather who tries to pull his loved one towards death seems to nudge her back to life, reminding her of her desire to live.

Unfriendly ghosts: The zombie

The unfriendly ghosts that follow here fall into a broader category than the recognisably human(e) figures above (best friends, grandparents, and so on). What unites them, however, is an antithesis to the human(e). The *Oxford English Dictionary* defines 'zombie' as 'A hypothetical being that responds to stimulus as a person would but that does not experience consciousness'.[14] These visions are perhaps less dead than undead, representing different ways that the body can be disconnected from vivacity and personhood during delirium.

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[13] Also known as 'sudden arrhythmic death syndrome', in which adolescents and adults die suddenly, usually in their sleep.

[14] https://en.oxforddictionaries.com/definition/zombie.

The zombie is also of course a pop-cultural figure, which helps denote the vivid surreality of some of these hallucinations. Here is how one woman described her vision of skeletons, for example: 'So you know, like, you watch something like *Dr Who* or *Star Trek*? That sort of thing. And it's that type of movement as well, it's not like human movement; it's just like they're robots, or that type of thing, but you just know that they're coming towards you'.

These are machine-like figures, evacuated of consciousness. A few interviewees also made reference to skeletons, another sort of structure without spirit. One said, 'I remember my mum and my sister were there; and the first thing I saw – they just looked like skeletons, and I actually thought I'd died'. Another similarly recalled, 'as I laid in bed, the nurses would come to see me or the doctors and all I would see was a skeleton, and I couldn't see their face; so every time I closed my eyes I thought, "Well, am I alive or dead?", cause that's how I felt; you know, "Am I really alive?"' Melanie Gager, the senior nurse mentioned earlier, remembered caring for a patient who also saw people as skeletons: 'every time he looked at a face, he initially saw the flesh and then he just saw it disappear, so it was just skeletons nursing him, and he – yeah, he almost vomited telling me because it was just so real to him'.

The two patients quoted above were at this point in their hospital stay seesawing between life and death; the skeleton in their accounts is reminiscent of fifteenth-century European murals of the 'Dance Macabre', in which skeletons lead people of varying degrees of social import towards death, representing its indiscriminate nature and intertwining with life.[15] Like the Scottish wraith, the Irish fetch, or the German *doppelgänger*, these figures may warn of the death of the person who sees them.[16]

The zoomorphic hallucination is another unfriendly figure that runs counter to the human. For one interviewee, at one point the nurses 'looked like farmyard animals. . . . One had . . . a pig's head and one had like a cow's head'. Later in the conversation she added that the nurses were 'faceless, like they weren't actually people'.

A third unfriendly ghost encountered in these interviews is the Capgras clone, essentially an empty reflection of a loved one or the self, which, like a zombie, 'does not experience consciousness'.[17] Morton (2015, 97) tells us that 'The Chinese character for ghost (Guǐ 鬼) is

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[15] See for example: https://en.wikipedia.org/wiki/Danse_Macabre.

[16] This seesawing between life and death is by no means always characterised by disrupted bodies. Two other interviewees, for example, found themselves on the edge of a cliff; another was involved in a quiz, and needed a particular answer to survive.

[17] https://en.oxforddictionaries.com/definition/zombie

based on an early ideogram that depicts a human figure wearing a mask'. The ghost is not a real person, after all, but a simulacrum.

Lastly, a South African health care professional described an encounter with a woman who was 'minutes away from death', in which the woman felt that her body parts were distributed around her room: 'I could see my feet there; I could see my arms there'. For the health care professional, this disassembling of the body, of personhood, was 'extremely spooky and unnerving' despite her many years of experience with severely ill people.

The examples given here are too few to attempt to fix a single meaning to these phenomena. It is possible that these images of the body losing its human-ness or breaking apart are how our imaginations process near-death experiences; in this sense they are indeed wraith-like warnings of death. But they may also be depictions of how we, as patients, are made to feel about ourselves.

One woman described her anger at being treated like 'a piece of meat' in hospital, and another interviewee seemed almost to translate this metaphor into a delirious hallucination of being 'served up as kebabs'. A third interviewee summed up the dehumanisation implied by this image:

> Interviewee: I just remember a sort of total lack of – it's like you're sort of treated like a body basically, like *there's no one in there*, they don't talk to you or – they sort of, you know, wash you or whatever. It was all very perfunctory, and it was kind of …

> Hume: D'you think that the fact that you're treated like a faceless thing means that you then impose that, or reflect that back in the way that you regard people?

> Interviewee: Yeah. Definitely. (emphasis added)

It seems plausible that there is a relationship between being treated as if 'there is no one in there' and visions of zombies.

Conclusion

In a way the term 'ghost' is misleadingly narrow. The figures of the dead I describe above are simply one group in a far broader cast of characters in delirium that includes fairies, police, terrorists, living relatives, pirates, and so on – as well as, of course, more abstract experiences that lend themselves less easily to narrative. But tightening our focus onto this group may help

us understand some of what delirium can tell us about hospitalisation and how we conceptualise our own vulnerability.

As with Hughes's (2006) delusions of torture, there is a truth inside delirium that is hard to reach by other means. The culture of the hospital – its white quietness, its apparent neutrality – continually disguises the violence inherent in the system, its attacks on personhood. Delirium is one of the cracks in this surface. But these narratives can also tell us something beyond even the current culture of care about how the imagination processes such attacks.

The figure of the zombie in particular reveals both the existential trauma created by intensive hospital stays and the power structures that play out in illness; it is an expression of our vulnerability, both a symbol of how we (are made to) feel – 'like there's no one in there' – and of everything faceless, hard, and incomprehensible that threatens us in the hospital machine.

For some, however, a figure of selfhood reappears; in the guise of grandparent, guardian, or a less specific felt presence, benign figures intervene to reconstitute our fragments and send us back to the world.

'Delirium' is one of the oldest terms still in use in relation to health, recorded by Celcus in the first century CE in relation to fever (Adamis et al. 2007). Hippocrates associated it firmly with oncoming death (Adamis et al. 2007); delirium remains closely associated with mortality (see for example Klouwenberg et al. 2014). The two figures I describe – friendly and unfriendly – are one frame through which to understand this world. Cartoonish though they may seem, they represent our innate capacity to narrativise both our dissolution and our recovery.

Acknowledgements

About the author

Victoria Hume is a composer, arts manager, and researcher specialising in the meeting points between the arts and health. She is currently working with the medical humanities initiative at the Wits Institute for Social and Economic Research and at the Wits School of Arts. Before this she was an arts manager in the NHS for fifteen years. In 2017, she received a distinction for her master's-degree work in music and health communication, which focused on hospital-induced

delirium and brought together narrative research and musical composition. Her most recent EP, 'Closing' (released by Lost Map records), was featured on Lauren Laverne's best of 2016 playlist (BBC Radio6 Music). See her music website (www.VictoriaHume.com) for more information.

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