**Informal Clinical Drawing project outline, 18.10.13**

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**1. Introduction**

It has been anecdotally observed that health care professionals sometimes draw for patients as part of the clinical consultation. Drawing also occurs between one health care professional and another as a means of explaining the nature of patients’ conditions and the required treatment and care. It is also thought, but not established, that patients occasionally draw as a means of explaining symptoms such as pain. These acts of drawing appear to be spontaneous and informal, taking place at significant points in the spoken exchange when additional information or emphasis is required, or as an expression of the need for a different type of communicative interaction.

Initial observations and investigations by Martha Turland (2013a; 2013b) have highlighted the way in which these acts of informal, clinical drawing are sequential in nature. Performed live by the drawer for the spectator, the drawings are created and viewed as a sequence of marks. They are not generally recognizable as ‘representational’ or aesthetically pleasing and there are few similarities with formal, published medical illustrations, whether hand-drawn or digital. Informal clinical drawing can be accompanied by talk, written annotations, gestures and opportunities to invite questions and establish comprehension of the information being conveyed.

A number of questions arose from Turland’s observations. First, does this type of informal clinical drawing display a common underlying order or set of rules; a syntax or grammar? Are there patterns in the way these drawings are made, in terms of the speed of mark-making, the intensity of mark, the repetitions of mark for emphasis or the simultaneous use of text, speech, gesture? Does the drawing process convey information in a way that is perceived by health care professionals or patients to be more helpful than the spoken word alone? Are there other reasons that either party in a clinical consultation turns to drawing? Do patients request or initiate drawings? What impact does the witnessing of the drawing have on the recipient: is it perceived as mystifying, or explanatory (providing context to the specific issue)? Does it have a positive or negative effect on the interpersonal dynamic? Do these drawings convey to patients a sense of their own body rather than a generalized notion of the body?

There appears to be little academic literature that investigates or analyses this particular type of informal drawing and its significance systematically, either in relation to the clinical consultation, health care practice or patient understanding. Nor does its significance to the understanding of drawing appear to have been explored. This research therefore sets out to test and explore the initial observations.

**2. Theoretical contexts**

The study draws on selected elements of the following areas of drawing theory: first, it takes into account theory relating to production and reception of sequential image-making in comics (McCloud, Sabin and Versaci); second, theory relating to the sketch and cognition (Kantrowitz, Fish and Scrivener, Goldschmidt); and third, theory about the relationship of image and text, particularly the ‘anchorage’ and ‘relay’ theory of Barthes and the possibility that the marks and words that comprise informal clinical drawings might have an underlying syntactical structure.

The study will also consider the potential fruitfulness of Foucault’s theorizations of the structures and processes of power in medicine and medical institutions and the nature of the clinical gaze. This will be considered in relation to the impact of informal clinical drawing as a focal point for participants, both drawer and viewer, and whether this consolidates, questions or disrupts the structures of clinical power. The study will also consider whether there is any relationship to work underway in recent years into the potential of visual arts practices and skills in improving observation and diagnostic skills (Bardes, Friedlaender).

In addition, the study draws on the theory of Merleau-Ponty and others relating to phenomenological fields of perception and the embodied experience that needs to be accessed to understand the impact of informal clinical drawing.

 **3.** **Research questions and aims**

The research question is:

*How can informal drawing practices within clinical consultations and exchanges be understood?*

1. What is the nature of informal drawing during clinical consultations and exchanges: why and how are such drawings made?
2. Is there a ‘grammar’ and ‘syntax’ to informal clinical drawing?
3. What is the impact of informal clinical drawing upon the participants involved?

**4. Methodology and research design**

The methodology chosen is intended to enable the capture of rich, individual experiences of informal clinical drawing. The wish is both to understand the individual participant’s account in its own right and to be able to create interpretations across a range of individuals’ accounts about the nature and impact of this type of clinical drawing.

The experiences of such drawing might cover a wide range of factors. Participants might feel shaped (although not exclusively defined) by their formal role and function in the consultation (consultant, patient, nurse etc) and by their personal understanding and enactment of that role in a specific consultation. Patient participants might be affected by health concerns or information such as diagnoses and treatment strategies. It is also possible that level of experience or a particular approach to clinical communication might influence healthcare professionals. The institutional location of the clinical exchanges and the set up of the consultation space are also potentially relevant factors. Participants’ experiences of informal clinical drawing are considered to include the moment and act of mark-making but also any contiguous explanation and discussions, locutions and non-verbal behaviour.

Participants are theorised as bringing their ideas, beliefs and preconceptions to bear in clinical consultations, constructing meaning collectively with other participants through both dialogue and the act of drawing or viewing of the drawing process. The study therefore takes a phenomenological perspective to explore and develop an understanding of informal clinical drawing and is influenced by the social constructionist approach to the human generation and construction of knowledge.

The researchers will make a call for volunteer patients and healthcare professionals to come forward with experiences of informal clinical drawing within the last year. Participants will be asked to narrate their memories of the experience, including memories of at what point the drawing was made, how the drawing emerged and developed on the page and how it was used during the consultation. The researchers will prepare for the interviews by reflecting on their own assumptions, preconceptions and hopes. They will aim to keep some distance from these and will avoid forming a hypothesis. Participants’ memories will be elicited through semi-structured questions in interview, as this will allow the opportunity for interviewers to build trust and allow participants time to reflect and recall memories in their own time and in their own words. Where possible, the informal clinical drawings witnessed or produced during consultations will be used in the interview as a reference point. The participants who drew the images will also be invited, if they wish, to demonstrate how they make such drawings. This will form part of their account of whether they create informal drawings routinely in consultations and to help them articulate (again, only if they wish) how and why they make these drawings.

1. **Ethics**

Ethical approval will need to be sought through NHS Ethics and Governance in order to advertise to and recruit from patients and staff. It is anticipated that this will take some time to prepare and gain approval for as there are many issues to be taken into account in a study like this. Whilst the study is not concerned directly with patient medical history or details of their current condition, it is indirectly concerned with these through the focus on clinical drawings that describe or explain pathology or treatment plans. Further careful consideration is to be given to what type of clinical specialism/s this study might concentrate on and advice will be taken on what type of consultations might be selected that risk the least harm to participants. A fuller project plan will articulate in much more detail how power relations, anonymity, confidentiality and data storage will be handled.

**6. Methods and timetable**

6.1 The first stage will be the preparation of an NHS Ethics application (see section 5 above) and a literature review covering: selected theory in the areas indicated (see section 2); drawing practice in healthcare, including diagrammatic and notational practices; the use of medical illustrations in clinical consultations; the use of sequential drawing in medicine more widely, including the current fast-expanding field of graphic medicine.

6.2 A pilot study will be carried out initially with 2-3 individuals from each of the two participant groups: patients and healthcare professionals. The aim of this will be to test whether, in response to the interview questions, participants are able to recall and describe the memory of the drawing being made (ie, whether the sequential aspect of the drawing is available to memory) and what impact this had, as well as whether and how the completed drawing was referred to post-consultation.

6.3 Following the pilot evaluation, the full study will aim to recruit between 15 and 20 participants. The draft timetable for the study is based on the estimate that NHS Ethics approval might take approximately 10 months:

September 2013 to June 2014 – NHS ethics approval

June/August 2014 Call for participation, information and recruitment

September 2014 Setting up of interview schedule

October – end of December 2014 Interviews

January – March 2015 Analysis and coding

April - June 2015 Writing up

**7. Data processing and analysis**

Stage one:

The researchers will transcribe the interviews verbatim.

Stage two:

The drawings will be considered individually and then as a data set. They will be analysed in detail for meaningful elements in terms of the type of mark, the use of space, annotations, diagrammatic elements, indications of repetitive or emphatic mark-making and indications of a process of ‘tidying’ or refining the drawings. This will then be refined and an initial interpretation made of any emerging patterns and themes.

Stage three:

Each interview transcript will be analysed carefully and in detail in its own right for meaningful statements and significant thematic categories that arise from these. Particular attention will be paid to dissonant responses.

Stage four:

The researchers will then consider the relationship between individual transcripts and associated drawings, and then the relationship between the themes identified from the set of transcripts and from the set of drawings. A further stage of interpretation will be carried out of the relationship and significance of the themes identified.

Stage five: writing up

**8. Indicative list of references**

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