RECONFIGURING THE CONSULTATION: RITUALS AND STORYTELLING IN GENERAL PRACTICE

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ABSTRACT

This theory and art practice thesis investigates the activities of patients and doctors in a general practice health clinic from my perspective as both an artist and a doctor.

Theories of ritual and performance are used to analyse the behaviour of the patient in the clinic waiting room and to consider the roles of the doctor and the patient in the consulting room. The notion of the symptom is presented through stories told to me by patients about their illnesses. The symptom is reflected upon by using Freudian and Lacanian theories of psychoanalysis, theories of narrative and ideas based on personal experience as a general practitioner. The interaction between doctor and patient is analysed with particular emphasis on their speech. Theories of narrative are used to consider stories told in the consultation, the complexity of the interpretations made by the doctor and the inter-subjective nature of the relationship between doctor and patient.

The theoretical considerations brought to an analysis of general practice within the thesis are not generally considered relevant to studies of medicine. They bring new insights into the nature of the clinic, the symptom and the doctor-patient relationship.

The art practice, which is mostly in the form of video, has developed in two directions. The first direction enquires into the effect of using the form of ritual and performance in depictions of technical medical procedures. The artwork shows a variety of procedures, and transforms them by exaggerating the symbolism of their rituals. The effect is to reveal the hidden psychological undercurrents that lie beneath the surface of the performance of the procedures and threaten their success.

The second direction uses documentary video practice to create a three screen video installation in which the viewer is confronted with the dilemma of an artwork presented as a documentary and a documentary presented as an artwork. The installation enquires into the nature of story telling and interpretation in a general practice consultation. The work reveals the importance of an evidentiary epistemological paradigm in understanding the nature of illness. It suggests that not knowing is a form of knowledge in its own right.

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ACCOMPANYING MATERIALS

A DVD of the video *Frozen Section* made by Vanda Playford in 2004, is to be found in a plastic sleeve accompanying the thesis. *Frozen Section* was made as a three-screen video installation, and was shown at the Royal College of Art fine art degree show in July 2004. It is part of the practice of the PhD. This DVD is a single split screen version made for projection or to be shown on a single monitor screen. The running time is 36 minutes and it is in PAL format.

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INTRODUCTION

Whilst researching the theoretical part of my thesis I will also carry out research using art practice. The theoretical and practical concerns are related and will inform one another throughout the duration of the research. The final artworks are distinct from the theory and can be considered as bodies of knowledge in their own right.

The theoretical research is an analysis of the relationship between doctor and patient in the context of a contemporary British general practice. I wish to bring new insights into this relationship by reflecting upon it through theoretical discourses, which lie outside the discourse of medicine and through my art practice.

This relationship is of considerable interest to me because I have worked as a general practitioner in London for eighteen years. During this time I have also developed an art practice using video and photography. The research by project will enable me to bring the less systemised and non-reductive reflections of art practice to a consideration of the practice of medicine, and in particular to general practice. Existing theoretical models of general practice are mostly framed within medical, psychological, sociological, political and economic discourses. These perspectives give valuable insight into the many factors in society that affect health and illness. Research in these disciplines is used to assess the needs of populations with regard to health services, and to advise governing bodies on the best ways in which to provide such services. Medical discourse defines illness according to diseases. It looks at ways in which physicians can treat disease and provide appropriate services to patients. The medical model and the psychological model give doctors knowledge and guidance about managing patients with specific problems within the consultation.

However, use of these disciplines places limitations on the understanding of the doctor-patient relationship. They tend to subordinate the position and experience of the patient to the authority of biomedical knowledge and the institution of medicine. The patient thus becomes an objective figure of study and a passive recipient of medical services. These models fail to recognise fully the inter-subjective dimension of the patient-physician (and other health professionals) relationship in which the patient is party to an exchange of knowledge. These discourses tend not to acknowledge that many aspects of a patient's problems cannot be accounted for.

Furthermore they do not allow for insight or reflection upon either the subtleties or the occult aspects of the doctor-patient relationship and the practice of medicine.

My research will attempt to reconfigure the doctor-patient relationship outside these traditional perspectives. This is not only to gain new insights into the nature of the exchange, but also to include and evaluate the hidden and uncertain aspects of the relationship. I will refer to theories of ritual to understand how and why the actions carried out in the roles played by doctors and patients have effects. Apart from the roles of doctor and patient I am interested in the relation between the speech of patients and their symptoms. I will draw particularly on psychoanalytic theory as well as narrative theory to reflect upon this relation. Narrative theory[1] has recently been used to draw attention to the role of story telling between the doctor and patient in the consultation. Research undertaken in such diverse fields as social anthropology, medical humanities, literary studies and social psychology suggests that the use of narrative theory can play an important part in understanding the complexities of the exchange between the doctor and the patient in clinical medical practice. I will use theories of narrative to provide insight into my own role and the role of the patient in general practice. These insights will guide my approach to my art practice, the outcome of which will enable me to re-consider the doctor-patient exchange from the perspective of an art practice.

One of the most challenging aspects of carrying out this research will be to place myself in a critical position in relation to being a doctor. In order to do this I will have to stand outside my usual position as a practitioner of medicine and consider medical practice from the perspective of an artist and a researcher. I will learn to give myself permission to speak about medicine from a personal perspective, and not from a professional perspective. This will lead to a greater understanding of my ambiguous position in relation to medical practice.

The thesis will enable me to identify and analyse these ambiguities. They arise in part from unresolved contradictions between my position as a medical scientist, a doctor with an interest in psychoanalysis and an artist interested in looking at medicine from a non-scientific perspective. They arise also from the application of a strictly empirical, rational scientific method of interpretation to the symptoms of patients whose health problems are related to social and psychological factors and to issues that we (doctors and patients) are unable to explain. The research will attempt to explore some of these contradictions.

In chapter one I will discuss how both patient and doctor are unconsciously implicated in a set of actions, statements and codes of behaviour, which are characteristic of rituals. I will consider the effects of ritualistic behaviour on the very layout and organisation of the waiting room and consulting room. The activity of waiting will be discussed in relation to issues of where the patient is situated in the hierarchy of the clinic. I will reflect upon the activities carried out by the patient during waiting and the psychological and emotional impact of waiting.

I will discuss the notion that being a doctor and being a patient involves performing roles. Within this context, I will evaluate the effect of configuring the consulting room as a stage where doctors and patients perform their roles, tell stories and enact rituals. These roles will be analysed in detail for their ritualistic properties. I will consider the effect of rituals in establishing and maintaining boundaries between doctor and patient and in effecting transformations of the patient. I will also take into account the effect of those times when doctor and patient move away from the formal and ritualistic aspects of their roles into more informal territory. I will analyse the roles we adopt when we are ill in order to reflect on how illness can be considered not only as an effect of a disease but also as a cultural phenomenon.

In chapter two I will discuss the notion of the symptom in the context of the consultation and consider it's characteristics beyond that determined by a biomedical model. Throughout the chapter I will refer to consultations that I have had with some of my patients. This is in order to provide the reader with an idea of the issues at stake when patients present the stories of their symptoms to the general practitioner. Western medicine, whose principles are founded on the empirical method, considers that symptoms are sensate bodily phenomena, which indicate the effects of a disease. However, given that many symptoms exist without any observable markers of disease, I will enquire further into the nature of the symptom. In general practice patients represent their symptoms in the form of oral stories. Detailed attention to the patients' speech is therefore important in determining how to understand the symptom. The chapter will refer to psychoanalytic approaches, which establish a crucial link between the speech of the subject and the symptom.

My enquiry into the symptom situates it as a form of bodily representation. I will question the motive for the representation, its formal qualities and its message. The medical and the Freudian psychoanalytical models consider the symptom in relation to causation. In medicine it is regarded as an effect of a disease, in Freudian theory[2]

it is an effect of the repression of unfulfilled wishes. Lacan's view reveals how the nature of the symptom excludes the possibility of being able to identify its cause or meaning. For him it has an enigmatic message and he states that the meaning of the symptom "remains hidden"[3]. In my discussion I will consider how the symptom relates to the desires of the subject. (This discussion will be continued in chapter three, where I will reflect upon the symptom in relation to the [1]inter-subjective nature of desire in narrative).

In the consultation there is a verbal exchange between the doctor and patient, which is often focused on the story the patient tells of their symptoms. During the verbal exchange there is a simultaneous process of visual exchange. I will investigate the visual component of the patient-doctor exchange, not only in terms of 'body language' but also and most interestingly in terms of the visual perceptions, which are stimulated by the speech of both doctor and patient.

In Chapter three I will reflect on the activity of story telling in the doctor-patient relationship. Throughout this chapter I will refer to the story of a patient whom I have named Lydia. Lydia is a refugee from Kurdistan who now lives in London. She sees her doctors regularly for treatment of headaches and abdominal pains. I will use narrative theory to show how these visits lead to a process of exchange of knowledge between doctor and patient and to a greater understanding of the patient and the meaning of their symptoms. Although the exchange takes place between the doctor and patient, I will explore how the doctor's response to the patient's story implicates other narratives and discourses within a discursive field. I will consider how this affects the process of interpretation. I will examine how the dialogue between doctor and patient moves between formal medical narratives and informal, more personal narratives. I will analyse the effect these different narratives have on the process of interpretation and diagnosis.

Desire operates within narrative to motivate its continuation and subsequent progression towards endings. I will engage with psychoanalytic ideas of desire in order to consider their relevance to the doctor-patient dialogue. I will consider how desire, operating within the inter-subjective field of the narrative, is implicated in the meaning of the symptom.

I will introduce the notion of 'plot' with reference to Lydia's story. The discussion will identify how patients construct plots when telling stories about illness and the effects

of social and cultural influences on their constructions. I will discuss the plots constructed by doctors when they write case studies. I will enquire into the factors affecting how these plots are constructed and how they affect the listener's or reader's interpretation of the patient's illness.

I will consider the temporal aspect of a doctor's and a patient's narrative and analyse how this effects the experience of time in a consultation. Finally I will discuss the importance of context in the patient's story of their symptoms, and how this affects the meanings of symptoms.

In the concluding section I will summarise the findings and conclusions of the theoretical research. I will also describe the artworks made during the research and discuss how these have evolved from the theoretical questions. I will discuss how these in turn lead to their own questions as artworks and bodies of knowledge.

The dissertation engages in a debate between positions of truth upheld within medical discourse and positions of not knowing and ambiguity which arise from my experience of listening and speaking to patients in consultations. The problem posed by the notion of the symptom and its relation to knowledge is the nodal point of this debate. By bring theories of ritual, psychoanalysis and narrative into the context of the doctor patient exchange I intend to gain insights into this problem.

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[1]See Greenhalgh T and Hurwitz B, (Eds), *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, London: BMJ Books, 1998

[2] Freud S, *Introductory Lectures on Psycho-Analysis (Part 111),* SE Vol XV1, translated by James Strachey. London: Vintage, 2001, pp349,350, 358-361

[3] Lacan J, *The Four Fundamental Concepts of Psycho-analysis,* translated by Alan Sheridan. London: Vintage, 1998, p248

RITUALS OF THE CLINIC

In this chapter I look at the complexities of human behaviour within a formal health setting—the health clinic—and focus especially on the interaction between patients and doctors. I will argue that what determines our behaviour is more a consequence of the rituals of the clinic and especially those in the doctor - patient relationship than an institutional requirement to follow rules and regulations. I am interested in considering illness as a form of behaviour, which can be partly understood and explained by complex socio-cultural processes, and not simply as a biological phenomenon.

It is not necessarily apparent that we (doctors or patients) behave in ways that relate to ritual when we are in a health clinic. Common understandings of ritual tend to equate this with special activities that lie outside our daily routines, such as traditional forms of religious and mystical ceremonies or the healing rituals of Shamans. By reflecting on the nature of ritual, it becomes apparent that it plays a significant but somewhat hidden role in the activities of a clinic. In a contemporary analysis of the phenomenon of ritual Bell states that it

> is not an intrinsic, universal category or feature of human behaviour [...] it is a cultural and historical construction that has been heavily used to help differentiate various styles and degrees of religiosity, rationality, and cultural determinism[1].

Within anthropological discourse, ritual is regarded as a complex socio-cultural medium that is used in a wide variety of functions (religious, ceremonial, traditional and conventional) and to create and communicate social messages. It is a culturally constructed medium with a rich vocabulary of gestures and words. An important attribute of ritual, according to Bell[2], is that it serves to create ordered relations between human beings and enables them to embody assumptions about their place in a larger order of things. I am interested in considering how this attribute of ritual operates within the clinic.

By contextualising the interactions that take place in a clinic within the cultural construction of rituals, I intend to shed light on those relationships that go beyond

strictly bio-medical parameters. I will consider whether these interactions maintain a tangible relationship between the unknown or occult (that which lies outside our conscious realization) and the scientific. I am interested in how ritual is encoded within this specific medical environment and intend to analyse the effects of ritual behaviour. I wish to consider how aspects of the interactions resemble elements of performance[3] and why this activity is an important part of attending a clinic. I am interested in the effect of different types of ritual behaviour on the part of doctors and patients. At times, interactions between doctor and patient are more formal and structured and at other times, where ritual codes are not observed, they can become more personal and intimate. I will consider how the consultation room becomes a site for the ritual of performing the role of doctor and patient and the ritual of telling stories about our lives and our bodies.

Ostensibly a general practice health clinic is a place where we as patients go to seek medical help, advice and treatment for ailments. As we cross the threshold between the outside world and the world of the clinic we find that this service is systematically delivered within a set of conventional routines and social exchanges. Our participation in these routines and exchanges, as well that of the clinic employees, is as important to the delivery of the service as are the rules that have evolved to govern their order. It could be argued that these conventions, which we feel obliged to follow, mark the clinic as an institution. Within institutions governing bodies make rules, and our participation depends on our willingness to obey them. Within such as system it is easy to think of the patient as relatively powerless. However in a clinic there is no decree that demands obedience. The patient's compliance with its rules may be, at least in part, better understood in terms of hers or his unknowing participation in the formality of an exchange that is 'ritualized'[4]. It is the actions within the ritual that prescribe and establish the patient's position within the hierarchy of the clinic.

Foucault perceives that ritual or ritualization plays an important part in establishing and maintaining mechanisms and dynamics of power[5]. Although Foucault does not specifically define what he means by ritual, it is a term that he frequently uses to indicate formalized, routinised and supervised practices that mould the body. For example in speaking of the function of public executions in the seventeenth century he states "The Public execution is to be understood not only as a judicial, but also a political ritual. It belongs, even in minor cases, to the ceremonies by which power is

manifested"[6]. Moreover "the characteristics of the liturgy of torture and execution - above all, the importance of a ritual that was to deploy its pomp in public. Nothing was to be hidden of this triumph of the law"[7]. He also refers to "meticulous rituals of power," "penal rituals," "legal liturgies of punishment," "public execution...ritualized as a political operation"[8] Likewise in his analysis of the clinic or sexuality he uses the notion of ritual techniques to "specify how power works, what it does and how it does it"[9].

Foucault's discussion on ritualization and power clarifies how the production of ritualized bodies (or in the case of the clinic, patients and doctors) is a strategy for the construction of particular relationships of power effective in certain social situations. The body is central to Foucault's understanding of how relations of power are constituted. The body is inextricably linked to politics. The body is "the place where the most minute and local social practices are linked up with the large scale organisation of power"[10]. Furthermore he states "the body is the most basic and fundamental level of power relations, the microphysics or the micro politics of power"[11] In reflecting upon the social forces that play on and organise the body, Foucault speaks of a form of knowledge and mastery "which might be called the political technology of the body". Bell[12] likens this description of the political technology of the body to the process of ritualization of the body.

It is important here to mention resistance to power, because in the clinic, as will be discussed later, we as patients accept and enact certain ritual roles, not because we are in a subservient power relation to the medical institution, but because there are benefits to acceptance. Acceptance does not imply belief. As Foucault states, a necessary correlate of power is the freedom to resist power. "Freedom is power's 'permanent support', since without the possibility of recalcitrance, power would be equivalent to a physical determination"[13] In other words without resistance, power would be equivalent to violence or coercion. Bell notes that "the fact that there are no relations of power without resistance means that the body is not appropriated by power and neither is consciousness"[14]. Ritual in the institution of the clinic is not coercive in the way that threats of violence are coercive, but ritual is "the arena for prescribed sequences of repetitive movements of the body, the person and the macro- and micro networks of power"[15]. Thus in effect ritual, through its actions creates structures of power. Power is not external to ritual. Foucault regards

ritualization as a "strategic play of power, of domination and resistance, within the arena of the social body"[16].

The clinic is an institutional setting, which enables the enactment and staging of socio-cultural exchanges between patient, doctors and other health workers. Exchanges that are specific to the individual, but also specific to how one thinks one should behave when one perceives ones self to be a patient, a doctor or a health worker. The behaviour or action is performative[17] in that it is specific to these roles and is enacted for an audience upon whom it has effects. The audience are those around us in the clinic: patients, doctors, other health workers and clinic reception staff. The behaviour is not only performative, it is also ritualistic because it adheres to a structure with a symbolic code. The effects of the performance of ritual codes of behaviour are to create order and establish conventions.

The Waiting Room

The waiting room of the medical clinic is a transitional zone, a space that lies at the junction between the public world, the home and the medical world. When we enter we have the impression that we have temporarily left our normal world behind. It is still a public space where we share a similar experience of waiting with other patients, before being called into the privacy of the consulting room. Waiting here is a public act and at the same time it is a solitary and personal experience.

The clinic and its waiting room are part of an institutional world of illness and disease. An environment that is structurally separate and distinct from everything that surrounds it. A world relating to medical science and its institutions, which operate within a system of knowledge that is both familiar and strange.

On a personal level this system is not strange for me because I am a doctor and understand the language and methods of science. However for those less familiar, the thought that one's body may be subjected to the practices of science can cause a great deal of anxiety. Yet this anxiety is not absolute. Although we might believe that we have little control over what will happen to us, at the same time there is comfort in the thought that we will be taken care of. The clinic and the waiting room hold us, and allow us to abdicate responsibility for ourselves. We can surrender to the care of the clinic that its medical experts provide. This is not unlike surrendering to the care and trust of the mother in the primary pre-linguistic phase. We afford

ourselves some comfort by placing trust in the employees who appear efficient, aware of their roles and tasks and how to manage and take us through its routines.

However, our surrender is not complete. The clinic is also a threatening place. The waiting room holds not only us but also other patients who might be contagious or aggressive. Whilst we wait we prepare ourselves for the consultation. We get ready to let down defensive barriers in order to tell the doctor personal details about our bodies and ourselves. We prepare to make ourselves vulnerable, but at the same time we need to stay in control, maintain a sense of ourselves and preserve our dignity. Our fears about our illness and what the doctor might say is wrong make us anxious and apprehensive. She or he may need to tell us we are seriously ill, or that we need an operation, or that the medicine we are advised to take for our complaint has unpleasant side effects. The doctor might want to carry out an unpleasant examination or medical procedure, or send us for hospital tests, all of which provokes anxiety. Our visit to the clinic therefore has the potential to be both comforting and frightening.

Most of my experience as a doctor and a patient has taken place in busy inner city London practices. Waiting rooms in these practices are usually bustling with people, some waiting and others passing through. Every patient knows that every other patient is waiting and likely to be ill and equally anxious. This can make the atmosphere tense. Some patients become over-anxious. Doctors pathologise this phenomenon when it has a physiological or psychological manifestation and name it 'white coat syndrome'. At worst this can mean that the patient fails to turn up for their appointment. Usually it is revealed when the patients are examined and are mysteriously sweaty, have a very rapid heartbeat and a raised blood pressure reading.

Whilst we wait, we look for distractions. We find them by looking at other patients and speculating about what might be wrong with them. Some seem ill, others appear well and it is hard to imagine why they have an appointment. We flick through the worn magazines left out for our attention. These are usually conventional magazines such as *Hello*, *Elle*, *The Lady, Home and Gardens*, travel magazines and weekend colour supplements; magazines that offer a superficial form of escape from all that surrounds us. Waiting room posters with practical

advice about how to stop smoking and prevention of infectious diseases are another source of distraction.

In this atmosphere of waiting suffused with tense apprehension, arguments and even fights can break out. Someone being called out of turn can cause a storm of protest, especially from patients who are particularly emotionally or mentally unstable. Such patients are likely to direct their frustration towards other patients or towards the receptionists by being rude and aggressive. Children also become frustrated and bored. They start playing, climbing over furniture, running around and making far too much noise. Parents who try to control them by shouting at them and threatening them can seem just as irritating as the children, especially to frail elderly patients. Despite these distractions we are also waiting expectantly for our names to be called or for them to appear on the computerized LCD screens.

As patients, sitting in our seats, surrounded by noise and by strangers who could be sick and even contagious, we act to protect ourselves. We build psychological boundaries. Enclosed within psychic walls that allow us to remain observant we remove ourselves into a realm of personal thoughts that inevitably revolve around our own illness, pains, fears and memories. It is often now, at this point in waiting, that we plan the story[18] we are going to tell the doctor: the story of the sequence of events of the illness, with their causes and effects. Planning this story can be likened to a rehearsal except that instead of reading a script we are preparing one. We think about the course of the illness: when it started, what we were doing when it started, if it has got better or worse, what we have done to alleviate it, and so on.

The thoughts are not just words—they are often accompanied by mental images, possibly self-reflective images of things we have done during the course of the illness, or images of friends and family who have helped us or who have been involved in other ways. In trying to piece together our story we think through the images—we attempt to describe them. The descriptions lead to new thoughts and new images. It is as if we try to put all the ideas, images and thoughts we can remember of the illness together in a logical and coherent series of events and causes. In other words, we give the remembered events a form, we arrange them chronologically, we draw causal links between them. In short, we construct a narrative[19].

Subsequently, when we start talking to the doctor, we are suddenly aware that the rehearsal is over and we have an audience. Quite often at this point, as with stage fright, the details of our careful rehearsal escape us. We usually manage to tell the same story, ultimately delivering a similar message, but the careful plan of how we were going to tell it can become scrambled. Where we had decided to place emphasis, the important secondary details and the precise ordering of the events may be delivered in another way. In other words the same basic story, but a new narrative.

As a doctor, working in the consulting room, I sometimes imagine that the waiting room is a container and a safety net. It is a large space where the patients are contained, sorted and released, slowly, one by one into the corridors and various consulting rooms. The door between the waiting room and the corridor is like a stop valve, preventing an overwhelming flood of distressed patients from simultaneously bursting into my room and making impossible demands. Knowing that the longer patients wait in the waiting room, the more anxious and bored they become, serves to keep up the pressure for me to work fast. I try to ensure that each patient in the consultation does not stay for much longer than the designated ten minutes.

The entry of the patient into the waiting room and subsequent waiting has effects that go beyond the merely functional. The effects are achieved through the ritualistic aspects of our entry into the waiting room and of waiting. Within cultural discourse, and in particular in anthropological discourse, there is no clear or widely shared explanation of what constitutes ritual and therefore ritualistic behaviour. The study of ritual in anthropological discourse arises from debates concerning the origins of religion. The fundamental question at the heart of these debates is whether religion and culture were originally rooted in myth or in ritual. This has led to essentially three different modes of interpretation[20].

1,The myth and ritual school of anthropological thought, which originated in the work of James Frazer who argued that in order to understand a myth one first had to determine the ritual that accompanied it.
2, A sociological approach, as exemplified in the work of Emile Durkheim and subsequently Marcel Mauss and Radcliffe Brown. This approach focuses on the social function of ritual in maintaining the unity of a group, and its effect of enabling

us to connect what lies outside our individual experience to the unknown or the occult.

3.The third interpretive approach came from the psychoanalytic school in which Freud was influenced by Frazers' and subsequently Robertson Smiths' portrayal of totemism in primal sacrifice and the social origins of religious authority, morality and guilt. Freud came to view ritual activity as an obsessive mechanism that attempts to appease repressed and tabooed desires by trying to solve the internal psychic conflicts that these desires cause. In other words ritual has therapeutic value in that it helps to accommodate the repression of desire demanded by culture and civilization.

Ritual is complicated to describe because of the variety of activities that can be considered ritualistic and the multiplicity of ways in which those activities can be interpreted. Definitions of ritual tend to be quite broad and encompass not only highly specific rituals—such as religious rituals—but also behaviour that has ritualistic aspects, such as athletic events and ceremonies. These events include many of the forms and structures of ritual, but are not specifically determined by their historical relation to a recognised religious ritual. Within this context Rappaport's admittedly inclusive definition of ritual is useful to consider:

> "I take the term ritual to denote the performance of more or less invariant sequences of formal acts and utterances not entirely encoded by the performers"[21].

It is a formal definition, which does not specify what rituals are for or describe their content. Its importance lies in the fact that it implies that ritual is a term for a structure. The elements, such as performance, utterance and invariance, are not necessarily unique to ritual, but the relations between them are. What is also important is that ritual as a form of action has material and social consequences. Rappaport describes how ritual encodes or organises most aspects of human social life and invests what it encodes with morality.

Ritual leads to what he calls "logical entailments"[22], where the ritual performance logically entails the establishment of convention, the sealing of the social contract and the construction of the integrated conventional orders called logoi[23].

An individual walking into a clinic 'becomes' a patient through a specific set of actions or performatives, which are more or less invariant, and formally and sequentially structured. These performatives occur in the waiting room and in the consulting room. But to what extent are these merely conventional codes of behaviour that have emerged for practical reasons and to what extent are they operating as ritual that brings states of affairs into being and establishes convention? Certain specific actions and utterances[24] deployed in the clinic bring things into being. When individuals walk from the outside world across the threshold of the clinic towards the reception, announce their name to receptionists, declare that they have an appointment to see a particular doctor at a particular time, are then ticked off on the computer by the receptionist, and obey instructions about where to sit, then they have performed a ritual. Within these actions or performatives, there is a self-referential message, which declares that this individual is now in the role of being a patient, a message that is publicly visible and communicated to others in the clinic.

The effects achieved through rituals are dependent upon participation by the appropriate performers—in this case, by patients and medical staff. The effect of the acts would not be the same if the patients announced themselves to the cleaning staff. Austin, in his influential writing on speech act theory, understands this when he argues that in certain instances performatives can go wrong, or as he puts it are "unhappy" or "ill"[25]. In his list or scheme of things that are necessary for the happy functioning of performatives, he includes "the uttering of certain words by certain persons in certain circumstances"[26]. The effect of ritual is also only achieved because they are taking place in the right context. The right context for the patient is the space of the clinic, the appropriate audience, the reception staff and other patients. Interestingly, Austin[27] considers that this potential for a performative to be ill or unhappy is a particular feature of all acts within rituals or ceremonies and conventions.

For a considerable part of his lectures[28], he argues how the precise conditions laid out in his schema for a "happy" or successful performative utterance or gesture, are always subject to various forms of ambiguity, imprecision or misreading with consequent effects on the success of the performative acts and utterances. In their reading of Austin, Parker and Sedgwick[29] consider that an essential feature of performatives is the inevitability of their being unsuccessful or ill. They state that

"illness [is] ... understood here as intrinsic to and thus constitutive of the structure of performatives"[30]. If any of the contexts for the performative utterance or action are inappropriate, then the performative will fail.

With regard to utterances[31], Derrida[32]points out that Austin makes the context of the utterance—that is aspects of the convention of the utterance—the feature that is at risk. Austin thought of convention as the features surrounding the utterance, not a feature within the utterance. But for Derrida it is also "a certain intrinsic conventionality of that which constitutes locution itself...that extends, aggravates, and radicalises the difficulty"[33]. In other words, the risk or failure is inherent in the use of language, since this is itself a convention. A frequent example of an unsuccessful performative in the clinic occurs if the individual announcing their name at the reception is either not registered on the computer, or is not registered under the correct spelling of their name. The conditions that satisfy their right to be a patient are not satisfied until they are correctly named and registered.

The messages performed in a ritual say something about the state of the performers (they are self referential or indexical) and they also do something to them. When we are outdoors and travelling to the clinic we are not yet patients. The action of walking through the clinic doors to the reception desk, announcing our name and stating that we have an appointment initiates a transformation—that is, from being indistinguishable from other members of the public on the street, to becoming a patient. When the receptionist finds our name on the computer appointment list, marks us off and asks us to take a seat, the transformation has taken place.

The public and personal action described is a ritual action, in that it shares the features of a unique ritual structure. This ritual action has the effect of declaring that one is a patient. One's status as a patient is confirmed in the act of accepting the receptionist's request and walking from the desk and taking ones seat—seats that are specifically reserved for patients. Ritual acts and utterances that signify states of affairs bring the states of affairs into being. Having brought the states of affairs into being, the rituals and utterances also indicate them. A constant feature of ritual is that it communicates its effects. Rappaport describes this as the sleight of ritual: "In the case of the ritual acts and utterances with which we are concerned, the sign brings the state of affairs into being and—here is the sleight of ritual—having brought it into being it cannot help but indicate it"[34].

Austin[35] observed that the act of speaking itself is instrumental. In other words, to say something is to do something. This is especially relevant in certain rituals where the utterances or spoken acts have been termed "performative sentences" or "performative utterances" or "illocutionary"[36]. In his well-known account of the performative in speech, Austin distinguishes between utterances that are statements of fact, descriptive or constative and utterances that are performative.

Performative speech utterances (speech-acts) are not just statements they also change the states of affairs that they are speaking about. In his account, he refers to the example of the ritual convention of naming a ship. With the pronouncement "I name this ship the Queen Elizabeth", the words do not describe the action, they are the action. Similarly, with regard to the physical actions in rituals, these are performative gestures that bring the *state of affairs,* into being. *State of affairs* refers not just to the process, but also to what is happening to the participants. In Austin's example the naming of the ship is completed in the gesture of smashing the bottle against the side of the ship. Likewise, the action of the sword in the dubbing of a knight is the crucial perfomative gesture.

Bell[37] notes that it was important for those involved in an analysis of ritual to understand that in exactly the same way that bodily actions adhering to codes in rituals are performative so are words. Some words do things; they do the actions they describe[38].

The spatial arrangement of doors and furniture in health clinics prompt staff and patients into their roles. The furniture has an analogous function to props on a stage. Not only does it set the scene, but it also delimits and prompts the actions of the performers. The performatives are said and done only at specific places and at specific times depending on where one is situated. The position of the reception desk is considered so that patients are generally invited to walk towards the desk as soon as they enter the clinic. Desks are designed to be high enough to serve as a protective measure for staff against theft or aggressive patients; they also serve to establish a hierarchical boundary between patients and staff.

After announcing their arrival and being registered into the system, patients are ushered to seats arranged in rows in the waiting area. Sometimes the seats, and

rows of seats, are colour coded according to which doctor the patient is due to see. The rows and spaces between them are arranged so that patients are obliged to pass from the desk to their seats and then towards the consulting rooms. Consideration is given to the proximity between seats—hence proximity to others and to the direction in which they point. It is preferable that the receptionists can observe the entire waiting area and it should be easy for patients to see or hear when their names are called and which way to go towards a consulting room.

Other aspects of the 'role' or performance of the role of patient further enacts the patient's position. For example, patients are often asked to pass urine samples in small plastic containers before taking a seat. The question is asked of the patient in public, and the urine sample is handled in public. This insensitivity towards the feelings of the patient, who may be embarrassed at being witnessed in public, is often overlooked. It may be necessary for medical reasons to produce a sample of urine, but making the act public serves to infantilise the patient and demonstrates that their position is one of subservience to the workings and staff of the clinic. It also reduces the patient's body to a 'purely' biological fact or entity rather than a sexual and affective body.

Patients are frequently asked to fill out health questionnaires whilst sitting in the waiting room. Completing these always makes me feel aware of my status as a patient. I imagine that I am answering to an absent authoritative other—presumably my doctor or a medical scientist. The questions generally ask for quite personal details about lifestyle and health. These are details that I willingly provide, because although doubtful, I maintain a hope that this will help the doctors or scientists to help me and other patients.

Clemens Krauss, an artist and doctor working in Berlin, has made art works involving medical health questionnaires that humorously reflect their arbitrary nature and their role in establishing what is considered to be a normal and therefore healthy body. His work also involves his audiences in participating in the role of a patient in that they are invited to complete and hand in the questionnaires. He designs his own questionnaires that are similar in style but different in content to a typical psychological questionnaire or general health questionnaire. His questions carry the same weighted seriousness but also seem slightly off the mark so one is not quite sure how precisely relevant the answers are to ones health. In completing

them, one is reminded of the cultural specificity of questionnaires, the arbitrary nature of the questions relating to the topics that one is called to answer and how the questions imply that there is a normal state of healthy subjectivity, defined by those devising the questions.

In a normal and healthy state a person does not smoke, drinks moderately, does not have on-going illness and is able bodied. Furthermore, questionnaires assume that the typical addressee is heterosexual, married (if an adult) and ethnically white, and thus normalises these sexual and ethnic categories at the expense of those lying outside them. Krauss's work highlights how the act of completing a questionnaire is not just functional. The information gathered is seldom used and indeed is often not very useful unless it is specifically part of a research project. It is also another ritual that functions to surrender the patient to the institution. It subordinates the patient's knowledge to the knowledge and authority of the 'medical profession'.

Once in our seats we anticipate that we may have to wait—in an order determined by the time of our appointment and delays added by the work of the doctors and nurses. We observe (more or less) an unspoken code of silence and are invariably required to wait (without complaint) until we are called into the consulting room. The waiting is generally regarded as an unfortunate and unavoidable part of the role of being a patient. As the term 'patient' implies, to be a patient is to have patience, to endure waiting. It is not something we can reasonably complain about since we know that it is likely to be caused by another patient's misfortune and the difficulty and time involved in treating them. It could also be our misfortune. We are required to wait until the doctor, nurse or other health care specialist has the time to see us. Our time is determined by their time, our time is subordinate to their time. The waiting places us low in the hierarchy.

The performatives, acts and utterances that we carry out in our role of patient are visible to everyone we encounter in the clinic. They are public. By performing the ritual, the patient-performer is seen to publicly participate in the order of the clinic. This implies acceptance of the messages it encodes and the order it suggests[39]. However, it is not necessary for the performer to believe the message. Acceptance is a visible and public act but belief is an internal and complex process. Acceptance does not necessarily imply belief. Many of us have doubts about the effectiveness of medical science in relation to the complexities of the problems it purports to solve,

yet in spite of this, whilst in the clinic we accept our various roles as patient, nurse, doctor and so on. Acceptance and performance has an important effect. As Rappaport puts it:

> "Participation in a ritual demarcates a boundary between private and public processes [...] participation in public orders constitutes an acceptance of a public order regardless of the private state of belief of the performer"[40].

Our private beliefs and ambivalences become subordinate to the public act of acceptance, which is not only witnessed by others but is also realised and acknowledged to ourselves.

We perform within a system that is strange and highly regulated. This regulation regulates us too. We become part of its system of order and our role is to comply with its conventional codes of behaviour. We accept the roles, which are generally quite passive: waiting, restrictions on where we can sit and walk, limitations on our interactions with others, what we can say, what we can do. Our time is subjected to the running time of the clinic.

The ritual has thus far ordered our behaviour and established our position in the hierarchy of the clinic and in this way conforms to Bell's understanding of a primary function of ritual which is to invoke ordered relationships between humans and establish convention and order. Although there has been no specific dictate to us that this is our position, through the performance of the ritual codes, we implicitly accept this ordering and positioning, while demonstrating or indicating its effect through the very act of performing it. As Rappaport suggests, one of the functions of ritual performance "is not to control behaviour directly, but rather to establish conventional understandings, rules and norms in accordance with which everyday behaviour is *supposed* to proceed"[41]. Participation may not prevent anyone from going against the convention, but it establishes for individuals the rule, which they have brought into being by performing it, and by implication, have accepted.

When entering into institutions in general we automatically participate in its conventions. Searle describes such participation as a form of commitment and by doing so implicates a sense of duty and morality:

> "When one enters into an institutional activity by invoking the rules of that institution one necessarily commits oneself in such and such ways, regardless of whether one approves or disapproves of the institution"[42].

Whether or not we then abide by these rules we have nevertheless committed ourselves to do so. With commitment we are obligated. Obligation is closely related to accepting, recognising and acknowledging. This suggests that there is no obligation without acceptance, and perhaps that morality begins with acceptance. This is unlike the terms of a dictate, which forces us to agree to regulations without any sense of commitment. In contrast, ritual does not insure compliance but it establishes obligation and with it morality. Workers within the clinic operate according to a set of moral values, which they broadly agree with and accept. Patient's however come from a diverse range of social and cultural backgrounds and thus approach the clinic with a diverse range of moral beliefs, which determines their expectations and behaviour. In recognition of this, the workers in the clinic accept and respect those differences and at the same time set limits on patient's behaviour when it breaks with the conventions and order established by the rituals of the clinic. Those limits are set by way of explanation or if necessary more forceful means, such as denying patient's access to the clinic if their behaviour is morally indefensible. Such actions are usually reserved for patients who behave aggressively or violently whilst in the clinic.

The patient's place in the system is absolutely central and necessary for its operation. Yet his or her position in relation to the internal hierarchical structure of the clinic is difficult to define or locate. It lies outside the professional hierarchical structure and the economic and employment hierarchy. Class, race, mental health, age and gender may affect any one person's confidence and ability to negotiate the best outcomes in terms of care and access to services, but this does not necessarily affect the patient's hierarchical status.

The conventional role of the patient as already described can often contribute to a feeling of relative powerlessness and lack of authority and yet paradoxically the patient is also in a position of primary significance and importance. The patient's passage through the clinic is constantly checked by both care and control, and it is the administering of care that gives the patient an almost sacred position. The ritual signing by doctors of the Hippocratic oath enshrines the notion of care and the

primacy of the position of the patient above that of the doctor, into an official contract. As such, that the doctor is unable to practice without this agreement.

Foucault perceives that the relations between ritualized subjects in social relations is determined by micro and macro-networks of movements of power from the top downwards and the bottom upwards. The ritual role of the patient and doctor exemplifies these movements. Further it is through ritual that these movements are encoded within the body and their practice establishes relations of power in the clinic.

The Corridor

When our name is called, we gather ourselves and walk from the waiting room through the door that takes us into the corridor, leading to the consulting room. Suddenly we are in a different space. We have passed into the interior depths of the clinic and are walking down its main artery. In contrast to the waiting room, it is quiet and we suddenly find ourselves alone. Clinic corridors are usually gloomy and have an impersonal and bland institutional quality. They can feel slightly strange and even eerie. Generally the floors are carpeted and smell of cleaning agents. The paint on the walls often has a slight sheen and is an indefinite

pale colour, such as magnolia. The lighting is low and there might be paintings or posters on the walls. Such images are chosen to comfort and relax us. They have the familiar appearance of public-art: stylised paintings of animals, landscapes, ships at sea and replicas of impressionist paintings - there to please everyone. With the same gesture towards comfort and a sense of home, there might even be an occassional potted plant, standing in a corner in a plastic flowerpot. Often neglected, they stand in dried soil, wilting and gasping for water. The corridor is decorated with objects that remind us of home, yet their blandness and uniformity are alienating. This resemblance to home and yet estrangement from it, is uncanny[43]. As we walk along its length we can often hear the faint sound of private conversations, seeping from beneath closed doors. Walking down this alien corridor, in search of the right door, can feel like a moment out of time. It is a

> moment in which we feel apprehensive and sometimes nervous. It is not unlike the moment when an actor walks from the changing room onto the stage. During this moment we hold onto the story we rehearsed in the waiting room. We walk with a sense of foreboding and pending relief, as very soon we will be able to release the troubled thoughts about which we have been preparing ourselves to speak. A preparation that began during the days or even weeks before our visit to the doctor, and that we continued to rehearse in the waiting room.

Relations of Power, Knowledge and Authority in the Consultation

The doctor's role is traditionally seen as authoritative and underpinned by a system of power and knowledge, which at its core relates to empiricism, rational scientific method and reason. Power and knowledge, according to Foucault, mutually implicate one another. He states that:

> Power produces knowledge (and not simply by encouraging it because it serves power, or by applying it because it is useful); that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations[44].

In this light, the empirical method puts knowledge and with it the power to make decisions about the patient's body on the side of the doctor. The doctor thus represents an authority figure.

The basic principle of empiricism is that knowledge can be derived through careful observation and cataloguing of phenomena, from which laws or principles can be extrapolated. Foucault[45] dates the beginning of modern medical thinking to the end of the eighteenth century where previous systems of classifying disease were replaced by an empirical method based in the primacy on vision[46]. What was important to the change was a new relationship between vision and speech. Dissection and drawing of cadavers since the fifteenth century had led to precise anatomical knowledge of the body. However, physicians were now prepared to look inside the diseased body because autopsy had become common practice. As a result, the pathological changes of disease were observed not just on the surface of organs but also inside them. The invention of the microscope meant that previously invisible pathological changes were also available to observation. Connections were made between the external manifestations of illness, the symptoms and signs, and these newly visible pathological changes. This new visibility led to an entirely new understanding of disease. The old system of classifying diseases according to a description of the natural events of the illness became obsolete. A plethora of symptoms and signs, such as changes in heat, cold, dryness, wetness, weight, colour, intensity of spasmodic episodes, colour and consistency of secretions, all meticulously recorded by the physician had previously been 'theoretically' assigned to diseases inside the body. Now there was visual evidence for a 'real' understanding of the spatial localisation of those diseases inside specific organs of the body. For the first time, as Foucault notes:

> "The space of configuration of the disease and the space of localisation of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy"[47].

Now the description in words of what was perceived, what "the slowness of the gaze of the doctor"[48]saw as it passed over the body of the patient, became the evidence

of a disease process within the body of the patient. Foucault suggests that this had implications for scientific discourse about the body. He states:

> The gaze is no longer reductive, it is rather that which establishes the individual in his irreducible quality and it thus becomes possible to organize a rational language around it[49].

In other words it became possible to hold a scientifically structured discourse about an individual.

However knowledge of the individual was not rendered objective solely through the gaze, but through accurate description, within a constant and fixed vocabulary, of the symptoms and signs of the patient. In clinical medicine, the visible and the expressible came together. In this new constellation, to describe is to see and to know at the same time. In his account of the relation between seeing and knowing, Foucault introduces the idea of a speaking eye. He points out that within this new and totalising clinical thought "hovers the great myth of a pure Gaze that would be pure Language: a speaking eye."[50]

The practice of holding such an objective and rationally structured discourse about an individual has in turn become problematic. In a partial return to the wisdom of the ancient Greeks[51] the invisible, or that which is not visible to the speaking eye, has become reinstated. Contemporary medicine has incorporated knowledge gained about illness from different disciplines, such as sociology, anthropology, epidemiology and psychology. As a result, diseases are no longer considered in isolation to the circumstances of the individuals in which they occur. Political, geographical, social and personal factors impinge on the aetiology, course and outcomes of diseases. It is now widely understood that health, illness and disease are inter-related and inseparable from their cultural context.

The term consultation refers to the traditional idea of a patient consulting with a doctor, nurse or other health professional, in order to take their advice or expertise. This tradition assumes a hierarchical relationship in which the doctor is a figure of authority and the patient accepts this authority without question. Contemporary approaches to medicine and general practice have challenged this traditional view. Psychoanalysis and narrative based medicine[52] has influenced the way in which

doctors perceive their role within the consultation. The discourse of the patient and the psychological and social aspects of their lives are now integral to configuring the cause of illness. Thus in the general practice consultation, it is important to acknowledge the speech of the patient. It is the speech of the patient that brings the patient's world into the doctor's room and the doctor's world. The consultation is the outcome of the meeting between these two worlds.

The consultation functions at its best when understood as an inter-subjective relationship in which the doctor's practice relates to the unpredictability of the personality and world of the patient. The doctor's approach to the patient needs to be fluid and heterogeneous in order to effectively understand and interpret their stories and symptoms. These changes in the relationship between the doctor and patient have meant the doctor is no longer perceived as an authority figure who represents traditional forms of knowledge upheld by the institution of medicine. These changes have coincided with the crisis of authority that has occurred across the social spectrum. Royalty, religious institutions, politicians and even teachers no longer exercise the same power over citizens. This is in part due to the democratisation of knowledge and access to information. The traditional and hierarchical power of the doctor has been altered not only by external factors but also through the influence of psychoanalysis and narrative based medicine (regarded as peripheral disciplines by the medical establishment) on the relationship between the doctor and patient. This has caused changes in perceptions of knowledge between doctor and patient. The speech of the patient (and the knowledge that this implies) is integral to the knowledge and understanding of the doctor, such that the doctor has become less of an authority figure. Decisions regarding diagnosis and treatment now tend to be made collaboratively and in full recognition of the knowledge and position of the patient.

The Consultation

Consultations can have a strong emotional impact upon doctors and it is therefore important that there is a brief opportunity for doctors to clear their thoughts and feelings of the last patient in order to be ready for the next. In this regard, the act of washing one's hands in the short interval between consultations is an effective ritual. It is both physically and psychically cleansing. There is also a chance to briefly glance through the records of the next patient—a glance that jolts memories of the new patient's case and personality, as well as what they look like, sound like and

possibly smell like. The notes hold particular aspects of the patient's life discussed at the last visit—details, as it were, of their medical, social or personal history. As the patient walks through the door, the doctor is holding those memories and conjuring up a mental picture of their world. In general, patients are usually focused on their immediate needs, which may or may not relate to the last or to previous consultations. They bring a new atmosphere into the room with a new kind of personal charge. It is a charge full of emotion, which changes or affects the feelings of the doctor, feelings that it is always important for the doctor to notice. In Chapter Two I will discuss the importance of this change in feeling, especially in relation to the Freudian concept of transference.

Having established our role as a patient in the waiting room, by the time we walk into the consulting room, we are ready to perform the role in its fullest sense. Waiting has prepared us for this moment, and crossing the threshold of the consulting room places us on the stage for this role.

Consultations are usually private but sometimes involve more than two people. Relatives and friends of the patient may wish to be present and adults usually accompany sick children and babies. If patients are unable to speak English, they are usually accompanied by a health advocate, a friend or a relative, who can translate for them. The details of what happens in a consultation are held in confidence. Although the room has stage-like qualities—the furniture sets the scene of a clinic in which doctor and patient become one another's audience—it is nevertheless an enclosed and private stage.

In most contemporary consultation rooms the furniture is arranged so that the doctor sits at their desk in front of or adjacent to a computer and important items such as medical equipment, books, stationary, draws and telephone are close to hand. Patients generally sit either obliquely on the other side of the desk or next to the doctor. Traditionally the doctor's chair was larger and more comfortable than the patients. However, changes in approach to the consultation, which encourage developing a non-hierarchical relationship between the doctor and patient, mean that the chairs now tend to be of equal comfort and are of similar size. Some doctors arrange the chairs so that the patient sits against a wall facing towards the doctor. This means that the doctor is able to control how far away the patient sits from them.

The intention is to prevent patients from moving too far away if they feel uncomfortable and to encourage an intimate atmosphere.

In addition to a desk and chairs, there is also usually an examination couch, a curtain, weighing machine and measuring equipment. Often doctors bring personal furniture, pictures, plants, art objects, and family photographs into the room, in an attempt to make a less clinical, more relaxed and homely atmosphere for the benefit of both patient and doctor. The arrangement of the furniture and objects creates a stage for the dialogue and medical procedures. The dialogue and procedures are a set of utterances and actions that have ritualistic properties. Unlike theatrical performances, the dialogues are not strictly scripted. To a certain extent they are rehearsed by the patient in the waiting room, and by the doctor because she or he has enacted similar scenarios with different patients on previous occasions.

The medical procedures, such as examinations, minor surgery and taking blood samples, have been rehearsed many times by the doctor both in training and with patients. Thus, the doctor and patient are in different roles, which have different characteristics (actions and utterances), which to varying degrees have been previously rehearsed and enacted with other patients or with doctors. Importantly the doctor and patient act as an audience for each other. The sense of audience and stage gives those in the consultation the impression that although they are carrying out their roles for practical reasons, they are also carrying them out within the context of a performance. This element of performance theoretically enables the actions and utterances to be considered in relation to both theatre and ritual, the theatricality of ritual.

Performance—an essential feature of ritual—has effects both for the participants and the audience. In ritual the audience is integral to the successful effect of the ritual. In the consultation, doctor and patient are in the roles of performer and audience. Although the doctor's role is rehearsed in medical training, this role is considerably transformed through the experience of working with many different patients. The doctor's role is in part an effect of that experience. Once in the consultation, both patient and doctor's roles are further transformed through the evolving interaction between them.

The role that I adopt when a doctor is ritualized. It is a role that I have learnt and is similar to an acting role in that I am conscious of performing. This role I perform within the relatively flexible structure of a consultation, which is repeatedly re-established with each patient. In everyday practice as a doctor, it is continually repeated but with different patients. This repetition gives me the impression that I am operating and acting in a structure that has many features characteristic of rituals. Not only is it a sequence of events in which the relations between the elements—performance, invariance, formality and so on—of the structure are unique to it, but also it is not unlike a ritual rite of passage[53]. The doctor takes the patient through a transformative ritual. In undergoing transformation in a ritual, subjects have been observed to enter a liminal state[54].

Liminal[55] is derived from the Latin word limen, meaning threshold. Liminality is an in-between state, ambiguous and relatively passive. In the rituals of the consultation, the patient's state of being is caught in a position that has similarities with that of a liminal subject. Unlike the liminality of a rite of passage however, the patient's position involves moving between the passivity of liminality and a more active state. This fluidity is determined by the exchange with the doctor. The doctor at times takes an active, structuring and controlling role in the consultation. For example, she or he asks the patient specific questions, interrupts and directs their narrative, instructs the patient what to do in order to be examined, examines them, takes blood samples, and towards the end of the consultation, gives the patient advice or offers a diagnosis. At these times the patient state becomes reciprocally more passive and liminal. At these times the patient is least resistant to the impact of the ritual and this passive state of liminality allows for transformations in the patient. The patient becomes more of an active agent when they present their story, question the doctor, argue, disagree or offer alternative perspectives about the nature of their illness and the treatment or make demands (appropriately or inappropriately). Thus, unlike a liminal subject in a ritual rite of passage who accepts orders from those in control of the ritual, a patient can be in a relationship of reciprocity with the doctor, with the power to effect and change the particulars of a consultation.

The doctor-patient relationship is, at times, very intimate. It is a relationship in which a patient may need to express difficult feelings and release emotions. The doctor's role is to facilitate the patient's contact with their feelings and to contain emotions. Although there is frequent physical contact between doctor and patient, sexuality is

beyond the limits of the interaction. Without discussing or openly agreeing to these limits, both parties generally adhere to them. The agreement is tacit but rituals within the roles give a message that establishes and secures boundaries. For example, when performing an examination of a patient the doctor makes the contact through a set of rules. This highly coded form of contact is called the clinical method of examination. The clinical method means adhering to a set of scientifically prescribed rules about how to examine a particular part of the body. Although following this procedure provides information about the body, its other performative and ritual effect is to establish a boundary which signals that the physical contact is clinical rather than sexual. Why rituals establish boundaries can be understood through reference to Freud, who observed the taboo effect created by rituals in certain primitive societies.

In 'Totem and Taboo' Freud posited that taboos were enacted through rituals. The ritual behaviour substituted for the repressed and desired behaviour that the taboos forbade[56]. The taboos placed strict prohibitions on certain types of behaviour—behaviour of a sexual and violent nature, which, if allowed to occur, would threaten the cohesion and possible survival of groups or clans.

Clinical examination has all the features of a ritual. The place and performers are specific to the context of the examination, and the actions and utterances performed are relatively formal and invariant. As with Freud's understanding, the ritualistic apparatus serves to create a taboo against sexual or violent behaviour between the doctor and patient (the breaking of such taboos is the subject of David Cronenberg's 1988 film *Dead Ringers*). However it is important that there is flexibility within these roles, so that sensitive issues can be discussed and either party can express their feelings and emotions. In these circumstances the performatives of the rituals, to use Austin's terminology, "misfire". With less prescribed and rigid the performatives, the boundaries are more flexible.

This process, I would suggest, involves a kind of 'getting to know'. Relaxation of the boundaries created by taboos means that psychologically defensive boundaries are also relaxed. Over time the patient begins to see behind the professional mask of the doctor. This enables them to judge the empathetic and emotional skills of the doctor more easily, for example how she or he might react when the patient reveals personal information or expresses their emotions. Sometimes patients assess the

doctor by asking questions that are informal and lie outside the expected framework of the consultation. For example, they might ask the doctor how they are, or if they have had a good weekend or they might make comments upon their appearance. These questions have the potential to flatter and thereby seduce the doctor into a position in which the roles are temporarily reversed. In answering the questions, the doctor is directed towards thinking about themselves, and has to consider carefully how much personal detail to reveal. Although the doctor does not wish to reject the patient by refusing to answer them, at the same time they do not want to jeopardise the effectiveness of their role. By revealing too much about their personal life they would inappropriately place the patient in the role of a 'carer'. Doctors therefore tend to answer these types of questions in a fairly light-hearted fashion and thereby avoid revealing intimate details about themselves.

Generally the sequence of the consultation is structured as follows:

The patient tells the doctor why they have come to the surgery and gives a history of their complaint. They tell the history of their illness and whilst telling their story the patient and the doctor are mutually assessing each other.

The story is refined through further dialogue between the patient and doctor with an opportunity for further mutual assessment.

The doctor may assess the patient by clinical examination (inspecting, auscultation (listening through a stethoscope and palpating the patient's body) and biomedical tests, or there is further story telling or narrative exchange between both parties

Management—the patient listens to the doctor's story, which usually includes making a diagnosis of the patient's illness. A plan of further action is agreed between the doctor and patient.

The consultation draws to a close, often by the doctor giving the patient a prescription or a sick certificate or the offer of another appointment.

As patients, each one of us approaches this role differently according to a variety of characteristics such as: personality, class, gender, race, age, cultural expectations or simply how we feel on the day. Distressing symptoms, which we do not

understand, tend to preoccupy our thoughts. They can make us feel afraid, out of control and vulnerable. We place trust (but not necessarily belief) in the knowledge and experience of the doctor. This can be comforting or alternatively frightening. The requirement to place trust in another automatically makes our role more passive and this is further emphasised since it is the doctor who is responsible for structuring events and managing time.

The patients' role is perhaps more straightforward but also slips between formality and towards variance and individuality. The patient's state changes or is transformed by their passage from the waiting room, through doors and corridors into the consultation room. In the waiting room, the patient is generally composed, psychically separate from other patients, lost in thoughts and preparing what to say to the doctor. This is a time when their fear about the consultation and what the doctor might tell them causes anxiety. As soon as the patient is called and arises from their seat there is a sense of walking towards their fate. As they cross the threshold of the consulting room and take a seat, their anxiety rises and there is often a sense of urgency, vulnerability and loss of composure. The first knowing look of the doctor adds to their sense of vulnerability and potential loss of control. It is a measured glance. The doctor sees the patient in relation to many other patients who have occupied the same seat. It is a glance that threatens individuality. The patient feels that they are not unique. They are unable to imagine what the doctor sees with their knowing eye. After an initial greeting the doctor generally invites the patient to say what is troubling them. As described earlier, the anxiety of the new situation makes the intention of delivering the same carefully rehearsed script of the waiting room, a task that often escapes them. They now have an audience with different guises—a figure who is both comforting and to whom they can abandon themselves, but who also carries the weight of authority, knowledge and the potential to deliver both good and bad news.

The patient has now progressed into a state that bears some of the qualities of liminal subjectivity. As discussed above, liminal subjects are in a transitional state[57], removed from the network of classifications that normally locates individuals in their socio-cultural positions. Liminality can be likened to a state of eclipse; it alludes to darkness, to invisibility, to indeterminacy and to the occult. Turner describes how liminal "entities" or "initiants" in rites of passage often go naked to demonstrate that they lack status and have no possessions[58]. They do not have any of the normal

rights of other social subjects. They are also required to be humble and passive, to obey instructions and to accept arbitrary punishments without complaining.

As well as carrying a lowly status, the liminal subject carries a sense of being sheltered and protected because of the importance of the effect of the ritual. At the end of the ritual these subjects will have undergone some kind of transformation, which changes their status in society.

An interesting result of the research on rituals carried out by Turner[59] in the 1950s derives from his observations of communality between the subjects of rituals. He noted that all the subjects of a ritual are together in the same situation, and share similar features of loss of status and lowliness. According to Turner this facilitates a feeling of intense comradeship and egalitarianism. In this moment in and out of time, they have this much in common. In addition, within the rite, there is a loss of normal social structures and normal hierarchies. In this communal unstructured state the subjects of the rite become similar or homogenised. As an equal group of individuals they submit to the general authority of the elders who determine and organise the ritual. The sameness of the liminal personae led Turner to develop his notion of 'communitas'. Communitas can generally be defined in opposition to structure: communitas appears where structure does not.

An analogy can be drawn between *liminality* and *communitas* of individuals in a rite of passage and the role of being a patient. As patients we play a passive role (although as previously discussed the patient also plays a significant active role) and are outside our normal social structures. We share similar roles with other patients, with the same sense of loss of individual identity and are readily able to identify with the position of other patients. This homogenised role is more overt in hospital settings where patients are required to wear name tags and institutional clothes, obey strict time codes for eating and sleeping, agree to routine tests such as regular blood pressure and temperature measurements, take medications regularly as instructed, comply with routine preparations for investigations and surgical procedures and to adhere to the general working routines of the hospital.

Although strictly speaking, a patient is not a liminal subject in a rite of passage, there are a number of ways in which the patient is transformed through the consultation; through the emotional and psychological effects of telling their story and of being

listened to, through being examined by the doctor, gaining medical knowledge over their condition, being given a diagnosis, the biological and psychological effect of medical treatment given during or after the consultation and by being given a medical certificate. The certificate names the diagnosis and provides a legitimate right to abstain from work or our normal social duties. It gives the patient permission to be in a sick role.

Clinical diagnosis refers to how a doctor makes an initial diagnosis of an illness from the immediate findings, which result from speaking with and examining a patient. The method involves abstracting or editing the story of the symptoms as described by the patient, and observing any corresponding signs of illness in or on the patient's body. The signs occur as a result of the illness and are recognised by the doctor. The doctor then classifies the symptoms and signs according to their correspondence to medical descriptions of recognised and named patterns of disease. These external markers of disease (symptoms and signs) are known to correspond to pathological changes occurring inside the body. If necessary the pathological changes can be identified through medical tests, which look for evidence or markers of change occurring inside the body. Naming of a disease, or making a diagnosis, by an authority figure potentially alters the way in which the patient sees them self, and the way in which others perceive them. To have the disease gives permission to be 'officially' ill and to take on a 'sick' role. It enables the patient to accept the illness and also to behave in a way that is appropriate to illness. In other words, to adopt illness-behaviour that is partly culturally determined and also depends upon how the disease itself incapacitates the patient. Illness not only means that a person is suffering from a disease, which makes them feel unwell, but also that they behave in ways that indicate to others that they are ill. Illness is performatiive and is symbolized through bodily behaviour that is coded, culturally specific and indicates that the person is unwell. Illness is ritualized behaviour. Grimes[60], in his analysis of the use of the term ritual, in cultural theories of health and illness, considers the body to be fundamentally semantic or meaningful. Furthermore the meanings are embodied in actions, gestures and postures, which are culturally determined. He sates that "bodies are encultured. Cultures are embodied"[61]. With regard to illness he observes how "During illness not only does the body's load of meaning become more evident, the body itself becomes a focus of activity and passivity"[62]. He describes illness as "a ritualized process" and interestingly if one considers how rituals in the clinic effect transformations in

patients he remarks, "the transitions back and forth between illness and health ought to be seen as rites of passage"[63].

Unlike the role of the patient and illness itself, which have been considered here for their performative and ritual aspects, the sick role is usually referred to because of its social and economic implications. The sick role concept was derived from sociological models of illness behaviour. The American sociologist Talcott Parsons, working in the 1950s, wrote extensively about the medical profession and is famous for his conceptualisation of the "sick role" in which he states:

> "The sick role is also an institutionalized role, which shares certain characteristics with that of criminality but also involves certain very important differences. Instead of an almost absolute Illegitimacy, the sick role involves a relative legitimacy, that is, as long as there is an implied agreement to 'pay the price'[64]".

According to Parsons' theory, illness is an institutionally legitimised type of motivated deviant behaviour. It is socially categorised as a kind of role and legitimately allows for temporary withdrawal from normal social roles. Interestingly his analysis falls within a chapter of the book on social control and deviant behaviour. He made an analogy between criminal behaviour and illness behaviour, where both involve deviance from normal role expectations, and where motivation (to gain) is an important part in the action.

He was one of the first medical sociologists to refute that illness is the straightforward result of a disease process or a biological state, requiring a biomedical cure. He saw illness as an institutional role, legitimated as such by four characteristics:

First the withdrawal from a number of social obligations, especially work and family duties and compliance with the notion that the sick person ought to stay at home and rest. Secondly the exemption from responsibility for their condition and the reliance upon external help and support, generally from those not in a sick role. Thirdly an obligation to get better. Finally the expectation that the sick person will seek out technically competent health-care from a physician.

The sick role concept and the notion of illness as ritualized behaviour are important because they identify how illness can be considered, at least in part, to be more than an 'objective' condition. They show how illness behaviour is culturally determined and allows us to think of it in far more flexible terms than that of a biomedical model. Importantly, illness is not independent of motivational factors such as legitimate withdrawal from normal social duties. The sick role concept shows how illness is used as a form of social control that specifies how one should behave when ill. Time taken out of one's normal social and economic role is only legitimate as long as one obeys an authority figure, such as the physician. It assumes that the ill person will recover, and that they will then return to their normal social duties.

There are interesting parallels between patients in the 'sick role' and liminal subjects within a ritual. Like liminal subjects, patients in the sick role are removed from their normal conventional social positions. The sick role creates order for the patient and for an order for their wider role in society. Through conformity, there is obligation and the sick role obliges the patient to seek care from a prescribed authority figure. Ritual is remarkably resilient to non-conformity. This is because of the effect, as already mentioned, of acceptance, which is revealed through being seen by others to be involved in the ritual. This conformity places an obligation on the part of those in the ritual to surrender to its effect. Belief is not a necessary part of acceptance. We might not necessarily believe that western medicine has all the answers but nevertheless we suspend our doubt by accepting its recommendations. It is the properties of ritual, acted out in our behaviour, that induce conformity rather than the imposition of a law from, in this case, the medical authorities giving permission to be in the sick role.

Turner talks of both lowliness and sacredness within the liminal state. There is recognition that the change effected through the ritual is one that those in charge of the ritual have been through themselves, and the change in status afforded by the ritual is important for the structure and function of society. Although relatively powerless within the ritual these subjects are protected by the sacredness of the process. Similarly, there is an expectation that patients in a sick role will be protected by society and cared for by those responsible for their care, that is, health professionals, family and friends. Beyond the home, at least in western cultures,

protection is generally afforded through social and voluntary services and by hospitals.

This chapter has contextualised the clinic as a stage for the performance of the roles of doctor and patient. It has looked at the way in which a patient moves between different spaces within the clinic and the activities that occur within these different spaces. The roles of the patient and doctor have been analysed for their ritualistic properties and the effects of the ritual behaviour evaluated. The idea that ritual performs its effects through the things done and the words spoken is considered in relation to the activities of the patient in the waiting room and doctor and patient in the consulting room. These effects are about, creating order in the clinic, establishing roles for the doctor and patient and drawing boundaries in the doctor patient relationship.

The chapter compares practices of contemporary medicine with those practices at the end of the nineteenth century. Contemporary practices under the influences of narrative based medicine and psychoanalysis (as well as contemporary patients' rights movements) have become increasingly heterogenic, less authoritarian and in contrast with nineteenth medicine are increasingly privileging the speech of the patient in order to understand illness.

By comparing the consulting room to a stage in which doctors and patients perform their roles, the relevance and effects of introducing the idea of audience, script, rehearsal and performance to this medical stage are evaluated. The ritual role of the patient is further examined with reference to anthropological concepts of rites of passage and liminality. These concepts are useful in considering the process of transformation in the consultation and the dynamics between doctor and patient. Moving away from the performative aspect of the patient role, Parsons' sociological model of the sick role is introduced in order to understand how the activity of being sick is culturally determined. Evaluation of the sick role in relation to ritual and rites of passage shows how both the sick role and the ritual role create order and a form for
the patient to inhabit both in the clinic and in the wider role of the patient in society.

Notes

[1] Bell, C, *Ritual, Perspectives and Dimensions*, New York: Oxford University Press, 1997, pix

[2] Ibid., 1997, pxi

[3] Performance refers to the role of performing actions for an audience and is an inherent and necessary feature of ritual. Unless there is performance there is no ritual. As Rappaport—reflecting Marshall McLuhan—puts it (Rappaport: 1999, p38) "The act of performance is a necessary part of the order performed [...} the manner of saying and doing is intrinsic to what is being said and done. The medium is itself a message".

[4] Ritual behaviour can occur within a specific and isolated event, which is consciously constructed as a separate activity from the routines of daily life Equally ritual behaviour can occur within the routines of daily life. Under such circumstances the behaviour is consciously or unconsciously ritualized as part of a flexible and strategic way of acting (Bell: 1997, p138). Grimes (Grimes:1999, pp9,13-14,151) identifies three levels of ritual: Ritualizaton, Interactional Ritual (as in a ritual rite—see definition in footnote 54) and Liturgy (rituals of religion). Ritualization is less differentiated and is more likely to go unnoticed as a level of ritual because of its low degree of formalisation.

[5] Here I am using Foucault's interpretation of power. He broke with the longstanding premise that power consists in some substantive instance or agency of sovereignty. He was not concerned with analysing power in terms of regimes of dominance where one group is subservient to another or as existing in one central or sovereign point from which secondary points emanate. He writes "the idea that there is either located at-or emanating from- a given point something that is power seems to me to be based on a misguided analysis" (Foucault: 1980, p198). He was concerned with an analysis of power that could be analyzed in terms of human relations "power means relations, a more-or-less organised, hierarchical, co-ordinated cluster of relations" (Ibid., p198), and further power is "the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation" (Foucault: 1976, pp92-95).

In Foucault's conceptualisation, power operates from the top downwards, from the centre to the perimeter, and in the exact opposite way from the bottom upwards. He states " in order for there to be a movement from above to below there has to be a capillarity from below to above at the same time" (Foucault: 1980, p201). Although he was specifically analysing the social forces impinging on sexual behaviour, he considered that relations of power were immanent to differentiations and inequalities in other kinds of relationships such as knowledge relationships and economic relationships. In the context of medicine this involves relations of power operating within in a highly discursive field of knowledge, economics and human relations. Movements of power or relations of power acting within the medical institution and acting externally from forces of social changes have considerably altered the power structure of the doctor-patient relationship. This is discussed later in this chapter.

[6] Foucault, M, *Discipline and Punish: the Birth of the Prison*, translated by Alan Sheridan, London: Penguin Books, 1977, p47

[7] Ibid., p49

[8] Ibid., pp47-53

[9] Ibid., p25

[10] Foucault, M, 'The Subject and Power'. In Hubert L. Dreyfus and Paul Rubinow, (Eds.) *Michael Foucault: Beyond Structuralism and Hermeneutics*, Brighton: Sussex, The Harvester Press, 1982, p111

[11] Foucault: 1977,p25

[12] Bell, C, *Ritual Theory, Ritual Practice,* New York: Oxford University Press, 1992, p202

[13] Foucault: 1982, p221

[14] Bell: 1992, p203

[15] Ibid., 1992, p205

[16] Foucault: 1977, pp23-31, 47-57, 68-69

[17] I am taking performative from the name coined by Austin (Austin: 1976, p6), which he derived from the verb 'perform' and the noun 'action'. A performative means any action and or utterance that has effects. In the case of certain utterances it means that to say something is to do something. For example, in the context of a wedding ceremony the utterance 'I do take this man to be my lawful wedded husband', the words perform the act of marriage.

[18] Narratologists refer to a story as succession of events, real or fictitious, which are the subject of a discourse (Genette: 1980, p26). The story refers to the content of the patient's speech, that which is signified. It depends upon the patient's knowledge of past events and the iteration of those events in a sequential order that carries meaning.

[19] Narrative: there is no easy way in which to define narrative. It refers to the narrative statement or the narrating discourse itself. Story and narrative are interdependent. One cannot exist without the other, yet they are not reducible. Narrative consists of the story and the discourse, interrelated as an articulation. While the same story can be retold each narrative is unique.

Discourse: a distinction is made between discourse (also referred to as recit or sjuzhet) and story (histoire, fabula). Discourse is the narrated events as they are presented to the reader or listener; story is the sequence of events as they would appear in chronological order. Discourse refers to how the story is presented. It consists of the medium (written, oral, cinematic) and the form (the order of presentation, the point of view, the narrator etc) (McQuillan: 2000, p317)

[20] Bell: 1997, pp3-60

[21] Rappaport, R. A, *Ritual and Religion in the Making of Humanity,* Cambridge: Cambridge University Press, 1999, p24

[22] Ibid., p27

[23] Logoi relates to the word logical and to the meaning of the Greek word Logos: to gather, to collect, list, calculation, account, speech, narration, all relating to the notion of togetherness and that all things are one. In establishing Logoi, Rappaport (Rappaport: 1999, p27) states that "ritual establishes the construction of time and eternity; the representation of a paradigm

of creation, the generation of the concept of the sacred, the generation of theories of the occult, the evocation of numinous experience, the awareness of the divine and the holy, and the construction of meaning transcending the semantic".

[24] Where utterance is any minimal meaningful act of speech.

[25] Austin, J.L, *How to do Things with Words*. Oxford: Oxford University Press, 1970b, p13

[26] Ibid., p16

[27] Ibid., pp18-19

[28] 'How to do things with words', is the text of a series of twelve lectures delivered by Austin at Harvard University in 1955.

[29] Parker, A and Sedgwick, E K (Eds.), *Performativity and Performance,* New York and London: Routledge, 1995, p2

[30] Ibid., p3

[31] Austin defines an utterance as "anything that is said", Austin: 1970a, p233

[32] Derrida, J, 'Signature Event Context' in *Margins of Philosophy,* translated by Alan Bass, Brighton: The Harvester Press, 1982, p 321

[33] Ibid., p323

[34] Rappaport: 1999, p108

[35] Austin: 1970b, p1-11

[36] Ibid.,pp4-6

[37] Bell: 1997, pp68-69

[38] According to Austin, in order to generate effective speech acts one must have knowledge of the rules of speech, to which one must conform. Within this speech has a performative element and must have content. Searle (Searle: 1969, p59-61) demonstrated that all these elements: codes, performance and content are inseparable form the very act of speaking itself. For Searle the act of speaking, the act of producing symbols, words or sentences is the basic irreducible unit of language. This illocutionary act is rule governed, and it is the combination of speech action operating within conventional codes that enables words to perform, that is, to do the deed they describe. Interestingly the ritual bodily act is analysed in exactly the same way.

[39] For an in depth discussion of the affect of participation in rituals and the relation between acceptance, belief and faith, especially in religious rituals, see Rappaport: 1999, p 120-123.

[40] Rappaport: 1999, p121

[41] Ibid., p127

[42] Searl, J. *Speech Acts*, Cambridge: Cambridge University Press, 1969, p189

[43] I am referring to Freud's notion of the uncanny, which is translated from the German word unheimlich. This is directly translated as unhomely and is derived from heimlich which means homely (Freud: 2001, SE Vol XV11, p220). The uncanny for Freud involves the return of a familiar phenomenon, which has been made strange through repression. The experience of the phenomenon (image, object, person, text or event) renders the subject

anxious and the phenomenon ambiguous. What is essential to the uncanny is the estrangement of the familiar (see, Foster: 1993, p7, Freud: 2001, SE Vol XV11, pp218-252).

[44] Foucault:1977, p27

[45]Foucault Foucault, M, *The Birth of the Clinic,* translated by Alan Sheridan. London: Routledge, 1973, p xii

[46] In this debate Cartesian philosophy and the idea of perspectival vision, introduced primarily by Rene Descartes in the 17century were important. Although Descartes believed in observation and experimentation, his method was deductive rather than empirical. He was primarily a visual philosopher but privileged internal vision over the senses. .For him it was the rational mind with innate ideas that interpreted images. His thinking opened the door for reasoning through non-indexical representation (signs), rather than through the resemblances of the world produced by the eye (in: Jay: 1994, pp71- 82, 303-4 and Grene and Smith: 1940, pp12-16).

[47] Ibid.,p3

[48] Ibid.,pxii

[49] Ibid.,pxiv

[50] Ibid.,p114

[51] This notion of wisdom is exemplified in the teachings of Hippocrates (Porter: 1997, pp55-66)

[52] For an introduction to the ideas of narrative based medicine see Greenhalgh, T and Hurwitz, B, eds. *Narrative Based Medicine, Dialogue and Discourse in Clinical Practice,* London: BMJ books, 1998, the first comprehensive book on narrative based medicine to be published in Britain.

[53] The anthropologist Arnold Van Gennep observed or defined what he called “liminal phase” of "rites de passage", where “rites de passage” are “ rites” which accompany every change of place, state, social position and age of an individual as he passes form one stage of life to another. A ritual that marks the end of one phase and the start of another. A rite here relates to the formal procedures and acts within the rituals. (Turner: 1969, p24)

[54] Turner, V, *The Ritual Process, Structure and Anti-Structure,* London: Routledge, 1969, p24

[55] Lim·i·nal (an adjective) is derived from Limen signifying threshold in Latin. Liminal is that which belongs to the point of conscious awareness below which something cannot be experienced or felt. Liminal relates to being in between, not knowing and being invisible and near to death. Encarta Online World English Dictionary, Bloomsbury Publishing, 1999

[56] Turner: 1969, p24

[57] A state is any type of stable or recurrent condition that is culturally recognised. It is a more inclusive concept than status or office.

[58] Turner: 1969, p95

[59] Turner lived and worked in Northern Rhodesia (now Zambia) in the 1950s in order to carry out anthropological research into the rituals of the Ndembu people. Many of his ideas on ritual stems from the observations he made during this early fieldwork. (see Turner: 1967, introduction)

[60] Grimes R.L, 'Illness, Embodiment, and Ritual Criticism', in *Ritual Criticism: Case Studies in its Practice, Essays on its Theory,* Columbia: University of South Carolina Press, 1990, pp145-157

[61] Ibid., p148

[62] Ibid., pp148-9

[63] Ibid., p150

[64] Parsons, T, *The Social System*, London: Tavistock Publications, 1952, p312

SYMPTOMS AND STORYTELLING IN GENERAL PRACTICE

In this chapter, I will discuss the interaction between doctor and patient in the general practice consultation, with specific reference to the symptom.

Symptoms[1] are the focal point of most consultations. They are usually the reason for a patient presenting at the clinic and they are often the main focus of the doctor's attention. Western medicine traditionally investigates the symptom through the empirical method. This rational approach fails to account for the enigmatic qualities of symptoms. This chapter offers an opportunity to consider the symptom through different perspectives in order to reflect upon these enigmas. In Western medicine it is generally considered that symptoms are caused by pathological changes in the body that are classified as diseases or processes of disease. Once reduced to this formula of cause (disease) and effect (symptom), the focus is towards identifying the pathological changes, and eliminating them through pharmacological or surgical interventions. However, symptoms do not generally conform to this logic. Many symptoms remain resiliently intact and defy all attempts to find identifiable pathological changes that might cause them. These inorganic symptoms, which in western medicine are typically identified with the imagination or psychological processes, have been categorised at different stages of medical history as hysterical[2], psychosomatic or neurotic.

Some symptoms are readily attributable to diseases, which have identifiable pathological changes in the body such as cancer or infectious diseases—in other words symptoms caused by organic disease. In practice, my experience as a doctor has been that, generally symptoms resist purely organic explanations as well as purely hysterical ones. In this chapter I do not attempt to differentiate between psychosomatic and organic symptoms. I am interested in an approach to symptoms that privileges the patient's experience of them. Moreover, in order to think more about the enigmatic ways in which symptoms behave, I will consider the symptom as a message, a form of bodily representation and a sensation that carries emotion[3]. Generally we access symptoms through the limitations of our verbal descriptions of them, that is, through speech. I will use psychoanalytic theory in my analysis of symptoms because in psychoanalytical interpretations of the symptom emphasis is placed on the details of the patients' speech. I will also use ideas in contemporary

narrative theory in order to reflect upon the presentation of the symptom by the patient in the context of a consultation, since here the symptom and the ensuing dialogue between the patient and doctor involve an exchange of stories. Narrative analysis of this exchange enables me to reflect on the consultation and the patient's symptoms in relation to paradigms of language and culture, rather than to the pragmatics of biomedical discourse.

Background to Practice of Medicine in General Practice

Medicine practiced in general practice is very different to that of hospital medicine. Hospital medicine is heavily grounded in the empirical method and generally relies on the results of scientific research as a guide to the diagnosis management and treatment of illness. Although many general practitioners do not stray very far from this method, their self-employed and independent status allows them more freedom to embrace medicine from its potential as a heterogeneous practice. A point rightly observed by Berg and Mol when they state that

> "Medicine is not a coherent whole. It is not a unity. It is rather an amalgam of thoughts, a mixture of habits, an assemblage of techniques. Medicine is a heterogeneous coalition of ways of handling bodies, studying pictures, making numbers, conducting conversations. Wherever you look [...] there is multiplicity [...].even inside medicine's 'biomedical' core"[4].

Ideally this means considering the patient and their problems in relation to their whole social context. Apart from using clinical medicine, such a heterogeneous practice incorporates ideas and techniques learnt from other disciplines such as psychology, psychotherapy, acupuncture, homeopathy and so on. Psychotherapy in general practice has been primarily influenced by the ideas of Michael and Enid Balint[5]. More recently methods based in attachment theory, which was developed by Bowlby[6] and subsequently Holmes[7], have become influential. One of the principal ideas used in attachment theory is to view the general practice clinic as a 'secure base'[8] for the patient and their family. In this perspective the medical clinic and health workers provide a place of safety for the patient, whereby safety includes reliability, responsiveness, and the capacity to engage with the negative aspects of a patient's emotions.

Michael and Enid Balint were instrumental in recognising the importance of the role of the unconscious and transference in the doctor-patient relationship. Rather than seeing the ten-minute appointment as an obstacle to using psychotherapeutic techniques, the Balints viewed it as an opportunity to develop a psychotherapeutic approach specific to general practice. This approach acknowledges the restrictions of a ten-minute appointment system and evolves ways of circumventing what may otherwise seem to be a prohibitively small period of time. The ten-minute hour is used differently from the Freudian fifty-minute hour, where time for the development of free association and transference (see later) are of primary importance. In the ten-minute hour, continuity between patient and doctor is still maintained and the therapeutic relationship is established over short and frequent periods of time. Even though it may take longer to recognise and use therapeutically, transference is nevertheless part of the relationship. This psychotherapeutic aspect may not always be openly declared, but it is nevertheless an important part of the practice, and is drawn upon in an organic way and when appropriate. Unlike conventional weekly psychotherapy or five times weekly psychoanalysis, the patient is free to choose when and how often they see the doctor. Equally the doctor can ask the patient to come back regularly if they feel this is important. Alternatively, if the doctor feels a patient is demanding too many appointments they are able to curtail the frequency of their attendances.

Unlike conventional psychotherapy, the doctor often gets to know other members of the patient's family and even their friends. This happens in the surgery and during home visits and allows the doctor to witness the patients social and domestic environment. The doctor thus draws their knowledge of the patient from a variety of encounters with different people in different places. This knowledge is constantly in flux and changes with each new interaction. It is primarily dependant upon the communication in the consultation through which the patient brings their world into the doctor's world. The idea that the patient brings their world into the doctor's world is important as it immediately suggests the consultation is a site for an interaction between two or more people. Moreover it is an interaction in which it is understood that the patient is an equal relationship with the doctor and as such is not an object of scientific scrutiny.

In bringing their world into the doctor's world each patient brings a new atmosphere with them and a new kind of personal charge. It is a charge full of emotion, which changes or affects the feeling of the doctor, a feeling that it is always important for

the doctor to notice. By way of example, the following is an account of a recent consultation I had with a female patient.

A short time ago, a Bangladeshi woman, named Fatima came to see me at the surgery. She brought her eldest daughter along with her. Neither woman could speak much English. Fatima looked a great deal older than her fifty-eight years, more like seventy-eight. Most of her teeth were missing; she walked uncomfortably as if in pain and was wrapped in several layers of shawls and saris. As the couple entered the room I was immediately struck by our cultural differences. Infact both women wore saris and the younger woman wore a veil and long black Burkha. As I recall, I was wearing a typical western outfit of jeans and a summer shirt. The older woman's teeth were stained from chewing beetle nuts and she smelt heavily of chilli and curry. Everything about her manner and disposition spoke of a very different culture to my own. She grew up in a small village in Sylhet in rural Bangladesh. She lived there until she was in her late thirties, whereupon she moved to London to join her husband, bringing their three daughters with her.

Via a Sylheti speaking female interpreter, she complained, with a great deal of elaboration, that her whole body was paining her; she had a hot head and night after night, could not sleep because of all the discomfort. She seemed miserable. Prior to this encounter a physical check-up had shown her to be in reasonable health and an array of x -rays and blood tests were all normal. Paracetamol had not helped, so where to go next? Discussing her family circumstances seemed to provide some answers. Her husband died some years ago. She subsequently raised her daughters on her own whilst living in a tenth floor council flat in Tower Hamlets. When her youngest daughter became eligible she arranged a marriage. A large number of families at home in Sylhet volunteered their sons. Unfortunately the man whom she chose turned out to be violent, neglectful and abusive. Within two years a divorce ended the unhappy union. On hearing of the divorce, the families of the sons whom she had turned down were angry with Fatima for her 'mistake'. They took revenge by casting spells on her. She believed that it was the spells that were causing her pain. According to Fatima the only person qualified to remove them lives in Sylhet. Until she can find the airfare home she believes she will have to live with the spells and the pain.

This account or story highlights how the analysis of symptoms and signs[9] within medical discourse does not sufficiently allow for the patients whole story. It was only

through listening in depth to Fatima's story that the reason for her pains became apparent. These reasons are related to a cultural system of belief that lies outside the framework of conventional medical knowledge.

The Oxford English Dictionary gives the following definition of the word symptom:

> A (bodily or mental) phenomenon, circumstance, or change of condition arising from and accompanying a disease or affection, and constituting an indication or evidence of it. Especially, in modern use, a subjective indication, perceptible to the patient, as opposed to an objective one or sign[10].

This definition considers the symptom as evidence of disease. However, symptoms do not always leave evidence of disease—that is identifiable physical and pathological changes in the body—and it is sometimes difficult to ascertain what they are evidence of. When listening to the patient describe their symptoms, the doctor is interested in what the patient perceives, in the subjective indication of a phenomenon. Usually it is only possible for patients to represent this through speech. Art therapists work with other forms of symbolisation, but speech is still an important part of their communication with patients.

Although psychoanalytic theory places primary emphasis on the dimension of the patient's speech in order to understand why symptoms occur, it should be stated that unlike the practice of psychoanalysis, in general practice there is greater emphasis on the meaning and context of the patient's story. Psychoanalytic practice is more interested in the details of a patient's speech, their parapraxes, their descriptions of dreams, the gaps in their speech and their symptoms in order to reveal unconscious mental processes.

Most consultations begin with the patient, or the parent, or guardian of the patient trying to describe an illness or symptoms that are making them feel unwell. I use the word 'trying' because symptoms are often difficult to describe. The surgeon Professor Norman Browse, well known in the medical profession for his book *An Introduction to the Symptoms and Signs of Surgical Disease*, manages to avoid defining a symptom. He sidesteps the issue by talking about the "history of the present complaint"[11] He effectively describes symptoms as verbal complaints about the body, which have a history. Symptoms are described through the patient's narrative[12]. The narrative gives the history of the events, which coincide with the

onset and duration of the symptoms. The symptoms are described according to times and places.

Thus patients usually describe their symptoms in the form of a story. The story ideally includes the context and history of the symptoms and what they feel like or look like. The story can seem straightforward with a direct correspondence between the symptoms and their cause, (for example, the sore throat caused by an upper respiratory viral infection or the broken and painful leg caused by a car accident). Or there is no direct correspondence and understanding the relationship between the symptom and the story for both doctor and patient requires complex unravelling. The unravelling often impinges on many aspects of a patient's life. Social, cultural, sexual, psychological, economic, environmental, legal and biological factors are important co-determinants that contribute to an understanding of what becomes manifest in the form of symptoms. Alternatively the story telling itself can seem fragmented and unclear. This could be because the patient's use of language gives an unclear narrative, or the story is itself unclear, or both[13]. Unclear narratives serve to indicate how the meanings of symptoms defy reduction to simple explanations and often remain enigmatic. .

Symptoms have a material quality because they have an effect on the body. Generally they are presented by patients as verbal descriptions of unquantifiable sensate phenomena usually occurring within the body (visual and auditory hallucinations are example of symptoms whose precise location is not readily identifiable). I consider symptoms to be forms of bodily representation, which are communicated through language.

If symptoms are a form of representation in the body, it is interesting to consider what the motive is for their representation, what their formal qualities are and what their message is. The patients' speech represents the symptom through language. The symptom is therefore intimately connected to speech. Understanding the meaning of symptoms requires that the doctor be attentive to the language of the patient and follow their linguistic clues. It further requires that the context of the emergence of the symptom be considered. In Fatima's case the onset of her symptoms coincided with her daughter's divorce. The symptoms were unrelated to her daily routines—such as doing house work, climbing stairs or cooking—because they were, in Fatima's opinion, related to the work of spirits and spells.

The bodily gestures which patients' make as they describe their symptoms are also relevant to the doctor's understanding and knowledge of them. These gestures help not only to locate where they experience their symptoms but also reveal something of the patients' emotional response to them, for example whether they are afraid, embarrassed ashamed or even angry. Pain, especially if it is prolonged, can make people look sad, but also resentful and angry. Symptoms often make patients afraid and because of this their body language can be defensive. The picture is further complicated since symptoms often occur at times of psychological stress such as during relationship problems, work crises, family disputes and so on. The patients' body language may therefore also reflect their emotional response to these problems. Bodily gestures impart the potential for recognition by the doctor of emotional responses, which are not necessarily recognised by the patient and are only indirectly articulated in their speech (through for example, intonation and slips of the tongue).

A further complication arises as the patient reads the doctor's gestures, which they translate as both the doctor's response to them and the things that they say, as well as a facet of the doctor's personality. In this exchange the doctor's and the patient's gestures are constantly altering in relation to one another. Ideally the doctor needs to be aware of the effect of gestures on the patient, as these subtleties can affect the patient's willingness or not to share important confidences with the doctor. They are important to the process of confluent image making and transference, processes occurring within the consultation, which I will discuss later in this chapter.

In general symptoms are accompanied by feelings that patients are not always aware of. Telling the doctor about the symptom can sometimes release these feelings and arouse strong emotions in patients. Facial expressions and bodily gestures are particularly relevant with symptoms that are related to the psyche, such as depression, anxiety and paranoia to name a few. Body gestures are often just as important in assessing the nature and extent of these types of symptoms, as is the patients' speech. For example, patients who are considered to be suffering from depression are often withdrawn, make poor eye contact and hardly smile. When making mental health assessments of their patients, psychiatrists translate these gestures into objective signs or indexes of illness, which they document in the patients records.

With regard to the indexical nature of symptoms, Lacan[14] notes that in medicine the symptom is regarded as an index, whereas in psychoanalysis it is a signifier. Neither concept accounts for the dimension of emotion within the patients' perception of symptoms. However since emotions are revealed symbolically through body language, the emotional feelings of symptoms can be read either consciously or unconsciously by the doctor. Lacan's later formulation, where he situates the symptom outside symbolic interpretation and as a trace of the subjects jouissance[15] [16], is I believe of some relevance to my description of the emotional charge of symptoms, where equally emotions lie outside symbolic interpretation. Lacan's concept of "synthome" and "jouissance" will be discussed further in this chapter.

A remarkable aspect of symptoms is that they are bodily sensations (and signs) that have no referential content. They exist independently from objects in the outside world with no necessary indication of a causal relationship. Elaine Scarry's insightful writings on pain—and by analogy symptoms, which are often an experience of some degree of pain—explores this characteristic rather interestingly. In comparing the sensation of pain to other bodily sensations, Scarry[17] points out that most bodily states of consciousness have "objects" in the external world that we attach to them. For example, we feel hungry for certain foods, thirsty for liquids, envious of other people, love for someone. Scarry sees this as "the human being's capacity to move out beyond the boundaries of his or her own body into the external sharable world"[18]. This stands in contrast to the symptoms of pain. In these states, we can describe the feeling but not what the feeling relates to. We don't say that we have a headache for someone or something, (although we may well believe that some annoying person might be responsible for a headache!). As Scarry observes "it is precisely because pain takes no object that it, more than any other phenomenon, resists objectification in language"[19]. The difficulty patients have in describing pains or symptoms relates—in part—to this resistance. Scarry believes that resistance to language is in fact essential to what pain and therefore symptoms are. Lacan goes as far as describing the symptom as "the silence in the supposed speaking subject"[20]. Given this linguistic impasse, it is then interesting to reflect upon how we use speech to approach the symptom.

I will return to this point later, but while on the subject of pain I would like to reflect upon a question that has a bearing on the relationship of pain to language: why is pain such a difficult phenomenon to share with others? The experience of pain is internal to the body. It is not an expansive state of being but on the contrary, it is an

internal solitary state. Severe and persistent painful symptoms can make one feel as if one is retreating from and separating from the world. Freud made a similar observation when speaking of a man with toothache; thus "[...] the sick man withdraws his libidinal cathexes back upon his own ego, and sends them out again when he recovers"[21].

Pain makes one acutely aware of one's own body. In so doing, in contrast with other bodily experiences, it has the capacity to make one aware of a division between one's own reality and that of other people. It is not a phenomenon that one can easily ignore. No effort is needed to acknowledge pain. In fact, unlike other states of consciousness, it is difficult, if not impossible, to deny. We cannot unconsciously repress symptoms and to consciously suppress them requires a great deal of will. (Here I am thinking of people who attempt to consciously suppress pain by inducing transcendental states in which it is claimed that the 'mind leaves the body'). Yet paradoxically, to share the reality of pain with others is almost impossible. Severely painful symptoms, like nothing else, have the ability to induce a form of pre-linguistic regression, wherein we are only able to utter the kinds of noises we made before we had learnt to speak. Painful symptoms can be so total and so absorbing that they make it impossible to think of anything else. Even the thought of trying to speak becomes prohibitive. They can thus effectively render one speechless.

Regardless of their severity, the difficulty of expressing the experience of symptoms can leave the sufferer vulnerable. Their lack of materiality and resistance to attachment to objects in the outside world makes them difficult to grasp. It is thus hard for those in the outside world to identify with them and even believe the sufferer might be experiencing them. Scarry is worth quoting here for her insightful recognition of this problem:

> So, for the person in pain, so incontestably and unnegotiably present is it that "having pain" may come to be thought of as the most vibrant example of what it is to "have certainty", while for the other person it is so elusive that "hearing about pain" may exist as the primary model of what it is "to have doubt"[22].

To return to the dilemma of the linguistic impasse of symptoms: given their resistance to language, how are we then to account for them? It is paradoxical that we turn to language to access their cause and it is therefore important to reflect upon how we use speech in this approach to the symptom. The following

consultation provides an opportunity to reflect upon this issue. The story is based on my memory since I am unable to reproduce the precise dialogue of the consultation. It is thus my story of the events rather than that of the patient's and thus not an objective account. The re-workings and interpolations are therefore a secondary narrative[23] recounted so that the story embraces some of the qualities of symptoms that I am investigating. It is also exposes the problem of where, in the story, I situate myself as a doctor and where I situate the patient.

The sensation of a stabbing pain in the back is a common complaint or symptom and can have many interpretations. Recently a middle-aged woman named Jacqueline made an appointment to see me. This was our first meeting. She was running out of her regular prescription for antidepressants and had come along for some more. Since I was not her regular doctor, neither she nor I had any intention of talking much to one another about her depression. She was feeling reasonably well and simply needed more tablets.

Before she left, she happened to mention that a stabbing pain in her back, which had been troubling her for some time, was not responding to the painkillers her doctor had given her. In fact the pain had become a lot worse recently, to the extent that it was keeping her awake at night .She described it as very sharp and penetrating and just beneath her shoulder blade. It was not made worse by movement, breathing or eating and seemed to come and go without any kind of pattern. Physical examination of her back and lungs revealed no abnormalities and she had already had a chest x-ray, which was normal. She had had the pain for about a year and when I asked if anything significant had happened to her a year ago, after some hesitation, she suddenly realised that the it had started after the murder of her son. He had been stabbed in the back during a quarrel with another young man. Strangely the whole incident occurred in a street behind Scotland Yard. My interpretation of this symptom, which I explained to her, was that although she wasn't conscious of it, the stabbing and her son's death was still very much on her mind. Her body was letting her know about this in the form of the symptom rather than say a conscious thought. To my surprise she readily agreed with this explanation, although she had not thought of it before. Previous doctors had told Jacqueline she had a torn muscle, but she was unhappy with this explanation as she thought a torn muscle would have healed by now.

I next met Jacqueline some three months later and her pain had long since gone. She barely remembered the details of our consultation so there was no way of knowing whether our discussion was responsible for the resolution of her symptom.

The narrative that I have chosen is in the form of a case study. A case study is a metafiction about the events of the consultation, generally written by a physician in order to be read or heard by other physicians. Aside from the intention of the physician it is a subjective account and is told in such a way that it reinforces the medical interpretations of the events. In discussing narratives of psychoanalytic case studies, Roy Shafer states that:

> The narrative structures present or imply two coordinated accounts: one, of the beginning, the course and the ending of human development: the other of the course of the psychoanalytic dialogue. Far from being secondary narratives about data, these structures provide primary narratives that establish what is to count as data. Once installed as leading narrative structures, they are taken as certain in order to develop coherent accounts of lives and technical practices.[24]

In Jacqueline's case study, I have included medical psychological and social factors as data for the 'primary narrative'. I have interpreted my account of her symptoms with a psychological discourse rather than with a medical one. I have also described my role in active and heroic terms. This role involved an intervention in order to move the events of the story in a different direction and towards resolution. The patient's story of her symptom, in terms of an inexplicable pain which previous doctors were unable to treat, is now represented as the result of the suppression of her grief and incapacity to mourn the death of her son. The grief finds its outlet through the symptom—a symbolic representation in her body—that has material and structural qualities, which mimic the event of her son's death. This re-narrativisation of the patient's experience, in psychoanalytic terms potentially allows for cathexis and resolution.

In as much as symptoms are represented through the telling of stories, they can be considered through the telling of more than one story or discourse. They can for example, be considered through scientific, psychological and mystical discourses. My re-evaluation of the case study provides a narrative approach to the symptoms, seeing them in relation to a number of different discourses: the events as described

by the patient, the events of the consultation, the re-telling of the consultation in the form of the case study, the medical discourse and the psychological discourse.

As previously said we put our symptoms into contexts by describing the events that coincide with their occurrence and appear to trigger them. We put our knowledge of them into a story. We also talk about how they feel. We give them material descriptions such as stabbing, burning, throbbing, pricking, gnawing and so on. The descriptions themselves seem to call for objects to which they can be attached as a means of explaining their existence. For example, a hot iron burns, a knife can stab and a pin can prick. However there are no visible or realisable objects and instead we fall upon the imagination in order to make sense of them.

Using our imaginations in this way is a form of intellectual work. In his essays on infantile sexuality Freud[25] writes that intellectual work originates in infantile theories, which attempt to make sense of the three great enigmas of the origin of the subject, of sexuality and of sexual difference. The idea that babies grow inside one's mother's stomach and are excreted in the same way as faeces is a typical example of such a theory. Mannoni[26] writes that such infantile elaborations are 'rationalising' rather than 'rational'. Whilst Laplanche acknowledges that the three great enigmas undoubtedly mobilize the child's theoretical activity, he posits the confrontation with the enigma of the mothers (and fathers) unconscious as another significant factor. He designates the term 'primal seduction' to situations in which "an adult proffers to a child verbal, non-verbal and even behavioural signifiers which are pregnant with unconscious sexual significations" [27]. Whilst these situations—for example during breast feeding—have nothing to do with sexual assault they are opaque and enigmatic and are thus seductive. The child's attempt to make sense of these signifiers or his or her suspicion of them arouses intellectual activity.

Not only is the question of where do babies come from caught up with the child's observations of sexual difference and parental sexual behaviour, but it is also related to the inadequate explanations to the question, provided by parents and adults. The adults' inability to explain these enigmas produces a traumatic effect. Laplanche [28]points out that adult language is traumatic only insofar as it conveys an unknown meaning, or only in so far as it manifests the parental unconscious.

Moreover, since the infant perceives its own explanations to be inadequate and lacking in success, Freud suggests that "brooding and doubting becomes the

prototype of all later intellectual work directed towards the solution of problems"[29]. Freud also postulates that since the arrival of new babies is felt as an intrusion, the activity of thinking is related to preventing dreadful or fearful events. He states that:

> The question itself is like all research, the product of vital exigency, as though thinking were entrusted with the task of preventing the recurrence of such dreadful events [30]

All of this may be relevant to a consideration of how small children talk about the enigma of their symptoms, because attempts at making sense of them may be more immediately caught up with the other great question of sexuality. As we grow older our explanations for the experience of our own symptoms become more rational as opposed to rationalizing. For example, in the video *Frozen Section*[31] Lilah gives an account or story of her symptoms that is both rational and rationalising. She spontaneously recalls that at age eleven she experienced tight muscle spasms in her lower back and legs on walking home from school. Her explanation as an eleven year old was that this was either because she had forgotten to do something, like "pee", or that she was wearing tight pants.

In speaking of how we use stories to explain or rationalize phenomena it is interesting to consider how Freud uses myth as a way of accounting for human desire, which transcends the history and variations of individual life experience. His use of myth also relates to his understanding of the development of neurotic symptoms.

Freud has observed how the first question of the three great enigmas—'where do babies come from?' is echoed in innumerable myths and legends[32]. In his use of the story of Oedipus, he invokes a Greek myth as an example in Western culture of the long-lived fascination with a story of incest and patricide. A fascination, which suggests to Freud that there is something like a fundamental truth that we recognise in this story. Furthermore he uses the story of Oedipus to develop his formulation of the Oedipus complex[33], a structure, which explains the origins of sexual wishes[34], the psychic structure of desire and their prohibition in the incest taboo. Interestingly Freud arrived at the formulation of the Oedipal complex through analysis of his own dreams as well as those of patients.

The myth is used in his theorisation of the onset of neurotic symptoms[35] where unsuccessful resolution of the conflict arising from incestuous wishes leads to the development of some forms of adult neurosis. (A more or less successful resolution occurs when the prohibition on incest leads to the displacement of infantile sexual wishes away from the child's original love objects, the parents, towards others outside the family). For Freud the neurotic symptom is the symbolic expression of a conflict[36] between two trends: the unconscious wish and the conscious ego's [37] defences. In accordance with the pleasure principle, the unconscious wish, although frustrated, ultimately seeks fulfilment and finds its outlet in a 'compromise-formation'[38], which is the symptom. Through the formation of the symptom both trends have found incomplete expression.

In his discussion on the formation of symptoms Freud made it clear that he was referring only to psychogenic symptoms[39]. In the context of general practice creating a binary distinction between psychogenic and organic symptoms limits the message of the symptom and how its message can be useful for the patient.

Even when symptoms are clearly related to a disease process, for example with diseases such as diabetes, high blood pressure and stomach ulcers, they are also connected to the psychological or social world of the patient and exhibit psychogenic properties. The following story of a young girl called Katie is an example of an illness that seems to call for explanations that can only be partially explained by biomedical knowledge. Psychoanalytic theory is perhaps equipped to offer a more plausible interpretation. Katie's story suggests how little we really know about the mind, body and symptoms and something of the cunning determination of symptoms to represent more than we can say and more than we know.

Katie is ten years old, her younger brother Michael is seven years old and both children live with their parents. I have known the family for about six years. They registered with the practice when the family moved only a few miles in order to live in a larger council flat. Michael was born with a relatively mild form of cerebral palsy, and his parents have dedicated a lot of time and effort into caring for him. Most of my meetings with Katie have occurred when her mother has brought Michael to the surgery to see me. Her mothers' attention during these visits was noticeably focused on Michael, and Katie was required to be good and quiet. If Katie tried asking me questions or attempted to get either her mother's attention or mine, her mother would swiftly and very firmly tell her to be quiet because "Michael needs to be seen".

Katie was a little overweight, intelligent and always calm, quite reserved and needed encouragement to talk to me. She was generally physically well. Her parents only occasionally brought her to be seen by herself, and this was usually for some minor problem such as an earache. Often Michael would attend these consultations too, and it was always apparent to me that his parents–especially her mother—were more focused on him, even if it was Katie's turn to be ill and in need of their care.

This pattern continued and I was obviously very concerned that Katie was probably not getting enough attention from her parents when she was at home. However, over night, the family dynamic completely changed. Katie was rushed in to the surgery one busy Monday morning, accompanied by both her parents. Michael had been left at home with a neighbour. Her parents had noticed that she had been slowly losing weight and was tired all the time. Over the weekend Katie had been passing urine constantly, was very thirsty and on the day she came in was looking very pale and unwell. A urine test revealed sugar in her urine and that she had diabetes. A blood test showed that the level of sugar in her blood was dangerously high and I therefore arranged for her to be admitted into hospital straight away. She stayed there for over a week and she was commenced on treatment with insulin. This was administered by injection. Katie and her parents had to be taught how to monitor her blood sugar levels and how to give the injections.

Three weeks later Katie and her mother came to see me. To my surprise Katie was quite cheerful and talkative. Her mother however was very worried about her because her blood sugar levels were too high and Katie was not being careful with her diet. She was also forgetting to take her insulin. Over the next months Katie was in regular contact with the community diabetic nurses, the hospital doctors and me. Sometimes she would come to the surgery accompanied by one of her parents and sometimes Michael would be bought along as well. However, now the attention was very much on Katie and Michael had to be persuaded to be quiet and well behaved.

Despite Katie's intelligence and her cooperative personality, she more or less refused to go along with the treatment, and her sugar levels continued to be too high. However she had undoubtedly become a lot more talkative, appeared happier and far more confident. Eventually Katie's mother decided to tell me that she felt very guilty about Katie, and blamed herself for the onset of her diabetes. She felt that she and Katie's father were probably too focused on Michael (because they felt guilty about his illness as well). They had somehow assumed that because Katie

was so quiet and well behaved, that she was coping with their need to dedicate so much time to Michael. I thought that the family's problems could be helped through working with a family therapy team. They responded positively to this suggestion with the outcome that, eventually Katie began to take better control of her diabetes as her parents were able to devote more of their time and attention towards her.

The development of Katie's illness suggests to me that she had unconsciously made herself dangerously ill, like her brother, in order to obtain her parents' love and attention. At the same time, her symptoms could only be alleviated by responding to them as if evidence of her body's inability to produce sufficient insulin. In other words her symptoms (confirmed by biomedical investigations) confirmed a diagnosis of diabetes mellitus. In this instance the illness can be accounted for through both organic and inorganic aetiological factors.

Within medical training emphasis is placed upon the value of "good history taking". This implies attentiveness on the part of the doctor and careful listening to the patient's descriptions of illness. However in practice, most of what a patient says is disregarded. The doctor is listening for descriptions of symptoms that relates to or fits in with recognisable patterns of disease. Iteration by the patient that falls outside the scope of this understanding tends to be lost or edited out by the doctor, as if unrelated to the problem and therefore insignificant. Psychoanalysts will pay attention to whatever an analysand speaks about and how they express themselves. Within general practice, as already described, the structure of appointments leads to restrictions on the amount that can be spoken. However listening to patients' without interruption and including the less well storied aspects of a patient's narrative is just as crucial to understanding symptoms as is listening for coherency. The body is in a fluid state a state of motion and in constant interaction with the environment. Symptoms are embodied in that process and are not just the result of a reaction to external agents acting upon an intact and normal body. Symptoms are a part of who we are. They are a reflection of our culture and individuality. They are not separate phenomena, which only relate to a temporary state of unhealthy abnormality.

As well as understanding symptoms in relation to any accompanying pathological changes, it is equally important to understand them in relation to spoken language, the symbolic order[40] and to representation.

As previously noted Lacan describes the symptom as a gap or "first and foremost the silence in the supposed speaking subject"[41].(psychoanalysis is about overcoming the barrier of silence). When I first came upon this concept it resonated with many of the stories of symptoms I have heard from patients in general practice. Jacqueline's persistent stabbing pain would seem remarkably consistent with this conceptualisation. The barrier of silence is particularly noticeable in patients who return time and again with similar symptoms that are resistant to all manner of treatments. It is highly plausible in these cases that symptoms appear to be behaving like hidden messages with a secret that one is constantly trying to uncover but can never quite find the way to do so. In general we have huge resistances to psychological explanations for our symptoms. Their embodied reality makes these kinds of explanations seem implausible. Psychological explanations might also imply one is suffering from a mental illness. Like a tabooed subject, this is a thought that is generally socially unacceptable. The idea first put forward during the enlightenment (as discussed in chapter one) of the split between mind and body remains a fundamental belief within our culture. It is difficult for us to believe how an experience felt in the body can be related to the mind.

I would like to reflect upon how Freud's attention and use of the patient's speech enabled him to postulate a relationship between the body in the form of symptoms, and the mind, in the form of unconscious thought processes. I would then like to reflect upon how these ideas are relevant to both an understanding of symptoms and to the doctor patient interaction.

Symptoms lie within the symbolic order, that is, the symbolic dimension of language and culture[42]. The unconscious speaks through symptoms and they present as material bodily forms of speech or symbolic representation.

We attempt to reach the meaning of the symptom through speech, but speech can only give us a clue or a partial entry into its significance. When Freud and Breuer were making their discoveries about the symptoms of hysteria, medical science was still rooted in the method of looking and display. Indeed Charcot tried, unsuccessfully, to understand hysteria through this method[43] He carefully documented and photographed the gestures of hysterical patients, made during hysterical attacks. By using the documented photographs, he attempted to locate patterns of behaviour that could then be identified as signs, which present in all hysterics. The patterns would thus become synonymous with its definition. The

hysterical symptom, in the form of an indexical sign, would then become synonymous with its diagnosis.

Freud and Breuer's challenge to this method was reached through recognising the importance of listening to the patient. A radical approach since it was effectively treating the patient's narrative as if it was a kind of symptom itself. Or certainly they understood how the narrative is inextricably bound to the symptom and therefore equally important.

Their analysis of dreams and hysterical symptoms shows that perceptions in dreams represent wish fulfilments, as do the symptoms of hysterics. However because of cultural demands (authority, the laws that govern behaviour) these wishes or desires are inadmissible to the subject in conscious life. The unconscious works in order to make these wishes inadmissible. The manifest content of dreams represents displacement and condensations of the latent or hidden content of the dream by the work of the unconscious. The latent content relates to wish fulfilments. The repressed desires find their unsatisfactory outlet in the compromise-formation that is the symptom[44].

As with the wish fulfilments of dreams, likewise a symptom represents something that is fulfilled—a satisfaction. He states:

> by means of extreme condensation that satisfaction can be compressed into a single sensation [...] and by means of extreme displacement it can be restricted to one small detail of the entire libidinal complex[...]. We have difficulty in recognising in a symptom the libinal satisfaction whose presence we suspect and which is invariably confirmed"[45]

Lacan, links the symptom to the process of language, such that the symptom can be attached to a metonymical and metaphorical reading of traces of pre-conscious memories and representations (signifiers) in the unconscious[46].

Lacan subsequently observed that the unconscious was structured like a language, likening the process of condensation and displacement of the latent content of dreams to the metaphorical and metonymical process of structuring words or signifiers in language.

Through a process of condensation and displacement, formations of the unconscious are represented in everyday pathology in the form of slips of the tongue, jokes, bungled actions and symptoms[47]. Furthermore, Freudian and Lacanian concepts of how language is related to the unconscious show how symptoms can be linked to unconscious thoughts and desires of the subject. This is recognised through a psychoanalytical interpretation of their speech. Lacan configured the symptom as a form of ciphered message relating to signifiers in the patient's unconscious. The message could be decipherered by reference to the unconscious structured like a language. He states:

The double-triggered mechanism of metaphor is the very mechanism by which the symptom, in the analytic sense, is determined. Between the enigmatic signifier of the sexual trauma and the term that is substituted for it in an actual signifying chain there passes the spark that that fixes in a symptom the signification inaccessible to the conscious subject in which the symptom may be resolved—a symptom being a metaphor in which flesh or function is taken as signifying element[48].

The materiality of the symptom is not its message, it rather the enigma of the signification, of that which is fixed, or petrified between the signifiers as they are displaced, and the signified. In this sense Lacan regarded the symptom as a kind of fiction bearing a truth.

For Lacan, the symptom not only bears upon the subject's past relations to others, if it can be dissolved by an Other's interpretation, this is because it is formed with an eye to this interpretation from the start. To quote Slavoj Zizek on the Lacanian notion of how the symptom is from the start addressed to an Other supposed to know it's truth:

> The symptom arises[...]where the circuit of symbolic communication was broken: it is a kind of 'prolongation of communication by other means': the failed, repressed word articulates itself in a coded, ciphered form. The implication of this is that the symptom can not only be interpreted but is, so to speak, formed with an eye to its interpretation ... in the psychoanalytic cure the symptom is always addressed to the analyst, it is an appeal to him to deliver its hidden message[...]. In its very constitution, the symptom implies the field of the big Other as consistent, complete, because its very formation is an appeal to the Other which contains its meaning[49].

Interpretation of symptoms involves an appeal or an address by the patient (or analysand) to the Other "presumed to know" his or her truth– the analyst or the doctor. In psychoanalysis, through this process[50] the patient's "hidden" truth, their signifiers are returned as it were in "inverted form" and integrated into a symbolic formation, which he/she can understand. They are no longer alien to the subject but relate to the subject's identity That is, a symbolic formation relating to the patients culture and to their individual and symbolic interpretation of the world. Interpretation is not so much about a change in the way the patient sees the past but rather it re-orders their understanding of it. Interpretation thus provides symbolic self-understanding. In general practice, the doctor provides an interpretation, or a new narrative in which the patient can frame and understand their symptoms. As some of the patient's stories that I use in this chapter demonstrate, the doctor's narrative often includes a psychological interpretation as well as or instead of a medical interpretation. In both cases these narratives provide another form of symbolic self-interpretation for the patient.

It is worth noting that in his later writings Lacan thought that the symptom did not play a signifying role that was open to interpretation. Rather than a form of symbolic acting out it was a trace of the subject's jouissance. He states " the symptom can only be defined as the way in which each subject enjoys (jouit) the unconscious, in so far as the unconscious determined him."[51] Subsequently he replaced the word symptom with sinthome, where the sinthome, as clarified by Evans:

> designates a signifying function beyond analyisis, a kernal of enjoyment immune to the efficacy of the symbolic. The sinthome allows one to live by providing a unique organisation of jouissance. .....The task of analysis is to identify with the sinthome.[52]

The exploration of the symptom in this thesis conforms with Lacan's earlier conceptualisation. However if one uses Freud's conceptualisation of the symptom where it represents a compromise formation and an outlet for unsatisfied wishes one can further speculate, as Freud points out, that the person who suffers their symptom also gains unconscious pleasure or jouit from it. As Freud says "We have difficulty in recognising in a symptom the libinal satisfaction whose presence we suspect and which is invariably confirmed" [53]. The pleasure gained is an

unconscious satisfaction and it enables us to persist with symptoms despite their conscious debilitating effects.

In my psychoanalytic interpretation of Jacqueline's stabbing pain in the back, I felt that repression had a part to play in the formation of this symptom and that it was a symptom she "needed" in order to avoid distressing thoughts. It was as if she could not consciously let herself believe her son had been killed. The event, of which she could not speak or mourn, had then become represented as a bodily event, through the material quality of the symptom. If we accept the idea of unconscious satisfaction in the symptom, then her symptom, although a compromised form of expression of grief, was nevertheless allowing her some satisfaction.

What we have at our disposal in trying to comprehend symptoms is the discourse of the patient and different discourses or stories about what they might mean. Ranging from a scientific rational discourse to perhaps a more, to the uninitiated at least, obscure psychoanalytic explanation, or to non-western cultural explanations such as Fatima's, whose pains seem to have originated with the casting of spells. What is consistent within the history of medicine, as evident for example in Roy Porter's book *Medical History of Humanity*[54], is that different cultures, in different times, have variously employed culturally specific narratives, discourses and stories in order to explain and treat symptoms. Within contemporary British general practice one can opt to take a pragmatic approach. To follow the discourse that leads to the most effective outcome for the patient. Underlying this approach is a belief that there is no single truth for what constitutes a symptom and successful 'treatment' is about following the most appropriate option, which works for the individual patient now.

The Consulting Room as Theatre

In the general practice consultation room, the patient brings their world into the doctor's world. It is a site for a ritual where stories are told about symptoms. The consulting room can then be regarded in dramatic terms. The room becomes a stage, where patients tell stories, demonstrate symptoms and display their bodies. The doctor's role in the drama is to listen and interpret the stories, take part in the action, perform rituals, drive the narrative forward, intervene to change its plot[55], create resolutions or allow for open endings. The audience for the patient is the doctor, and the patient addresses the doctor in confidence. The doctor's professional role implicates another wider audience of health professionals and the

legal profession. The narrative structure of the events of the consultation has a parallel with the defining features of tragic drama. Tragic dramas evoke strong emotions upon audiences, based on identification with the hero and consequent pity for his demise. With the unfolding of often distressing stories, the doctor empathises with the patient and in so doing identifies with their feelings. The position of the patient, if unfavourable, will also evoke a feeling of pity in the doctor. Re-working and resolution of the narrative can evoke a catharsis for the patient and also for the doctor. When described in these terms, as an unfolding drama with a plot structure, one is able to consider the place of desire within the story of the consultation. How desire operates in the narratives of the consultation will be considered in chapter three.

The doctor and the patient have other potential audiences, that persists in the doctor's awareness like pale shadows. Although consultations are confidential, this imaginary audience has a psychological presence. They are one of the factors that provide the consultation with its sense of performance and in conscious and unconscious ways influence the way I behave. The imaginary presence of an audience introduces a tension between 'confidence' (addressed to one listener) and 'performance' (addressed to more than one listener whether it is actual or imagined). Although the patient may be aware of this imaginary audience, it is an audience that is more likely to affect the doctor's performance and sense of ease with the patient. (Other factors relating to a sense of performance, as discussed in chapter one, are to do with roles and the performativity of speech). The wider audience consists in a variety of other health workers who may need to be involved in the future care of the patient. For example, other general practitioners, psychologists, hospital consultants, district nurses, midwives and so on.

Although unlikely, each and every consultation could lead to a case of medical negligence. In which case, the events of a consultation are then open to the scrutiny of medical defence doctors, expert witnesses and the legal profession. The events of the consultation are documented only by the doctor, and in the form of brief notes. The layout of the notes follows a distinctive set of guidelines, which serves to place the events firmly within medical discourse. These are; the subjective statements of the patient, the objective findings of the doctor, the diagnosis, the management plan and treatment. Ostensibly this script is written as an aide memoir and historical reference for future consultations. However, it is also written for the other wider audience and for patients, who have a legal right of access to the notes. The script

is therefore not only for the benefit and legal protection of the doctor—which ultimately makes it a defensive narrative, it also exists as a legal document, to be read by the medical and legal profession in case of litigation.

The sense of audience thus has other outcomes beyond the performative. It ensures that the work of the doctor is responsible for the welfare of the patient, the legal protection of the doctor, and also is in constant check through the rules and regulations of the profession.

Although the patients' narrative holds a key to understanding what their symptoms might mean and the doctor's narrative involves an interpretation, the exchange is not purely verbal. It is an exchange that also involves looking and seeing. The doctor and patient look at one another, but they see a great deal more than their immediate perceptions. As soon as a patient starts to describe their illness, although I cannot literally see what they are talking about, I produce mental images from their descriptions. These images are presumably triggered from a store of mental pictures held somehow in my memory and accessible to conscious thought. If for example, a patient starts to describe a burning sensation in the stomach, the symptom makes me think of ulcers and then I think that I can see vague images of ulcers at the same time. These images come from having carried out endoscopies. Somehow the images of magnified bright red bleeding ulcers have left an impression in my mind strong enough to be recalled at the first mention of a classical pain associated with ulcer formation.

There are other images too if I think harder, for example those from textbooks and pathology slides. However the endoscopy images are the strongest and clearest. Other images seem to interlace with these as the conversation progresses. When the patient describes their diet and what makes their symptoms worse, they may mention that they smoke and drink. My response involves imagining them smoking and drinking and seeing anatomy displays of pathological changes in the body caused by smoking. More images come to mind in the form of anti-smoking adverts on the one hand and glamorous film actors exhaling cigarette smoke, on the other. These imagined images appear like shadowy displays hovering in my visual field. If I try to look at them, find them with my 'inner eye', they disappear. These 'recollected images' of degenerating body tissue, fatty secretions dripping onto clothes in anti-smoking adverts and a cool Marlene Dietrich exhaling cigarette smoke in the direction of a disappointed suitor, are thus not clear and strong. These images do

not displace the 'real' image of the patient in front of me, but they maintain a visual presence, which I see, to use Descartes term, with my mind's eye.

I frequently confirm to patients that I have understood what they say with expressions such as yes, right and aha, which are usually accompanied by a nod of the head. What I am also confirming is that I have seen something that coincides with what I think they are talking about. Presumably as they speak they are also creating or recalling their own mental images. Although I doubt if their mental images coincide with my own, I see something which I think approximately coincides with what they are describing. It seems unlikely that patients are conscious of the visual side of their exchange with me, but it is something of which I have become increasingly aware. It is interesting that on reflecting upon the exchange with the patient, what at first I thought of as a verbal exchange is evidently both visual and verbal. The extent to which I use these images beyond their ability to provide insight and awareness of a patient's reality needs to be considered. Through an interrogation of their practice of psychoanalysis, Robert Gardner[56] and Michele Montrelay[57] have commented on the effectiveness of the visual. Their experience calls for some re-evaluation of the role of visual imagery within the doctor-patient consultation.

Gardner investigated the way in which images—which he calls evanescent hieroglyphs—are produced in his consciousness during and after psychoanalytic sessions. He realised that these images were as important as speech in the analytic process. Whilst making notes about the things his clients had spoken about, he realised that he was in fact often describing images generated in response to the words. In recalling these images, after the sessions, he uses them to make free associations[58] of his own.

Subsequently he introduces his associations to his patients in the next or later session. In this way he describes a process of confluent image making, a complicated process of visual and verbal exchanges, in which each uses the other's images to fine-tune their understanding of one another. What the analysand sees and describes shapes what the analyst sees and describes and so on, in a long drawn out exchange, until Gardner thinks that they see in the same way. Whilst Gardner does not wish to be considered to be prioritising the visual over the verbal, for two reasons he regards the images as vanguards to verbal thinking. As images with the ability to signify more than one meaning, they contain more than he

immediately realises. As such they are able to "pulls things together and inform me more quickly than if my ideas and feelings had to be or could be put into words"[59]. At the same time the visual does not have to be stated. As he puts it, "they nudge rather than insist upon ideas that are too charged to be spoken about. They allow for tentative and elliptical thinking until he can manage more"[60]. So whilst they make the process more efficient, they also allow for a degree of timidity.

In Gardner's opinion, confluent image making "reflects no more than the ordinary, extraordinary likenesses of one person and another, and a little more than the ordinary effort to get at it"[61]. In the general practice consultation, I am aware that I read images semantically and from them am able to generate narratives. Quite often I spontaneously produce my own images in association with those already generated from the patient's words. These serve to enrich the story and sometimes lead to new ways of thinking about the story. Likewise with Gardner's view of the effectiveness of images; they are rich in content, they signify more than their verbal descriptions and consequently they are more efficient than a purely verbal exchange. They allow me to grasp the meaning of situations more quickly and thoroughly and with greater intensity.

However, Gardner's free associations to the images implicate the process of transference[62] and counter-transference within a free analytic field—the field of free associations between analyst and analysand. This goes beyond the process of generating likenesses as it occurs in general practice, and is clearly closer to Freudian psychoanalysis.

Michèle Montrelay[63] in her discussion of dream interpretation in analysis considers that the words of the analysand should be used poetically. That is, their words should be grasped in excess of their literal or every day meanings, and be restored to what she describes as their original magic. She cites Freud who writes, "words which we use in our everyday speech are nothing but watered-down magic. But we shall have to follow a roundabout path in order to explain how science sets about restoring to words a part at least of their former[64] magical power"[65].

Words then are to be valued for their phonetic, musical, visual, homologous, ambiguous and graphic qualities, the idea being to make each word say as much as it can, not according to some aesthetic principle, but as a form of efficiency. Her use of words is subordinate to the clinical work, to the method of free association and

suspended attention. Interestingly, and in accordance with how a doctor listens to a patient, she notes that in free association, images and words are not in conflict. Words call for images and images call for words.

Piecing the patient's story together in a visual way is important to how I understand what has happened. The result, not unlike a film narrative, seems to happen automatically and is not something I think I can stop. However, unlike Gardner and Montrelay, I am not attempting to make free associations to the images, but rather to use them to imagine what patients have experienced.

I now turn to the story of a patient called Lydia, a story that highlights the issues that I have been discussing, such as the importance of listening to the patient's story, how the visual and verbal interact and how symptoms relate to the context of a patient's life.

Lydia is a 24-year-old Kurdish refugee whom I have seen approximately once a month for the past year. She delivers the descriptions of her problems in a very visually stimulating way. For several years she has had symptoms that are similar to those caused by stomach ulcers and severe shooting headaches. She describes intermittent sharp stabbing and burning pains in her upper stomach, which sometimes spread into her chest. These usually occur during the day but sometimes start in the night and wake her up. Her headaches come and go with no fixed pattern. Sometimes they come on after an argument with her husband and at other times they seem unrelated to life's events. They can last anywhere from two hours to a whole day. Endoscopies and other tests have never revealed any underlying ulcers or other evidence of pathology. She has had a normal brain scan and all relevant blood tests have been normal. Her symptoms have persisted, sometimes with alarming severity. On one of her visits to the surgery, I enquired if any other family member had suffered from stomach complaints. To which she replied "Yes, my mother had operations on her stomach for pains but she is dead now". To which I asked, "How did she die?" Lydia replied, "She was killed by soldiers", and then explained how this had happened. She was about fourteen years old when one day a group of Turkish soldiers turned up in their village and came to their house.

Already as she was telling the story I envisage her mother as a small busy woman, long dark hair tied back, wearing a skirt to cover her knees and a smart dark sweater. I could see armed soldiers in combat uniforms with rifles walking through a

small mountain village in Kurdistan. Since I have not travelled in Turkey or Kurdistan, the images I was making in my mind I assume are reproduced from images I have seen on TV, in films and in magazines and I am recalling them in order to create a visual story.

The soldiers had come in search of her brother Tariq, who they believed was working for a Kurdish nationalist movement. Before they arrived Tariq had fled into the mountains to hide with some other young men. It was cold and remote up there, with little food so they were very hungry. Soon after this her mother developed stomach pains. Lydia believed that because she was so worried about her starving son, she developed the same hunger pains he was experiencing out of sympathy. Some weeks later the soldiers returned to look for Tariq. When they could not find him, they came back to the house to interrogate Lydia's mother. They were very violent and beat and kicked her in the stomach. This caused severe internal damage requiring a visit to hospital, where she had an operation. Eventually the soldiers found Tariq, whereupon they shot him in the head and killed him. Lydia did not know why, but they also returned to their house and again beat and kicked her mother. This time her operation wound opened up, it became infected and as a result Lydia's mother died at home from septicaemia.

Lydia told this story in quite a matter of fact way although there was a lot of sadness in her voice and she frequently looked down at the floor as she was talking. As she recounted this story, it continued to evoke visual scenes in my mind, to the extent that I began to loose the sense of sitting with Lydia in a small clinic room in north London. Although I was looking at Lydia's face, it began to recede as the mental images became more prominent. It was as if I was being transported into the mountain village in Kurdistan and was witnessing what Lydia had witnessed. It felt that I had been temporarily taken into the past and had witnessed what had happened. The world her story evoked in my mind looked very much like a film, edited so that it cut seamlessly from one scene to the next. As with Benjamin's good storyteller[66] it felt like a story I could retell myself.

The strength of her story, in terms of my position as her doctor, lay in how it then enabled me to understand just how afraid she must have felt and how this tragic event had left her rather desperate. Although she had other siblings and an extended family that could look after her, her father, whose comfort and protection

she most wanted was not someone she was able to turn to. She described him as a harsh person who used to beat her mother.

As a doctor trying to make sense of her symptoms, in other words introducing my story, I presented the following interpretations to Lydia: I thought that it was no accident that Lydia experienced her physical pain in the same place that both her brother and her mother had experienced not only great pain but extreme trauma. In her everyday life Lydia avoids speaking or thinking about their deaths, and said that she had tried to forget about it. When I pointed out the connection I had made between her pain and theirs, Lydia was incredulous and thought I was wrong. She contradicted my opinion and firmly believed that her pain meant that she had a disease and it was the job of all the doctors she has seen so far to find it and cure it. A great deal more had happened to Lydia since that time (which will be discussed in chapter three), and no doubt is contributing to how she feels now. However the events from her past were so extreme and significant, that it seemed only likely that they had left bodily impressions, especially since Lydia had tried to forget about the past. In my view the past was continuing to exert its presence, in the form of her symptoms.

I believe there are several reasons why Lydia's story has had a memorable impact upon me. One is the strength of her personality and the effect of the transference between us. The second is the social and political relevance of her story with its sense of tragedy. Thirdly, Lydia told her story in a visually stimulating way, which makes it easier for me to remember and retell. Finally, Lydia came to see me quite frequently and we built up a consistent relationship, which was transformative for both of us.

I wish to conclude this chapter by discussing the concept of transference and its relevance to the interaction between Lydia and me.

An important factor which affects the things that I say and the decisions I make in the consultation is how the patient and their story makes me feel. This is analogous to the process of counter-transference in psychoanalysis, which relates to the question of desire in the analyst (see footnote 17). Lacan believed that for the analyst to differentiate between transference and counter-transference in analysis was, "a way of avoiding the essence of the matter"[67], the essence that is of the phenomenon of transference. For him, subject and analyst are both included in *the*

transference and he uses of the word 'bound' to suggest that analyst and subject are bound in the transference, by desire. Gardner's descriptions of confluent image making and exchanges of free associations would imply that the transference operates in both directions and it is counterproductive to make a distinction between the analyst's and analysand's desire. Equally Montrelay's observations, of the floating exchanges in the free analytic field with her own and the analysand's associations means, as she declares, that she has "subordinated the analysand's fantasies to my own and nobody knows anymore what belongs to him and what belongs to me" [68]. Montrelay believes that to differentiate consciously between associations (her own and the analysand's) would make the analysis less creative and ultimately "the dynamics of transference would disappear"[69]. Whilst recognition of transference and counter-transference—but not necessarily their difference—is an essential part of psychoanalysis, in general practice it is not a factor that is openly worked with. This is always a matter of what I would call secrecy in the general practice consultation. A mutual awareness of the feelings generated in the consultation but not stated.

Patients undoubtedly project their feelings onto the doctor for a variety of reasons, especially as the doctor is an authority figure. Lacan states of such a person that they are "a subject who is supposed to know"[70] This makes me aware that patients are likely to take what I say seriously but also, and especially in young people where it is often more noticeable, they often have certain unaccountable reactions towards me—reactions which I read in their body language and in their speech. Lacan states "where there is a subject supposed to know, then there is always transference"[71]. Unlike Freud[72], Lacan recognized that transference operates in both directions: he states. "It is the patient's desire, yes, but in its meeting with the analyst's desire"[73]. Recognizing that these forces are in operation and communicating in such a way that I do not react to them (through my bodily gestures and speech) defensively or otherwise, is an essential part of building a relationship with a patient so that they feel recognized and understood. However, neither the patient nor I usually discuss how we make each other feel. Occasionally, if I am stuck, especially with those who frequently present with the same symptoms, it can be useful to tell them how they make me feel. This is in order to find out if anything in their lives makes them feel the same way and so exposing what is contributing to generating symptoms.

When I first met Lydia, I recall feeling a need to help her. At the time I felt that this was something to do with my sense of injustice that such a young and vibrant

person should be suffering so much. As our meetings continued I quite often felt that I was letting Lydia down and that despite my attempts I could not help her in the way she wanted. (The reasons for my feelings of helplessness will become more apparent in chapter three where I continue to discuss Lydia's story and the outcome of our consultations). On reflection I began to realise that in fact these feelings of a desire to help and subsequent feelings of helplessness on my part were to do with the transference between us. If our meetings had continued and my feelings of helplessness had continued, it might have been useful for me to ask Lydia if she felt either helpless herself or if others were not helping her. If in her view I was not helping her, then it is likely that in general she feels that those close to her also do not help her. This is a factor that we might have been able to discuss. Furthermore, it is also likely that my desire to help vulnerable people, which is generally upheld as an important attribute for a doctor, is also contributing to the transference, and, in a negative way is itself actually restricting the progress of the consultations. However, as will be revealed in chapter three, this opportunity, for the foreseeable future at least, is lost.

In this chapter I have used stories of consultations with patients to give an idea of the multiple ways in which symptoms present in general practice and the complexities involved in their interpretation. I have presented the symptom in terms of its enigmatic qualities, which defies simple reduction to organic diseases. By suggesting that the symptom is a form of bodily representation with its own message I have turned to the discourses of psychoanalysis and narrative in order to reflect upon its meanings. Both these discourses prioritise the use of the details of the patient's speech including slips of the tongue, silences and gaps as an entry into our understanding of the symptom because symptoms are, to use Lacan's terminology, 'first and foremost the silence in the supposed speaking subject'. I have considered Scarry's detailed analysis of pain, to show how symptoms resists language, yet also call for language in our attempts to share our experience of them with others. Psychoanalytic theory understands the 'neurotic' symptom as a symbolic expression of unconscious psychic conflicts. Through discussing examples of symptoms presented by patients in general practice, I have suggested that organic symptoms can not only be understood within the discourse of biomedicine, but also in the same way as psychosomatic or neurotic symptoms.

In the relationship between the doctor and patient, I have underlined how the feelings of both the patient and the doctor have to be taken into consideration when

interpreting and understanding the patient's stories of their symptoms. I have used the psychoanalytic concept of transference as a way in which to consider how those feelings are produced and their relevance to an understanding of symptoms. I have introduced some of the ways in which narrative theory is brought to an analysis of the doctor-patient relationship. Narrative theory is especially relevant to the idea of the patient and the doctor telling stories and also to how narrative provides a context for symptoms to be interpreted. In addition narrative offers an alternative perspective to the idea of the case study as an objective rationalisation of the patient's history of symptoms by the doctor.

In chapter three I will elaborate further upon ideas of narrative in the consultation and will discuss this primarily in relation to Lydia's story.

Notes

[1] The word symptom derives from the Latin symptoma and is adopted from the Greek where it means chance, accident, mischance, disease, which is from, to fall together, fall upon and happen to (Oxford Dictionary of English Etymology: 1966, p1122).

[2] Here I am referring to McDougall's use of the word *hysteria*, which relates to an imaginary body with purely symbolic significance (McDougall: 1973, p16). In Freud, Hysterias belong to a class of neuroses with diverse clinical pictures. He called the commonest type, "conversion Hysteria", in which a psychical conflict is expressed symbolically in somatic or bodily symptoms. Freud saw this as a crisis through representation (Janet: 1973, p195) Another form of expressing this conflict was anxiety hysteria or phobias, where the anxiety is attached in more or less stable fashion to a specific external object (Laplanche: 1973, p 194).

[3] As both a message and a form of representation the symptom conforms to the idea of a Saussurian signifier, and has been identified as such by Lacan in his early writings (Lacan: 1977, p130). Thus in this conceptualisation the symptom has symbolic function: it is a ciphered message, decipherable through an interpretation of the patient's unconscious (Evans: 1996, p204). However this concept doesn't account for the emotional charge or intensity, which accompanies our perceptions of symptoms. Lacan subsequently describes the symptom as necessary to living and lying outside the scope of symbolisation and therefore interpretation. Furthermore in his later understanding he considered that the symptom was an expression of a trace of the subjects "jouissance" (Evans:1996 ,p204), and as such I would suggest can be regarded as being charged with emotions that lie outside symbolisation. This will be discussed further in this chapter.

[4] Berg and Mo Berg, M, and Mol, A, *Differences in Medicine*, Durham and London, Duke University Press, 1998, p3

[5]Balint, E and Balint, M, *Psychotherapeutic Techniques in Medicine,* London: Tavistock, 1961

[6] Holmes, J, *John Bowlby and Attachment Theory*, London: Routledge, 1993

[7] Holmes, J, Attachment, Intimacy, Autonomy: Using Attachment Theory in Adult Psychotherapy, New Jersey: Jason Aronson Inc., 1996

[8] Holmes, J, 1993, pp122 and 223

[9] A sign in medicine refers to recognizable signs of illness, which are detected whilst examining a patient's body. For example a pale tongue, rapid pulse, abnormal heart sounds and breath sounds as heard through a stethoscope, an enlarged liver detected by pressing on the abdomen and so on.

[10] *Oxford English Dictionary*, 2nd edition, prepared by Simpson, J and Weiner E.S.C. Oxford: Clarendon Press, 1989 Vol XV11, p464

[11] Browse N, L, An Introduction to the Symptoms and Signs of Surgical Disease, London: Edward Arnold, 1978, p2

[12] For a definition of narrative, see chapter one p6.

[13] The effects of unclear narratives will be discussed in chapter three in relation to the notion of chaotic narratives

[14] Lacan J, *Ecrits: a selection*, translated by Alan Sheridan, London, New York: Routledge, 1977, p142

[15] Jouissance is translated from French into the word enjoyment. The English word lacks the sexual connotation of orgasm implied in jouissance, and so is left un-translated in most English editions of Lacan's writings (Evans: 1996, p91)

[16] Lacan, J 'Le Seminaire Livre XX11'. RSI, 1974-5 published in Ornicar?, nos, 2-5, febuary 1975 in Dylan Evans, *An Introductory Dictionary of Lacanian Psychoanalysis*, London: Routledge, 1996

[17] Scarry, E *The Body in Pain: The Making and Unmaking of the World*, New York: Oxford University Press, 1985, p4

[18] Ibid., p5

[19] Ibid., p5

[20] Lacan, J, '*The Four Fundamental Concepts of Psycho-Analysis'*, translated by Alan Sheridan with an introduction by David Macey, London: Vintage, 1998, p11

[21] Freud, S, '*On Narcissism: an Introduction'* SE.Vol X1V translated by James Strachey. London: Vintage, 2001, p82

[22] Scarry: 1985, p4

[23] I am using secondary narrative in reference to the process of secondary revision. A term used by Freud to describe the dream-work, whose business it is to bring coherence to the first products of the dream (Freud: 2001, SE Vol XV, p182)

[24] Shafer R, 'Narration in the Psychoanalytic Dialogue,' *Critical Inquiry* 7, no.1 (Autumn1980), p29

[25]Freud, S, (1906-08) *Jenson's 'Gravida' and Other Works*, translated by James Strachey, SE Vol 1X, p212-213

[26] Mannoni Mannoni, O., *Freud: The Theory of the Unconscious*, translated by Renaud Bruce. London: New Left Books, 1971, p123

[27] Laplanche, J, *New Foundations for Psychoanalysis*, translated by David Macey. Oxford: Basil Blackwell, 1989, p126-8

[28] Laplanche: 1989, p125-30 and Laplanche, J, 'The Kent Seminar', in *Seduction, Translation, Drives,* J.Fletcher and M.Stanton (Eds.). London: ICA, 1992, p125

[29] Freud: 2001 SE Vol 1X p218-19

[30] Ibid., p219

[31] *Frozen Section* is the title for a three screen video installation I made during the course of my PhD research. The video revolves around the story of Lilah's illness.

[32] Freud: 2001 SE Vol 1X p 213

[33] Laplanche: 1973, p283

[34] The term wish is translated from the German word Wunsch. Freud uses it to describe infantile hallucinatory perceptions of objects, for example food, which it associates with memories of an original satisfaction. Satisfaction of a wish is attained by the reappearance of the perception, and wishes are thus bound to memory traces. The search for the objects in the real world is entirely governed by this relation to signs and it is the organisation of these signs that creates phantasy—and its correlate desire (LaPlanche: 1973, p482).

[35] Freud: 2001 SE Vol XV1, pp338, 344, 349, 358-59.

[36] Laplanche, J, and Pontalis J.B, *The Language of Psychoanalysis, t*ranslated by Donald Nicholson-Smith. London: Hogarth Press, 1973, p266

[37] Desires are repressed by the ego/super-ego, for fear that following them will lead to retribution, either from society and culture or from parents. The ego is a defensive mechanism responsible for the interests of the person as a whole and tends to balance the demands of external reality with the desires of the subject. The superego is a censoring mechanism of the ego. Its functions are to do with conscience, self-observation and ideals. In classical psychoanalysis the super-ego is considered to be constituted through internalisation of parental prohibitions and demands (See Laplanche: 1973, pp130-140, 435-438).

[38] Freud, S, (1920-22), *Beyond The Pleasure Principal,* SE VOL XV111, translated by James Strachey. London: Vintage, 2001, p242

[39] Freud, S, (1916-17) *Introductory Lectures on Psycho-Analysis (Part111),* SE Vol XV1, translated by James Strachey. London: Vintage Press, p358

[40] Here I am referring to Lacan's notion of the symbolic. The symbolic is one of the three orders that structure human existence, the others being the real and the imaginary. The symbolic order refers to the symbolic dimension of language and culture. Any aspect of

psychoanalysis that has a linguistic structure pertains to the symbolic order (see Evans: 1996, p 201 and Macey: 2000, p373-4).

[41] Lacan: 1998, p11

[42] The Symbolic Order refers to the function of symbols and symbolic systems, including the social order and cultural symbolism. Language belongs to the Symbolic Order. The subject's relationship with the symbolic is the heart of psychoanalysis. The Symbolic Order is structured by laws, which Lacan believes relate to that which governs the structures of the social order. According to Levi Strauss and Marcel Mauss the social order is structured by the laws, which regulate kinship relations and the exchange of gifts. Therefore language is a system regulated by laws, the structure of which pertains to the rules of kinship and the exchange of gifts. The most obvious example of exchange occurs in communication with the exchange of words (an exchange of words is equivalent to an exchange of gifts), and since the concepts of law and of structure are unthinkable without language, the Symbolic is essentially a linguistic dimension. Any aspect of psychoanalysis that has a linguistic structure pertains to the Symbolic Order. In Lacan's view it is through language that the subject can represent desires and feelings, and so it is through the Symbolic Order that the subject can be represented and constituted. This includes the unconscious, which is also the realm of the Other. Lacan refers to the Other as the realm of radical alterity. The unconscious is the discourse of the Other, and thus it belongs to the symbolic order. (see Benvenuto and Kennedy: 1986, pp80-81, Evans: 1996, p201-2 and Macey: 2000, p373-4)

[43] See Didi-Hubermann, G, *The Invention of Hysteria*: *Charcot and the Photographic Iconography of the Salpetriere,* Translated by Alisa Hartz. Masachucettes: The MIT Press, 2004, chapters 2 and 3.

[44] See p11, of this chapter for a discussion of psychical conflicts leading to symptom formation.

[45] Freud: SE Vol XV1, p 366-67

[46] Evans: 1996, pp186-188

[47] Lacan: 1998, p130

[48] Lacan: 1977, p184

[49] Zizek, S, *The Sublime Object Of Ideology*, London: Verso, 1989, p73

[50] In analysis the content and unconscious wishes of the analysand's unconscious are identified through the method of free association and the process of transference, this is explained in footnotes 58 and 62 of this chapter.

[51] Lacan: 1974-5: seminar of 18 February 1975

[52] Evans: 1996, p189

[53] extract from full quote cited in this chapter, p58

[54] Porter, R, The Greatest Benefit To Mankind: A Medical History of Humanity From Antiquity To The Present, London: Harper Collins, 1997

[55] The plot refers to the way in which the events in a story are structured. In Chapter three I discuss the difficulty of defining plots according to fixed structures.

[56] Gardner, M.R, 'On Seeing Things' in *Self Inquiry,* The Atlantic Press, 1989, pp 49-77

[57] Montrelay, M. 'On Folding and Unfolding: An Example of Dream Interpretation in Analysis' in *Psychoanalytic Inquiry*, The Analytic Press, 4 (2) 1984, pp193-219

[58] Free association is a technique in psychoanalysis whereby the patient or analysand is required to say whatever spontaneously comes into her or his mind during the session and to withhold nothing. A corresponding rule requires the analyst to listen to all the verbal associations made by the patient, giving no particular importance to anything and paying attention to everything. The analyst must listen with evenly suspended or poised attention. The process allows access to both the analysands' and the analysts' unconscious mental activity (Freud: 2001, SE Vol XV111, pp238-39)

[59] Gardner: 1989, p71

[60] Ibid., p72

[61] Ibid., p66

[62] Transference is the actualisation of unconscious wishes during psychoanalytic treatment. In his later writings Freud uses the word to describe the process of transferring on to a contemporary object, feelings which originally applied, and still unconsciously apply, to an infantile object. (He first called it false connection (Breuer and Freud: 2001, SE Vol 11, p302). The feelings re-emerge within the psychoanalytic context with a great sense of immediacy and are projected onto the object of the analyst, who is often identified with a significant figure from the patient's childhood. Counter-transference constitutes the analysts unconscious reactions to the patient, and to the transference itself. Within psychoanalysis, recognition of the transferences and their interpretation and resolution is what constitutes the cure. (Breuer and Freud: 2001, SE Vol 11, p302, Laplanche: 1973, p455-57)

[63] Montrelay: 1984, pp194-5

[64] The roundabout path refers to Hypnosis. Montrelay points out that the German word used by Freud, was fruh, which becomes translated in English to former but in fact it means early (Montrelay: 1984, p194).

[65] Freud, S, quoted in Montrelay: 1984, p194

[66] Benjamin, W, 'The Storyteller' in *Illuminations: Essays and Reflections,* translated by Harry Zohn, New York: Schocken Books, 1968, p91

[67] Lacan: 1998, p231

[68] Montrelay: 1984, pp203–2

[69] Ibid., p202

[70] Lacan: 1998, pp224-5, 230

[71] Ibid., p231

[72] Freud only occasionally alludes to the concept of the analyst's transference to the patient. He called this counter-transference and recognised it as the patients influence on the physician's unconscious feelings (see footnote 62 and Laplanche: 1973, p 92).

[73] Ibid., p254

NARRATIVE IN THE CONSULTATION

In general practice, doctor and patient work with the symptoms presented, the patient's narrative, the doctor's medical observations, the doctor's narrative and the exchange between them. Conventionally, treatment and possible cure rests on the willingness of the patient to accept the doctor's knowledge and interpretation. The interpretation rests on the idea that what is invisible—the aspects of symptoms which cannot be reduced to something concrete—is not usually relevant to the doctor's treatment. Less traditional approaches involve the doctor and patient sharing knowledge, the doctor incorporating a degree of invisibility into her or his understanding of the symptoms, and both patient and doctor reaching an agreement about treatment.

In contrast, within psychoanalysis it is the interpretation of the patient's speech, including slips of the tongue and descriptions of symptoms and dreams, within the context of the transference relationship that affects a cure. In both practices there is an inter-subjective relationship and the narratives involved are crucial to the exchange.

Before proceeding to discuss the content and meaning of the doctor's and patient's narratives, it is important to consider in some detail what is meant by narrative and how this is different from other terms such as story and discourse[1]. By introducing theories of narrative into the analysis of the dialogue of the consultation, I hope to provide an understanding of the consultation, which lays out side the parameters of the biomedical model.

In the general practice consultation patients bring their world into the doctor's world through the stories they tell. Understanding their stories is therefore a crucial part of understanding them and their problems. But are they telling a story or a narrative or both? After all we commonly speak of telling children bedtime stories rather than bedtime narratives. This suggests that there is a difference between story and narrative.

Both story and narrative have etymological roots that relate them to knowing and knowledge. Narrative is related to the Latin word gnarus, which means knowing[2].

Story relates to the Latin word *historia, which means history, account or tale,* and ultimately to the Indo-European word *idein, which means to see,* and to *eidenai* to know[3]. Thus knowledge is articulated and communicated in the form of narratives and stories. Exchanging narratives and telling stories involves an exchange of knowledge. In the context of the consultation, what is primarily communicated is an exchange of knowledge about symptoms. Lyotard regards narrative as a mode of knowledge and that narratives determine the limit and possibility of knowledge, and hence action in a society. Speaking of narratives he says:

> they define what has the right to be said and done in the culture in question, and since they are themselves a part of that culture, they are legitimated by the simple fact that they do what they do[4].

This would suggest that our knowledge of the symptom is limited by the mode of its expression. The limit of our knowledge of symptoms is also limited by our knowledge of narrative.

In chapter one, I identified narrative according to a structuralist model. In this model narrative operates on the two levels of story and discourse. Culler describes story as "a temporal sequence of events or actions", and "discourse is the discursive presentation or narration of events or the story as reported in the narrative"[5]. Narrative is the articulation of story and discourse. Culler also states that in a story the events are "conceived as independent of their manifestation in discourse"[6] However, since the discourse refers to the story as reported in the narrative, (which could be real or fictitious) the story is also determined by the discourse. Thus the discourse affects the way in which the story is received by the reader or listener. It has the effect of bringing meanings to the events. Culler describes narrative as having a double logic. He states "one logic assumes the primacy of the events; the other treats the events as products of meanings"[7]. This contradiction in logic is essential to the way in which narrative functions.

When patients bring their stories of illness to the doctor, they describe the events that coincide with their symptoms, but not just as a report of a series of events in chronological order. The events are described within their discourse. A discourse that provides, a subjective nuance to the story and also the patient's understanding of cause and effect. In medical training, doctors are encouraged to give primacy to an objective rendering of the sequence of events. They encourage the patient to

describe the things that have happened and to disregard why the patient thinks they have happened. When the doctor subsequently describes the patient's illness, for example to other doctors, they introduce their discourse. The narrative of the doctor tends to attribute the events of the patient's of illness to biomedical phenomena. The patient's determinations are either discounted or considered to be of secondary importance. This is generally the case in the practice of hospital medicine. However, in the general practice consultation there is an opportunity for the doctor to consider the narrative of illness in the way in which it is presented by the patient. In this approach the discourse of the patient is as relevant to the symptoms as the events they describe, that is, to their story of the events.

Of relevance to this discussion is the distinction between two systems of grammar described by Benveniste[8]. He describes two planes of utterance[9], both used concurrently within narrative, that of *histoire* (history) and discourse. In *histoire* "the events that took place at a certain moment in time are described without any intervention of the speaker in the narration"[10], they are uttered in a historical temporal expression, using the past tense and in the third person. *Histoire* is thus a form of expression that makes no reference to the author or narrator. It is a mode of utterance which excludes every autobiographical linguistic form and in which the events seem to narrate themselves. The events lie outside the person of a narrator[11]. The historical intention is an important function of language. This use of tense and person delivers to the narrative an objective truth, which lends it authority. In contrast, within discourse, the subjectivity of the narrator is included. Discourse is a narrative delivered in the first or second person and in the perfect, present of future tense[12] Benveniste says of discourse "it must be understood in its widest sense as every utterance assuming a speaker and a hearer, and in the speaker, the intention of influencing the other in some way"[13]. Discourse is the form *par excellence* of oral speech and is also used in forms of writing, which refer to oral speech, such as plays, letters and diaries.

If these two distinctive modes of expression are considered in relation to the doctor and the patient, discourse falls on the side of anything to do with the speaking narrating subject, typically the patient. In contrast, *histoire* is on the side of neutral, objective medical discourse. That is, the discourse which supposedly informs the doctor. However, within the consultation the doctor frequently speaks in the first person and present tense. The doctor speaks as if to give the patient a point of view

that is personal and relates to their own experience of being a doctor. The doctor's use of *histoire* or medical discourse in the consultation is referential and hermeneutic. It is an authoritative discourse, which may, at times, be of use in evaluating and treating the patient's condition.

In her critique of this dualist account of narrative Barbara Herrnstein Smith[14] points to the difficulty or impossibility of making a distinction between the events reported and the way in which they are told. In her view, this is because there is no definable essential narrative component within a story (the story can be told or written) that can be abstracted from the process of narration. There is no definable abstract structure within narrative.

Barthes explores the problem of structures in narrative in his essay 'Introduction to the Structural Analysis of Narratives'. Drawing on structuralist semiotics whose observations and conclusions came principally from an analysis of literature and the novel, Barthes[15] tries to account for finite structures within the narrative form that are universal to all forms of narrative. However he does not succeed in identifying such an objective unit or code. Instead he identifies universal structures—which he calls levels—whereby meaning is created by movements horizontally along them and simultaneously vertically across[16]. His account of levels is attributed to those described by Benveniste[17]. Levels are broken down into units of similar structure, for example, phonemes, words and sentences. Movements described as distributional relations across the same level in a horizontal axis and at the same time integrational movements across different levels along a vertical axis create meaning. The horizontal axis relates to the paradigmatic function of language and the vertical axis corresponds to the syntagmatic function in language[18]. Subsequently in an essay discussing textual analysis Barthes points to the impossibility of identifying fixed structures in narrative and insists on the importance of intertextuality. He says, "what founds the text is not an internal, closed, accountable structure, but the outlet of the text on to other texts, other signs; what makes the text is intertextual"[19]. This suggests an order of infinity, where all texts lead to more texts. Barthes reconciles the two positions by saying that "language, which we are getting to know better, is at once infinite and structured"[20]. Derrida identifies the difficulty as that of an aporia: he talks of "the impossibility of the rigorous taxonomies and typologies required to uphold the structuralist model of narrative"[21] and the simultaneous necessity of such boundaries and borders in order for there to be a conceptualisation of narrative.

In distinguishing between narrative and story, Herrnstein Smith[22] introduces the idea of the plot. The plot refers to the way in which the events in a story are structured. This conceptualisation of plot is a further refinement of the idea of discourse, but suggests that a plot could be an external structure applied to a story. However if plot has a structure, this is not one that can be easily defined or abstracted. While the same story can be retold, each narrative is unique as it has its own unique plot. She questions the structuralist notion that there is a single identifiable plot summary or basic story, upon which all retellings are dependant. For Herrnstein Smith there is no pure or platonic ideal basic story because:

> for any given narrative, there are always *multiple basic* stories that can be constructed in response to it because basic-ness is always arrived at by the exercise of some set of operations, in accord with some set of principles, that reflect some set of interests, all of which are, by nature, variable and thus multiple[23]

Each narrative is irreducible to any other narrative because retelling a story only results in its re-inscription in the form of another narrative. Smith implies that narrative discourse is no different from other linguistic acts, that story and narrative are one and the same, there is no distinction between them. Although one cannot make absolute distinctions between narrative, story, discourse and plot, to think of them within an abstract model that defines their distinctive features is useful. This accounts for the observation that despite the many ways in which a story can be retold, there is nevertheless something stable and irreducible within a story. This consistency is transmitted even in the various retellings. Thus a patient's story of illness has consistency, in spite of the various ways in which it can be retold.

The patient's story can be retold according to a number of different narratives or modes of knowledge: the narratives of the general practitioner, the medical scientist, the psychoanalyst or the best friend. There can be many narratives associated with one person's symptoms. In the course of a consultation the patient's presentation of her or his symptoms is revised through the doctor's interpretation and narrative. The doctor's interpretation is always already a narrative, even if it falters, fails or is undermined. I am speaking here of the medical interpretation of the symptom, which has already been scripted when the doctor learns to make an interpretation in medical training. The discourse of interpretation has little room for play with rhetoric and poetry, and is the script, which we as patients listen for because of its narrative

development and closure—that is, for what the symptom represents, the diagnosis and how it can be cured.

The doctor's spoken narrative with the patient may or may not include elements of this narrativised interpretation. The patient's story may exclude the possibility of direct interpretation and could be something that the doctor does not actually formulate so that the interpretation remains non-narrativised. The doctor's narrative is always a conflation of their response to the patient's narrative, a medical interpretative narrative, a narrative determined by other discourses (for example, psychological, sociological, philosophical), and is also determined by the doctor's experience. In addition, the doctor's narrative is frequently revised through a consideration of further narratives such as the response of the patient and representatives of the patient—relatives or friends—who may be present in the consultation. The doctor's experience locates the inter-subjective field of exchange of the consultation beyond that between doctor and patient and possibly others involved in that particular patient's illness.

The field also has an historical relation to other consultations. Whilst the narrative of the patient is unique to the patient, for the doctor it is located within a set of other narratives, both those heard from other patients in previous consultations who present with similar stories and also to a set of model narratives he or she has learned in training as examples of a particular conditions or illness. The process of diagnosis, interpretation and the evolution of the doctor's narrative, which can now be understood as a process of knowing, always involves comparing and mapping aspects of a patient's particular narrative with many other narratives. The final outcome of the consultation may conclude with a narrative that is open to further interpretation, for example if the patient is referred to another doctor, therapist, psychologist for their opinion. Thus knowledge of the patient's symptoms evolves through an exchange of narratives within an inter-subjective field of more than two people. As previously described it also involves exchange of images between doctor and patient and hence the mode of knowledge is not only verbal and linguistic, it is also operating in a visual economy of exchange.

An interesting aspect of the doctor/patient relation is the constant tension between the more formal and circumscribed elements of the roles, which I have described as the ritualistic aspects, and the informal elements of the roles[24].

The narratives within the relationship also hold this tension. This is created through a movement that occurs when the narratives slip between the more conventional, or 'scripted' aspects of the dialogue, into the 'unscripted', or between the rehearsed and unrehearsed aspects of the dialogue. The script is bounded by a context. It refers to what the patient thinks is appropriate to tell a doctor in a consultation, and is limited by what they understand the role of the doctor to be. A conventional understanding of these roles makes it legitimate for a patient to describe the specifics of their symptoms, how they have progressed and how they have treated them so far. Beyond this a patient might feel confused about what more they are able to say and how much personal detail they should bring into the story, whether to discuss what relatives, friends and colleagues have said about their illness, what their own opinion is and so on.

Equally the doctor's attitude has an effect on how much and what is said. The doctor decides what aspects of the patient's narrative to pay attention to and what aspects to ignore and edit. They may adhere to the conventional script, which is determined by the discourse of medicine, or they may break from this discourse and move into less scripted territory. The use of discourse here is distinct from its use in structuralist theory. It refers to a body of knowledge, which the doctor has learned and for which there is a specific language. This is the language or discourse of medicine, through which medical knowledge is transmitted. How far the doctor breaks from these conventions is dependant on many factors such as, how well she or he knows the patient, the doctor's experience and personality and what is being discussed in the consultation.

Adherence to a strictly medical discourse on the part of the doctor places a boundary on the content of what is said. The dialogue in this context is more formal and its content restricted. It thus has analogous effects to the language of ritual, which is a conventional language with a restricted code. Restricted codes of speech influence people not by transmitting information but by compelling them into using standardised statements and responses. As discussed in chapter one, this type of language with its emphasis on form rather than content, has performative effects, which are about maintaining social order. Writing on the effect of syntax, Bell states "The obvious codes of formalized and restricted speech used in ritual are the very means by which it does what it does-namely exercise considerable social control by creating situations that compel acceptance of traditional forms of authority"[25]. By an analogy, adherence to a formalised and medicalised language transforms the

context of the consultation into one that is strictly medical and thus maintains the authority of medicine and the power relations consistent with that authority.

The eruption of unscripted, non-medical narratives creates an anxiety because the stories that are exchanged between doctor and patient reach beyond the boundaries of acceptable discourse and have potentially no limit.

According to the etymological roots of narrative, patient and doctor are exchanging knowledge. They are also creating new narratives, new sources of knowledge which are open to interpretation. A pivotal moment of any consultation relates to the decisions involved in determining the direction of the narrative and its limit. One choice is to accept a degree of anxiety and leave the narrative open-ended so that it is not framed within a specific discourse, and no definite conclusions or endings are reached. An easier choice, which generally dissipates anxiety, is to 'institutionalise' the unrehearsed scripts and new narratives, by situating them within a discourse. For example, discourses of medical science, psychoanalysis, homeopathy and so on. This frames the patient's narrative of his or her symptoms within the conventions of a discourse, thus placing limits on the very narrative and the meaning of the symptom.

An objection to the idea of leaving the narratives unframed and outside conventional discourse is that making a diagnosis and offering appropriate treatment are potentially life saving and in the best interests of the patient and the doctor. However it is often the case that a diagnosis cannot be made. Sometimes a diagnosis or medical explanation can only be offered but not proven. Even if one can be made, it is also important to remember the anxiety created by the unscripted aspects of the narrative. The anxiety relates to what is unknown, and it is the unknown that contributes to relapses of the same illness or to new illness. (I will refer to the notion of anxiety in the consultation later in this chapter with reference to chaotic narratives).

In Lydia's story, or now my story of Lydia's story, she was the main character, and the selected events of her story were fictionalised and recounted from the past. In addition to the story I recounted I also provided another narrative. That is an interpretative narrative, which explained the symptoms according to a medical and a psychological discourse. They were classic symptoms of gastritis, as explained at the beginning of the account, but could also be understood in terms of

psychosomatic symptoms. That is symptoms produced as an effect in the body of repressed thoughts. Lydia's symptoms seem to mimic the pains of the trauma that caused her brother's and her mother's death.

In Barthes' analysis of narratives, he talks of the universality of narratives which are infinite, everywhere, and expressed through a diversity of forms, in different cultures, times and places. He says:

> Narrative is first and foremost a prodigious variety of genres, themselves distributed amongst different substances—as though any material were fit to receive man's stories [...] narrative is international, transhistorical, transcultural: it is simply there like life itself[26]

Consultations generate a great variety of narratives with different types and styles of speech. These types of speech, such as medical, psychological, sociological, political, social, gossip, autobiographical, travel and so on, constitute genres. In order to gain some further insights in to how speech is used in the consultation it is useful to analyse the narratives through theories of genre.

Genre is used in rhetoric, literary theory and media theory to describe different types of text[27] or speech. There appears to be no general agreement on how genre should be categorised. It poses a problem of differentiation since any one genre also has elements of other genres. As Gledhill puts it, there are no "rigid rules of inclusion and exclusion"[28] and genres can overlap. This leads to mixed genres such as comedy-thrillers or documentary-dramas. Although I have listed some types of speech, which evolve in general practice consultations, these are not stable categories and tend to move imperceptibly from one type to the next or occur simultaneously. The features of one particular genre are not unique to that genre, and as Neale[29] explains it is their relative prominence, combination and functions, which are distinctive. Traditionally genres have been thought of as stable entities, but in fact, their forms and functions are dynamic, and they are constantly changing alongside cultural changes.

Contemporary theory introduces a more triangular view of genre, which has relevance to how genres are created or constructed in the consultation. Different types of speech depend on factors such as the patient's social and cultural back ground, their gender, their expectation of the doctor, their expectation of the

consultation and will always be affected by the doctor's response. Likewise the doctor's response to the patient is affected by similar factors and includes their expectation of the patient. Thus the genres or types of speech are dependant on the socio-cultural perspectives of the doctor and patient and the interaction between them.

This confers with contemporary views of genre. Miller [30]understands genre as an articulation between text, producer of the text and audience (where doctor and patient both act as producers of texts and audience). Furthermore she states that "a rhetorically sound definition of genre must be centred not on substance or the form of discourse but on the action it is used to accomplish"[31]. Patient and doctor use particular genres in order to achieve specific aims. For example, if as a doctor I want a consultation to end quickly, I try to keep the dialogue strictly in the realm of a medical genre, avoiding all attempts by patients to introduce psychological or autobiographical genres. Likewise patients will use genres to achieve particular effects. Elderly patients who are lonely will turn towards social and autobiographical genres in order to prolong the consultation by entertaining the doctor.

Genres provide frameworks within which texts are produced and interpreted. Fowler[32] has pointed out that there is a shared code in genre between the producers and interpreters of texts, which makes communication possible. Authors of texts position readers so that they respond according to a position constructed by the writer. For example, positions such as listener, interviewee, someone who instructs or someone interested in politics. The position is constructed for an ideal reader which makes assumptions about their attitudes towards the subject matter and often their class, age, gender and ethnicity. If we regard a medical questionnaire as a genre, then medical questionnaires, as indicated in chapter one, make assumptions about an ideal or typical patient. If in the consultation, the doctor uses medical discourse and utters it in the style of Benveniste's *histoire*. For example:

> The pain in your neck Mr. Smith is caused by facet joint dislocation and spasm in the surrounding muscles for which the treatment is diazepam and dihydrocodeine and you are advised to wear a neck support. This will relax the muscles and enable the joints to slide back into place, at which point you should find that your pain subsides.

This type of medical speech positions the patient in a medical context and the doctor on the side of medical authority. It considers that the patient respects medical authority. Alternatively, the doctor could say:

> You seem to have had a lot stress at work recently Mr. Smith and not enough sleep. I think this is your body's way of asking for a break. Diazepam and dihydrocodeine usually help to relieve the pain, which is due to muscle spasm, if you would like to try this. But don't worry it should all settle down with some rest.

Although this type of speech refers to medical discourse it is also the speech of a carer. It places the patient in a social context and the doctor is positioned as a healer. It considers that the patient responds to a feeling of being cared for.

Production and interpretation of texts has a social dimension so that genre, as Kress puts it, can be seen as a " kind of text that derives its form from the structure of a frequently repeated social occasion, with its characteristic participants and their purposes"[33], As well as this social dimension, individual texts are also seen and interpreted in relation to other texts. In semiotic terms, they are interpreted inter-textually. Fiske describes this rather succinctly by reference to a car chase.

> A representation of a car chase only makes sense in relation to all the others we have seen—after all, we are unlikely to have experienced one in reality, and if we did, we would, according to this model, make sense of it by turning it into another text, which we would also understand inter-textually, in terms of what we have seen so often on our screens. There is then a cultural knowledge of the concept 'car chase' that any one text is a prospectus for, and that it used by the viewer to decode it, and by the producer to encode it.[34]

It could be argued that it is impossible to produce texts which bear no relationship whatsoever to established genres. Indeed, Jacques Derrida proposed, "a text cannot belong to no genre, it cannot be without... a genre. Every text participates in one or several genres, there is no genreless text"[35].

In the consultation other preceding narratives influence the dialogue, as already indicated. The response of the doctor to the patient's narrative is determined by many factors, including the narratives of preceding consultations and those learnt in

medical training. The narrative content and style is also affected by the intentions, cultural backgrounds and personalities of the two people, doctor and patient, constructing the dialogue. The effect of the exchange of narratives is an exchange of knowledge, which creates new understandings and meanings, in the form of new narratives.

The narratives we exchange in consultations, and in many other situations, are potentially endless. One story leads into another, one narrative into another, in a continuous economy of exchange. We are conscious that this exchange involves a process of listening and replying. However, all stories require a listener. Even when one tells a story to oneself, one tells it to an imaginary other person. Margaret Atwood's lonely handmaid recognises this. When telling her story in her head she says, "You don't tell a story only to yourself. There's always someone else. Even when there is no one"[36]. This would suggest that any story is always addressed to another, that it always implies an inter-subjective relation and the act of speech anticipates, or desires, a reply. Desire, is at work in the very structure of the narrative itself: from the deferral of meaning which is structural to language and therefore to narrative, to the telling of a story, where the story teller defers endings through subplots, in order to arouse suspense for the listener. This notion of desire refers to the Freudian concept of a search for a lost object that the subject endlessly tries to regain.

Teresa De Lauretis[37] points out that Freud, through his choice of the mythical story of Oedipus as the emblem of 'everyman's'' passage from childhood to adulthood (and their advent to culture and history) allows us to see, that overlaid in every narrative is an Oedipal logic. This logic is a movement both forwards towards resolution and backwards to an initial moment, a paradise lost. The logic of a dual movement is based on the lost object, or the fantasy of an object that was lost, as it were, facing two directions: the past when one supposedly had it and the future when one hopes to re-find it—a narrative with a beginning, a middle and a forever deferred ending.

Freud points this out to us in a passage from the essay 'Creative Writers and Day Dreaming[38]'. Here he talks of three relations of time within phantasy, where phantasy is the source for the activity of creative writing[39]. He says "The relation of phantasy to time is in general very important. We may say it hovers between three times [...]". The phantasy is linked to a current impression, which has been able to

arouse a particular wish. It is linked to the past in that it harks back to a memory of an earlier experience—an infantile one—in which this wish was fulfilled. Finally, it is linked to the future in that is anticipates a situation in which the wish will be fulfilled. 'Thus past present and future are strung together, as it were, on the thread of the wish that runs through them"[40].

This structure is evident in the story of Oedipus and through her referral of us to this story De Lauretis points out that Freud

> allows us to see that in the very process of narrativity (the movement of narrative, its dramatic necessity, its driving tension) the inscription of desire, and thus—and only thus—of the subject and its representations[41].

Freud's use of the myth of Oedipus points to an inherent tension or frustration in the 'split' subject of civilization, which is reflected in the subject's speech[42]—that is in gaps, parapraxes and so on. The tension between the polymorphous, transgressive subject who does what he wishes (desires his mother and kills his father), a subject of expenditure without exchange, and a divided subject who returns later to law, civilization and repression. When he finds out that he must have committed such deeds he blinds himself. The tension in the myth reflects Freud's view that we need repression otherwise we regress to lawlessness and the polymorphous perverse[43].

Roland Barthes[44] and Peter Brooks[45] in locating the figure of Oedipus lurking behind the very structure of narrative, allow us to understand an analogy between the repressive organisation of infantile sexuality and the repressive organisation of textual elements in narrative. An analogy that is between on the one hand, the repression of polymorphous perversity and component instincts into a unimorphous, Oedipalized normality and on the other, the repressive organisation of disparate textual elements into an anxiety-assuaging narrative or syntactical coherence. As Barthes writes, "it may be significant that it is at the same moment (around the age of three) that the little human ' invents' at one sentence, narrative, and the Oedipus"[46].

How desire operates as a structuring element within narrative can, if we follow Freud's thought be seen to be related to myths and the repression of an original desire. The narrative relates to the story of the events and how it is told. How narrative is told or how the narrative is structured, relates to how stories are told in

culture. Storytelling, prior to the novel, was handed down from generation to generation through the oral tradition. The first stories to be handed down through story telling, were, according to anthropological research, mythical stories[47]. Furthermore myths evolved out of rituals, and the rituals were about acting out—according to Freud—the taboos of incest and of patricide.

Thus myths were based on stories about an original desire and its lack of success through repression. Consequently, inherent in the structure of narrative is myth and the structure of desire. Freud believes that these mythical structures[48] (mythemes[49], as Levi Strauss called them) operate through the unconscious and although repressed to conscious thought are ultimately reflected in the speech or language of the subject. Freud refers to this phenomenon in his essay 'Creative Writing and Day Dreaming'[50]. In speaking of creative writing (more precisely he uses the word 'poetry' which has been translated from German into 'Creative Writing') or imaginative works he states:

> we have to recognise these not as original creations, but as the re-fashioning of ready made and familiar material [...]. In so far as the material is already at hand, however, it is derived from the popular treasure-house of myths, legends and fairy tales [...] it is extremely probable that myths, for instance, are distorted vestiges of the wishful phantasies of whole nations, the *secular dreams* of youthful humanity[51].

Later in the essay Freud refers to the aesthetic effect of creative writing in which the audience unconsciously identifies with the disguised contents of a poem, which like the manifest contents of a dream, can only emerge in consciousness in disguised form but are a manifestation of the original repressed wishes of the unconscious.
Lacan[52] locates the taboos to a symbolic order of kinship and the exogenous exchange of women, rather than within the family. He states:

> The primordial Law is therefore that which in regulating marriage ties superimposes the kingdom of culture on that of a nature abandoned to the law of mating. The prohibition of incest is merely its subjective pivot [...]. This law then is revealed clearly enough as identical with an order of language. For without kinship nominations, no power is capable of instituting the order of preferences and taboos that bind and weave the yarn of lineage through succeeding generations"[53].

Either way the decree against incest comes from the father figure, who symbolically castrates the child by denying him/her access to the mother, whose desire is for the phallus. The phallus then symbolises authority and the law. Lacan famously calls this "in the name of the father"[54] (translated from French where it is both the name and the 'no' of the father) since in order to accept the taboo a subject agrees to the law of the father and the patrilineal inheritance of taking his name. A subject otherwise does not have a name and does not exist in language or in culture. In other words, a subject can only become a subject through admission into language, the symbolic register. This simultaneously requires that their desire is repressed according to the sexual taboos ordered by that culture. The acquisition of language is thus connected to a negative, the suppression of an original desire, decreed by male or phallic authority.

In criticising Freud's use of the Oedipal story Teresa de Lauretis[55] raises two important points. First she explains that the desire described in the Oedipal story is the desire of a mythical male hero. It is Oedipus's disguised and unrecognised desire for his mother. One of the obstacles to his desire turns out to be in the guise of a female, that is, the Sphinx. In answering her question he succeeds in his heroic quest to save the inhabitants of Thebes. His reward is marriage to Queen Jocosta, whom he fails to recognise as his own mother. Secondly she illustrates that within mythical plot structures, a gendered binary opposition is in operation, which supports and creates ideologies about gender difference. The narrative directs the reader to identify with the desire of a male, who occupies a heroic position. Furthermore the male character signifies overcoming obstacles and movement across spaces. Spaces and obstacles are womb-like and morphologically female. In opposition to this, the desire of the female is subordinate to the male and female characters signify resistance to movement and enclosure or entrapment.

De Lauretis[56] subsequently reflects upon how the structure of desire and language is dependant on dominant (and generally patriarchal) socio-cultural orders revealed in the myths of those cultures. The orders revealed in myths available to Levi Strauss are consistently structured around the exogenous exchange of women and a patrilineal kinship structure. She uses Propp's[57] analysis of the fairytale and Lotman's[58] work on plot structures to show how myths change over time and come to reflect the laws and orders of a culture. She argues therefore, that myths based on a matrilineal system of law and order, have disappeared since matrilineal

cultures are virtually extinct. Furthermore she speculates that within matrilineal kinship systems, the rituals determining the ordering of sexual taboos would be reflected in the myths, and by extension in the structure of the unconscious and language.

I am using this argument not only to allow reflection upon how the order of culture determines how we structure language but also to suggest that the structures proposed by Freud are in fact not stable. They depend on the specificity of cultural taboos around sexuality and the dominant structures of power that determines them. Freud's enquiry seems to stop at this point, as if he sees this structure in myth operating in the unconscious, the products of the unconscious (dreams and symptoms) and language, as a universal truth. This recourse to structure and equivalence, which necessarily determines the shape and structure of dreams and symptoms, thus still lies within the framework of western metaphysical thought. A metaphysics, that like science, looks for the presence of objects and structures to explain phenomena. Freud's point of departure lies in his early emphasis on using language, in psychoanalysis, in a poetic way. This led to a conceptualisation of the unconscious structuring its map of words, images, sounds and precepts through a fluidity of associations, combining fragments or signifiers as in a rebus.

Lacan's account of how desire functions in narrative relates to that of Freud's, in which he describes movement as a process of exchange. This occurs during any instant of narrative production. For Lacan the movement of metonymic exchange in narrative is analogous to the structure of desire. The metonymic process of deferral where one signifier is replaced by another in the signifying chain of narrative operates in the same way as desire. Desire is 'always eternally stretching forth towards the desire for something else'[59], since it is impossible to desire what one already has. In this way, as in metonymy, the object of desire is continually deferred.

In speaking of desire, Lacan states that "man's desire finds its meaning in the desire of the other, not so much because the other holds the key to the object desired, because the first object of desire is to be recognised by the other"[60]. Furthermore, "the function of language is not to inform but to evoke. What I seek in speech is the response of the other. What constitutes me, as subject is my question"[61].

These psychoanalytic reading points to how the structure of desire is always at work in the process of speech. It is driven by the subjects appeal to the Other in speech

and the inadequate response of the other to that call[62]. All speech is both an appeal to the virtual Other and at the same time the incomplete response of the socially positioned other. In this sense all speech (even if, as with the lonely handmaid, it is to one's self) is an exchange, which implies an inter-subjective relation.

Each act of speech seeks the Other in a demand for recognition. Recognition by the Other would be an affirmation of that experience. The subject thus constitutes itself in this exchange. The Other is a virtual other, and Lacan states of this Other:

> The Other is, therefore, the locus in which is constituted the I who speaks to him who hears, that which is said by the one being already the reply, the other deciding to hear it whether the one has or has not spoken[63].

All speech is there already for a reply, as is listening. Speech involves a process of exchange in which the other provides an incomplete response to the subjects appeal to the Other, and thus implies an audience. The isolated handmaid already seems aware of this as she decides to tell her story to her imaginary audience:

> A story is like a letter. *Dear You,* I'll say. Just *you,* without a name. Attaching a name attaches you to the world of fact, [...]. I will say *you, you* like an old love song. *You* can mean more than one. *You* can mean thousands. I'm not in any immediate danger, I'll say to you. I'll pretend you can hear me. But it's no good because I know you can't.[64]

Her appeal to the Other is thwarted. McQuillan[65] explains that this is because the reply to her appeal to the Other, is in fact misrecognition by the socially positioned other. He states, "the act of narrative production determines the location of the Other—the Other being the locus of linguistic possibility [...]. The response of the Other is always already contained within the act of narrative production itself [66]". However as Lacan proposes, the Other is only ever acceded to by the other, and "In order to be recognised by the other, I utter what was only in view of what will be[67]". In other words my utterance already anticipates a reply, and a reply that the other cannot give because the other is socially positioned and not the symbolic Other. Lacan then says "I call him by a name that he must assume or refuse in order to reply to me"[68] –his reply is not the reply of the Other that I seek, but the misrecognition of the subject by the socially positioned other.

McQuillan[69] makes the point that the exchange of narrative always ensures that what is received (by the socially positioned other) is always a relationship of incomplete receivership. Further, because of this misrecognition or inadequate identification of and by the other within an exchange, desire is never satisfied, it is insatiable, and the process of exchange within narrative is endless. The process of inter-subjective communication persists. If the identification were satisfied, McQuillan notes that a state of plenitude thus created would lead to an end of exchange and to silence. Therefore misrecognition and insatiability prolong the exchange and forestall silence and death.

In Freud, desire in narrative relates to an effect of a divided subject. That is a subject split between the unconscious and conscious. Whereas within Lacan desire in narrative relates to a process of exchange for a subject divided through unconscious misrecognition.

To return to the story of Lydia : throughout the time I spent listening and talking to Lydia I was always aware of a conflict between us, which in the end was brought to the surface and discussed. This was a conflict between her view of what was causing her symptoms and mine—a conflict between her narrative and my narrative and thus a conflict of knowledge. She believed that her symptoms were in her words "medical" and had nothing to do with her past, with her history and what had happened in her life. In my view her symptoms were bound with her past and that since all the medical tests had been negative, there seemed little point in repeating them. Our discussions never took us beyond this difference.

Quite often I felt that I was letting Lydia down and that despite my attempts I could not help her in the way she wanted. This feeling of helplessness can be related to the Freudian concept of transference, and I think, to the anxiety generated in a consultation when there is no conclusion, diagnosis or narrative closure. This dynamic persisted throughout our interaction, which subsequently continued for a long time. Eventually it came to an interesting non-resolution, as I will now explain.

Lydia continued to come to see me about once every month. She always complained of the same problems. Recurrent headaches and burning stomach pains that did not respond well to the medication I gave her. She occasionally felt that it had helped her slightly. My probing to uncover any further events in her life that might be relevant, lead her to reveal more difficulties and complications.

As soon as she was sixteen, she married a young Kurdish man and shortly afterwards gave birth to a baby girl. Her family's involvement with the Kurdish nationalist movement meant that she never felt safe from the possibility of arrest and torture by soldiers of the Turkish government. Eventually she and her husband managed to escape from Kurdistan and successfully found asylum in London. Initially they stayed with relatives and eventually found a flat on their own. Lydia felt very happy to be in London. She felt more free here than in her small Kurdish village and a great deal safer. Unfortunately her taste for freedom caused problems between her and her husband. In her view, her husband was a traditional Muslim and wanted her to adopt the roles that he considered appropriate for a Muslim woman. This meant that she was unable to do certain things that she wanted—for example to go swimming on her own, go out with friends in the evenings unaccompanied or smoke cigarettes. Eventually after a great deal of conflict, their marriage broke down. Unfortunately her husband then left England, returned to Kurdistan and without Lydia's consent took their daughter with him. She has never seen her since. She thinks of her constantly and misses her all the time.

Subsequently Lydia married a Lebanese man who works as a cook. She now has another child, a two year-old boy. Lydia is very attached to her husband and to her son, but similar problems to those of her first marriage have arisen between her and her second partner. She describes her husband as very possessive. He tries to forbid the freedoms that she sees 'other' women enjoying and wants for herself. They argue a lot and she does notice that her headaches and sometimes stomach pains start after their arguments. Her husband now wants to return to Lebanon and to take her and their son with them. Lydia does not want leave England. Recently, her first husband contacted her and is prepared to let their daughter come back to live with her in London. However her second husband is not very supportive of this idea. Her main fear is that if she stays in London, her second husband will leave for Lebanon and kidnap her son. She complained of feeling trapped and angry and never in a position to have what she most wants. The last time we talked, this was to live in London with her two children.

Whenever I tried to make connections between the difficulties of her life and her symptoms, Lydia considered the possibility for a while and then disagreed with me. She usually insisted on more medical tests and sometimes suggested she would go to Lebanon to have them done privately if I was not willing to arrange them for her.

Finally she told me that she did not want to come to see me anymore because the conversations we had upset her too much. This was not the end. Several weeks later, Lydia bought her son to see me. She seemed very proud of him and keen for me to meet him. She told me that he was suffering from headaches and stomach aches. I did not mention how similar his symptoms were to her own. I examined him and could find no evidence of any serious illness. Like his mother he seemed very bright, alert and healthy. I gave him some paracetamol and antacids. Needless to say Lydia returned with him a few weeks later to complain that the medicine had not had much effect and could I give him something else.

Of the many stories I have heard as a general practitioner, Lydia's is one that has made a lasting and powerful impact. It has remained in my memory and I often find myself wondering what has happened to her, if she went to Lebanon or stayed in London and whether she was reunited with her daughter.

The stories patients tell doctors fall into the domain of oral stories, which are different to written stories. Speech is generally more spontaneous and less controlled than written language. It tends to be more haphazard, contains slips of the tongue, hesitation, stutters and is in the context of the consultation is intimately caught up in a dialogue with the doctor. Patient's stories are personal but they are always told within a social context—contexts that relate to family, friends, work and the culture of the patient. In this sense they are also social stories. However they are not told to a public audience and are not intended to be part of a tradition of storytelling that relates to folklore and the passing on of social stories. Nevertheless, it is useful to reflect upon oral storytelling in relation to patient's stories, as there are some similarities.

In his essay 'The Storyteller'[70] Benjamin laments the disappearance of oral storytelling, which he sees as a dying art that has been replaced by the novel. The novel is created in entirely different circumstances to the oral story. As Benjamin puts it, "What differentiates the novel from all other forms of prose literature—the fairy tale, the legend, even the novella—is that it neither comes from an oral tradition or goes into it"[71]. It is dependant on a text, which is written by an isolated author. It also read by an isolated reader. The essence of the oral tradition is that something is handed down from mouth to mouth. For Benjamin this relates to experience:

> The storyteller takes what he knows from experience - his own or that reported by others. And he in turn makes it the experience of those who are listening to his tale[72].

The general practice consultation operates within its own oral tradition and bears some similarities with the idea of an experience being handed down through storytelling.

Patients tell their experiences through their stories and hand these on to the doctor who then ideally makes time to listen carefully. The patient's particular story becomes incorporated into a constellation of other narratives previously heard by the doctor. However the patient's unique story can potentially alter the doctor's perspective on the situation (medical, personal and social) described by the patient. Consequently it may inform the doctor's narrative response, not just to this patient but also to subsequent patients with similar experiences. The doctor's response can often involve interpretation and reshaping of the patients story so that the patient understands their experience through the doctor's experience. An experience and therefore context, which is constantly under review and in a process of change itself. The doctor's experience and knowledge is shaped by the knowledge formed by the many layers of stories told by patients.

Through telling her story Lydia was certainly able to evoke a sense of her experience in me, and I have attempted to evoke this experience to the reader of this text. It is this communicability of experience that in Benjamin's[73] view gives storytelling one of its most useful features. It has counsel which when woven into the fabric of real life is wisdom. In order for it to have this counsel for its readers it should be free from explanation especially a psychological one.

Lydia's story had a powerful and lasting affect upon me. When she first spoke of her experiences in Kurdistan and also of her experiences here, she presented them with very little explanation. She simply recounted the events, in a sequential form as she remembered them. To a certain extent this coincides with how we live. We do not generally explain the things we experience, we simply experience them. However, Lydia's story is selective. It depends upon what she remembered, and from this what she considered relevant to her account. She then placed the important events in a sequential order that bears a relation to cause and effect. She thus created a plot, which gave the story its sense of coherence. Her account was thus intelligible

and understandable but she did not attempt to explain things. Like wise, the storyteller takes the listener through an experience and leaves them to draw their own conclusions.

Benjamin[74] makes the point that to forgo commentary allows the listener to integrate the experiences described in the story, with their own experiences. This implies that it is not simply a matter of absorbing the experience but that there also needs to be some form of exchange between listener and teller, even if this is in the form of an internal exchange or dialogue occurring in the mind of the listener. Stories one hears as a doctor stimulate thinking in which there is an exchange of experience and knowledge, and this in turn can generate new narratives in the form of explanations and commentaries. Under these conditions of minimal explanation, stories have more impact and are more likely to be committed to memory and retold. It is as if the impetus to re-tell stems from a story which is able to generate thinking and knowledge in the listener.

Even though a patient's story is highly individual and personal, it can be seen as if constructed through culturally specific genres of storytelling, which have a communal or social dimension. Narratives are formed by use of a shared language in which we rely on pre-existing structures in order to make them intelligible. When we construct our stories of events, and in this case personal stories of illness, we shape them around plot structures, which are specific for a given culture. The plot, (as previously defined) refers to the way in which the events in a story are structured. The tellers understanding of cause and effect determines how one event follows the next in a temporal sequence.

As previously discussed, post-structuralists such as Brooks and Herrnstein Smith have contested the structuralist idea of being able to identify a plot as a fixed structure within a narrative. Herrnstein Smith[75] claims that there are no original narratives or stories and that all narratives are re-tellings. Any précis of a given narrative is merely another textual inscription and subject to précis itself. In his critique of structuralist attempts to identify a pure structure in narrative, McQuillan takes her observation one step further and argues that "any attempt to extract a narrative, grammar or structure from a given text will merely create a new text"[76]. Thus any reduction to a finite structure will be infinitely evaded.

Similarly for Brooks[77], plots do not have fixed identifiable structures. He refers to the plot as a "structuring operation", which determines the logic of the temporal succession of events. His preliminary definition of plot is that it is "the logic and dynamic of narrative, and narrative itself is a form of understanding and explanation"[78]. When patients present their stories to doctors, the way in which they structure their narratives is determined in part by their subjectivity and as previously mentioned, by such factors as the communal use of pre-existing forms in language, their culture, the context of the dialogue and the inter subjective nature of the exchange with the doctor. If we accept Freud's and Lacan's view (and that of Barthes, De Lauretis and Brooks) of the effect of desire as a movement which runs through and structures a narrative, then desire is always at play in the way in which the patient and the doctor structure their narratives. That is, the desire and hence subjectivity of the patient and the doctor. As described in chapter two, close attention to the patient's speech is important as it provides the doctor (and analyst) with an opportunity to understand how the patient's speech relates to unconscious wishes and the symptom. The doctor's narrative, similarly determined by subjectivity and desire, is important when considering the transference between doctor and patient, typically their own desire for closure and endings as exemplified in making a diagnosis and in their desire for active heroism in reconfiguring their patient's stories in case studies.

Even if the plots are not quantifiable as such, they nevertheless lead to different narrative structures with different outcomes and effects on audiences. Frank identifies four principal plot structures, or as he calls them "narrative types"[79] used by western patients in illness narratives: the restitution, the quest, the chaos and the testimonial. These narrative types are analogous to genre, referred to earlier. He observes that any patient's narrative may involve a mixture of all types. For him the use of identifying these different types is to encourage closer listening to people who are ill. He calls them "listening devices"[80], which help to distinguish different narrative threads in any patient's individual and unique story.

A brief description of these is useful in order to consider if they have any relevance to Lydia's story and my account of her story. The restitution narrative is the predominant type. It is a narrative about being restored from illness to health and tends to involve frequent references to medical care and treatment. It is also reflects dominant narratives within contemporary culture, which regards health as the normal condition. It has interesting parallels with Parsons' sick role (as discussed in

chapter one)—a role in which the sick person is exempt from normal duties but in return is expected to comply with the authority of a recognised professional. The sick role can be regarded as a form of social control where exemption is balanced by obligation. Such role demands of the patient that they eventually recover and return to their normal professional and familial obligations.

Chaos stories reflect how a patient is overwhelmed by their immediate situation, for example if faced with an unexpected diagnosis of cancer, or if living with on-going violence or abuse. In such circumstances they imagir.e life is unlikely to get any better. Their narrative lacks any form of coherence. They are told as the storyteller experiences things, without sequence or recognisable causality. This lack of cohesion makes them difficult to hear and understand. They provoke anxiety in the listener as they reveal vulnerability, hopelessness and a sense of failure. Chaos stories confound our expectation of what a story is supposed to sound like. That is, as one event leading into another in an ordered sequenced and leading to an ending. Chaos stories are in fact anti-narrative. They occur in situations where the patient's immediate situation is overwhelming and they are unable to take any distance, reflect upon their life and transform their situation into a meaningful narrative.

Quest narratives are told by people who are ill. The ill person is the active player and author of their own story. This is distinct from restitution narratives, where the medical remedy or the physician is the active agent. The quest is defined by the ill person's belief that something is to be gained through the experience of ill health. These stories are often published, as for example Oliver Sacks' *A Leg to Stand On*[81]. The account reads as a psychological and philosophical reflection upon Sacks' experience of breaking his leg whilst running from a bull. It tells about his subsequent recovery in the hands of his doctors who were initially ignorant of the fact that he had also sustained serious nerve damage.

Testimonies are stories that require a witness—either a witness to the illness itself or a witness to the story of an illness. They often involve issues which society finds difficult to speak about, such as AIDS, holocaust survival or illness through torture. Testimonies are used as ethical tools in which there is something socially useful for us all in hearing these stories.

By extracting a narrative type or plot from a patient's story, what one creates, as McQuillan suggests, is merely a new text. Frank recognises four distinct narrative types, but theoretically there could be an infinite number of types. Chaos narratives represent one way in which patients tell their stories, but one could identify a variety of other ways in which they do this. A chaotic narrative may reflect something of their current situation but could also be related to whole range of other complex factors, which impinge on their ability to tell a coherent story.

If, as in Frank's categorisation, the abstracted narrative type is given a name, it then starts to function like a finite structure that can be used as a diagnostic category. This may be of clinical use in making the physician aware of something about the patient, but it is also a way objectifying the story and therefore the patient—thereby reducing the patient's story to the level of plot type. It prioritises a subjective position for the doctor and an objective one for the patient, and takes the emphasis away from the inter-subjective nature of the exchange. Being aware of these mechanisms can help to avoid a simplistic reading of the patient's narrative, and maintain an awareness of the affect of the context in which the story is told, and the effect of the interaction between the patient and the physician.

However, according to these distinct narrative types, Lydia's presentation of her story was at times extremely chaotic, especially in the details of her current life situation. When she spoke of the past, especially referring to the events leading to her escape from her country, her story became more fitting of a testimonial narrative, to which she was the witness.

My account of her narrative bears no sense of chaos. I have condensed all the elements of her disparate account into one coherent narrative—a temporal sequence where there is a logic of cause and effect. Within Frank's framework her story as relayed to me in the consultation was both a quest narrative and chaos narrative, but had elements of a restitution narrative in so far as Lydia was looking for a medical cure for her symptoms. My account could be described as a testimonial narrative, in which there is something to be gained for all of us from reading the testimony of Lilah's experience.

If patient's narratives of illness fall into pre-existing plot structures, so do the narratives used by doctors in describing a patient's illness. Typically doctors present their patients stories of illness in the form a case history. These are usually for the

benefit of other doctors or health care professionals. Listening to or reading a case history leads the doctor towards making medical interpretations and diagnosing. The patient's entire narrative is rarely included. They are edited and represented by placing emphasis only on the aspects of the story that are relevant to a medical knowledge. The patient's circumstances are presented as subplots or as supplements to the main medical events. The responses and actions taken by the doctor or other health workers are detailed as well as the patient's medical response to these actions. Case studies tend to be written by psychologists and psychiatrists. Patient's stories are paraphrased by the doctor or psychologist, who place emphasis on the psychological and social aspects of the illness. The medical discourse plays a relatively minor role. Both forms of narrative retellings lead to either medical or psychological and psychiatric interpretations.

As previously discussed, the accounts in case histories and case studies create a binary opposition between the roles of doctors (or psychologists) and patients. The doctor's role is described in active terms. He or she is generally an agent who transforms the narrative of the patient towards a more favourable outcome and often determines the resolution of the symptoms. The patient's role is usually described in quite passive terms; sometimes resistant to the doctor's good and heroic intentions but eventually compliant. They also tend to reinforce the authority of medical and psychological discourses. According to Frank's categories they are restitution narratives.

The heroic position of the doctor is a culturally constructed role, which is portrayed in both official western medical narratives—case studies—in medical television documentary programmes and in television soaps. Typically they tend to reinforce the authority of medical discourse. However fictional accounts of medicine offer an opportunity to be more critical of this role. Lars Von Trier's film 'The Kingdom 1' (1994), is such an example. In this film a 'mystical and spiritual' discourse is used to undermine the traditional authority, knowledge and status of doctors. Lately the stereotypical heroic roles of doctors have been re-configured within television medical soaps. It seems more than coincidental that the change in status of doctors and nurses within these programmes has occurred at a time of change in media portrayal and public perception of doctors. Since the exposure of the crimes of Dr Harold Shipman and the illegal activities of senior paediatricians at Bristol General Hospital, there has been a great deal of disquiet around the professional and personal conduct of doctors. However, there have always been reports of

disreputable doctors and perhaps the disquiet is related to deeper questions about the value of science, the political and economic domination of pharmaceutical companies in medical practice and the potential for co-opting doctors into supporting them through financial incentives.

Older generation soaps such as 'Dr. Finley's Casebook' unequivocally revolved around the upright figure of a doctor as a male mythical hero. In more contemporary soaps, such as 'Casualty' and 'ER', the doctors are still heroes, are male or female but it is characteristic for the authority and power of the doctor to be undermined by a strong-minded patient or nurse. Even so, the doctor tends to be portrayed as sympathetic and willing to learn from his or her mistakes. The latest soaps such as 'Nip/Tuck', 'Holby City' and 'Bodies' go further in undermining the status of the doctor. They are portrayed as both heroes and villains. A sensitive heroic and (usually) junior doctor is either in conflict with an older corrupt and licentious doctor, or covers up for their mistakes in order to protect their own position. The message in these soaps suggests that some, if not many, doctors are corrupt and not to be trusted.

Since the conversations I had with Lydia were not recorded I have been unable to present Lydia's story as she presented it to me or detail the specifics of our dialogue. In my rendition of Lydia's story and our consultation, I have tried to avoid presenting it in the form of a case study by accounting for her symptoms through psychological and medical discourses. These types of explanations would prevent a fuller exploration of the inter-subjective nature of the consultation and the potential meanings created in the exchange. I have pointed out the differences between us without attempting to privilege one position or offer too much rationalisation through medical and psychological discourses. I have attempted to describe the events of Lydia's life as she presented them to me; both in terms of the content and the manner (the emotional factors) in which she presented them. She tended to refer to the past with little emotion but was very upset by her current circumstances. As already mentioned, when discussing her immediate situation, her narrative could at times become extremely chaotic, although less so at other times. The intention of my account is in part to encourage the reader to consider a medical or psychological kind of explanation for Lydia's symptoms as well as leaving it for the reader to make their own conclusions.

Upon reflection, my narrative appears to refer to another narrative—a narrative of western cultures, of which I am a part, a pre-existing plot structure, which I unwittingly use. The whole story has a structure similar to a testimonial narrative in Frank's system, but also has features of a tragic drama. Aristotle[82] described tragic drama as having the ability to evoke strong emotions upon audiences, based upon identification with the hero and consequent pity for his demise. The audience here is both the reader of my account of Lydia's story and myself. As previously stated, Lydia's story had a powerful and lasting affect upon me, perhaps because of identification with Lydia's position and my feelings of pity for her. Lydia is undoubtedly the hero. She has had to overcome many obstacles in order to survive yet her position is far from secure and is fraught with pain and difficulty. Even though she told her story to me in a far more emotional and dramatic fashion to the way in which I have described it, I think her position in the story is one that an audience can identify with, especially a female audience, and certainly one that evokes pity. My position in the story is more akin to that of a fallen hero rather than the usual heroic position reserved for doctors, as I failed to treat her symptoms.

As a doctor, I am never able to interpret a patient's story simply for itself. It is always a story that relates to other stories. There are a large number of Kurdish refugees in the practice where I work, many of whom have similar (but different) stories of escaping from arrest and torture in Kurdistan. Since I work in the East End of London, I have also met many refugees from different parts of the world, who have also fled from oppressive and murderous regimes. Thus I have a mental picture of the plight of refugees, which is built from many layers of different stories. Lydia's story has its own specificity. It is about her family, her village, her relatives and her escape from the threat of violence and more loss. However many refugees are escaping from similar dangerous situations and their feelings and reactions to violence, loss of home and family bear a resemblance to each other.

Lydia's history and the effect it has had on her body, powerfully represents something of the times in which we live. Her body has become symbolic of the situation in Kurdistan, and the plight of Kurdish people and political refugees in general.

When Lydia told her story she was certainly able to evoke a sense of her experience in me. This sense of 'in me' comes not simply from the ability of the patient's words to take the listener through their journey, to stimulate visual perceptions and evoke

thoughts, but also because narratives simultaneously affect the whole body in a physical way. The meaning of the patient's words is related to their ability not only to stimulate thoughts and images but also sensations in the body. When we hear that somebody has died, and in this case somebody was shot and killed, it resonates not only mentally but also in our joints and muscles as well. It is as if our joints and muscles physically shudder in response to such a story. The felt responses to events, stories or narratives such as joy, anger or sadness, what we call emotions, are embedded not just in our minds but also in our bodies.

This therefore implies that the inter-subjective nature of narrative is not only a mental exchange but also a bodily exchange. Our body language changes as we physically respond to narratives, thus adding a visible and embodied dimension to Austin's notion of the performative of speech—when to say something is to do something. In their list detailing the defining features of narrative, Bennet and Royal state that one attribute of narrative is embodiment: "not only do we tell stories, but stories tell us: if stories are everywhere, we are also in stories" [83]. This relation of symbols to bodily feelings makes narrative a powerful factor in directing our actions and it is also perhaps what makes it so difficult for us to change our narratives or our perspective.

When a patient brings their world-view into the consulting room, they do so in the form of personal and culturally specific narratives. Culturally specific narratives included in songs, novels, fairytales, and also cultural narratives of health and medicine. This world-view is not just stored in their minds, in an abstract constellation of thoughts; it is also physically and emotionally embedded in their bodies. It is because of this physical embodiment that it takes more than a rational conversation with a doctor to alter a patient's perspective—if indeed that is necessarily desirable. Hence it is unlikely that Lydia will accept my highly culturally specific narrative with regard to her symptoms and reject her own without my narratives engendering both an intellectual, emotional and physical bodily reaction in her.

The events in Lydia's life had bought her close to death—both the possibility of her own death and the death of her mother and brother. Throughout our conversation it seemed as if this had lent urgency and clarity to her story. It was indisputable. Benjamin states "Death is the sanction of everything that the storyteller can tell. He has borrowed his authority from death"[84]. Death is an ending, a closure and we look

for meaning with endings. The knowledge and wisdom of stories of a lived life first assumes transmissible form at the moment of death. For Benjamin, the authority of the story is claimed at that instant of death where the most important aspects of an individual's life, which are often not spoken about, suddenly appear, like visions. It is at this moment that the significance of their entire life becomes clear. Patients' stories of their symptoms and illnesses often seem to carry the same kind of authority. The incapacity caused by any illness makes us very vulnerable. During episodes of ill health we tend to magnify the significance of our symptoms. They become threatening and raise our worst fears about death. Under such circumstances the more trivial and mundane aspects of our lives are disregarded. Our minds become focused on the things that matter to us most. The clarity and honesty which we bring to the stories of ourselves during illness, especially serious illness, where we speak as if under the threat of death, of an ending that gives meaning, lends them their authority.

A central feature of narrative, which any storyteller depends upon, is its sense of temporality. The conventional expectation of any narrative, held alike by listeners and storytellers, is of a past that leads to a present and sets a place in a foreseeable future. The order, or temporal narrative structure of a story is usually characterised by having a beginning, middle and an end. This gives it a linear structure. With endings we look for and usually find resolutions. Narrative plots lead the reader towards endings, and successful narratives delay endings with subplots—suspending the reader's desire to know, to understand and to have something explained.

In recounting Lydia's story I have unwittingly resorted to using a linear temporal narrative structure, despite realising that she neither presented her story in a linear fashion, or attempted to give it an ending. My account of Lydia's story has beginnings, which are the events that occurred in Kurdistan. It has a middle, which involved her reaction to those events such as getting married and seeking refuge in London. The end involved separating, remarrying, facing choices for the future and finally bringing her son to see me because he had symptoms that were very similar to her own, and equally failed to respond to my treatment. However Lydia told her story to me in fragments and not always in chronological order. Sometimes she provided details, which were in response to my questions, rather than by being spontaneous. Thus her account was not structured in a linear temporal sequence. As I recall it was often told in haste and in a chaotic fashion. Sometimes I had to

summarise and repeat to Lydia what I thought she was trying to say. I attempted to bring what I thought was some logic to her account so that I could understand it, and confirm this with her. I was in effect making links between the events she spoke about and what had caused them. Lydia's real life is not lived according to a narrative structure of cause and effect and she did not always present it with such a structure. Her life and her story continue with no resolution, no ending and no doubt only more difficulties.

Narratives are characterised by the unfolding of the events or actions in time, but not necessarily in real or chronological time. The experience of reading or listening to the succession of events in narratives, gives us a particular knowledge of being with-in-time. This does not mean that narrative is time but it allows us to experience time in a specific way, such that it is not reducible to linear or chronological time. That is, where time is structured into a succession of abstract instances and represented by clocks and numbers. Narrative time, for a doctor speaking with patients, is characterised by a particular kind of focus on the patient's story. With this preoccupation one loses a sense of linear time.

Ricouer[85] distinguishes between two types of attention or 'care'[86]. One kind of attention is to do with pre-occupation. The other kind is circumspection, when we stand back and take the measure of something. In either state, the sense of time has nothing to do with measured time, the time of clocks ticking. In consultations one often has the sense that both doctor and patient loose their sense of time. A consultation can seem to have lasted for a very short period when in fact it has continued for twice as long as it should have. The experience of pre-occupation with a patient's story easily obliterates one's sense of abstract time. Ricoeur makes an interesting proposition in relation to the experience of time through narrative. He states:

> it is because we have to account for or make sense of an experience of being in time that we need to measure; to create something called time." Furthermore things of our concern, (care), precedes temporality. "It is our preoccupation, not the things of our concern, that determines the sense of time[87].

The need to measure this with tools of physics and cosmology is merely an abstraction.

Stories report the past in terms of the present for an audience in the future. The lived time of the past events in the story is condensed and recounted according to another timeframe. This is the narrative time, or the time of recounting the story to the listener. Writing on the temporal sequence of narrative, Metz says:

> The narrative is a [...] doubly temporal sequence [...] the time of the thing told and the time of the telling (the time of the signified and the time of the signifier). This duality not only renders possible all the temporal distortions that are common place in narratives (three years of the hero's life summed up in two sentences of a novel or in a few shots of a "frequentative" montage in film etc.). More basically, it invites us to consider that one of the functions of narrative is to invent one time scheme in terms of another time scheme"[88].

This difference between lived time and narrative time is a typical feature of oral narrative. The difference between being in the time of the story and being in lived present time, perhaps accounts for a certain sense of disorientation one experiences after consultations. It is as if one has lost a sense of time, and then re-orientates oneself into the present time. My recounting of Lydia's story tends to structure the events in a linear sequence. Whilst reading this sequence, the time of the original events is experienced in contrast to the narrative time of the story. The experience of being-in-time whilst reading the narrative thus relates to the disorientation created through the juxtaposition of these two time frames, which is a different experience from that of linear narrative time—for example, the experience of time that the reader has in reading this text.

I want to return now to an earlier point in the essay where I was talking about subjectivity and language and to now discuss how the meanings we as subjects make through our use of language are not stable and depend on an aporetic[89] relation between that which is iterated or spoken and its context.

Language lies within and between people. It is both about who we are as subjects and at the same time it is about exchange between people. Events and things that happen to us are not knowable outside language and those events and things are affected by the fact that language is part of who we are. For post-structuralists, (and psychoanalysts) narrative is intimately related to subjectivity and the formation of the subject. It is also inseparable from inter-subjective experience. Language or

narrative both constitutes the subject and is constituted by the subject. Lacan[90] describes how one is not a subject prior to one's entry into language. At this point one determines - in an inter-subjective way - the use of language to construct who we are. It is inter-subjective because one is also born into " the narrative forming process" - which is already in existence within a communal use of language. Wittgenstein said that " language is an institutionalised being-able to because it is from the beginning the element of a communal form of life ...there is no private language"[91].

Semiotic descriptions of the production of meaning within language[92] suggest that in order to produce meaning any utterance must be both paradigmatic (substitutional), that is the choice or selection of signification must be paradigmatic, and the utterance depends on a syntagmatic (segmental) context to frame meaning. The paradigmatic and the syntagmatic functions, integrate simultaneously to produce meaning. This semantic discussion concerns the difference between use and context of words. Words are used in a grammatical sense to make meaning. Wittgenstein notes that "the location of the word in the grammar is it's meaning—and meaning is dependant upon use"[93]. The ultimate meaning of 'pass me the water' does not become apparent until the context is explained—that is whether the context is in a chemistry lab, gardening, at a meal table or painting a picture. The context is explained though a choice or use of grammar and the two are mutually dependant upon each other in order to produce meaning.

In chapter two I stated that a symptom is a message and a form of bodily representation. How a symptom achieves its meaning is analogous to how an utterance achieves its meaning. Symptoms bear resemblance to utterances in that they have no decipherable meaning outside their context. In the video *Frozen Section*, Lilah, whilst recounting her story of illness, describes experiencing severe pain in her back and legs such that she was unable to walk. The meaning or significance of this symptom is not apparent until we know where she was, what she was doing, why and something about her physical state at the time. The context was that she was working in the Russian embassy, it was her first night at work, she was short of money, she was carrying round heavy plates of caviar and she had not been eating much. In other words she was rushing around lifting heavy plates for new employers whilst she was mentally stressed and physically run down. Whilst carrying the plates she developed symptoms of intense muscle spasm and eventually collapsed. It is not unreasonable to speculate that the symptoms were

related to the context in which they had occurred. When isolated from their context the symptoms do not have any discernable meaning. Her doctors chose to contextualise her symptoms in relation to genetic diseases and low blood sugar levels. Although they could find no scientific evidence, they speculated that the symptoms could be attributed to a genetically inherited enzyme deficiency, which leads to muscle spasm in the context of low blood sugar levels.

The symptom is intimately related to the social context of the mind and the body. When the symptom is thought of as merely a physical perception in the body and separate from its relation to context, an opportunity to understand its complexity is lost. Symptoms and utterances have analogous semiotic dispositions: an utterance and a symptom may be valid or invalid outside context, but the meaning is indeterminate. Equally, contexts are determined by the utterance or the symptom. The context of Lilah in the Russian Embassy carrying heavy plates of caviar is only meaningful in her story when it is understood that this was where her symptoms occurred. The inter-dependence of context and utterance is described by McQuillan when he writes:

> the relationship between the utterance and the context is not one in which either component is privileged. The context provides the utterance with meaning, while the utterance constitutes the context. The context does not have any meaning until the utterance is iterated. [94]

In other words, meaning is made possible through the context and the context only has meaning through the utterance. The relationship between them is aporetic and there is no separation of the paradigmatic narrative utterance from the syntagmatic narrative context.

All utterances can have any number of meanings depending upon the context. Utterances are potentially 'open' to new meanings through use in different contexts. The context has no border as such. The intelligibility of the context is determined by the utterance and is continually open to the possibility of re-narrativisation. In returning to the symptom, by syntagmatically substituting symptom for utterance this suggests that symptoms are able to have any number of meanings depending on context. This can be illustrated by returning to Lydia's and Fatima's stories. Both women complain of headaches, but the context for their headaches and thus the meanings we attach to them are entirely different. Lydia's headaches occur after

arguments with her husband and can (in my view) also be contextualised in relation to her brother's death. Fatima's headaches relate to the casting of spells and the work of spirits: as Margaret Atwood's handmaid declares, "context is all"[95].

In this chapter I have analysed and discussed characteristics of narrative in order to gain an understanding of the function and effects of the narratives used in the doctor-patient relationship. I have reflected upon what constitutes narrative and upon the role of desire operating as a structuring movement within it. Freud has shown the unconscious desire of the speaking subject is implicated in narrative and through its link to the unconscious, so too is the symptom. Detailed attention to the patient's speech therefore enables the doctor to understand the patient's symptoms beyond an understanding considered within paradigms of biomedicine.

I have returned to Lydia's story of illness as discussed in chapter two in order to considered the doctor's and the patient's narratives in relation to the notions of stories, plots, discourses and genres. I have used these concepts to show how the doctor's narrative and interpretation involves not only an immediate response to the patient, but implicates many other narratives in a wider historical and inter-subjective field. Equally the patient's narrative is implicated by their relationship to language within a social, psychological and historical context. I have briefly considered narrative in relation to time, the time of the patient's story and narrative time, to reflect on how narrative affects time in a consultation. Finally I have considered the axis of context and use of utterances in narrative and by analogy, context and use of symptoms in narrative in order to discuss how we make meanings of symptoms.

Notes

[1] Narrative means that which narrates or recounts or that which is occupied or concerned with having the character of narration. (Oxford English Dictionary, Vol X, p 220). Narration means the action of relation or recounting, or the fact of being recounted or an instance of this. It is derived from Latin Gnarare which is related to gnarus, knowing, skilled and is ultimately allied to the verb to Know. Narratology is the branch of knowledge that deals with the structure and function of knowledge (Chambers:1988, p 694).
Story is a narrative which is true or presumed to be true. It relates to important events, and celebrated persons of a more or less remote past. It has a historical relation or anecdote. Story is also defined as a recital of events that have or are alleged to have happened, and a series of events that are or might be related (Oxford English Dictionary, Vol XV1, p 797). It is

derived from the latin historia. This means history, account, tale, story, a methodological narrative of events, and a branch of knowledge dealing with these. It is derived from the Greek historia, which means a learning or knowing by enquiry, history, record or narrative. Historia is from historei, which means inquire, and this is from histor, which means wise man or judge. Its earlier roots are from istor, which is from indo-european wid-tor, meaning root. Weid / woid / wid are related to idein to see and eidenai to know (Chambers: 1988, p1072)

[2] *Chambers Dictionary of Etymology*, Barnhart, R.K. and Steinmetz (Eds.), S. New York: Chambers, 1988, p 694

[3] Chambers: 1988, p1072

[4] Lyotard, J F, *The Postmodern condition: a Report on Knowledge*, translated by Geoffrey Bennington and Brian Massumi. Manchester: Manchester University Press, 1984, p23

[5] Culler, J, 'Story and Discourse in the Analysis of Narrative,' in
Culler J, *The Pursuit of Signs: Semiotics, Literature, Deconstruction.* London: Routledge, 1981, p169

[6] Ibid., p169

[7] Ibid., 1981, p 178

[8] Benveniste: 1971, pp206-210

[9] By Utterance I am referring to what Herrnstein Smith calls natural discourse which she describes as "all trivial or sublime, ill-wrought or eloquent, true or false, scientific or passionate verbal acts of real persons on particular occasions in response to particular sets of circumstances" (Herrnstein Smith: 1978, p15).

[10] Ibid., p206

[11] Ibid., p 208

[12] Benveniste points out that in French, the perfect tense is used in both *histoire* and discourse. (Benveniste: 1971, p209).

[13] Ibid., p209

[14] Herrnstein Smith, B, 'Narrative Versions, Narrative Theories', in *Critical Inquiry*, 7, 1980, pp 209-18

[15] Barthes, R, 'Introduction to the Structural Analysis of Narratives' in *Image- Music -Text*, translated and edited by Stephen Heath, London: Fontana Press, 1977, pp 86-87 and 122-23

[1616] Ibid., p122

[17] Benveniste: 1971, pp101-111

[18] By paradigm I am referring to a set from which lexical items—items in a list of similar terms of vocabulary—are selected and then combined to form a syntagm. Barthes demonstrates how items are selected from a paradigmatic menu to form a syntagmatic meal. "A restaurant menu actualizes both planes: the horizontal reading of the entrees for instance corresponds to the system (*or paradigm*), the vertical reading of the menu corresponds to

the syntagm". Paradigms work metaphorically and syntagms metonymically (Barthes 1967, pp58-63).

[19] Barthes, R,' Textual Analysis: Poe's "Valdemar"', In R.Young Ed. *Untying the Text: A Post-structuralist Reader*, London: Routledge 1981, p178

[20] Ibid., p179

[21] McQuillan, M, *The Narrative Reader*, London and New York: Routledge, 2000, p323

[22] Herrnstein Smith: 1980, p 211

[23] Ibid., p217

[24] See chapter one for elaboration of what is meant by roles and rituals.

[25] Bell, C, *Ritual, Perspectives and Dimensions*, New York: Oxford University Press, 1997, p70

[26] Barthes: 1977, p79

[27] Text, reader and writer all refer to texts in whatever medium us being discussed. Privileging of the written word (graphocentrism) is not intended.)

[28] Gledhill, C, 'Genre'. In Pam Cook (Ed.): *The Cinema Book*, London: British Film Institute, 1985, p60

[29] Neale, S, *Genre*, London: British Film Institute 1980, p22-3

[30] Miller, Carolyn R, 'Genre as Social Action,' in *Quarterly Journal of Speech* Vol 70 (2) 1984, pp 151

[31] Ibid., p151

[32] Fowler, A, 'Genre', in Erik Barnouw (Ed.): *International Encyclopedia of Communications*, Vol. 2. New York: Oxford University Press, 1989 pp216

[33] Kress, G, *Communication and Culture: An Introduction*. Kensington, NSW: New South Wales University Press, 1988, p 183

[34] Fiske, J, *Television Culture*. London: Routledge, 1987, p115

[35] Derrida, J, 'The law of genre', in W J T Mitchell (Ed), *On Narrative*. Chicago: University of Chicago Press, 1981,p61

[36] Atwood, M, *The Handmaids Tale*, London: Virago, 1987, p49

[37] De Lauretis, T, *Alice Doesn't: Feminism, Semiotics, Cinema,* Bloomington: Indiana University Press, 1984, p125

[38] Freud S, *Jenson's 'Gravida' and Other Works,* SE Vol 1X, translated by James Stratchey. London: Vintage, 2001 SE Vol 1X, pp 142-153

[39] Freud describes phantasy as an adult form of play, manifested in the mental activity of daydreams. However daydreams tend to harbour shameful wishes. Creative writing is the form to which an artist turns in order to disguise the wishes of daydreams and transform them into as a source of identification and cathartic release or pleasure for the reader or listener. For Freud phantasy is thus a source for the activity of creative writing (Freud: 2001, SE Vol 1X pp143-53). A critique of Freud's positioning of the phantasies of the author in creative writing can be found in Peter Brooks essay 'The Idea of Psychoanalytic Criticism.' (Brooks: 1994, pp 27-29). He describes Freud's error in suggesting that a connection exists

between the life of the author and his works since the past evoked in the construction of phantasy is not necessarily that of the author.

[40] Freud: 2001, SE Vol 1X, p147

[41] De Lauretis: 1984, p129

[42] Speech here refers to Freud's inclusive use of the word. "Speech must be understood not merely to mean the expression of thought in words but to include the speech of gesture and every other method, such as, for instance, writing, by which mental activity can be expressed" (Freud: 2001, SE Vol XV111).

[43] See Freud: 2001 SE Vol V11, pp192-93.

[44] Barthes: 1977, pp124

[45] Brooks, P, *Reading for the Plot: Design and Intention in Narrative*, Oxford: Clarendon Press, 1984, p9-10

[46] Barthes: 1977, p124

[47] Bell p6

[48] Freud suggests that the mythical structures are based on Darwin's hypothesis of a primal horde, to which he brings the dimension of an oedipal struggle. The theme runs as follows: the horde is dominated by a jealous and possessive father, who drives his sons away and forbids them sexual access to a group of females to whom only he has access. Eventually the sons rebel, join forces and return to slay and eat the father. They were then filled with shame and remorse over their actions. Although they feared and envied him they also respected him. Consequently they renounced their claim on the females they had originally desired, (who were set free) and forbade the killing of the totem—the father substitute. According to Freud we still carry the archaic remnants of this criminal deed and the attached shame (Freud: 2001, *Totem and Taboo,* pp 164-170).

[49] Levi-Strauss, C, Structural Anthropology, translated by C.Jacobson and B.G.Schoepf: London: Allen Lane, 1967, p211

[50] Freud S, SE Vol 1X 142-153

[51] Ibid., p 152

[52] Lacan: 1998, pp xxv-xxvi

[53] Lacan: 1977, p 73

[54] Ibid., p74

[55] De Lauretis: 1984, p112

[56] De Lauretis: 1984, pp125-131

[57] De Lauretis refers to three works by Propp. 1) Vladimir Propp, *Morphology of the Folktale*, 2nd edition revised and edited by Louis A. Wagner. Austin and London: University of Texas Press, 1968. 2) An essay entitled 'Oedipus in the light of folklore', first published in Russian in 1944 and translated into Italian in 1975: *Edipo alla luce del folklore,* ed. Clara strada Janovic, Turin: Einoudi,1975, pp85-78. De Lauretis quotes in translation from the Italian version. 3) *Istoricheskie korni volshebnoi shazki* (The Historical Roots of the Fairy Tale) Leningrad, 1946, quotes translated from Russian.

[58] FN Jurij M. Lotman, 'The Origin of Plot in the Light of Typology,' translated by Julian Graffy, *Poetics Today* 1, no. 1-2 (Autumn 1979): 161-84; originally published in 1973

[59] Lacan: 1977, p184

[60] Ibid., p64

[61] Ibid., p94

[62] Here I am referring to Lacan's two notions of otherness: o(ther) and O(ther) - *a*(autre) and *A*(autre), *a* belongs to the order of the imaginary. It tends to refer to an other that is not truly other but a projection or an effect of the ego. It originates in the mirror-phase around the age of three when the infant misrecognises and identifies with its specular image in the mirror. *A* or the big Other refers to the Symbolic Order. This is the order of speech and language and is inassimilable to the subject, but into which he must be inserted or inscribed if he is to be able to speak and exist as a human being. Speech according to Lacan does not originate in the subject or the ego (in the conscious) but in the Other; speech is outside the subject's control, and thus ' the unconscious is the discourse of the Other' (Macey: 2000, p 286)

[63] Ibid., p141

[64] Atwood: 1987, p50

[65] McQuillan: 2000, p17

[66] McQuillan: 2000, p17

[67] Lacan: 1977, p94

[68] Ibid., p94

[69] McQuillan : 2000, p17-19

[70] Benjamin W, 'The Storyteller' in *Illuminations: Essays and Reflections,* translated by Harry Zohn, New York: Schocken Books, 1968, pp83-109

[71] Ibid : p87

[72] Ibid., p84

[73] Ibid., p86

[74] Ibid., p91

[75] Herrnstein Smith: 1980, p217

[76] McQuillan: 2000, p5

[77] Brooks: 1984, p10

[78] Ibid., p10

[79]Frank AW, *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: Chicago University Press, 1995, p75-76

[80] Ibid., p75

[81] Sacks O, *A Leg to Stand On,* London: Picador, 1991

[82] Aristotle, *Poetics*, translated by Malcolm Heath. London: Penguin, 1996, p10

[83] Bennett, A, Royle N, *An Introduction to Literature, Criticism and Theory*, 2nd Edition, London: Prentice Hall Europe, 1999, p52

[84] Benjamin: 1968, p93

[85] Ricoeur. P, 'Narrative Time', in Martin McQuillan, *The Narrative Reader,* London and New York: Routledge, 2000, p258

[86] In his text Ricouer uses Heidegger's notion of care, which he relates to 'things of our concern'. Concern here refers to preoccupation or circumspection. Concern involves time of labour, time to do things, and time of days, where a day is not an abstract measure, it is a magnitude that corresponds to out concern. Concern, preoccupation or circumspection is thus of a temporal nature

[87] Ibid., p258

[88] Metz C, *Film Language: A Semiotics of the Cinema, translated by Michael Taylor.* London: Oxford University Press, 1974, p18

[89] An aporia is a word used in Greek philosophy to describe the perplexity induced by a group of statements that are individually plausible, but are inconsistent when taken together. They cannot be reduced to a play of binary oppositions. In rhetorical analysis it is a rhetorical figure of doubt in which the conditions of possibility of an event or concept are paradoxically, its own conditions of impossibility resulting in an interpretative impasse or moment of undecideability. Given such a contradiction, an impossible resolution can be reached by working the aporia through in the text (Macey: 2000, p18 and McQuillan: 2000, p315).

[90] Lacan: 1977, p72-74

[91] Wittgenstein L, 'Philosophical Investigations', trans. G.E.M. Anscome, (Oxford: Blackwell, 1968, p243) cited in McQuillan: 2000, p8

[92] Benveniste, E, *Problems in General Linguistics,* translated by Mary Meek. Florida: University of Miami Press, 1971, pp101-104, Barthes: 1977, p122)

[93] Wittgenstein L, 'Philosophical Grammar (Part 111)' in *The Essential Wittgenstein*, ed. Gerd Brand, translated by Richard Innis. Oxford: Blackwell, 1979, p23

[94] McQuillan: 2000, p11

[95] Atwood: 1987, p154

CONCLUSION

My theoretical and practical research centred around three questions relating to the doctor-patient relationship. Each Chapter of the thesis considers these questions in detail.

Within my art practice I used these questions as a starting point for the development of art works. These works in turn set up and create new questions in relation to art practice and the nature of medical practice. They have also prepared the ground for the development future artworks

My first question was to ask what aspects of the communication between the doctor and the patient operated visually, and what occurred in this type of communication. This led me to analyse the activities in the health clinic in the context of ritual and performance. Although not exclusively visual media, they both rely on visual communication to achieve their effects.

Secondly, I was interested in thinking about the symptoms of the patient beyond the parameters of biomedicine. By considering the symptom as a form of bodily representation, I wanted to think about the messages of symptoms. Given that most symptoms do not speak, but are felt as sensations in the body, how can we understand their messages? To answer these questions I used psychoanalytic theory and narrative theory to reflect upon the enigmas and complexities of symptoms presented to me during some of my consultations with patients.

Finally I investigated how speech operates within a consultation and questioned its affect upon the outcome of a consultation. I considered the speech between the doctor and patient in relation to narrative theory and semiotics, rhetorical analysis and literary theory.

In chapter one the rituals of the clinic are described and analysed as the patient moves within its different spaces. When a person walks into a health clinic they become a patient through a set of actions and utterances, which can be thought of as ritual or ritualized behaviour. Subsequent ritualized actions by the patient in the waiting room, further establishes their role as a patient. The act of waiting itself, although in some senses subordinates the patient to the working practices of the

clinic, nevertheless enables the patient to rehearse the story they will tell to the doctor in the consultation. Foucault's analysis of power indicates how he views the production of ritualized bodies (or in the case of the clinic, patients, doctors and other health workers) as a strategy for the construction of particular relationships of power effective in certain social situations. My discussion shows that rituals in the clinic create order and establish conventions. They serve to both empower and disempower the patient whose position, once in the consulting room, is transformed into one that has features of liminality. In such a state, although vulnerable, the patient is also protected and cared for by the doctor and other health care workers who take the patient through 'clinical' rituals. The effect of these rituals in the consultation room is to create physical and emotional boundaries between the doctor and patient, which make it safe for either party to perform their roles. The function of the roles is about effecting transformations—psychological, emotional, biomedical—in the patient. The psychological and physical boundaries between the doctor and the patient are constantly under threat as their behaviour changes from that which is formal and ritualised to that which is informal and less ritualised. This movement brings anxiety and tension into the relationship, which if recognised by the doctor, can be used therapeutically. Drawing on the work of Grimes, I discuss how illness itself is a type of ritualised behaviour. I compare this with the concept of the sick role as described by Parsons, where the sick role operates as a mechanism of social control.

The research has enabled me to reflect on the extent and effects of the performative and ritualistic aspects of the behaviour of the patient, doctor and other health care workers in the clinic. This research inspired me to make several artworks that emphasise the rituals of clinical procedures (see figures 1 to 3, pp120-22). I made works about the clinical examination of a patient, immunisation of babies, and surgeons scrubbing prior to operations. One of these works, entitled *Scrub*, a four-minute video loop, depicts a surgeon scrubbing their hands in a white porcelain hospital sink. The cleaning fluid contains iodine, which lends it a darkish red colour, suggestive of blood as well as liquid soap. As the scrubbing progresses it becomes progressively more vigorous and overly thorough. The noise of the scrubbing brushes on the surgeon's hands and arms make the procedure appear painful as if the surgeon starts to scruoff layers of skin. The piece transforms the surgical scrub from a simple technical procedure into a scenario where the surgeon appears to be indulging in an obsessive ritual of hand washing with undertones of self-harm

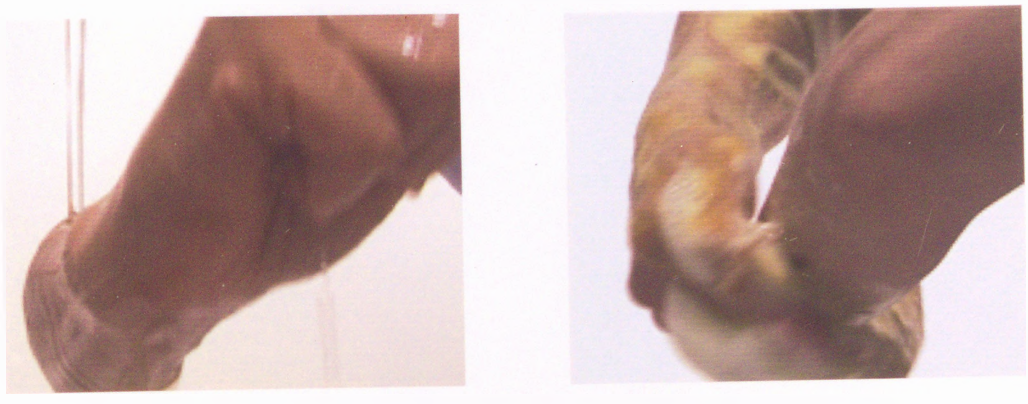

Figure 1: **Scrub** | 2003 | 4 minutes | video loop

Figure 2: **Mr.Gray** | 2003 | colour print 30 x 40 inches

Figure 3: **I Know** | 2003 | colour print 30 x 40 inches

I will develop some of these ideas in future art projects where I will continue investigating the ritual of the doctor's examination of the patient's body and the ritual of storytelling between the doctor and patient in the consulting room.

In chapter two I enquire into the nature of the symptom. Symptoms are enigmatic, and as Scarry suggests, one of their defining features is their resistance to language. Despite this, we understand them through the ways in which patients speak about them.

Using the details of consultations with patients, I was able to reflect on the symptom as it is presented by the patient in general practice. Patients present their symptoms in the form of stories, which offer a context in which the symptom can be understood. By contrast, in psychoanalysis, attention is paid to the detail of the patient's speech—to the gaps, silences, slips of the tongue, inaccuracies of their descriptions of events and to their symptoms, in order to reveal the nature of unconscious repressed wishes. The symptoms discussed in psychoanalysis have a psychogenic origin. I have used the stories of symptoms described by patients in general practice to show how some symptoms although related to organic pathological changes in the body, also exhibit psychogenic properties. This leads me to question the distinction of the meanings attributed to symptoms described as neurotic—of a psychogenic origin—and those considered as relating solely to organic disease.

In both general practice and psychoanalytic practice, communication involves an exchange, which is verbal and visual. The visual involves rituals and an exchange of body language. However, what is often overlooked is the way in which the verbal exchange leads to an additional form of visual exchange—described by Gardner as 'confluent image making'. This entails exchanges of information about the doctor's and patient's visual perceptions which are stimulated initially through the patient's stories. This form of exchange, which is related to the process of free association in analysis, improves the efficiency of verbal communication and enriches the understanding of the patient's speech. The process of transference is crucial to the psychoanalytic method. Through a consideration of one patient's story of illness and the many consultations that took place between us, I have reflected upon how transference operates in the doctor-patient relationship. When recognised within the

consultation, transference is a potentially important tool, which enables further understanding of the patient and their symptoms.

In chapter three I discuss how the patient brings their world into the doctor's world through their stories. The patient's stories are also narratives, relating to knowledge, and thus in the consultation doctor and patient exchange knowledge in order to shed light on the meaning of the patient's symptoms. Narrative theory reveals that the doctor's narrative interpretation of the patient's speech is informed and related to many other narratives in a discursive field relating to experience, medical discourse, psychological and sociological discourse, narratives used in medical training and the narratives of previous consultations.

Interpretation can involve making a diagnosis and reduction of the symptom to definitive meanings. Interpretation brings closure to a narrative. Making a diagnosis is not a necessary outcome of a consultation—narratives can be left open ended. The anxiety of the absence of closure may have therapeutic significance.

Patients and doctors construct their stories with a plot structure and temporal sequence. The temporal structure creates a movement, which drives the narrative and is analogous to the psychic structure of desire. All narratives are animated with this movement, which ultimately relates to plot structures within myths and according to Freud, Levi Strauss and Lacan, to rituals and taboos against incest and patricide.

Teresa De Lauretis has argued that as a result of the effect of kinship rules on language, we construct stories according to a binary opposition between male and female, where the listener or reader identifies with the desire of a mythical male hero, who overcomes obstacles—obstacles that have attributes typically ascribed to females.

I have used these arguments in my analysis of case studies to show how they tend to place the doctor or analyst in a heroic role with whom the medical audience identifies. They also reinforce dominant medical or psychoanalytical discourses. Through a consideration of how I constructed my own narrative of patient's stories of illness, I take a critical view on how I situated myself in those stories and identify to what extent I disregard the patients discourse—a personal discourse with a story that embodies the patient's experience of illness—in favour of dominant medical

discourses which may negate the patients experience. Narrative theory offers an opportunity for the doctor to understand why it is important that the patient's discourse remains central in the consultation and how knowledge, as an exchange of narrative, is gained through an exchange of the narrative between the doctor and patient. Another important consideration, understood through narrative theory, is how the meaning of a symptom described in the patient's story can be understood in the same way as an utterance in narrative, that is, through its use and context. In general practice, insights into the messages of symptoms, must involve reference to their contexts.

The three screen video installation, Frozen Section, was made in order to investigate the nature of stories told about an illness in a consultation between a doctor and patient, through art practice. The video exploits the distinctions between art practice and documentary film practice. It has features of both and cannot be strictly defined as purely one or the other. All those participating in the video were aware that they were performing their roles as either interviewee or interviewer for an artwork that would eventually be screened in an art gallery. Despite the performative nature of their roles they were also participating in a real consultation as either a patient, a doctor or an involved family member. They were thus performing for a documentary/art work and an unknown future audience and participating in a real situation. The outcome of the interviews had real and significant meanings for those involved. A significance that was separate to the experience of for example the audience experiencing the final artwork in a gallery. However the participants consciously performed their real and documentary roles for an audience. The video footage was edited for presentation as a three-screen installation within a carpeted room. A format more associated with video-art practice rather than with documentary film.

The filmmaking in Frozen Section draws upon the techniques of documentary practices such as the talking head interview and evidentiary editing.

The body is the primary referent of documentary. Bill Nichols makes an analogy between the necessity of the body in both the juridical process and documentary film. He notes that without the body, demanded in law by the writ of habeas corpus[1], "the legal process comes to stand still"[2]. Likewise, without the body "the documentary tradition lacks its primary referent, the real social actor(s) of whose historical engagement it speaks"[3]. In both law and documentary film the body is

present to bear witness and give testimony about events, or in other words to give evidence about events.

Different modes[4] of documentary film practice – for example, observational, reflexive performative represent evidence according to how they wish to address an audience and whether they wish to reveal the presence of the filmmaker and filmic apparatus. What is characteristic of documentary is the use of "the evidential" in order to deliver a point of view.

The evidential is not simply about representing evidence but also relates to epistemology, narrative construction, points of view and interpretation. This idea is discussed by Carlo Ginzberg who describes the emergence of an epistemological model in the nineteenth century which he calls an 'evidential paradigm'[5]. In this epistemological model, observations, statements, and often seemingly insignificant details about an individual are collated in order to make conjectural statements about that individual. Unlike empirical scientific data, these observations are qualitative rather than quantitative and the knowledge conjectural rather than empirical. The evidential mode is used in documentary practices and lends documentary an 'evidentiary' aesthetic: typically juxtapositions of selected interviews and images. These material representations accrue throughout the film to reveal evidence about those individuals and events. How the material is selected and edited together gives the film its subjective turn. Nichols describes how "evidentiary editing organizes cuts within a scene to present the impression of a single, convincing argument supported by a logic"[6]. Furthermore he notes that the evidentiary function of editing "not only furthers our involvement in the unfolding of the film but supports the kinds of claims or assertions the film makes about our world"[7]. The argument or perspective of the film is embedded in these representations. The perspective is implicit and also depends on interpretation by the viewer.

In Frozen Section different stories about one person's illness are told by three members of the same family and by the patient's physician. I interviewed Lilah, who is the daughter and the person with the illness, at her home in New York. The idea was to visit her as a general practitioner carrying out a home visit and to record our interview so that it could be used in an artwork. Subsequently I interviewed Lilah's mother, Cynthia and her father Stephen in their respective apartments and her hospital physician, Dr. Keegan to discuss their views about Lilah's symptoms. The

installation consists of three separate monitors each facing the viewer. On the central screen there is a continuous shot of the inside of Lilah's apartment. She is not seen and is represented entirely through her disembodied voice. Her father and mother are depicted as 'talking heads' on the right and left hand screens respectively. The doctor, also represented as a talking head, is introduced intermittently, faded in and out to replace the image of Stephen.

The narratives of each interview were broken down into fragments, and selected fragments were interlaced to produce a linear narrative. These fragments of speech operate as evidence for the events described and also provide details about each persons ideas and beliefs. They are the elements of an evidential paradigm which provides qualitative knowledge about Lilah's illness and life. The perspective or point of view of the film is revealed through the constructed narrative. The perspective is determined by which fragments of speech or "evidence" I have chosen from the original footage and by how the fragments of speech are edited together.

Apart from Lilah each person in the narrative is represented as a talking head, interviewed by the filmmaker (myself) who is off camera. Although my voice is included it has been substantially edited out. I mainly prompt and ask questions but sometimes my reflections and responses are included. Thus my role in the film is participatory and the film itself can be situated within the participatory mode[8]. Furthermore my role in the film is about investigation rather than interpretation since I mainly ask questions rather than provide medical or psychological opinions about Lilah's symptoms.

Since all those participating in the video were aware that they were performing their roles as either interviewee or interviewer for an artwork that would eventually be screened in an art gallery, they were simultaneously performing for a real event and a documentary or artwork. Thus the video falls within the domain of both a participatory mode and a performative mode of documentary production.

The narrative is constructed as if each person was speaking in the same room. However since they were all talking to me at different times and in different places, it becomes clear that they are not speaking directly to each other, even though the fragments are selected to form a coherent and sensible dialogue. In constructing the narrative sequence, attention was paid to building suspense. Narrative closure,

such as providing a medical diagnosis or a psychological interpretation was denied, thus suspending the viewers desire to know. Each person speaks in turn, but beneath their speech the faint noise of the preceding persons voice is heard imperceptibly in the background. This auditory device makes reference to my experience in general practice. When speaking to a patient one also recollects other narratives in relation to the patient. These narratives may belong to another family member seen previously, another doctor with whom one might have discussed the patient, another patient with similar symptoms, or even the voice of the patient remembered from a previous consultation.

The video reflects upon how one patient's story of illness also involves other people's stories. The narrative does not conclude with an answer, it provides endless clues and potential meanings according to who is speaking, but no definitive interpretation. It gives the viewer extensive knowledge about Lilah's illness and allows them to draw their own conclusions. The knowledge accrued leaves the viewer with an understanding of Lilah and her symptoms, yet this knowledge cannot be reduced to a concluding diagnosis. The video creates a dynamic between that which is known and that which is not known. The knowledge that the viewer is presented with cannot be assimilated within a body of knowledge. There is a kernel of unassimilated knowledge which remains unknown. Like Lilah who remains unseen and off frame, this knowledge cannot be framed. The video suggests that not knowing, or that which cannot be known, is a form of knowledge.

Frozen section exploits the problematical distinction between objective documentary form and subjective fictional form of filmmaking, in order to reflect upon an analogously problematical distinction at work within the doctor—patient consultation. Within the consultation interpretation of the patient's complaint according to objective scientific knowledge is continually disrupted by the subjective knowledge of both patient and doctor. The video questions the objective claims of both the documentary form and of scientific knowledge.

The research and analysis has bought new insights into my understanding of the patient, their symptoms and the doctor-patient relationship. It has allowed me to disengage from my role as a doctor and to reflect upon medical practice using philosophical, psychoanalytical and narrative perspectives. Importantly it has allowed me to bring the non-reductive and less systemised reflections of art practice into an analysis of medicine and general practice. It has provided me with many rich

and interesting ideas and lines of enquiry to follow in future theoretical and practical research.

I have produced a variety of artworks using photography and video, which have evolved from the research and its questions. The practical research has allowed me to understand how I can overcome the problem of bringing critical use of art practice to a discipline—medicine—whose visual metaphors are already over-determined. The skills and methods learnt from these works will allow me to think about and develop future works in which I will continue to investigate the unspoken and hidden aspects of medical practice.

Notes

[1] In English: '*you should have the body*'.

[2] Nichols, B, History, Myth and Narrative in Documentary in *Image, Reality Spectator: Essays on Documentary film and television*, Willem De Greef and Willem Hesling (Eds.). Leuven and Amersfoot, Belgium: Acco, 1989, p167

[3] Ibid., p167

[4] see Nichols, B, *Introduction to Documentary*, Bloomington and Indianapolis: Indiana University Press, 2001 pp109 -138

[5] Ginzberg,C, 'Clues: Roots of an Evidential Paradigm' in *Myths, Emblems, Clues,* translated by John and Anne C. Tedeschi. London, Sydney, Auckland, Johannesberg: Hutchinson Radius, 1990, p106

[6] Nichols, B 2001 p 30

[7] Ibid., p30

[8] Documentary films have been categorised according to at least seven modes (Nichols: 2001 p138). There is often overlap between modes and new modes continue to evolve from existing forms. The performative mode is considered to be an openly subjective form of documentary where those in the film, sometimes including the filmmaker, re-enact events or situations for the documentary.

APPENDIX: INTRODUCTION TO *FROZEN SECTION*: A Video Installation by Vanda Playford, 2004

Frozen Section is a three screen video installation, which can be shown on three separate monitors or projection screens (see figures 4 and 5, pp 131-32). It can also be shown on a single monitor or projection screen where the screen is divided into three sections. It has a running time of thirty-five minutes. Although the viewer can leave at any time, my intentions for the artwork can only be understood by watching the installation from beginning to end.

Frozen Section is an artwork, which draws on the conventions of documentary film-making: for example I adopt the convention of the 'talking head'. Its status as an artwork is constantly unsettled by features that sustain it as a documentary. Likewise, its status as a documentary is questioned and destabilised by features that sustain it as an artwork. The story told in *Frozen Section* is that of one person's illness. The way in which it is told raises a question about knowledge by suggesting that not knowing is also a form of knowledge. These concerns will be discussed in more depth later in this essay.

Represented in the installation is a family of three – a mother, Cynthia, a father, Stephen, their daughter Lilah, – and a medical doctor. Each person talks in turn about Lilah's illness. Each family member is represented on a different screen: Stephen is seen on the right-hand screen, which partially reveals the inside of his apartment. Likewise, Cynthia is seen on the left hand screen, sitting on the sofa in her sitting room whilst talking and facing the camera. Lilah is represented on the middle screen. Rather than seeing her image, the viewer sees a continuous shot of the interior of her apartment and hears her disembodied voice. The doctor appears on the right hand screen, occasionally fading in and out to replace the image of Stephen. He is seen in his office, talking to me and facing the camera.. Throughout the recordings I was situated off frame next to the camera, so that the viewer hears my voice but does not see me.

The voices are synchronized except for those of Lilah and myself, since we never appear on screen. The narratives of those interviewed are fragmented and the

Figure 4: **Frozen Section** | 2004 | 35minutes | 3 screen video installation

Figure 5: **Frozen Section** | 2004 | 35 minutes | 3 screen video installation

fragments interlaced together so that the subjects appear to be talking in turn to me and to each other, as if in the same room. Although the four subjects are rarely shown speaking simultaneously, running beneath each person's speech, is the faint sound of the preceding person's speech, which is never loud enough to be deciphered.

Throughout *Frozen Section* the middle screen depicting the inside of Lilah's apartment, remains permanently in view. In contrast the right and left hand screens continually fade in and out according to cues in the narrative. This movement reinforces the content and structure of the narrative (See figure 6, p134).

Frozen Section was shown as an installation at the Royal College of Art summer show in June 2004. The monitors used were the size of an average domestic television and stood on low plinths, at the approximate viewing height of a seated audience. They were placed close to each other facing the audience so that the inter-activity across the screens could easily be seen. The room was carpeted with charcoal grey carpets and the same carpet covered the plinths and walls. The carpets not only served to reduce sound reflection but to create an atmosphere of domesticity reminiscent of a home visit and of the familiar experience of watching television.

Four speakers placed in the top corners of the room were used to create a surround sound effect. Stephen's voice was heard through the right hand speakers, Lilah's through the right and left speakers at the front and Cynthia's through the left hand speakers. Amplifiers and DVD players were hidden in the plinths.

Methodology

When considering how I was going to make this work I had the following requirements:

1. To make a video about the consultation between a doctor and a patient that was primarily concerned with the narratives of the consultation.
2. To record the video in a situation where the doctor and patient were as uninhibited as possible by the presence of a recording device or camera. This would

Figure 6: Digital stills of changes of images seen across monitor screens during running of **Frozen Section**

enable the conversation between us to be spontaneous and thus resemble the open-ness of conversations with patients during 'real' consultations.
3. To obtain the patient's agreement that the consultation be recorded and that the recording would be available to be used for the development of an artwork that could be shown in art galleries.

In order to create this situation I decided to use myself in my role as a doctor and to invite volunteers with symptoms to consult with me as if they were real patients. I wanted the discussion or consultation to take place in the patient's home, as if the doctor was carrying out a home visit. I also wanted the patient to have no prior knowledge or experience of a National Health Service (NHS) style consultation or home visit, in order to avoid the possibility of both patient and doctor using the stereotyped codes of language and gesture of NHS consultations. For medico-legal reasons it was important that I was not the patient's usual doctor.

Foxy Productions, a gallery based in New York, invited me to develop the project in New York with their assistance and support. This was an ideal proposition because I would be able to find English-speaking patients, with no knowledge of the NHS and I would not be their regular doctor.

I accepted the invitation to use the Foxy Productions gallery for one evening where gallerists were invited to attend a soiree. During the evening I showed some of my previous photographic and video-works, introduced the project and invited those present who had an illness or symptoms, to participate in the project. They were asked if they would like to discuss their health problems with me in my role as a doctor in the context of an NHS style home visit. In exchange for this "free" service they had to agree to the event being recorded on video for the development of an artwork. The evening attracted interest from six people and I was subsequently contacted by a further six people who had heard from friends about the project and who wanted to participate in it. I carried out home visits to twelve people in total during the following ten days. I recorded my journey to each person's home, which often entailed walking through the New York subway system, as well as outdoors in the streets. At each visit the volunteer, now in their role as patient, discussed with me their health problems. The discussions were recorded such that the camera faced away from them, merely recording a continuous shot of the inside of their home, whilst the microphone recorded our conversation. I returned to London with twelve interviews.

After listening and watching the recordings, I was able to make the next decision about transforming the journeys and interviews into an artwork concerned with the narratives of a doctor-patient consultation. My original idea was to make a multi-screen installation using fragments from all the interviews, in which the narratives interweave with each other. This piece would also incorporate the video footage of the journeys to each person's home. However, upon hearing the interview with Lilah, I decided that I wanted to use only her story. I felt that by focusing on one interview I would be able to explore the complexities of my subject matter more effectively. Lilah's story contained the elements that I was most interested to consider, namely the relation between the body, symptoms, speech and family dynamics. It was also a complex and medically challenging story. Many factors impinged upon Lilah's illness and there was no obvious resolution or conclusion concerning the cause of the disease or indeed it's diagnosis. Although the multi-screen piece would be of interest in exploring the relationship between the body, symptoms, speech and the city, I thought it would be less effective in considering the psychological aspects of symptoms. This is because I would develop the narrative in the multi-screen piece according to the issues connecting the twelve individuals together. This would be about their symptoms and the daily struggles and routines of living and working in New York City, rather than about their symptoms and the personal and psychological issues within the family.

When telling her story Lilah frequently mentioned members of her family and the doctors who had treated her. I thought it would be interesting to interview them about her illness and to incorporate their story into Lilah's story as it would provide a way of replicating my experience as a doctor in general practice. In consultations one often hears different perspectives about an illness and its related social factors, from a variety of people. The different perspectives affect the way in which a general practitioner understands a patient's symptoms[1].

Lilah's family agreed to the interviews and I therefore returned to New York City a year later to make the recordings at their respective homes. I also sought permission from Lilah's doctor to interview him about her illness. During the interviews of Lilah's parents I had hoped that our conversations would digress towards discussing their own lives and health problems, which might be relevant to Lilah's symptoms. Lilah's parents were very willing interviewees and when they spoke about their own health problems the conversations became like consultations.

Dr. Sagan[2], Lilah's hospital doctor, agreed to allow me to read her hospital records and to discuss her case with me, on the proviso that I had written consent from Lilah. Our discussion was straightforward and practical and Dr. Sagan was friendly and helpful. I did not ask to record the interview, but rather made notes about it after I had left. I then used the notes in order to write a script for an actor to play his part. I did not want to film the interview with Dr. Sagan because I felt that the presence of a camera would have made him defensive, uncomfortable, and worried about potential litigation. On my return to London I asked an American friend who looked a little like Dr Sagan, to re-enact the interview with me in a room that was made to look similar to Dr. Sagan's office in New York. The re-enactment was recorded on video.

I had now assembled the following footage from which to make *Frozen Section*:

A recording of a consultation in which I was in the role of the doctor and Lilah was in the role of the patient. The consultation was both real and performed for the camera. The awareness of the camera did not detract from our mutual understanding that we were also involved in speaking about real issues and that our concerns as doctor and patient were genuine.

Recordings of two interviews between Lilah's parents and myself, where I was both a doctor and filmmaker. In the interviews we discussed Lilah's health problems and at times we also discussed the parent's health and personal problems. At these times the interviews became like consultations, in which the parents were articulating their concerns and fears about their own health and revealing intimate details about the family and their past and current problems. Our awareness of the camera and knowledge that the recordings would be used to construct an artwork, heightened our sense of the performative aspect of the event[3], this instance I am using 'an event' to refer to a happening in which the state of things change. However, the value of the interviews as both event and material for an artwork relied on an understanding that the participants were speaking with honesty and that my questions were intended to shed light on the problem being discussed. It was important that the process was not merely about creating an artwork. In this sense in making the work I felt that I was being both a doctor and an artist. As an artist the experience of making the video became a reflexive insight into the performative aspect of being a doctor and indeed, of being a patient.

The final element was the recording of a re-enactment of an interview, in which I performed my own role as a doctor discussing Lilah's case with an untrained actor who performed the role of Lilah's real doctor. The re-enactment was filmed so that it had a similar look to the other interviews. In other words, it was performed as if it were a live, real and spontaneous interview. This enabled me to edit the performed and fictitious interview seamlessly into the final artwork.

In editing this material for the final artwork I had a number of intentions that I will now discuss. I will also discuss how I think the video achieves its effects and what I think these are.

I wanted the viewer to hear the story of Lilah's illness by listening to her describe her experience of it and also by listening to other peoples' perspective of her illness. This was in order to place the viewer in a similar position to a general practitioner, who has different threads of narrative from different sources in her or his consciousness, which she or he uses in order to interpret the meaning of the patient's symptoms. Thus in Frozen Section the viewer arrives at a knowledge of the symptoms by progressively weaving together the various threads of narratives from family members, Dr.Sagan and myself. Each fragment of narrative operates as a piece of evidence or a clue towards understanding the meaning of the symptoms. As such the fragments are used as part of what Ginzberg[4] describes as an evidential epistemological model or evidentiary paradigm. In this epistemological paradigm observations, statements, and often seemingly insignificant details about an individual are collated in order to make conjectural statements about that individual. Unlike empirical scientific data, these observations are qualitative rather than quantitative and the knowledge conjectural rather than empirical. In Frozen Section, even though the viewer gains substantial knowledge and understanding of the illness through listening to the interviews, ultimately the diagnosis and "true" meaning of her symptoms remains unknown. A precise definition of the illness is not revealed and the viewer is left to make his or her own interpretations and draw his or her conclusions. Thus although the video reveals substantial knowledge of the illness, it cannot be reduced to a particular diagnosis. Thus the video suggests that not knowing is also a form of knowledge.

Apart from the image on the middle screen, which remains static, the images on the other screens continuously disappear and reappear. The intention of this movement

is to use the fades to reinforce some of the family tensions and dynamics revealed in the narrative.

The body of Habeas Corpus[5] the primary referent of documentary is both present and absent in Frozen Section. Indeed Lilah is represented as a disembodied voice, as an absence in the frame. The room depicted in the middle screen is the room in which Lilah is interviewed. It dwarfs her body but her voice occupies the entire room. The static middle screen, which depicts the seemingly frozen view of her apartment, also reflects the idea of the ever frozen section of Lilah's muscle biopsy holding the secret of the illness. Equally the secret lies hidden in her voice, which the viewer hears emanating from the screen This representational form implicates a larger social space rather than her body as the site of evidence or clues for the cause of her illness.

The absence of Lilah's image invites the audience to imagine what she looks like by looking for clues in the fixed view of her apartment, by listening to her voice and seeing and hearing her parents speak. Thus the audience's image of Lilah is based on these perceptions rather than an image of her on a screen. Like the diagnosis her image remains elusive and unknown.

The position of each screen is important. Lilah's screen lies between those of her parents. Not only is this position suggestive of the Oedipal configuration of the child-parent relationship, it also emphasises the specific dynamics within this family. Lilah is an only child of divorced parents. Her importance to both her parents means that their relationship with one another, in spite of antagonism and difficulty, is maintained. Like the middle screen, Lilah is always caught between them. Introducing the doctor through a fourth screen would not have held the tensions of the dynamic so successfully, hence the decision to place him fading in and out over the image of Stephen on the right hand screen. His authority as a doctor is partially questioned through the interaction between his narrative and Stephen's narrative. Their contrasting beliefs on matters of health, creates an interesting opposition. Stephen constantly refers to his own quasi-mystical philosophies on how to live a good and healthy life and he is critical of the medical establishment. These beliefs stand in sharp contrast to the strictly scientific discourse upheld by the figure and voice of the doctor.

Throughout the video, the participants appear to be speaking in two simultaneous but distinct contexts. One context is that of the intimate private consultation. The other context is that of a documentary film in which participants speak to each other and to a wider public audience Through editing I have made it appear as if the family members are involved in an internal family dialogue which "inadvertently" reveals the family dynamics and tensions at stake in the evolution of Lilah's illness.

The video interviews have an aesthetic typically associated with an evidentiary practice of documentary filmmaking[6]. That is, 'talking heads' interviewed as witnesses to the events which they describe, thus providing evidence of the events.

Although the talking heads are interviewed for the camera, the camera also records a real life event: a doctor—patient consultation. The filmmaker thus participates with the social actors of the film. The video recording or document produced in this instance does not conform to the observational premis which gives an impression to the viewer that what they are seeing is a true representation of what would have occurred in the absence of the filmmaker and recording devices. Any documentary is never simply a document or straightforward recording of events as they unfold in the absence of the camera. The presence and intervention of the filmmaker introduces their subjectivity into the outcome and meaning of the film. In Frozen Section, both the filmmaker (myself as a doctor) and the patient knew that we were participating in a real event and at the same time making an artwork. Thus the document is a recording of a reality performed for the camera and the reality would not have occurred without the participation of the filmmaker. In this respect the video falls into the realm of both participatory and performative[7] modes of documentary practice. In speaking of the participatory mode Nichols states

> If there is a truth here it is the truth of a form of interaction that would not exist were it not for the camera. In this sense it is the opposite of the observational premis that what we see is what we would have seen had we been there in lieu of the camera[8].

In the performative mode the actual and the imagined are combined. The footage in these documentaries uses recordings of both real events and events re-enacted for the camera. In Frozen Section the interview with Dr.Kagan was a re-enactment based on my experience of a real interview that I had had with him. As already described the interviews with Lilah and her parents had both real and a performative

elements. Nichols understands the performative mode as that which raises questions about what is knowledge. Rather than leaving these questions of knowledge and understanding of events purely in the realm of philosophical reason, he asks

> Or is knowledge better described as concrete and embodied, based on the specificities of personal experience, in the tradition of poetry, literature, and rhetoric? Performative documentary endorses the latter position and sets out to demonstrate how embodied knowledge provides entry into an understanding of the more general processes at work in society[9].

Despite the artifice of Frozen Section, the resulting consultations and interviews have their own particular truth and validity. The consultation with Lilah had a powerful effect on both Lilah and myself, as we gained understanding about the nature of her illness. The recordings allow the audience to gain insights into what occurs in "real" consultations, and in this sense they partially achieve the ideal of the observational premis.

The narratives heard in the final artwork are highly edited versions of the original narratives. I have extracted fragments of the speech of one interviewee, often several sentences long, and juxtaposed them with fragments and sentences taken from the speech of another interviewee. This process of abstraction from their original context and subsequent juxtaposition of now disparate speech fragments, is a form of evidentiary editing. In addition to the original meanings intended by the speakers, the editing has the effect of creating new meanings. These meanings relate to my intentions as an artist and filmmaker and give the video it's point of view or perspective.

The narrative was structured in order to create suspense. The story has a clear beginning, which leads to a crisis where Lilah is admitted into hospital. Thereafter the middle section of the story contains a series of subplots, which reveal how the mysterious symptoms were analysed and understood by different people, and how Lilah's symptoms can be understood in relation to a larger context. The context that is of the events in Lilah's life, her parent's life, their different health beliefs and the family dynamics and tensions. No conclusion or resolution is offered and even the doctor finally admits that the diagnosis remains unknown.

For most of the sound track two voices are heard at once: running beneath each main person's speech, is the faint sound of the preceding person's speech, which is never loud enough to be deciphered. This was constructed in order to simulate the idea that when the doctor listens to the patient, in the back of their mind they remember other stories about the illness that they have heard form either family members, friends, the same patient in a previous consultation or other doctors and health workers involved with the same patient. It also creates a spatial illusion in which the participants sound as if they are speaking together in the same room.
The narrative is thus constructed as a linear story and at the same time it presents different people's points of view about a specific illness and health and illness in general. Within the story, evidence for an understanding of Lilah's symptoms accrues as in an evidentiary paradigm. Each fragment of speech provides clues or evidence for what the symptoms mean and what might have caused them. Ultimately however a precise diagnosis, which Lilah's physician seeks to uncover through his rigorous application of an empirical model, is denied. As the story reveals, the lack of diagnosis does not mean that there is a lack of knowledge about the illness. In this instance not knowing becomes a form of knowledge.

My role as a participant in the consultations, a figure represented in the film by my voice, and the producer and filmmaker, blurs the distinction between being a subject and an object of representation. I become both an object and a subject for the artwork.
In constructing the video I have sought to minimize my position. I am not seen on camera and my voice has been substantially edited out. With regard to the documentary aspect of the video, my role is portrayed as a doctor seeking an understanding of the patient's symptoms. As a filmmaker and artist constructing a semi-fictitious drama, I have constructed my role as that of a detective who prompts and urges the participants to reveal clues about the symptoms.

Frozen section exploits the problematic distinction between objective documentary form and subjective fictional form of filmmaking, in order to reflect upon an analogously problematical distinction at work within the doctor—patient consultation. Within the consultation interpretation of the patient's complaint according to objective scientific knowledge is continually disrupted by the subjective knowledge of both patient and doctor. The video questions the objective claims of both the documentary form and of scientific knowledge."

Notes

[1] See Chapter 3, p78 of this thesis

[2] In the interests of confidentiality I have not used the real name of Lilah's doctor.

[3] In the interests of confidentiality I have not used the real name of Lilah's doctor.

[3] Here the event refers to what Golding describes as "a kind of 'something' that goes beyond a simple/basic form of happening, in Golding, S (johnny de philo), " Games of Truth: A Blood Poetics in Seven Part Harmony", Inaugural Lecture Series London: University of Greenwich, 2003. In the event of a consultation, the state of play or being of those in the consultation changes through the unpredictable processes – discussions, examinations, procedures and treatments – that occur during the consultation.

[4] Ginzberg (1998, p106) describes the emergence of an epistemological model in the nineteenth century which he calls an "evidential paradigm"

[5] This refers to the legal writ of *habeus corpus*—you should have the body. The juridicial process would cease to function without the presence of 'the body' to provide the verbal evidence, or statements of witness to events. Similarly in documentary film the speaking body is the primary referent relating to the real social lives about whom the documentary speaks (Nichols: 1989, p167).

[6] In this type of practice evidence for the perspective of the film is often gathered from a variety of sources and not just from interviews. Other material such as supporting archival footage and photographs is often used.
Here I am using the event to refer to what Golding describes as "a kind of 'something' that goes beyond a simple/basic form of happening, in which the state of play changes." See preface to: Golding (johnny de philo) S., "Games of Truth: A Blood Politics in Seven Part Harmony" in *Inaugural Lecture Series* London: University of Greenwich, 2003. In the event of a consultation, the sate of play or being of those in the consultation changes through the unpredictable processes – discussions, examinations, procedures and treatments – that occur during the consultation.

[7] Nichols (2001: pp109-138) describes seven modes of documentary practice where each mode has a specificity, which distinguishes it from other modes. In practice a single documentary might employ more than one mode and new modes are constantly being invented along with cultural and technological changes. In participatory practices the filmmaker interacts with the social actors in film. In the performative mode, a highly subjective mode, the filmmaker is often included and elements of the documentary are re-enacted for the camera.

[8] Nichols, B, 2001 p 118

[9] Ibid., p131

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