**[SLIDE 1]**

**Embedded manual drawing in the clinical consultation**

**Introduction**

**[SLIDE 2]**

Manual drawing and sketching occurs in many areas of health care. It is deeply embedded in daily routines across a wide range of roles and specialties, and at different hierarchical levels. It happens in GP practices and in hospitals, from dementia wards to cardiothoracic clinics. It takes place in, for example, pathology labs (see drawing of thyroid cells) and on endoscopy units **[SLIDE 3]**. It occurs against, or perhaps despite, the backdrop of computer screens and easy access to professional digital and printed medical illustrations and models. Many of these drawings are significant only in the moment of their making: they are temporary; consigned to the bin at the end of a conversation. Some are kept on clinical records, or as personally significant.

There are no statistics on the prevalence of manual clinical drawing as a practice; it certainly isn’t carried out by all health professionals. But anecdotal evidence and research currently taking place is revealing that this drawing occurs, often quite informally, between patient and professional. It also occurs between one health professional and another, to record physical examination results or operative procedures **[SLIDE 4]**. Drawing takes place to explain care needs and sometimes in order to reach a common technical, diagnostic understanding **[SLIDE 5]**. Yet in epistemological terms, this visual practice that weaves through the health system has a paradoxically marginal place. There are departments of medical photography in hospitals, but there is no institutional locus for, or recognition of, this type of drawing. A search of the research literature suggests that it is barely acknowledged as a phenomenon.

Martha Turland and I currently have two NHS projects underway that aim to increase our understanding of these types of drawing practice. The first of these uses a phenomenological approach to explore the perceptions of health professionals who routinely draw: we have just completed the fourth of these interviews. The second study, for which ethical approval is pending, will use recorded observations of live cardiothoracic consultations to look at how, when and in what way this type of drawing is used, ‘in the moment’. Whilst the empirical data we are collecting in our first study is not to present as findings, I’d like to share with you some of the slippery issues we have been considering in framing and approaching this research. **[SLIDE 6]** We are, as arts researchers, entering a different disciplinary sphere and a pressurized and ethically sensitive professional world. We are also trying to find out about a visual practice of uncertain status. How can we contextualize, conceptualise and approach the manual drawing that takes place within the clinical setting?

**Framing doctor-patient communication**

Part of the context for clinical drawing is the strong cultural and social identity of the doctor-patient relationship (and I am using doctor here as code/shorthand). It has an existence as a kind of archetypal encounter, a familiar narrative form for the exploration of human vulnerability and mortality. It is also a key issue in contemporary health care communication, in the academic literature and the political discourses of health, for example in relation to what is sometimes referred to as ‘patient-centred care’. In coming to this field from the arts, from the ‘outside’, however, I was struck by the sense of tension and, to some extent, contradiction surrounding this concept or ideal.

**[SLIDE 7]** This comment is originally from a 1981 article by Hall et al, subsequently used as a preface in a 2010 literature review of doctor-patient communication, by Ha and Longnecker:

‘Medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of the patient-physician relationship’.

This quote, referencing the non-rational and the ambiguous, seems an unusual but not completely unique approach for the more qualitative medical and health journals to take; there is a long and continuing tradition of discussing medicine as an ‘art’. The same review goes on to describe ‘effective doctor-patient communication’ as a ‘central clinical function’ and to say that a “more patient-centred encounter results in better patient as well as doctor satisfaction”. At the same time it notes the ‘brutality of medical training’ that ‘suppresses empathy’ and the complexity of the process of doctor-patient, in which serious miscommunication is the potential pitfall. We can see from this review that there are different language registers, aspirations and pressures in operation and differing constructs of doctor-patient communication in play. A 2014 research article by Zanini et al concerns “doctors perspectives of which aspects of the patient perspective matters the most”. This article highlights a hovering sense of conceptual entropy. Despite referring to a broad consensus in the literature about the value of the patient perspective, they caution that: **[SLIDE 8]**

‘the concept of the patient perspective is unclear, as are the aspects of the patient perspective that need to be addressed in the consultation’.

At the moment when political and academic emphasis is being placed on the patient point of view, the terms of the debate and at times the methodologies used seem strained and the concept of patient-centredness itself elusive.

The practice of drawing between doctor and patient appears not (to our knowledge) to have been formally researched from any perspective. Given this, I think it is fair to ask whether doctor-patient communication has been framed in a way that occludes part of what it seeks to understand. It may be that a focus on dialogic exchange, in which the verbal has been overly privileged, has had the effect of veiling or eliding other meaning-making practices in health communication. In this context, the drawing practice that we are in the process of exploring appears to take place in the unexplored interstices of clinical encounters, the fluid between the cells. Yet illness and treatment experiences are intense and intensely visual, and there is a long tradition of artistic exploration of the complexities - the ‘stickiness’ – of doctor-patient experience, in its many forms.

**Arts-based approaches to health communication and illness**

So I’d like to look briefly at three visual approaches to illness and health care communication. I want to consider the insights they afford, and in particular what they offer to our study of the interstitial clinical practice of manual drawing. Many patients, some of whom are also professional artists, have used drawing as a response, a communicative strategy and as a visual method in health contexts. [**SLIDE 9]**  These images are by the illustrator Nick Wadley, who felt compelled to draw through his experience of serious illness, even to the extent of drawing shortly after emerging from a coma [**SLIDE 10]**. His drawings, annotated in an online gallery with brief verbal comments, offer some understated but challenging provocations about health care [**SLIDE 11]**:

“I made countless drawings about lying on consultants’ beds, **[SLIDE 12]** being prodded by consultants’ fingers. These are the first encounters with that peculiar sense of intimate confidence in someone who forgets you almost as soon as you leave the room (“Next!”)”

Is this one of the aspects of the patient perspective, in the words of Zanini et al, that would ‘matter the most’ to doctors? For Wadley, drawing seems to be an inevitability, an instinctive or compulsive act. Whilst this is itself is not surprising, given he is an artist, it raises wider questions about the use of – the facility offered by – the drawn mark. Perhaps the doctor (or patient’s) turn to pen and paper and the materializing, visualizing practice of informal manual drawing might be related to Heidegger’s notion of ‘readiness-to-hand’, which Tom McGuirk (in 2011) usefully highlighted as the “situated, engaged and transparent way we encounter things through their use”, as opposed to the more “theoretical and objectivist attitude” or ‘presence-at-hand’.

In a different example [**SLIDE 13]**, Jac Saorsa, philosopher and artist, describes how she uses her artistic practice “as a vehicle to understanding the existential experience of illness”. The images here are from her residency in Tanzania, in a unit for Obstetric Fistula, where she drew extensively (she is back there on a follow-up stay as we speak). She drew the women arriving, often in a state of pain, shame and alienation, to present themselves for treatment; [**SLIDE 14]** she drew the waiting and the pre- and post-operative phases; and the spaces and equipment of the clinic [**SLIDE 15].**

In a blog that accompanies her images, Saorsa writes that these drawings are a ‘meta-language’. They are, she says:

‘a form of communication that goes beyond .. the verbal language with which the patient tells her story[…]. The meta-language becomes itself a ‘voice’ that can communicate across the boundaries of convention and taboo, and articulate suffering so that, in dialogue with the drawings, the viewer is invited to engage and understand at a profound, intuitive level.’

Saorsa has talked elsewhere, after Deleuze, of the significance of rhizomatic thinking, the horizontal, spreading, exploratory research mode that moves not quite outside of but rather through the boundaries of disciplines and limiting structures. Hers is an iterative, generative visual research strategy constructed as a continual dialogue: between artist and patient, between artist, patient and viewer [**SLIDE 16]**. Saorsa sets out to enter a space where language seems to fail [**SLIDE 17]**, to bring out aspects of these women, their specific condition and predicament to wider attention.

**[SLIDE 18]** And a third example. In 2012, I carried out a project with my Brighton University colleagues Patrick Letschka and Tom Ainsworth, investigating professional understandings of drawing. We developed a methodology we called ‘conversational drawing’, the process of which we filmed. In the resulting wide-ranging discussion between design academic Chris Rose and hand surgeon Donald Sammut, the surgeon talked about his routine practice of drawing for patients, and drawing in preparation for operating. In one clip, Sammut describes drawing for a particular patient, a 6 year old boy who was accompanied by his parents. As he drew and the shape of the hand emerged, there was all at once a moment when the boy recognized, with complete delight, that the marks represented his own hand. **[SLIDE 19]** As you can see on this slide, as the surgeon told this story, he mimed the beaming face of the child looking for a corresponding delight in the faces of his parents. In the course of this conversation, Sammut described and demonstrated how his drawing could be functional and technical, in preparing to operate. Yet he also showed how it afforded a means of communicating information that did not rely on abstract or technical knowledge. My reading of Sammut’s account of his child patient is that in drawing a patient’s hand he is potentially enacting a transformation: **[SLIDE 20]** the abstract notion of surgical competence becomes transubstantiated, through the process of drawing, into a felt understanding of the physical presence of the dexterous, surgeon’s hand. The drawing is no longer a representative practice but an invitation to the patient to relinquish control of their body, to have faith. The patient recognizes, through the marks being made, that the drawing is not just of *a* hand, but of *their* *own* hand: there is an epiphany of bodily connection, a materialization of the temporary intimacy between doctor and patient. These ideas have been important in trying to  **[SLIDE 21]** build further research studies and theory in this field. But what is also worth noting is the way that the information about drawing in this video is produced. It is deeply integrated within and reliant on an act of communication both verbal, drawn and spatially located.

Each of these three examples explore connections between mark-making, communication in its cognitive and affective dimensions, and bodily experience. They suggest, I think, that dimensions of knowledge and experience that are hard, if not impossible to articulate in language, can be at least partly opened up through the drawing process and, to some extent, through the resulting drawing itself. These are elements that are already emerging in the few interviews that Martha and I have carried out with health professionals. What these works also show is that encounters more usually constructed as verbal can begin to be seen as deeply visual, gestural and haptic, dimensions that need to be brought more fully into the research process and research thinking.

**Multimodality and readiness-to-hand**

The practice of manual clinical mark-making that we are investigating takes place as part of many complex interactions: with gaze; with the position of the body; and with a range of non-verbal gesture, from the deliberate point of the finger to the subconsciously authored frown. Doctor and patient are temporarily bound within an often difficult process of meaning-seeking and exchange in which all the senses come into play. Gunther Kress (2010) writes about this multimodality in relation to meaning-making processes in daily life, arguing that:

“Texts – spoken, gestured, written, drawn, mimed and any combination of these – are the means of making some of these complex meanings material.”

As researchers, we need to feel our way through this web of meaning-making practices that constitute doctor-patient experiences and perspectives. Framing clinical drawing as multimodal, I would suggest, offers us a constructive and nuanced way to approach the social, performative, ambiguous and sheer messy context of clinical communication, and the often unacknowledged, embedded drawing practices that take place within it.