DANGEROUS CURRENTS
Risk and regulation at the interface of medicine and the arts

Sink or swim...

ASSOCIATION FOR MEDICAL HUMANITIES
ANNUAL CONFERENCE 2015
DARTINGTION HALL

Supported by wellcome trust
The biggest risk is not taking any risk... in a world that’s changing really quickly, the only strategy that is guaranteed to fail is not taking risks.
Mark Zuckerberg

AT-A-GLANCE CONFERENCE PROGRAMME

Tuesday 23 June 2015
15.00-16.30 Registration and welcome drink – Great Hall
16.30-16.45 Welcome – Great Hall (Alan Bleakley)
17.00-19.00 PLENARY 1 – Al Lingis and Adrian Heathfield
Screening of Transfigured Night @ Barn Cinema then to Great Hall for performance
20.00 Dinner: Great Hall

Wednesday 24 June 2015
07.30-9.00 Breakfast for conference residents – White Hart/Solar
09.00-9.15 Introduction – Great Hall (Alan Bleakley)
09.15-10.15 PLENARY 2 – Kira O’Reilly and Vincent Lam
10.15-10.45 Coffee Great Hall
11.00-12.30 Parallel sessions: delegates’ presentations (20 mins each + discussion)
Group 1 Ship Studio (this session will run 10.50-12.45)
Group 2 Griffiths
Group 3 Upper Solar (this session will run 10.50-12.45)
Group 4 Solar
Group 5 Great Hall
WORKSHOP: Wellcome Trust (grant bids) 11.00-12.00 followed by 1:1 clinics Holand
12.45-14.00 Lunch – Great Hall AMH AGM 13.00-14.00 Solar
14.30-16.00 Parallel sessions II
Group 6 Ship (this session will run 14.15-16.15)
Group 7 Great Hall
Group 8 Upper Solar
Group 9 Solar (this session will run 14.15-16.15)
Film screening: Daniel Mercy (Who Cares?) 70 mins + discussion Griffiths
Workshop: CUT! – David Alderson workshop Studio 1
16.00-16.30 Tea Great Hall
16.30-17.30 PLENARY 3 – Roger Kneebone and David Cotterrell Great Hall
16.30-17.30 Laura Dannequin – performance of ‘Hardy Animal’ Studio 2 or 3
18.00-18.30 EXHIBITION opening reception: David Cotterrell and Sue Bleakley + performance by
Martin O’Brien Dartington Gallery
19.00 Conference dinner Great Hall. Music by Sangeetha Saunder
Thursday 25 June 2015

07.30-8.45 Breakfast for conference residents – White Hart/Solar
08.45-9.00 Introduction to the day: Great Hall (Alan Bleakley)
09.00-10.00 PLENARY 4: Allan Peterkin and Suzy Willson Great Hall
10.10-10.30 Coffee Great Hall
10.30-11.30 PLENARY 5: Martin O’Brien Great Hall
11.35-13.30 Parallel sessions III: delegates’ presentations (20 mins each + discussion)
Group 10 Ship
Group 11 Solar
Group 12 Upper Solar
Workshop: Visualizing Pain Padfield Joanna Zakrzewska Griffiths
PERFORMANCE: Emily Underwood-Lee ‘Titillation’ Studio 2 or 3
13.30-14.30 Lunch Great Hall
14.45-15.45 PLENARY 6: Aaron Williamson Great Hall
16.00-16.30 Wellcome Trust recap/AMH 2016 University of Greenwich/ Round-up
16.30 Conference ends (takeaway food will be provided)
Delegates’ presentations: groups and rooms

Wednesday 24 June  Morning groups

Group 1
Getting under your skin: the surgical humanities
10.50-12.45 Ship Studio
Chair: David Alderson
David Alderson
Andrew Snedden
Teodora Manea
Sarah Whitfield
Hakan Ertin/Rainer Broemer

Group 2
Can the medical humanities shape better practitioners?
10.50-12.45 Griffiths
Chair: Claire Elliott
Claire Elliott
Anna Macdonald
Lori-Liell Hollins
Hilly Raphael
Andrew Williams

Group 3
The poetry remedy
10.50-12.45 Upper Solar
Chair: Paul Dakin
Paul Dakin
Claudette Phillips
Elizabeth Davies
Dorothy Lehane
Radhika Merh

Group 4
Why we need industrial strength theory
11.00-12.30 Solar
Chair: Alan Petersen
Alan Petersen
Carlos Moreno-Leguzamón
Jennifer Patterson
Stan Hamstra

Group 5
Graphics panel
11.00-12.30 Great Hall
Chair: Ian Williams
Ian Williams
Muna Al-Jawad
Neville Chiavaroli
Katie Green

Group 6
 Bodies located and dislocated
14.30-16.00 Ship
Chair: Gregg Whelan
Penny Andrews and Gregg Whelan
Bob Whalley and Lee Miller
Deborah Padfield and Joanna Zakrzewska

Group 7
How did I perform?
14.30-16.00 Great Hall
Chair: Linda Turner
Linda Turner
Penny Morris
Fiona Geilinger/Laura Marshall-Andrews/Rosario Gracia
Clare Penlington

Group 8
Imagination under threat
14.30-16.00 Upper Solar
Chair: Caroline Wellbery
Caroline Wellbery (two presentations)
Antonia Mortimer
Natalie Beasolesle

Group 9
When doctors create
14.35-16.15 Solar
Chair: Ian Russell
Ian Russell and Cosmic
Angela Hodgson-Teall
Sangheeta Saunders
Emily Graham
Tricia Thorpe

Wednesday 24 June  Afternoon groups

Group 10
People’s rights/ art’s rites
11.35-13.30 Ship
Chair: Joe O’Dwyer
Joe O’Dwyer
Zoe Playdon (3 presentations)
Mel McCree and Norma Daykin
Julie Parsons and Clare Pettinger

Group 11
Singular doubles
11.35-13.30 Solar
Chair: Michael Wilson
Michael Wilson
Gianna Bouchard
Alex Merrakides
Helen Collard
Bridget Macdonald

Group 12
Troubling histories
11.35-13.30 Upper Solar
Chair: Catherine Jones
Catherine Jones
Vassilka Nikolova
Fiona Johnstone
Allister Neher
Lisetta Lovett

Thursday 25 June Morning

Group 10
People’s rights/ art’s rites
11.35-13.30 Ship
Chair: Joe O’Dwyer
Joe O’Dwyer
Zoe Playdon (3 presentations)
Mel McCree and Norma Daykin
Julie Parsons and Clare Pettinger

Group 11
Singular doubles
11.35-13.30 Solar
Chair: Michael Wilson
Michael Wilson
Gianna Bouchard
Alex Merrakides
Helen Collard
Bridget Macdonald

Group 12
Troubling histories
11.35-13.30 Upper Solar
Chair: Catherine Jones
Catherine Jones
Vassilka Nikolova
Fiona Johnstone
Allister Neher
Lisetta Lovett
Films

Tuesday 23 June
17.00-18.00 Transfigured Night: A conversation with Alphonso Lingis (Adrian Heathfield and Hugo Glendinning 61 mins) Barn Cinema
Description above.

Wednesday 24 June
14.30-16.00 Daniel Mercy (Who Cares?) (Andrew Williams 70 mins) Griffiths Performance Film of stage play ‘Daniel Mercy’

“We will remember not the words of our enemies, but the silence of our friends”. Martin Luther King, Jr.

“What we’ve got here is failure to communicate. Some men you just can’t reach. So you get what we had here last week. Which is the way he wants it. Well, he gets it. I don’t like it any more than you.” Strother Martin

I am a NHS consultant community paediatrician, playwright and historian and for the last 10 years have undertaken my research in clinical medicine, history and ethics within a Virtual Academic Unit. Some things within medical practice can only be said through a different medium. This is a performance film of my play ‘Daniel Mercy’. Mostly set in an NHS consultant’s office the play deals with an ongoing truth that is of institutional cover up of child abuse. Based on real life events, ‘Daniel Mercy’ is a modern day allegory concerning Society’s attitude to child protection. In the post Climbie/Baby Pera, child abuse failings and cover-ups are inevitable. This play is named after the child who is the centre of the activity of this play.

References
1 Washington State University Martin Luther King Program
2 http://en.wikipedia.org/wiki/What_we%27ve_got_here_is_failure_to_communicate accessed March 1st 2015

Thursday 25 June
11.45-12.15: duet for pain (Deborah Padfield 12 mins) Griffiths
duet for pain 2012 (12 mins)
Duet for pain is an artist’s film made as a response to working as artist in residence at UCLH in a facial pain management environment. It investigates narratives of pain juxtaposing two perspectives: those of the pain sufferer and those of the clinician. It aims to raise questions around the representation and construction of identity through both medical and photographic lenses, asking what happens when the face that expresses pain is itself in pain. It hopes to highlight the potential value of narrative to medicine, particularly in relation to chronic illness.

Playing on continuous loop throughout the conference
The Quickening [2013]
The Quickening is a text-based film in response to a 14 hour site-specific durational performance piece in Theatre Academy Helsinki, Finland, performed by Joanne ‘Bob’ Whalley and Lee Miller in 2013. It is written in the space, for the space, whilst attempting to resist being tethered to either of these. An articulation between two bodies separated by an expanse of theatre foyer, and their failed attempts to communicate with each other, it speaks of broken things: bones, dreams, sounds, windows.

Workshops

Wednesday 24 June
11.00-12.30 Wellcome Trust (Nic Vogelpoel and Lauren Couch) 1 hr making grant bids/ 30 mins 1:1 consultations
Studio 2

14.30-16.00 David Alderson: CUT! (workshop on the play) Studio 2

Thursday 25 June
11.45-13.15: Visualizing Pain Deborah Padfield and Joanna Zakrzewska Griffiths

Performances

Wednesday 24 June
16.30-17.30: Laura Dannequin – ‘Hardy Animal’
Studio 1
Chair: Larry Lynch

Thursday 25 June
11.45-13.15: duet for pain (Deborah Padfield 12 mins) Griffiths

duet for pain 2012 (12 mins)
Duet for pain is an artist’s film made as a response to working as artist in residence at UCLH in a facial pain management environment. It investigates narratives of pain juxtaposing two perspectives: those of the pain sufferer and those of the clinician. It aims to raise questions around the representation and construction of identity through both medical and photographic lenses, asking what happens when the face that expresses pain is itself in pain. It hopes to highlight the potential value of narrative to medicine, particularly in relation to chronic illness.

Playing on continuous loop throughout the conference
The Quickening [2013]
The Quickening is a text-based film in response to a 14 hour site-specific durational performance piece in Theatre Academy Helsinki, Finland, performed by Joanne ‘Bob’ Whalley and Lee Miller in 2013. It is written in the space, for the space, whilst attempting to resist being tethered to either of these. An articulation between two bodies separated by an expanse of theatre foyer, and their failed attempts to communicate with each other, it speaks of broken things: bones, dreams, sounds, windows.

Workshops

Wednesday 24 June
11.00-12.30 Wellcome Trust (Nic Vogelpoel and Lauren Couch) 1 hr making grant bids/ 30 mins 1:1 consultations
Studio 2

14.30-16.00 David Alderson: CUT! (workshop on the play) Studio 2

Thursday 25 June
11.45-13.15: Visualizing Pain Deborah Padfield and Joanna Zakrzewska Griffiths

Performances

Wednesday 24 June
16.30-17.30: Laura Dannequin – ‘Hardy Animal’ Studio 1 Chair: Larry Lynch

Thursday 25 June
11.45-13.15: duet for pain (Deborah Padfield 12 mins) Griffiths

duet for pain 2012 (12 mins)
Duet for pain is an artist’s film made as a response to working as artist in residence at UCLH in a facial pain management environment. It investigates narratives of pain juxtaposing two perspectives: those of the pain sufferer and those of the clinician. It aims to raise questions around the representation and construction of identity through both medical and photographic lenses, asking what happens when the face that expresses pain is itself in pain. It hopes to highlight the potential value of narrative to medicine, particularly in relation to chronic illness.

Playing on continuous loop throughout the conference
The Quickening [2013]
The Quickening is a text-based film in response to a 14 hour site-specific durational performance piece in Theatre Academy Helsinki, Finland, performed by Joanne ‘Bob’ Whalley and Lee Miller in 2013. It is written in the space, for the space, whilst attempting to resist being tethered to either of these. An articulation between two bodies separated by an expanse of theatre foyer, and their failed attempts to communicate with each other, it speaks of broken things: bones, dreams, sounds, windows.

Workshops

Wednesday 24 June
11.00-12.30 Wellcome Trust (Nic Vogelpoel and Lauren Couch) 1 hr making grant bids/ 30 mins 1:1 consultations
Studio 2

14.30-16.00 David Alderson: CUT! (workshop on the play) Studio 2

Thursday 25 June
11.45-13.15: Visualizing Pain Deborah Padfield and Joanna Zakrzewska Griffiths

Performances

Wednesday 24 June
16.30-17.30: Laura Dannequin – ‘Hardy Animal’ Studio 1 Chair: Larry Lynch

Thursday 25 June
11.45-13.15: duet for pain (Deborah Padfield 12 mins) Griffiths

duet for pain 2012 (12 mins)
Duet for pain is an artist’s film made as a response to working as artist in residence at UCLH in a facial pain management environment. It investigates narratives of pain juxtaposing two perspectives: those of the pain sufferer and those of the clinician. It aims to raise questions around the representation and construction of identity through both medical and photographic lenses, asking what happens when the face that expresses pain is itself in pain. It hopes to highlight the potential value of narrative to medicine, particularly in relation to chronic illness.

Playing on continuous loop throughout the conference
The Quickening [2013]
The Quickening is a text-based film in response to a 14 hour site-specific durational performance piece in Theatre Academy Helsinki, Finland, performed by Joanne ‘Bob’ Whalley and Lee Miller in 2013. It is written in the space, for the space, whilst attempting to resist being tethered to either of these. An articulation between two bodies separated by an expanse of theatre foyer, and their failed attempts to communicate with each other, it speaks of broken things: bones, dreams, sounds, windows.

Workshops

Wednesday 24 June
11.00-12.30 Wellcome Trust (Nic Vogelpoel and Lauren Couch) 1 hr making grant bids/ 30 mins 1:1 consultations
Studio 2

14.30-16.00 David Alderson: CUT! (workshop on the play) Studio 2

Thursday 25 June
11.45-13.15: Visualizing Pain Deborah Padfield and Joanna Zakrzewska Griffiths

Performances

Wednesday 24 June
16.30-17.30: Laura Dannequin – ‘Hardy Animal’ Studio 1 Chair: Larry Lynch

Thursday 25 June
11.45-13.15: duet for pain (Deborah Padfield 12 mins) Griffiths

duet for pain 2012 (12 mins)
Duet for pain is an artist’s film made as a response to working as artist in residence at UCLH in a facial pain management environment. It investigates narratives of pain juxtaposing two perspectives: those of the pain sufferer and those of the clinician. It aims to raise questions around the representation and construction of identity through both medical and photographic lenses, asking what happens when the face that expresses pain is itself in pain. It hopes to highlight the potential value of narrative to medicine, particularly in relation to chronic illness.

Playing on continuous loop throughout the conference
The Quickening [2013]
The Quickening is a text-based film in response to a 14 hour site-specific durational performance piece in Theatre Academy Helsinki, Finland, performed by Joanne ‘Bob’ Whalley and Lee Miller in 2013. It is written in the space, for the space, whilst attempting to resist being tethered to either of these. An articulation between two bodies separated by an expanse of theatre foyer, and their failed attempts to communicate with each other, it speaks of broken things: bones, dreams, sounds, windows.

Workshops

Wednesday 24 June
11.00-12.30 Wellcome Trust (Nic Vogelpoel and Lauren Couch) 1 hr making grant bids/ 30 mins 1:1 consultations
Studio 2

14.30-16.00 David Alderson: CUT! (workshop on the play) Studio 2

Thursday 25 June
11.45-13.15: Visualizing Pain Deborah Padfield and Joanna Zakrzewska Griffiths

Performances

Wednesday 24 June
16.30-17.30: Laura Dannequin – ‘Hardy Animal’ Studio 1 Chair: Larry Lynch

Thursday 25 June
11.45-13.15: duet for pain (Deborah Padfield 12 mins) Griffiths

duet for pain 2012 (12 mins)
Duet for pain is an artist’s film made as a response to working as artist in residence at UCLH in a facial pain management environment. It investigates narratives of pain juxtaposing two perspectives: those of the pain sufferer and those of the clinician. It aims to raise questions around the representation and construction of identity through both medical and photographic lenses, asking what happens when the face that expresses pain is itself in pain. It hopes to highlight the potential value of narrative to medicine, particularly in relation to chronic illness.
Dangerous Currents: risk and regulation at the interface of medicine and the arts

Use the word ‘aesthetic’ in medicine and surgery and you risk being mocked – unless of course you are referring to aesthetic (i.e. plastic) surgery; yet, medicine is regularly described as an art as well as a science. Aesthetics at root means ‘sense impression’ and doctors must above all learn to use their senses in diagnosis. Medicine, like art, is grounded in the education of sensibility. Yet ‘sensibility capital’ or what is valued about how one should sense – as Jacques Rancière describes the political dimension of aesthetics in culture – is rarely discussed in medical education. Medical students do not learn that sensibility capital is a form of power held by senior doctors and not readily distributed to medical or healthcare students, other healthcare practitioners such as nurses, and – above all – patients. Indeed, senior doctors often render medical students insensible in medical education where they resort to teaching by humiliation or fail to demonstrate the humanity and artistry of clinical practice. Artists can teach both medical students and doctors a thing or two about using the senses, but they are not even invited to the medical education party.

This is true for most medical schools, but there are singular exceptions. In 2002, along with Dr Robert Marshall and Dr Rainer Brömer, I introduced a radical medical humanities curriculum to what was then Peninsula Medical School, a new school in the UK. Artists and humanities scholars worked alongside clinicians and students to educate for sensibility and sensitivity and the results were impressive. The underlying rationale was to redistribute sensibility capital across artists, humanities scholars, students, medical school faculty and patients, in a democratising of medical education. This has served to produce sensibility in students to make them more interesting, innovative and caring practitioners who can make them more interesting, innovative and caring practitioners who can tolerate ambiguity or uncertainty. Intolerance of ambiguity is the mark not only of the authoritarian individual but also of authority led cultures, and medicine historically is one of those cultures. The project of the democratisation of medicine – helped by grounding medical education in the arts and humanities – is furthered by feminising, as more women than men are now entering medicine; a move to patient centred practice; and the arts and humanities – especially their more radical, politicised modes – have come to challenge medicine’s paternalism, autonomy and scientific persona in developing critical conversations with medicine. Medicine must democratise and teams must work collaboratively around patients where improved communication lowers patient risk in reducing medical error.

The 2015 Association for Medical Humanities annual conference takes as its theme critical conversations between medicine (including surgery, and encompassing healthcare) and the arts (including the humanities and the liberal social sciences) focused on issues of risk and regulation. Again, we live in a culture that, paradoxically, generates risk (especially in the economic sphere) at the same time as it generates more and more regulation. Our greatest risk is that of environmental degradation, yet we continue to make aggregate lifestyle choices that are creating irreversible environmental damage. Our lifestyle choices – junk food, lack of exercise – are so often odds with maintaining ‘health’ and medicine’s resources are heavily biased towards curative intervention rather than prevention.

Art, too, is, or should be, a risky business. I have nothing against art that pleases but surely the main role of the artist is to subvert, upset
and challenge habit and convention to make us ‘think otherwise’. Art in critical conversation with medicine should make us think otherwise about descriptors such as ‘health’ and ‘wellbeing’. Nietzsche (and later Gilles Deleuze) described artists as ‘diagnosticians’ or ‘symptomatologists’ of the body of culture – setting out which symptoms emerge in a culture and how we might treat them. Our most pressing symptoms are environmental degradation, and poverty leading to health issues caused by the phenomenon – that the richest 1% are making obscene amounts of money that do not help to raise quality of life for all because of lack of proper redistribution of wealth. The wide range of performances, drama, film, conversations and discussion of ideas presented in this conference (from delegates and invited artists, doctors and surgeons) will debate Nietzsche’s notion as they address the conversation between risk and regulation across medicine and the arts.

I would like to thank the Wellcome Trust and Falmouth University for their generous sponsorship of AMH 2015.

Professor Alan Bleakley
President Association for Medical Humanities
Professor of Medical Humanities
Falmouth University
Emeritus Professor of Medical Education
Plymouth University
Peninsula School of Medicine
Visiting Scholar
Wilson Centre University of Toronto


This exhibition will run in parallel with the 2015 Association for Medical Humanities (AMH) Annual Conference 23-25 June 2015, and for a month afterwards will be open to the public. The exhibition responds to the conference theme of critical conversations between medicine/surgery and the arts, with a focus upon issues of risk and regulation. As medicine and surgery become more safety conscious this necessarily invites regulation to reduce risk. Yet, as medicine invites greater critical conversation with the arts, especially within the medical humanities in medical education, it is surely the function of the arts to destabilise habits and create risk. Paradoxically, the riskiest thing that can happen to medicine is to democratise and feminise, yet these are the very processes that will make medical practice safer and more patient centred. There is a growing body of evidence that arts and humanities interventions in the medicine and surgery curricula (medical humanities in medical education) can help shape better doctors – not just more caring for patients, but better team workers with colleagues and more innovative in their practices. This is partly because the humanities educate for democratic habits and medicine is in need of democratisation, bearing a historical legacy of authority-led structures and hierarchical teamwork in which patients, ‘other’ healthcare practitioners and medical and healthcare students are disempowered and even rendered insensible by poor medical and surgical education. These groups must be empowered to speak truth to the dominant power discourse of medicine as necessary forms of resistance. As more women enter medicine than men worldwide, surely this will help to feminise as well as democratise a historically patriarchal culture? And the drift towards a patient-centred medicine in which medicine also becomes more transparent and accountable to the public can only accelerate this wider change.

Art exhibition: David Cotterrell and Sue Bleakley

The Gallery at Dartington Hall
Exhibition: Wednesday 24th June – Friday July 24th 2015
Opening drinks reception: Wed 24th June 18.00

At the Sharp End of Bluntness

David Cotterrell and Ruwanthie de Chickera

Sue Bleakley

Martin O’Brien

This exhibition will run in parallel with the 2015 Association for Medical Humanities (AMH) Annual Conference 23-25 June 2015, and for a month afterwards will be open to the public. The exhibition responds to the conference theme of critical conversations between medicine/surgery and the arts, with a focus upon issues of risk and regulation. As medicine and surgery become more safety conscious this necessarily invites regulation to reduce risk. Yet, as medicine invites greater critical conversation with the arts, especially within the medical humanities in medical education, it is surely the function of the arts to destabilise habits and create risk. Paradoxically, the riskiest thing that can happen to medicine is to democratise and feminise, yet these are the very processes that will make medical practice safer and more patient centred.

There is a growing body of evidence that arts and humanities interventions in the medicine and surgery curricula (medical humanities in medical education) can help shape better doctors – not just more caring for patients, but better team workers with colleagues and more innovative in their practices. This is partly because the humanities educate for democratic habits and medicine is in need of democratisation, bearing a historical legacy of authority-led structures and hierarchical teamwork in which patients, ‘other’ healthcare practitioners and medical and healthcare students are disempowered and even rendered insensible by poor medical and surgical education. These groups must be empowered to speak truth to the dominant power discourse of medicine as necessary forms of resistance. As more women enter medicine than men worldwide, surely this will help to feminise as well as democratise a historically patriarchal culture? And the drift towards a patient-centred medicine in which medicine also becomes more transparent and accountable to the public can only accelerate this wider change.

Art exhibition: David Cotterrell and Sue Bleakley

The Gallery at Dartington Hall
Exhibition: Wednesday 24th June – Friday July 24th 2015
Opening drinks reception: Wed 24th June 18.00

At the Sharp End of Bluntness

David Cotterrell and Ruwanthie de Chickera

Sue Bleakley

Martin O’Brien
Perhaps these factors constitute the major risk that medicine must now take on board – the challenge to its own historical tradition of self-regulation and lack of transparency; and the dominance of masculine heroism or patriarchy, and of parallel autocracy and steep hierarchies. For all of its undoubted successes, medicine can no longer afford to be smug, self-serving or bullying. It must admit to its mistakes and weaknesses. If art interventions in medical education are to engage critically with medical culture, they must not be neutered or rendered sterile, and not treated as handmaidens by medical culture as it slips into its familiar role of paternalism. Art interventions in medical education must be more radical and offer a critical counterpoint to medicine. In a culture driven by both 'health' and 'safety', art must stand up for the worth of the sick and pathologised and for the aesthetics of danger and risk.

The artists and the work

David Cotterrell and Ruwanthie de Chickera
Mirror

Art related to surgery regularly focuses upon the surgeon for obvious reasons – here is the cut, the blood and guts, the suture, the bravado of the macho hero and lifesaver. Less sexy are the failures of surgery, the arguments in theatre, the tension between surgeons and anaesthetists and the inability of surgeons to collaborate well in teams.

In a two-screen work, David Cotterrell explores what he describes as: “the relative anxieties and thought-processes of two of the major protagonists in surgery – the patient and the surgeon, shown as two talking heads on opposite screens. The idea is to consider the shared concerns, the devices by which a serious event is philosophically contextualised and the way the mind might wander under the catalytic pressure of forthcoming professional and/or personal risk. Two rhetorical monologues – patient and surgeon – may be misconstrued as a polarised dialogue. It is ambiguous as to whether the two characters are talking to one another or to themselves; and as the dialogue continues the assumption of roles may shift from one video portrait to the other.”

Cotterrell continues: “Recorded in isolation from context, without pre-emptively revealing the categorising uniforms of scrub or gown, the conversation will offer an introverted and existential portrait of the two individuals. The portraits are constructed to transcend the place, or the
'It’s in the bag'

Virgin scalpels are packed into a see-through designer plastic ‘ghost’ bag. The whole is exhibited under a plastic cover on a plinth as a ‘look, but don’t touch’ object. Yet the object cries out to be touched or handled despite the encapsulated hundreds of sharp blades. The scalpels after all are designed to be handled. Scalpels always fascinate. Both scalpel and bag are at the cutting edge – modern, lightweight scalpels mould the surgeon’s or the pathologist’s hand movements; a designer bag moulds the personality of its owner. The scalpel is an embodiment of risk, but what of the bag? Normally a symbol of regulation as a fashion item, this bag of scalpels is surely an image of resistance.

‘It’s in the bag’

Surgery relies on the steady hand and confidence of the surgeon who makes the cut. But surgeons are notoriously over-confident and liable to act before they think. Over 40,000 patients die every year in the UK from medical error and half of these deaths are in surgery. Half of those deaths again are avoidable. Yet most mistakes in surgery do not come from technical errors – around 70% are grounded in poor communication in team settings, usually resulting from surgeons not listening to other team members such as nurses and anaesthetists, or acting independently and hastily. This poor level of team communication is grounded in a historical style developed in surgical culture – brusque, masculine, heroic, independent, over-confident, often bullying and aggressive. Hence, ‘it’s in the bag’ – an overconfidence that refuses the democratization of surgical teams for an authoritarian style and a steep hierarchy.

The scalpels

The scalpel acts as a metaphor for the surgeon – stiff, unbending, incisive, sharp and pointed. After the first cut, there is no going back. Handling of scalpels may be risky, but production of scalpels is steeped in risk and needs greater regulation. Two thirds of the world’s surgical instruments are made in Sialkot in northern Pakistan, where 70% of the UK’s registered manufacturers are based. It is still common for production to be based in sweatshops often using child labour (as young as seven).

The bag

A well-known UK shoe designer who sells in the top stores in Milan made this plastic ‘ghost’ bag as a joke about the fashion industry regulating our participants:

Screenwriter: Ruwanthie de Chicker – http://www.imdb.com/name/nm2897452
Actors: Simon Kunz – http://www.imdb.com/name/nm0475336
Keynote presentations

The format of the keynote presentations is critical dialogue between pairs of clinicians and artists around the theme of risk and regulation (to include issues such as ‘entertaining the abject’, ‘creative and destructive addiction’, ‘deliberate and accidental harm’ and ‘faulty equipment’). Dialogues will treat both medicine and art as performance. The dialogues include a transatlantic element to embrace a developing connection between AMH UK and Creating Space in Canada.

In dialogue:

Alphonso Lingis and Adrian Heathfield
Kira O’Reilly and Vincent Lam
Suzy Willson and Allan Peterkin
David Cotterrell and Roger Kneebone

The opening keynote will frame the focus of the conference, considering lives lived in extremity, through a collaborative presentation/performance by Al Lingis and Adrian Heathfield based on Adrian’s 2013 film about Alphonso Lingis Transfigured Night (Vimeo trailer: www.frequency.com/video/transfigured-night-conversation-with/143533071/-/5-5592890).

Professor Al Lingis – philosopher-explorer-ethnographer-writer-photographer-animal lover – reinvents philosophy through his unique way of looking at the countries he regularly explores. In her book Exultant Forces of Translation and the Philosophy of Travel of Alphonso Lingis, Dalia Staponikutė says: “Lingis believes that rational language is unable to fully transmit meaning, arguing that ‘translation of culture’ requires the use of all senses. He calls for spontaneity in translation as bodily performance – highlighting the importance of the remainder or surplus in translation by emphasizing ways of knowing that are channelled through taste, touch, vision, smell and sound. … The traveller to a foreign country finds himself in a place like a deep wood: the unknown language he encounters speaks to him like a silent language and conveys no meaning. By placing the body at the centre, Lingis questions the idea of silence as muteness, and posits that the human voice, coming ‘from the bowels and tubes of the body’, is able to connect and evoke a reply, because ‘our voice does not produce the sound out of silence’. Thus, even where there is absence of a common language, communication is still possible by means of a corporeal grammar.”
Born in 1933, Lingis’ journey began in the State of Illinois, and his first university experience was at Loyola University in Chicago, which he admitted afterwards was not entirely satisfactory. He then went abroad to continue his studies in Belgium at the Catholic University of Louvain, where he became interested in the history of philosophy, a discovery he describes as a “revelation.” His dissertation, written under the direction of the phenomenologist Alphonse de Waehrens, focused on Jean-Paul Sartre and Maurice Merleau-Ponty. Upon completion of his doctorate, he had no intention of taking up an academic profession but harboured a strong interest in the task of philosophy. Upon his return to the States, however, he obtained a position at Duquesne University in Pittsburgh and discovered, in spite of himself, a liking for teaching. In that same year, 1961, Lingis encountered the thought of Emmanuel Levinas and in particular, the publication of Totality and Infinity. He decided to translate the volume, and began working on the corpus of Merleau Ponty’s writings as well, contributing to the cross-Atlantic discovery of these works. In the mid-1960s, he decided to continue his career at the University of Penn State while continuing to translate French philosophers, including The Visible and the Invisible by Merleau-Ponty. Influenced by phenomenologists yet an equally fervent reader of Nietzsche, Deleuze, Lacan, Bataille and Foucault, he went on to publish a number of books on phenomenology, such as Libido: The French Existential Theories (1985), Phenomenological Explanations (1986) and Deathbound Subjectivity (1989). He is currently Professor Emeritus of Philosophy at the University of Penn State, having retired from formal academic life to live near Baltimore with a formidable set of aviaries.

Influenced by Lévi-Strauss, Lingis’ own thought draws upon his frequent journeys to countries deserted by global tourism (including Mali, New Guinea, Indonesia, and the Pacific Islands). His many books inscribe his thinking as the conjunction between theory and praxis, using his philosophical travels to investigate language and physical expression in, for example, Foreign Bodies (1994), as well as modes of bodily inscription in the world and in society by way of images, with a style that has been compared to Gauguin’s paintings. The lectures of this extraordinary scholar are themselves renowned for their originality, as different accounts assembled in a book dedicated to the philosopher entitled Encounters with Lingis attest. His lectures are closer to artistic performances, sometimes accompanied by music, chanting, or shadow projections.

Al Lingis’ contribution to the field of Performance Philosophy is invaluable. His inquiries into the semiotic value of language and the status of the subject (questions raised in Deathbound Subjectivity), as well as the status of the voice and the place of mainstream interpretations, the “just talk” (The First Person Singular), invite new perspectives on the specificity of theatrical communication. In addition, the remarkable interest shown by the philosopher for the body, in search of the other and the face of the other (to use Levinas’ terms) leads to a re-examination of the status of the actor’s body, his or her spectrality and “splendour,” revealed by the ornaments s/he wears and the props s/he uses. Lingis calls this the “eloquence of the body”. Between violence and splendour, Lingis brings performance and philosophy into dialogue, calling the meaning of corporality into question while paying close attention to what makes up the singularity of the other.

Selected Bibliography:

Adrian Heathfield
Adrian Heathfield is one of the foremost theorists and curators of contemporary art practices, particularly performance. www.adrianheathfield.com

Professor Adrian Heathfield writes on, curates and creates performance. His books include: Out of Now, a monograph on the Taiwanese-American artist Tehching Hsieh and the edited collections Perform, Repeat, Record: Live Art in History; Live: Art and Performance; Small Acts: Performance, the Millennium and the Marking of Time; and Shattered Anatomies: Traces of the Body in Performance; and On Memory. His numerous essays have been translated into seven languages. He currently works on a creative research project – Curating the Ephemeral – at Columbia University, New York, where he is a Marie Curie International Fellow in the School of Arts. He was co-director of ‘Performance Matters’, a four years AHRC funded research project on the cultural value of performance (2004-2013). He co-curated the ‘Live Culture’ events at Tate Modern, London (2005) and a number of other performances and durational events in European cities over the last 10 years. Adrian has worked with many artists and thinkers on critical and creative collaborations including film dialogues (eg Al Lingis, Hélène Cixous), performance-lectures, writing and workshop projects. He was President of Performance Studies International (2004-07) and is Professor of Performance and Visual Culture at the University of Roehampton, London.

Film: Transfigured Night a conversation with Alphonso Lingis

Transfigured Night is the record of an exchange between the celebrated American philosopher Alphonso Lingis and the British art theorist and curator Adrian Heathfield. Drawn to conversation by reading Lingis’ numerous books, Heathfield pays a visit to the philosopher’s house near Baltimore where he discovers revealing dimensions of his ways of being and thinking. The film assembles a rich patchwork of fragments taken from their dialogue over a period of two days. Lingis makes dynamic forays into thoughts that have preoccupied him in over 40 years as a writer and traveller, drawing on his influences in phenomenology and ethics, and his extensive encounters with many places and cultures. The discussion moves from questions of the face and the gaze of others, the sensual experiences of weight and being touched, through considerations of performance, sculpture and dance, to meditations on mortality and suffering.

http://www.thisisperformancematters.co.uk/transfigured-night-a-conversation-with-alphonso-lingis.html

Directed and edited by: Hugo Glendinning and Adrian Heathfield
Director of Photography: Hugo Glendinning
Written by: Adrian Heathfield.
Duration: 61 minutes

Transfigured Night is part of the Crossovers series, which includes filmed dialogues with leading intellectuals whose work has significant impact upon the understanding of contemporary culture and performance. Crossovers is curated by Performance Matters: a collaboration between Goldsmiths, University of London, University of Roehampton, and the Live Art Development Agency, funded by the Arts and Humanities Research Council.

Kira O’Reilly and Vincent Lam

Kira O’Reilly is a London based artist; her practice, both wilfully interdisciplinary and entirely undisciplined, stems from a visual art background; it employs performance, biotechnical practices and writing with which to consider speculative reconfigurations around The Body. But she is no longer sure if she even does that anymore. Since graduating from the University of Wales Institute Cardiff in 1998 her work has been exhibited widely throughout the UK, Europe, Australia, China and Mexico. She has presented at conferences and symposia on both live art and science, art and technology interfaces. She has been a visiting lecturer in the UK and Australia and U.S.A in visual art, drama and dance. Most recent new works have seen her practice develop across several contexts from art, science and technology to performance, live art and movement work. She has made movement works that she doesn’t like to call dances and has been increasingly informed by combat sports and martial arts as mode...
of investigating movement and embodied thinking, leading to running workshops that use grappling practices along side writing. She writes, teaches, mentors and collaborates with humans of various types and technologies and non-humans of numerous divergences including mosses, spiders, the sun, pigs, cell cultures, horses, micro-organisms, bicycles, rivers, landscapes, tundras, rocks, trees, shoes, food, books, air, moon and ravens.

**Vincent Lam**

Vincent Lam is from the expatriate Chinese community of Vietnam, and was born in Canada. Dr. Lam did his medical training in Toronto, and worked for thirteen years as an emergency physician in Toronto. He now works in addictions medicine. He is a Lecturer at the University of Toronto. He has also worked in international air evacuation and expedition medicine on Arctic and Antarctic ships. Vincent’s first book, Bloodletting and Miraculous Cures, won the 2006 Scotiabank Giller Prize, and was adapted for television and broadcast on HBO Canada. The Headmaster’s Wager, his first novel, about a Chinese compulsive gambler and headmaster of an English school in Saigon during the Vietnam War, was a finalist for the 2012 Governor General’s Prize. It was longlisted for the 2013 Andrew Carnegie Medal for Excellence in Fiction, long listed for the 2013 IMPAC Dublin Prize, and shortlisted for the 2013 Commonwealth Book Prize.

[Website](http://www.vincentlam.ca/about.php)

**Suzy Willson**

Suzy Willson is the co-founder and artistic director of Clod Ensemble and Performing Medicine. Performing Medicine is a programme originally put together to provide training to medical students and healthcare workers – but there is plenty for the wider public and dance audiences in particular to enjoy.

In a Q & A, Suzy says:

Q. What drew you to this work at the intersection between art and science?

A. I’m not a scientist myself. My interest in medicine, particularly medical education, came from my own experience as a relative and friend of people in hospital. I felt that in my own theatre training (first doing courses in applied theatre when I was at Manchester University studying Drama and then at the Jacques Lecoq School) there were a lot of exercises and ways of thinking that could be useful to healthcare professionals. When I began this work I felt that ways that medical institutions looked at people’s bodies were sometimes brutally reductive and I was interested in offering medical students some other ways of thinking about human bodies and sharing some practical skills to help them use their own bodies more sensitively.
Suzy willson

**ARS MEDICA:** a Journal of Medicine, The Arts and Humanities. Allan has been 14 books for adults and children and is a founding editor of the literary magazine academic and worldly Renaissance man of impeccable taste. He has published Professor Allan Peterkin is a Toronto-based physician, author, university

Performing Medicine is an award-winning programme created by theatre company Clod Ensemble, which uses methods found in the arts to develop skills essential to clinical practice and healthcare. Performing Medicine works in partnership with organisations across the UK such as Barts and The London School of Medicine and Dentistry, King’s Health Partners, and Health Education England to create courses for medical students, foundation year doctors and health professionals. It is the only initiative of its kind, unique because it is led by established associate artists from a range of creative disciplines, in collaboration with medical educationalists and health professionals.

So Performing Medicine is about what the arts can bring to medicine.

Q. What does a knowledge of medicine or, in this case, anatomy bring to the arts?

A. Many dancers and performers have a pretty good working knowledge of anatomy but have gathered that knowledge through an experience of their own bodies rather than in the ways that medical students learn anatomy – through dissection, for example, or through looking at diagrams or through examining patients. I would say the more understanding and awareness we have of our own bodies – how they function and change, how they relate to others and the environment – the better. It’s great to share different ways of thinking and seeing human anatomy in a different context, beyond the usual professional environments in which these things are discussed – the rehearsal room or the anatomy theatre. For me, thinking about anatomy for this project has made me think again about the ways of looking at things and how meanings change or are created depending on the point of view you take. In this way there is a lot of similarities between performance and anatomy.

Allan Peterkin

Professor Allan Peterkin is a Toronto-based physician, author, university academic and worldly Renaissance man of impeccable taste. He has published 14 books for adults and children and is a founding editor of the literary magazine ARS MEDICA: Journal of Medicine, The Arts and Humanities. Allan has been a leading light in developing the medical/health humanities in Canada. His first degree was in English and French Literature. He then trained as a doctor, working as a Family Practitioner and then a Psychiatrist, with specialism in the health of the LGBT community. Allan’s books on the cultural histories of beards and moustaches (well before the current hipster trend) are underground classics. His classic ‘survival’ manual: Staying Human During Residency Training: How to Survive and Thrive After Medical School (University of Toronto Press) is in its 6th edition in Canada and North America and a UK (Europe) Australasian edition is currently being written in collaboration with Alan Bleakley to be published by Taylor & Francis in 2016. In collaboration with Pamela Brett-Maclean, Allan has just edited a collection of essays on reflective practice: Keeping Reflection Fresh: Top Educators Share Their Tales of Professional Education to be published by Kent State Press in their Literature and Medicine series. Allan is a true Renaissance person in an age of specialists and one of the most energetic movers and shakers in the international health humanities movement. He has been a loyal supporter of the Association for Medical Humanities and sits on its Council as international representative; and has served on the editorial board of the British Medical Journal’s Medical Humanities. Over the years, the AMH has formed a close tie with its Canadian counterpart ‘Creating Space’ – a series of annual health humanities conferences set in Canadian cities. We are pleased that Allan has accepted to offer a collaborative dialogue keynote with Suzy Wilson as a key part of our ongoing and deepening collaboration with Creating Space. Please explore Allan’s website: www.adpeterkin.com you will not be disappointed!

Roger Kneebone

Roger Kneebone is Professor of Surgical Education and Engagement Science at Imperial College, London and founder of the Masters in Surgical Education, a highly successful programme – running since 2003 – that literally changes surgeon’s lives – not only shaping them into better educators and practitioners, but positively affecting the culture of surgery. He has written widely on surgical education and edited related collections. Roger was educated first as a general and trauma surgeon, working both in the UK and in Southern Africa. After finishing his specialist training, he decided to become a general practitioner and joined a large group practice in Trowbridge, Wiltshire. In the 1990s he pioneered an innovative national training programme for minor surgery within primary care, based around intensive workshops using simulated tissue models and a computer-based learning programme. In 2003, Roger left his practice to join Imperial.

Roger is committed to education in it widest sense. This challenging programme builds on educational theory and practice to explore relationships
In this two-screen work, David has collaborated with screen-writer Ruwanthie de Chickera and actor Simon Kunz to explore what he describes as: “the private anxieties of two of the major protagonists in surgery - the patient and the surgeon, shown as two talking heads on opposite screens. The idea is to consider the shared concerns, the devices by which a serious event is philosophically contextualized and the way the mind might wander under the catalytic pressure of forthcoming professional and/or personal risk. It is ambiguous as to whether the two characters are talking to one another or to themselves; and as the dialogue continues the assumption of roles may shift from one video portrait to the other.”

He continues: “Recorded in isolation from context, without pre-emptively revealing the categorising uniforms of scrubs or gown, the conversation offers an introverted and existential portrait of the two individuals. The portraits are constructed to transcend place, or situation, perhaps considering fear of the other, but often more internalized, describing a sense of self-image or personal narrative. There are differing social conventions at work for the articulation of anxiety and the consideration of failure. For the patient, there is often a requirement to be strong for their relatives; and the clinician must demonstrate confidence to command the trust of both patients and colleagues in the surgical and recovery rooms. Space for reflection may be deferred to a later date or constrained to the domain of the internal monologue. This outwardly simple video project will offer an imagined snapshot of these complex internal negotiations of vulnerability and bravado.
Alongside further performance work – Assisted Passage and The Charity Stall, The Disabled Avant-Garde has pushed the boundaries of inverting disability discrimination introducing a political dimension – what is it to speak truth to power and yet retain a wicked sense of humour?

Artist monograph: http://www.thisisliveart.co.uk/resources/catalogue/performance-video-collaboration

Martin O’Brien

Martin O’Brien’s work considers existence with a severe chronic illness within our contemporary situation. Martin suffers from cystic fibrosis and his practice uses physical endurance, disgust, long durations and pain based practices to address a politics of the sick queer body and examine what it means to be born with a life threatening disease, politically and philosophically. His work is an act of resistance to illness, an attempt at claiming agency and a celebration of his body. He has been commissioned and funded by the Live Art Development Agency, Arts Council England, Arts Catalyst, Midlands Art Centre, and the British Council. He has presented work in Britain, USA, and widely throughout Europe. He was artist in residence at ONE National Gay and Lesbian Archives, LA and performance space[, London and is currently an Artsadmin Bursary Artist. He has regularly collaborated with the pioneering performance artist Sheree Rose. Martin was awarded a PhD at the University of Reading and is a visiting lecturer at several UK Universities. He has published on his own work and on others, including in the special edition of Performance Research On Medicine which he co-edited, and has been written about in several books and journals including Access All Areas: Live Art and Disability and the forthcoming Performance and the Medical Body.

The project is designed to explore the common human characteristics that could provide an empathetic bridge that might offer a stronger solidarity between strangers than the context, roles and uniforms might suggest.”

Solo performances

Aaron Williamson

Age 54, male, born in Derby, England. Williamson’s work is inspired by his experience of becoming deaf and by a politicised, yet humorous sensibility towards disability. In the last fifteen years he has created over 300 performances, videos, installations and publications in Britain, Europe, Japan, Greenﬁeld, China, Australia and North America. His awards include: the Helen Chadwick Fellowship in Rome; Artist Links, British Council, China; Three-year AHRC Fellowship, UCE; Adam Reynolds Memorial Bursary; Acme’s Stephen Cripps Studio award. Williamson holds a DPhil in critical theory from the University of Sussex (1997). A monograph ‘Aaron Williamson – Performance, Video, Collaboration’ was published by the Live Art Development Agency in 2007.

Williamson has created some of the most outrageous and hilarious live performance interventions for public consumption. He starts with the premise of playing at being a live artist. Aaron has dedicated himself to upset self-governing values of what is acceptable behaviour in public places, courting anarchy and self-regulation – longstanding principles of the Dartington tradition. For example, Shouting Island was a performance in which Aaron spent seven hours walking the circumference of a tiny island just off the shore of Kuopio in Finland, shouting ‘I am an island’ in Finnish, turned from something mystical and slightly unnerving for an unwitting audience into an epic media event in which photographers were ordered off the island for invading its privacy. He ﬂirts with violence/violation in the effort to provoke a response. There is an attempt in much of the work to explore the notion of what the wild man, the shaman, means in contemporary society, with an emphasis on the ‘sham’. He has, perhaps, fashioned a shamanthropology of contemporary performance. Again, much of the work is informed by experience of disability and deafness. Obscure Display was a performance at the V & A Museum in London that sought to challenge medico-scientiﬁc notion of having lost hearing, rather than having gained deafness.

One of Aaron’s collaborations has been with Katherine Araniello. They produced the Disabled Avant Garde Today initiative – a sensational exhibition of digital media work at the Gasworks as part of Adjustments.
Laura Dannequin

Laura Dannequin is a French-born choreographer/performer/maker based in Bristol. She is interested in making and participating in work that is present, live, raw and explores bodily being in the world: the dancing body, the social body, the diseased and medicated body. She creates performance, installations and recently self-published a fine print bookwork to accompany her solo performance Hardy Animal. She is associate director at Still House. Laura will perform Hardy Animal. A tender solo that looks at chronic pain and human resilience, Hardy Animal is a goodbye letter to a former self and an ode to dance. Concerned with the human body and its failings, it tells of a dancer’s journey into immobility. Interweaving text and movement, it retraces a brutal journey of loss and hope. Written, created & performed by Laura Dannequin. Creative Advisor: Dan Canham

An accompanying fine-print limited edition bookwork will be available at Laura’s performance, or via her website. It contains the performance script, two specially commissioned texts by writers Jim Stenhouse and Nick Walker, a blind embossed cover and a hand drawn line drawing on transparent paper in each copy.

Emily Underwood-Lee

Emily will perform 'Titillation'. She says: 'Titillation is my attempt to celebrate the breastless, post-surgical, sexually desirable and desirous, confrontational, cancerous body. I am attempting to foreground my marked, scarred and scary body through a striptease where everything comes off – even my breasts. ‘Titillation’ is comprised of a series of revelations: I reveal who I think I am, I reveal who I think I was, I reveal who I thought I would be, I reveal my own desire, I reveal my body and I reveal my scars. I never reveal my real eyelashes, the false ones are much better. When I started the process of making this performance I wanted to look at the wider issues surrounding the body as a site of illness, not the life and death trials but the little things about cancer that make living with the marks of the disease a new, different, fascinating and challenging experience. In ‘Titillation’ I attempt to talk about my experiences of cancer while trying to be both funny and sexy.'
“there is nothing new under the sun.” The play has evolved over the last four years through radical re-workings of draft scripts, informed by dramaturgical support, actor workshops, professionally directed stagings, reflective comment from those quoted, and a collaboration with academics in healthcare education and performance studies. The script forms the basis of development in three areas: as a pedagogical tool to facilitate exploration of professional roles by members of healthcare professions; as a stage play with the power to engage the public and policy makers in deeper dialogue; and as the focus of an academic exploration of the concepts of failure and error across diverse domains.

Failure and error are – for better or worse – fundamental to human experience, but their significance depends on the context in which they are interpreted and responded to. The meaning of failure is also a function of disciplinary and professional perspective. Although there has been some comparative work between different readings of failure, this has tended to focus on a limited range of cognate areas, such as: aviation with engineering with medical practice. A broader interdisciplinary dialogue, crossing the arts, humanities and scientific, professional or technical contexts, is under-developed. We have started to bring together individuals working in contrasting disciplinary and professional contexts to explore where perspectives intersect and where they diverge, as well as how such similarities and differences might be understood – ethically, aesthetically, and pedagogically. We are aiming to explore, for instance, whether conceptions of failure from theatre and performance have the scope to illuminate a medical pedagogy that aims to enable doctors to learn from their errors; how risk management strategies in aviation or engineering might provide scenes for artistic staging and exploration; and how the ethics of professional failure are affected by the aesthetics of their performance. This presentation aims to give an insight into our progress towards these goals. It will include filmed excerpts from previous workshop productions, a discussion of the development work to date, sample text and a provisional report on our multidisciplinary theoretical and practical conversations.

Presentations
Mr David Alderson
david.alderson@nhs.net
True Cut
Mr David Alderson, Dr Kirsten Dalrymple, Dr Patrick Duggan, Dr Caroline Pelletier
1 South Devon Healthcare, 2 Imperial College, 3 University of Surrey, 4 University College London Institute of Education

Ericsson: Their first laparotomy on their own... is a huge step. I mean that’s when they really do seem to gain that extra confidence in their own... you know... realise their own skills and ability...

Your first solo Right. The same thing as when your mum or your dad lets go of the saddle and you start to ride your bike on your own. It’s sort of a rite of passage in a way. [But] you want to know that your Dad’s still running behind you ready to catch you if you fall.

When surgeons enter the lives of our loved ones, we yearn for the story to end with a ‘happily ever after’; but complications are inseparable from the reality of surgical practice. And trainee surgeons who wish to help their future patients must practice their developing craft on their current patients, with consequent risks. Close supervision must fade as they progress towards independent practice – but who decides when they are ready to ‘go solo’? Mistakes can have a devastating effect on patients and their families, but guilt and shame can also ruin the lives of the professionals involved. Coping strategies, rarely surfaced, often serve to the detriment of their patients, their colleagues and their families – and of their own health. These tensions, central to surgical practice, remain largely unexamined, both within and outwith the professions. In the implicit contract between society and medicine, perfection is expected and human fallibility is condemned.

True Cut presents a dramatic ‘biopsy’ from this largely hidden world in order to promote a wider diagnostic exploration of the concepts of error and failure – in healthcare and beyond. David Alderson has developed a play that blends fictionalized reconstructions – drawn from 30 years of personal experience of the practice of surgery – with verbatim theatre based on in-depth interviews with healthcare professionals and personal testimony from the patient’s side of failure. The main characters have developed as avatars of prominent educationalists, creating a powerful juxtaposition between pedagogical theory and patient care. The story arc draws on the structure of a narrative from the wisdom literature of 2,500 years ago – “there is nothing new under the sun.” The play has evolved over the last four years through radical re-workings of draft scripts, informed by dramaturgical support, actor workshops, professionally directed stagings, reflective comment from those quoted, and a collaboration with academics in healthcare education and performance studies. The script forms the basis of development in three areas: as a pedagogical tool to facilitate exploration of professional roles by members of healthcare professions; as a stage play with the power to engage the public and policy makers in deeper dialogue; and as the focus of an academic exploration of the concepts of failure and error across diverse domains.

Failure and error are – for better or worse – fundamental to human experience, but their significance depends on the context in which they are interpreted and responded to. The meaning of failure is also a function of disciplinary and professional perspective. Although there has been some comparative work between different readings of failure, this has tended to focus on a limited range of cognate areas, such as: aviation with engineering with medical practice. A broader interdisciplinary dialogue, crossing the arts, humanities and scientific, professional or technical contexts, is under-developed. We have started to bring together individuals working in contrasting disciplinary and professional contexts to explore where perspectives intersect and where they diverge, as well as how such similarities and differences might be understood – ethically, aesthetically, and pedagogically. We are aiming to explore, for instance, whether conceptions of failure from theatre and performance have the scope to illuminate a medical pedagogy that aims to enable doctors to learn from their errors; how risk management strategies in aviation or engineering might provide scenes for artistic staging and exploration; and how the ethics of professional failure are affected by the aesthetics of their performance. This presentation aims to give an insight into our progress towards these goals. It will include filmed excerpts from previous workshop productions, a discussion of the development work to date, sample text and a provisional report on our multidisciplinary theoretical and practical conversations.
Across the last decade popular narratives of running have broadened considerably to include the ethnographic, the anthropological and the geographical. The cultural turn is increasingly apparent, as is much more emphatically, the biological and medical: the former introduced by Bramble and Lieberman’s ‘born to run’ thesis (Nature 2004), the latter a response in part to that work, focused on the long-term impact endurance training might have on cardiac function. The runner’s body and the act of running have become culturally significant, its literatures reflecting this and far outweighing – if one goes by the shelves of Waterstones – instructional training texts.

In a dialogue that takes the above as context, Andrews and Whelan will examine ideas of identity and difficulty through the lens of Andrews’ work. Informed by training and racing as a sprinter with cerebral palsy, Andrews’ practice, as both athlete (T36 sprinter) and artist challenges the prevailing social and medical models of disability. Her approach to, and thinking around, athleticism offers a vibrant contribution to debate on wellness, the trained body/the unruly body, injury, endurance, competitiveness and performance.

Penny Andrews is an artist and T36 para-athlete, training and racing as a sprinter with cerebral palsy. Andrews’ sonic art has been commissioned by BBC Radio Wales and broadcast across BBC Radio 1, 4 and 5, XFM and Austria’s FM4. Andrews runs a small press commissioning and curating sonic and page-based publications, she is currently a Research Assistant for Autism&Uni, an initiative that designs, builds and evaluates tools to help people on the autism spectrum to access Higher Education.

Gregg Whelan formed the performance company Lone Twin with Gary Winters in 1997. The company’s work is regularly shown across the world to critical and popular acclaim. Lone Twin produced The Boat Project for the London 2012 Cultural Olympiad. Other partners include the South Bank Centre, Sadlers Wells, and the Sydney International Festival. Since 2007 Whelan has been Co-Artistic Director of ANTI Contemporary Art Festival, Finland. In 2010 Whelan became an AHRC Research Fellow in the Creative and Performing Arts at King’s College London with The Long Run, a five-year project looking at the common ground between endurance running and contemporary performance practice. In 2013 Whelan joined Falmouth University as Professor of Performance.
Natalie Beausoleil PhD
nbeausol@mun.ca
Reflection, risk and regulation: narratives of arts, selves and community engagement in medical education
Division of Community Health and Humanities, Faculty of Medicine Health Sciences Centre, Memorial University, St. John’s, NL, Canada
This presentation will address challenges and possibilities for critical thinking through the arts in a curriculum that is currently being renewed and aims to integrate significantly the roles of community advocacy and scholarship for medical students, but is still dominated by a biomedical model of health and illness.

Neville Chiavaroli
n.chiavaroli@unimelb.edu.au
Medical professionalism through the lens of the single-panel cartoon
Melbourne Medical School, University of Melbourne
One of the most popular and enduring forms of visual art is the single panel cartoon. While sequential or ‘strip’ cartoons can powerfully communicate a narrative, the single-panel cartoon conveys its message succinctly and often poignantly when produced from the perspective of socio-political commentary. The medical profession is a frequent target of cartoonists, and the way the profession is depicted in their cartoons can tell us a great deal about not only public perceptions, but also its particular vulnerabilities. This makes the single panel cartoon particularly useful for reflective and pedagogical purposes in medical education, where the humour can ‘disarm’ expectations or prejudices and potentially render students more receptive to, and more thoughtful about, its message. More importantly perhaps, it also provides a powerful medium for public resistance to the hegemony of a profession, especially by exposing practices that may be contradictory to some of the key principles or moral claims of the profession. This research seeks to articulate Foucauld’s concept of Technology of the Self and examines the emphasis Foucault places on Care of the Self (epimeleia heautou) to elaborate new kinds of relationships to ourselves; a technique of self-fashioning worth considering as a resistance to the usual formation of the western self. Foucault sees a Western self as formed by the biopolitical project. This research seeks to share the mechanisms used and transformations experienced in mind-body enquiry in expanded performative, visual and sonic form. The research is undertaken in order to raise questions such as: ‘What is connectivity?’ ‘What is technology?’ ‘What configures our actuality?’ within the corporeal, cognitive, psychological, technological and spiritual realms of our human lives, and hopes to breathe new insights into how we currently consider ourselves constituted as subjects.

I am a digital artist working with performance and sound. My presentation is in the form of an experimental sound film (15 mins) entitled Finding Prānā. This film is a collage of soundscapes and images collected from a five-weeks field trip to India in the search to discover Prānā. In yogic philosophy, prānā is the breath and the life force – it means respiration, life, and energy. Prānāyāma are the breathing practices and techniques that control and regulate prānā. Ayāma means expansion, regulation, restraint or control; therefore prānāyāma means the prolongation of breath and its restraint. This five weeks long expedition will seek to uncover the underpinnings of this yogic philosophy through sound, film, found footage and interview. This will be gathered from interviews with respected prānāyāma teachers, practitioners and scientists, documentation of prānāyāma practices (both my own and others) and documentation of the work currently done at the Kaivalaydhama Institute.
The Kaivalyadhama Institute has pioneered studies in the quantitative psycho-physiological and neurological effects of prānāyāma. Kaivalaydham’s quarterly scientific journal has been publishing findings since 1924. In addition to the scientific and the philosophical and literary research departments the institute has a health centre and ashram. Film and sound work will also be conducted there. This film seeks to explore the practice of prānāyāma and the power this practice imbues for the practitioner to self-regulate and control their own thoughts, desires and actions, furthermore this film examines the role these practices play for a practitioner to truly become and constitute themselves as subjects. This film looks to explore through sound and image what happens when we learn to regulate and control our own breathing. What happens when we learn to regulate and control ourselves? What happens when we learn to regulate and control prana? “What are the context and risks for this kind of philosophy and thinking to exist”? This film is part of my first year fieldwork research for my practice based PhD.

Dr Paul Dakin
p.dakin@nhs.net

“Through vast realms of air”: The poetry of Francis St Vincent Morris

Francis St Vincent Morris is a lesser-known First World War poet – Blackwell posthumously published a single volume of poetry in 1917. His letters and notebook reveal influences from a vicarage upbringing in Ashbourne, Derbyshire; a classical education and a joy of flying. The poetry is perhaps more romantic and aspirational, with a greater use of religious imagery, than that of many of his contemporaries. 2nd Lieutenant Morris transferred to the Royal Flying Corps shortly before being sent to France. He died in a field hospital at Vimy Ridge several weeks after crashing his plane in a snowstorm at the age of 21. I present a short history of his life and work illustrated by readings from his letters and poetry.

Dr Elizabeth Davies
elizabeth.davies@kcl.ac.uk

Exploring the existential and spiritual role of poetry in palliative care

Aims
Although many well-known poems dwell on coping with illness, loss, and bereavement, poetry tends to be perceived in Medicine more as an extra-curricular activity than an active element of existential or spiritual support in health care. Within palliative care, however, there is a relatively long history of interest in how poetry may help patients, their close relatives or carers, and health professionals find meaning and solace. This presentation aims to synthesise the academic, internet, and practice literature on poetry in palliative care to identify key themes for its potential role in existential and spiritual care and support.

Design, methods and approach
A Medline search was undertaken for English academic literature on poetry in palliative care, supplemented by a grey literature search including books, and the websites of health professional and poetry organisations. Papers were reviewed, classified by type of study, and quantitative and qualitative data extracted. Powerful examples of using poetry in popular culture around end of life issues and in clinical practice were also identified, supported where possible by accounts of the patients involved. Significant themes were identified and conceptualised using a health care system approach.

Results
Four overall themes emerged: 1) the poetry of leadership – exemplified by the work of Cicely Saunders; 2) developing a culture of poetry within health care organisations – an area where a few initiatives had been evaluated; 3) poetry for health professionals – represented by increasing poetry collections by or for them; and 4) poetry for people at the end of life. Here, the academic literature was mostly individual practitioner perspectives, case examples, or theoretical pieces on poetry therapy. Qualitative patient data or personal accounts when present were generally powerful, suggesting that poetry could promote existential and spiritual growth by helping some individuals express powerful thoughts and emotions, create something new, and feel part of a wider community of care.
goals and notions that the surgeon seeks to achieve results that are both medically and aesthetically acceptable. Organ transplants, which used to be performed exclusively as a procedure to save the patient’s life, are carried out today also to improve the quality of life and for primarily aesthetic reasons. In the latter category, one of the important developments of the last decade has been face transplants that are performed in collaboration with plastic surgery. Turkey’s first full face transplant was done in 2012, two years after the first operation in Spain. With these transplants, a necessity has emerged to adapt surgical and ethical paradigms of organ transplantation and to reassess these processes under psychological and legal aspects: Can the current laws related to vital organ transplantation, regulations governing kidney or liver transplants, for instance, be applied as they are now to face transplants? How can the great difference between aesthetic goals and the goal of saving a life be reflected in regulations governing organ transplants? What kind of risks would we have to face if we were to proceed without making such amendments? In this paper we seek to answer these and related questions.

Dr Ian Fussell
ianfussell@me.com
ActionArt
Ian Fussell1 and Cosmic2
1 University of Exeter Medical School,
2 The Street
People who attend this workshop will be invited to produce a piece of art. This will be based on an ActionArt project that we ran this year and was shown to improve year 3 medical students’ tolerance for ambiguity. There is risk. There will be no rules or regulations. The final piece will be collaborative. Visit the blog: http://actionartproject.blogspot.co.uk

Emma Graham
emma.graham@students.pcmd.ac.uk
Understanding leukaemia through art
Medical student, Peninsula College of Medicine and Dentistry
As a fourth year medical student at Peninsula College of Medicine and Dentistry I have recently completed a Medical Humanities study unit entitled ‘Working with Artists’. I chose to focus on leukaemia for this project and I have made three pieces based on the spherical shape of white blood cells.
Whilst completing this work I have considered my own family’s experience of this disease alongside the stories that patients and their families have shared with me during my clinical placements. Each of these pieces focuses on one of the various aspects of leukaemia that patients and family members have shared with me. The first piece reflects on our idea of normality, the second on the symptoms leading to a diagnosis and the third looks at some elements of patient care. The aim of this project was to try to look beyond the pathophysiology of this disease at a cellular level and consider the wider implications that abnormalities in these cells have on everyday life. As leukaemia is a disease that has impacted my family I have also considered how medical professionals manage and deal with scenarios where we can relate certain patient stories with our own personal experiences outside of medicine.

Katie Green
katie@katiegreen.co.uk; lighterthanmyshadow.com
Lighter Than My Shadow
Freelance graphic novelist

Like most kids, Katie was a picky eater. She’d sit at the table in silent protest, hide uneaten toast in her bedroom, listen to parental threats she’d have to eat it for breakfast. But in any life a set of circumstances can collide, and normal behaviour can soon shade into something sinister, something deadly. Lighter Than My Shadow is a hand-drawn story of struggle and recovery, a trip into the black heart of a taboo illness, an exposure of those who are so weak they prey on the weak, and an inspiration to anybody who believes in the human power to endure towards happiness.

Published in 2013 by Jonathan Cape, Katie Green’s Lighter Than My Shadow has achieved cult status and is a key graphic novel autopathography. Katie will talk about the genesis of the novel and its impact, and the importance of the graphic novel in contemporary culture.

Stanley Hamstra PhD
stan.hamstra@gmail.com
Caring and Compassionate Healers: A Matter of Professional Vision
Stanley J. Hamstra† and David M. Irby†
1 Accreditation Council for Graduate Medical Education, 1 Northwestern University Feinberg School of Medicine, 2 University of California at San Francisco.

Current conflicts in medical education over curriculum, pedagogy, and assessment of professionalism are rooted in part in the differing frameworks that are used to address professionalism. While each framework is useful and valid, we posit that the field of health professions education is currently engaged in several different discourses resulting in misunderstanding and differing recommendations for strategies to facilitate learning. In this paper, we review different frameworks for conceptualizing professionalism and provide a linkage that is based on recent work in anthropology and teacher education. Rather than focusing on behavioural indicators of professionalism (i.e. competencies), identity formation, or a virtue-based approach, we propose that professionalism depends on the presence of a guiding vision that enables sensitivity, interpretation and prediction of one's environment. Our goal in this paper is to provide greater insight into the nature of professionalism for the purposes of more effective teaching and assessment. In examining each discourse in detail, we highlight underlying commonalities to assist educators in the health professions in creating effective curricula, pedagogy and means of assessment.

Dr Angela Hodgson-Teall
angelahodgsonteall@hotmail.com
Drawing on the nature of empathy
Angela Hodgson-Teall
University of the Arts London in collaboration with Lewisham and Greenwich NHS Trust

My research investigated the impact of introducing structured drawing activities to staff of a mixed ethnicity hospital community in south-east London, to address the question of whether drawing is a useful tool in the practice of empathy. Empathy, ‘putting oneself in the shoes of another’ is examined critically through drawing as practice, conducted within the hospital environment. The research project focused on the benefits (and complications) of drawing within the hospital community, during a time of immense turmoil. Drawing was used to aid investigations, sustain the
craft skills of medicine and explore emotions and thoughts, in empathic therapeutic interventions. These interventions allowed staff to slow down, play, analyse and reflect, creating a space within the context of the hospital, where the practice of empathy was reviewed. The core practice, drawing, was embedded in a longitudinal study of drawing events based in the same hospitals at yearly intervals, so that a similar body of staff had the opportunity to participate in these collaborative events. The work used the dual practices of art and medicine to explore complex intersubjective communication.

At the core of my research is a definition of a practice of empathy based on my work in the research activities. The elucidation of a set of features, pertaining to the practice of empathy, has been defined by these events. My definition of empathy was constructed by building temporary collaborative communities during these events through which the dynamics of empathy were examined and its features described. I will present my art practice as methodologically relevant to the proper understanding of the problems, dangers and opportunities of empathy in medical practice.

The performance draws from social sculpture inspired by healthcare staff from the hospital in South East London, where I have done research into the hybrid roles of art and medicine. The practice uses splenic palpation, double blind drawing and Caminhando (walking with scissors along a Moebius strip), interactions of a challenging but empathic nature. A cello or singing bowl, used as acoustic objects, are sometimes included in the performances. Critical issues such as risk and resistance are alluded to.

Dr Lori-Linell Hollins
lhollins@metrohealth.org; mrs179@case.edu
The use of video and reflective writing exercises as tools for teaching and engendering empathy amongst medical students
Lori-Linell Hollins and Mansi Shah
1 MetroHealth Hospitals, Cleveland, OH, 2 MD Candidate Case Western Reserve University School of Medicine

Our study evaluated the use of video and reflective writing exercises as tools for teaching and engendering empathy amongst medical students, in an elective on women’s health [1-2]. First and second year medical students participated in an elective addressing topics such as abortion, sexual identity, childbirth, infertility, and reproductive illness. These topics are not addressed in the required curriculum at Case, making it an act of resistance to facilitate the elective. We supported students in engaging in discussions about film and literature that reflect experiences of illness, and tying the literature to clinical interactions. For example, in the elective, we showed scenes from the movie version of the play Wit which show the narrator’s becoming a scientific object as a patient on the oncology service. We discussed issues of professionalism and bedside manner, and tied these clips to The Cancer Journals by Audre Lorde.

For this presentation, we would like to have an interactive session showing 3-5 minutes of video clips with discussion questions for the group that use the video to link medicine, the experience of illness, and gender, identity, and sexuality. To fit the theme of risk and regulation, we will introduce nuanced narratives around abortion, breast cancer, and being transgender to explore the construction of gender meanings and norms.


Dr Fiona Johnstone
fjohnstone@hotmail.com
Department of Art History, Birkbeck, University of London

Edward Adamson (1911-1996) was a pioneer of art as therapy in British psychiatric hospitals. A practicing artist who had previously worked with patients in a TB sanatorium, between 1946 and 1981 Adamson was employed as ‘art master’ at the long-stay mental institution Netherne. A purpose-built studio was constructed in the hospital grounds, and inmates given access to their own workspace, easel and other equipment; at the end of each session all works were kept by Adamson and filed under the name of each patient. Doctors had access to the works, which were treated as diagnostic tools and as visual records of the patients’ mental health. The Adamson Collection (transferred to the Wellcome Archives in 2012-13) includes almost 6,000 examples of paintings, drawings, ceramics and sculptures made by the inpatients at Netherne: these objects – simultaneously clinical artefacts and works of art – are the focus of this paper.

Dr Lori-Linell Hollins
lhollins@metrohealth.org; mrs179@case.edu
Clinical artefacts or works of art? Works from the Adamson Collection, 1946-1981
Department of Art History, Birkbeck, University of London

Critical issues such as risk and resistance are alluded to.

The performance draws from social sculpture inspired by healthcare staff from the hospital in South East London, where I have done research into the hybrid roles of art and medicine. The practice uses splenic palpation, double blind drawing and Caminhando (walking with scissors along a Moebius strip), interactions of a challenging but empathic nature. A cello or singing bowl, used as acoustic objects, are sometimes included in the performances. Critical issues such as risk and resistance are alluded to.

Dr Fiona Johnstone
fjohnstone@hotmail.com
https://birkbeck.academia.edu/FionaJohnstone

Example: Drawing and splenic palpation performance
I have never done anything in my life except try to make myself ill when I had my health and try to make myself well when I had lost it, I have been equally and thoroughly successful in both and today in that particular I enjoy perfect health, which I wish I could ruin again but age prevents me. The malady which we call the 'French disease' does not shorten life when one knows how to cure it; it merely leaves scars.

[Vol. 3 chapter 11, p217 A.Machen.  History of my Life, Giacomo Casanova]

Giacomo Casanova (1725-1798) wrote his Memoirs at the end of his life whilst living at Dux Castle in Bohemia where he worked nominally as a librarian to Count Joseph Charles de Waldstein from 1785 to his death, thirteen years later, aged seventy-three. He had accepted Waldstein's invitation because he was impoverished, with no home and no companion. The Memoirs provide a staggering record of many aspects of European life from 1725 to 1774, at which point they end abruptly. They range from the cost of hiring a postilion to discussions with Catherine the Great about the challenges of adopting the Gregorian calendar in Russia.

It is significant for the subject of this presentation that the teenage Casanova wanted to study medicine at Padua but was not allowed to by his mother and his guardian, the Abbe Grimani, who both insisted he become an ecclesiastical lawyer. However, his interest in medicine continued throughout his life. He took many opportunities to discourse with physicians who were up-to-date and writes about these encounters. There is evidence that he was familiar with the medical works of Professor Boerhaave of Leiden one of the most respected physicians in early 18th century Europe; he often refers in the Memoirs approvingly of physicians who had been pupils of the famous Professor. Casanova's comments about his health and that of others reveal an understanding of both ancient medical theory as well as newer medical understandings. Indeed he often used his medical knowledge to advise others but never as a formally hired practitioner, rather as a friend or as an act of generosity although sometimes dramatizing is interventions through applying the cabbala. Thus when he describes symptoms and treatments, he does so as an observant, informed and interested medical commentator.

Casanova's Memoirs are full of descriptions of the effects of venereal disease and its treatments on himself, his friends and acquaintances. Even

Previous approaches to Adamson’s work have tended to take the form of historical narratives that track the development of the Art Therapy movement; in contrast, this paper places the patients’ artworks at the centre of the enquiry. By paying equal attention to the therapeutic and aesthetic dimensions of such works, it aims to address the (surprisingly inflexible) boundaries between art history and art therapy, as well as raising a number of important questions about the relationship between the visual arts and medical practice. What is the role of artistic self-expression in the clinical process? Can the visual arts be used as diagnostic tools, and what is at stake in doing so? What are the connections between creativity and healing, and how have views on this changed between the 1940s and the present day? What ethical issues are involved in writing about (or, from a curatorial point of view, displaying) such images today, and what are the potential challenges in seeking to bring together aesthetic and clinical perspectives?

Dr Catherine Jones
c.jones@abdn.ac.uk
Medical Literacies and Medical Culture in New Netherland and Early New York
University of Aberdeen

This paper will explore the circulation of medical theories and therapeutic practices in New Netherland and Early New York in the context of the Dutch Golden Age and its global diaspora. Using medical correspondence, library inventories, and court records relating to medical regulation and early malpractice suits, the paper will examine the different kinds of medical literacy that flourished in New Netherland, and the relationship of communication in print to oral and manuscript circulation of medical knowledge. The West India Company, for the most part, sent medical practitioners of the Dutch colony of New Netherland, some as ships’ surgeons and others to minister to the settlers. In time, a few physicians sailed from the Dutch Republic for New Netherland, such as Johannes la Montagne, a graduate of the University of Louvain, who became a member of the colony’s governing council under Willem Kieft beginning in 1638. The paper will pay particular attention to the exchange of medicinal information and plant knowledge between Dutch settlers and Native Americans. It will also consider attitudes towards risk and regulation in the colony, focusing on the Leiden-educated lawyer Adrian van der Donck's Remonstrance of New Netherland, Concerning its Location, Fruitfulness, and Sorry Condition (1650) and his A Description of New Netherland (1655).
though the pox had been known in Europe for over two hundred years there was still controversy in the 18th century about its cause and proper management. In general there was little awareness that ‘the pox’ (syphilis) was a different disease to gonorrhoea and carried a more serious prognosis. Therefore whatever the venereal symptoms, these were frequently treated the same which in effect often meant a course of mercury, the ‘Great Cure’ or Holy Wood. This presentation both summarises the many stories Casanova relates in his Memoirs regarding the lived experience of venereal diseases and treatments and refers to other events in the Memoirs which illustrate the risks of pregnancy, abortion and childbirth.

Anna Macdonald and Professor Marie-Andrée Jacob
A.Macdonald@mmu.ac.uk; m.jacob@keele.ac.uk
Striking through: writing practices and the discipline of research

Anna Macdonald1; Marie-Andréé Jacob2
1 Senior Lecturer Dance, Manchester Metropolitan University; https://vimeo.com/home/myvids
http://www.forecastdance.org
2 Professor of Law, Keele University
AHRC Fellowship: http://www.sciculture.ac.uk/project/judging-the-medics-science

This collaborative project, between law researcher Marie Jacob and artist Anna Macdonald, examines writing practices within medical research regulation. It stems from an AHRC funded project on the regulation of medical research, which studied how the General Medical Council engaged with the research activities of doctors over the past twenty-five years.

The study of regulatory responses to research misconduct, and of regulatory frameworks designed to eliminate risks of future misconduct, led to a focus on the material written practices shared by both medical research and regulation. In this paper we propose that exploring these practices from an analytical and aesthetic perspective, through the collaborative creation of artworks, can offer surprising dividends to the study of science and regulation across fields.

In this paper we will consider two artworks emerging from this collaboration. The first entitled Falling for everything https://vimeo.com/109323428 is a moving image work that looks at the way science-based representation of regulatory practices act as ways of pausing time, of creating a sense of stability that reduces our anxieties around risk and transience. It contrasts the relentless visual expansion, and then disappearance, of a diagram outlining medical research trial protocols with the sound of someone with a life threatening illness talking about their new sense of temporality. The second is a series of artworks, to be made in collaboration with researchers of the National Institute of Medical Research (tbc), which examine the typographic device of strikethrough, the deceivingly innocent writing practice of striking through text, used to display and authenticate regulatory and research processes.

The artworks engage the themes of the conference by looking sideways at the tension between excessive regulation of risk and resistance to regulation. They offer a nuanced perspective that goes beyond the traditional perspective that scientists, and regulators, either restrain their creativity or innovate through resistance to regulation.

Dr Bridget MacDonald
bridget.macdonald@nhs.net
Representation of sickness and the body in Haiti – lawlessness, vaudou, and creativity
Croydon University Hospital

Haiti is a country weighed down by a clichéd mass of the misfortunes of poor countries. But it is buoyed by its pride in its history and traditions. This has produced in an alarmingly unregulated arena a wonderful array of creative work often about the body but also about health and disease. In this presentation I will discuss some of the history of its current financial and regulatory chaos, the background to vaudou Haiti’s religion (unique albeit woven with Benin Vaudou, Cuban Santeria and other new-world voodoo as well as Catholic traditions).

This will be illustrated by examples of art, street performance and public health messages that I encountered during a recent visit.

Dr Teodora Mancea
E.T.Mancea@exeter.ac.uk
Skin Regulations and Posthuman Skin Condition
Exeter University

Our epidermal surface is the point where the interiority of the body and the exteriority of cultural and societal norms meet. The largest organ of the body is where a doctor begins to read a patient. I would like to develop the hermeneutical project of epidermal readings referring to NHS regulations regarding the general topic of skin. These readings will be complemented...
with posthuman representations of skin in the utopian and the critical posthumanist discourse materialised in films. I will analyse following topics: the personal identity focusing on skin removal (Gattaca); skin enhancement, identity and gender (The Skin I live in); and the infusion of technology into the posthuman body, the skin-clock (In Time). The particular NHS regulations analysed will concern skin colour, exposure, manipulation and touch.

Dr Laura Marshall Andrews, Dr Rosario Gracia and Fiona Geilinger
lauramarshallandrews@hotmail.co.uk; rosaria@googlemail.com;
www.fionageilinger.co.uk
Finding Your Compass
Dr Laura Marshall Andrews1, Dr Rosaria Gracia1 and Fiona Geilinger2
1 Brighton and Health Wellbeing Centre; 2 Finding Your Compass

Presentation and projection of a three minutes extract from an eight minutes long film.
Keywords: recovery; narrative medicine; integrative measures
Finding your Compass offers a creative route from depression to recovery, through:
○ raising awareness and addressing stigmas surrounding depression
○ exploring movement as a means of expression for those affected
○ artistic outputs for educational purposes and signposting
○ promoting positive mental health messages.

Following the three ‘R’s of contemporary critical inquiry, this project has proven to be ‘risky’, challenged ‘regulation’ and found ‘resistance’

Risk
○ How to provide enough trust and education for cautious participants, centres and facilitators to see the benefits of the project. What is the risk in implementing this project? What is the incentive?
○ The who as the what! (Oliver Sacks) Challenging identities and managing expectations.
○ Costs and benefits (financial, emotional and practical) for centres, participants and facilitators.
○ Fears about privacy and stigmatisation in patients.
○ Medics thinking in terms of fixing rather than listening.
○ Medics frightened of losing their job or being disciplined.

Regulation
○ What is considered efficient and not? In what context? Evidence of how narrative medicine works, the return on investment and if it can attract patients.
○ Provision of funding and institutional support – when the anecdotal becomes respected and listened to.
○ What is and is not appropriate in particular spaces (expectations and provision)?
○ Lack of long term vision, fear of culture change.

Resistance
○ From participants – perceiving that the project is not for them; feeling inadequate.
○ Don’t want to appear ‘difficult’ by asking for narrative medicine. Possibility of not being listened to.
○ Threatening potential role change from being passive to active in their own recovery.
○ Fear of commitment. Taster sessions are important so participants understand what’s involved and feel able to commit.
○ From the professionals, how past experiences affect the recognition of different paradigms and ways of working? Not being aware of narrative methods, how to use them, or what the value is.

This presentation will aim to explain and give the delegates an insight into the ‘Finding your Compass’ process, and pose questions about new avenues of collaboration to make an impact on facilitators and participants alike.

Finding your Compass
Dr Laura Marshall Andrews1, Dr Rosaria Gracia1 and Fiona Geilinger 2
1 Brighton and Health Wellbeing Centre; 2 Finding Your Compass

Risk
○ How to provide enough trust and education for cautious participants, centres and facilitators to see the benefits of the project. What is the risk in implementing this project? What is the incentive?
○ The who as the what! (Oliver Sacks) Challenging identities and managing expectations.
○ Costs and benefits (financial, emotional and practical) for centres, participants and facilitators.
○ Fears about privacy and stigmatisation in patients.
○ Medics thinking in terms of fixing rather than listening.
○ Medics frightened of losing their job or being disciplined.

Regulation
○ What is considered efficient and not? In what context? Evidence of how narrative medicine works, the return on investment and if it can attract patients.
○ Provision of funding and institutional support – when the anecdotal becomes respected and listened to.
○ What is and is not appropriate in particular spaces (expectations and provision)?
○ Lack of long term vision, fear of culture change.

Resistance
○ From participants – perceiving that the project is not for them; feeling inadequate.
○ Don’t want to appear ‘difficult’ by asking for narrative medicine. Possibility of not being listened to.
○ Threatening potential role change from being passive to active in their own recovery.
○ Fear of commitment. Taster sessions are important so participants understand what’s involved and feel able to commit.
○ From the professionals, how past experiences affect the recognition of different paradigms and ways of working? Not being aware of narrative methods, how to use them, or what the value is.

This presentation will aim to explain and give the delegates an insight into the ‘Finding your Compass’ process, and pose questions about new avenues of collaboration to make an impact on facilitators and participants alike.

What is the project?
A Finding your Compass (FYC) project consists of a series of immersive creative workshops, for small groups, that focus on recovery. The project was founded by Dr. Rosaria M. Gracia and Fiona Geilinger. The sessions are also led by a team of expert artists, dancers, teachers and technicians, working towards a high quality outcome of film and still images. Participants are a combination of GP referred patients and self-referred individuals who experience conditions such as depression and anxiety. Participants are invited to explore their stories, using firstly verbal, then pre-verbal language. Firstly, in a focus group setting, participants are encouraged to look at their stories from different perspectives. Storytelling techniques, character archetypes, and relevant
dance imagery (such as Afro-Brazilian divinities) are also used. The purpose of these methods is to explore, rather than limit, the participants’ vocabulary and perspective of their own situation. Secondly, using pre-verbal language, participants explore their stories through movement and drawing.

Movement: The project is based on the idea that movement is an innate condition so previous dance training is not required. Over a number of weeks, participants are supported in the development of a ‘movement script’ which develops their story told verbally. As their own movements emerge, they can reflect on them and the practitioner can feedback to them. Here, there is a need for balance between working within a framework (directed by the practitioners) and allowing room for the participants to hold a sense of ownership over their movements.

Drawing and photography: The language of drawing is also used to communicate different stages of their condition. Drawing and photography are used to intensify the human gesture by simplifying it into silhouette form. Participants cut paper silhouettes to layer with mono prints. They draw their emotional landscape onto their photographed silhouettes. The artistic content produced by the participants is developed through an overarching story structure, with a positive recovery message in mind. This positive message adopts different formats. In the first pilot project this was represented through a group dance that celebrates their journey. This reflects an aspect of recovery that can be found in working together, trust and a sense of community.

Product
The sessions always end in a creative product: a film or still images, which tell the participants’ stories. The film is used for feedback from both the participants and the audience, who engage with a high quality visual outcome. A hopeful message is translated to the audience through moving and still images, describing the participants’ journey towards recovery. This raises the audience’s awareness, empathy and insight in relation to themselves and others struggling with mental health conditions. Support services are sign-posted in the film’s credits and through FYC’s printed resource packs.

Discussion
Risk, resistance and resilience
Being out of one’s comfort zone: There is a risk of participants feeling overwhelmed when expressing painful experiences. To ensure their safety, at a very early stage of the project they are encouraged to have a contact number for further support if needed. Additionally, some of the members of the artistic team are trained in emergency mental health first aid. This context provides patients with a secure, healing environment for them to share their thoughts. Confidentiality is agreed within all sessions to ensure that everyone feels heard and respected. Although these sessions are not designed as support groups, the therapeutic outcome is very similar.

Uniqueness with a collective sense: While everyone’s experience is unique, commonalities between patients emerge that can help to normalise their conditions. This can also be challenging. Some individuals may have created identities based on their conditions, so raising awareness about commonalities may be threatening. At the same time, commonality is important to provide a safety net within the group.

Using different ways of communicating: Facilitating verbal and non-verbal narrative provides individuals and communities with tools for change; it benefits participants, audiences and facilitators alike. It can also be difficult for people for whom these languages are new. The project focuses on the development of narratives as expressions of human experience, examining different character archetypes and considering their strengths and weaknesses. This can also be used by individuals to gain a new perspective on their own life, building strategies for self-management and expanding their vision of possibilities. Thus, it moves us from a particular experience to a universal message.

Integrative measures: FYC is interested in working alongside medical professionals to make this approach both valuable and sustainable. This involves risk due to the lack of homogenous understanding across different platforms to prove the effectiveness of interventions such as this. The project focuses on the importance of providing services and platforms to support community members in providing mental health interventions to empower ordinary people to care for others. It is about raising awareness to help bring better mental health care to communities while teaching people to take care of each other. This is the framework in which FYC works.

Link to the Finding Your Compass film: https://vimeo.com/93264018
Finding your compass
Website: http://findingyourcompass.co.uk
Mob: 07854 542856
https://www.facebook.com/findingyourcompass
Dr Radhika Merh
radhikamerh@hotmail.co.uk
Exploring ‘The King of the Crocodiles’ by the 18th century poet, Robert Southey, as a parallel for whistleblowing processes in the modern day National Health Service (NHS)
Core Surgical Trainee, Margate Hospital (East Kent)

Written in the 18th century, Southey portrays a distraught mother who wants justice for her child eaten by a crocodile from the ‘King of the Crocodiles’ who is believed to ‘do no harm’ according to ancient Egyptian superstition. She risks her own safety in doing so, as the king decides to make a meal of her. Parallels can be drawn between the woman and courageous staff who speak up and highlight matters of patient safety and justice to seniors but are faced by condemnation. This creates an environment of threat and vulnerability for whistleblowers within the NHS highlighted by Francis’ Freedom to Speak Up 2015 review. Interestingly Southey has, in his later printed edition, included a second part to the poem that shows the mother avenging the king. Many eggs are broken during her struggle for escape, for which the queen holds him answerable on her return from the Nile, and six baby crocodiles serve as funeral supper, in remembrance of her son, rendering a ‘sweet revenge’. Thus, Southey transfuses hope in a dire situation and must aspire us to stand up against poor medical practice effecting eventual triumph of a culture of safety and learning. Indeed he proves a subversive post-modernist ahead of his times, enlightening us of the need for transparency of medical practice and incorporation of ethical values to enable society to entrust us with the responsibility of serving the unwell.

Dr Alex Mermikides and Dr Gianna Bouchard
A.Mermikides@kingston.ac.uk; Gianna.Bouchard@anglia.ac.uk
‘Themselves and not themselves’: medical chimerism and risking identity

Certain medical conditions and their treatment, in some instances, pose epistemological and philosophical risks to normative understandings of what it means to be human and a singular individual. These two papers will explore how the concept of medical chimerism – the phenomenon of two genetically distinct organisms co-existing in a single body – risks destabilising normative reproductive patterns and understandings of the individuality of the self. This is particularly focused through chimeraism’s

Dr Mel McCree and Professor Norma Daykin
Mel.McCree@uwe.ac.uk; Norma.Daykin@uwe.ac.uk
The risks and challenges of arts-based evaluation – notes from a practitioner’s toolkit
University of the West of England

This presentation explores the findings from an ESRC funded Knowledge Exchange project, ‘Creative and Credible’, which seeks to strengthen practice-led evaluation for the arts and health field, by providing resources to support reflexive engagement with evaluation and commissioning agendas (http://creativeandcredible.co.uk).

Arts and health interventions are complex and can be challenging to evaluate. Practitioners, drawn mainly from arts backgrounds and not from health or social sciences, often report a lack of confidence, knowledge and skills relating to evaluation. They also report that arts perspectives are marginalised in evaluation discourse. Nevertheless, there is a strong desire within the sector to understand and improve evaluation approaches and methodologies.

What is at risk when evaluation fails to capture the real outcomes and impacts of a project? Sometimes the meaning of a project gets lost; sometimes the real outcomes remain devalued. The successes of a project may not be well disseminated well, and opportunities to learn from the struggles that arise on the way are lost. . The ‘Creative and Credible’ project has generated a toolkit of resources to support practitioners, researchers and evaluators to try to strengthen evaluation throughout its entire cycle from design to dissemination.

Arts-based projects that are evaluated within ill fitting frameworks and monitoring systems may struggle to advocate successfully. Increased regulation and hierarchies of evidence can further diminish creativity. Arts-based methods have been a particular focus of the ‘Creative and Credible’ project, which explores their fitness for purpose and their sensitivity to settings, participants and the needs of evaluators. Examples of participatory and evaluation methodologies will be presented on film, in visual format and in practical activities.

This talk and multimedia presentation will be of interest to anyone who seeks to better understand how we think about arts interventions that seek to contribute to health and social care goals, as well as how new evaluation knowledge can support contemporary healthcare practice.

Dr Radhika Merh
radhikamerh@hotmail.co.uk
Exploring ‘The King of the Crocodiles’ by the 18th century poet, Robert Southey, as a parallel for whistleblowing processes in the modern day National Health Service (NHS)
Core Surgical Trainee, Margate Hospital (East Kent)

Written in the 18th century, Southey portrays a distraught mother who wants justice for her child eaten by a crocodile from the ‘King of the Crocodiles’ who is believed to ‘do no harm’ according to ancient Egyptian superstition. She risks her own safety in doing so, as the king decides to make a meal of her. Parallels can be drawn between the woman and courageous staff who speak up and highlight matters of patient safety and justice to seniors but are faced by condemnation. This creates an environment of threat and vulnerability for whistleblowers within the NHS highlighted by Francis’ Freedom to Speak Up 2015 review. Interestingly Southey has, in his later printed edition, included a second part to the poem that shows the mother avenging the king. Many eggs are broken during her struggle for escape, for which the queen holds him answerable on her return from the Nile, and six baby crocodiles serve as funeral supper, in remembrance of her son, rendering a ‘sweet revenge’. Thus, Southey transfuses hope in a dire situation and must aspire us to stand up against poor medical practice effecting eventual triumph of a culture of safety and learning. Indeed he proves a subversive post-modernist ahead of his times, enlightening us of the need for transparency of medical practice and incorporation of ethical values to enable society to entrust us with the responsibility of serving the unwell.

Dr Alex Mermikides and Dr Gianna Bouchard
A.Mermikides@kingston.ac.uk; Gianna.Bouchard@anglia.ac.uk
‘Themselves and not themselves’: medical chimerism and risking identity

Certain medical conditions and their treatment, in some instances, pose epistemological and philosophical risks to normative understandings of what it means to be human and a singular individual. These two papers will explore how the concept of medical chimeraism – the phenomenon of two genetically distinct organisms co-existing in a single body – risks destabilising normative reproductive patterns and understandings of the individuality of the self. This is particularly focused through chimeraism's
undermining of the core notion of DNA as providing unequivocal evidence of singular personhood. Our papers will examine how medical chimerism is represented in two recent theatrical performances, both drawn from real life events.

Alex will present on her current immersive performance work, Bloodlines, in which ‘John’, a young man diagnosed with a deadly leukaemia, undergoes an haematological stem cell transplantation for survival. This treatment is simultaneously miraculous, mysterious and slightly macabre. Alex’s discussion will focus on scenes relating to donor-recipient chimerism, a period of uncertainty and risk, in which the potentially lethal and life-saving aspects of the treatment are in balance.

Gianna will consider the 2014 play Chimeras, presented at the Gate Theatre, Notting Hill, which imagines a mother discovering that she has chimerism and that her son is, in fact, her nephew, as a result of this rare condition. Based on recent court cases in America, the play explores questions of kinship and destabilises the myth of DNA as providing unambiguous access to and confirmation of the individualised and originary self.

Both performances explore genetic science in order to consider identity through the mediation and findings of biotechnologies. Using modes of physical theatre, projections and text, they stage the chimeric body as both inherently destabilising and potentially life-saving - both risky and resistant. Using performance as a mode to explore the condition of chimerism, these works ask questions about our identity and humanise the molecular and biologised aspects of our selves.

This presentation uses an interactive art piece to interrogate how the current teaching of communication skills to undergraduates is discouraging students from speaking authentically and as themselves. Are doctors similarly developing a tendency to speak through verbal filters for fear that their words will come back as complaints or in litigation? This affects the patient-doctor relationship for both parties.

Is this manifestation of our becoming more risk-averse detrimental to the relationship we are working so hard to improve in a post-paternalistic era? These issues will be explored in the presentation.
Dr Penny Morris
penny.morris@nwl.hee.nhs.uk
Using performance to enhance communication between equals: a healthier outcome for all
Professional Support, London; Health Education England

Professional Support in London has been collaborating with members of patient, community and professional groups to produce learning workshops that enable shared understanding and development in health. Examples include long-term condition patient groups in Hackney and mothers’ groups in Tower Hamlets with local GPs, carers groups in Newham with social workers and voluntary groups, immigrant community support groups with refugee and local professionals in Islington. Meetings for the Medical Revalidation team of London’s community Healthwatch groups with doctors and a programme of workshops with patients and staff in a secure mental health unit. All involve observing and engaging in improvised, performed interactions that offer an authentic experience in a simulated setting of the communication challenges and systemic struggles for participants. Debriefing, discussion and rehearsal of alternatives pay attention not only to individual feelings, behaviours and possibilities but also to context, structures and wider professional and community resources.

The aim is to support effective conversations in our multicultural capital about responding to major change – in NHS services and pressures for improvements in quality, compassionate care, and individual life styles – with ongoing financial restraints. Equivalence and difference (of experience and power) are explored during meetings between experts and equals, within a humanistic and emancipatory framework for communication, using fresh consultation and group dialogue models that wrap around the patient and the personal.

The group leading such co-productive learning draw on theory and practice in performance, adult learning, citizen engagement and radical movements in mental health to explore how people come together in health related settings to learn with and from each other. Communication learning has traditionally been doctor to doctor with set scenarios from medical perspectives – this approach ensures an open and experimental method that models co-producing health.

The presentation will illustrate with recordings aspects of outcomes and the means and thinking that encourage creative risk, maintain morale and build the collaborative capacity of participants.


Dr Antonia Mortimer
antonia.mortimer@gmail.com
CTs Medicine, Royal Marsden Hospital, London

This presentation uses an interactive art piece to interrogate how the current teaching of communication skills to undergraduates is discouraging students from speaking authentically and as themselves. Are doctors similarly developing a tendency to speak through verbal filters for fear that their words will come back as complaints or in litigation? This affects the patient-doctor relationship for both parties.

Is this manifestation of our becoming more risk-averse detrimental to the relationship we are working so hard to improve in a post-paternalistic era? These issues will be explored in the presentation.

Allister Neher PhD
Aneher@dawsoncollege.qc.ca
Norm and Deviations: Anatomical Illustration in early Nineteenth Century Britain
Dawson College, Montréal, Canada

This presentation is about the conflicts and accommodations that characterized the relationship between a central current of British anatomical illustration and one of the ruling doctrines of art theory in the first half of the nineteenth century. In this era the most influential aesthetic doctrine in the visual arts was Neo-Classicism. By its very nature Neo-Classicism is at odds with anatomical illustration. Neo-Classical aesthetics shifts the act of depiction towards idealisation, simplification and the suppression of individualising characteristics. Anatomical illustration does not typically follow this approach; indeed, it usually needs to take one opposed to it. Accordingly, this current of British anatomical illustration found itself at odds with its guiding artistic ideas at its most fundamental epistemological level: the level of accurate description. Many would think that this would be a good reason to seek artistic guidance elsewhere, but Neo-Classicism was the doctrine most closely associated with cultural refinement and intellectual sophistication in the mind of the educated public, and this was an association gentlemen anatomists found difficult to put aside, given their tarnished reputation in the era of grave robbing and the
The idea of the paper is to reveal how hazardous situations in human life caused by different types of pestilent diseases led to taking risk in life and up-growth of art. Excellent examples in that aspect are the black death and syphilis. The thrive of art, economy and social activity as a response to the plague or the risk of artists’ life due to the unhealthy way of living which brought to production of masterpieces in art are to be discussed.

**Dr Joe O’Dwyer**  
jodwyer@doctors.org.uk  
**Artistic expression and access to art in a medical setting**  
Western Sussex Hospitals NHS Trust

This presentation will look at various ways in which the management of risk and accompanying regulations can interact with and interfere with artistic expression and access to art in a medical setting. Specific examples where management of risk has had a positive or an adverse impact on patients or staff will be showcased. Examples will also be presented of artistic expression leading to increased risks.

**Dr Deborah Padfield and Professor Joanna Zakrzewska**  
deborah.padfield@btinternet.com; j.zakrzewska@ucl.ac.uk  
**Visualising Pain**  
1 Visual artist and Research Associate, UCL CHIRP Interdisciplinary Research Fellow, Slade School of Fine Art  
2 Consultant Facial Pain, Eastman Dental Hospital, UCLH NHS Foundation Trust

Artist Deborah Padfield and Facial Pain Specialist Joanna Zakrzewska will discuss their collaboration with clinicians and patients from UCLH Pain management teams, exploring the potential for images and image-making processes to improve communication and expand the dialogue around pain. They will focus on the co-creation of photographs of pain with patients and their subsequent use with other patients in the clinic. Deborah will explore the creative process giving examples of images and metaphors produced which led to the development of a pack of PAIN CARDS as a new communication tool. Joanna will outline some of the complexities of pain experience and how the images can help in management. She will also draw on her personal experience of using the cards (including with non-English speaking patients), highlighting ways in which the research has influenced her clinical practice.

To date, we have no biomarkers for pain and the only way of making a diagnosis remains through the receiving of a comprehensive history where the patient has the opportunity to tell their story to a listener (the clinician) who is fully engaged. The cards encourage clinician and patient to risk moving away from familiar patterns of dialogue and interrogative styles of communication leading to more democratised encounters. They aim to improve the quality of listening, enabling clinicians to pick up on emotional clues that could otherwise be missed, reducing risk factors and improving outcomes. There is ample evidence that good communicators are at reduced risk of litigation. Early multi-disciplinary analysis of the cards in consultations by a range of pain experts and emerging themes will be discussed. It is worth noting that consultations with images did not extend the time frame but facilitated a more patient centred approach and a different kind of conversation. Participants will be given an opportunity to engage with the cards and discuss their potential use. Feedback will be welcomed.

**Description of the Film**  
Duet for pain 2012 (12 mins)

Duet for pain is an artist's film made as a response to working as artist in residence at UCLH in a facial pain management environment. It investigates narratives of pain juxtaposing two perspectives: those of the pain sufferer and those of the clinician. It aims to raise questions around the representation and construction of identity through both medical and photographic lenses, asking what happens when the face that expresses pain is itself in pain. It hopes to highlight the potential value of narrative to medicine, particularly in relation to chronic illness.
Meanwhile the photographs taken by participants form the backdrop to the presentation. Here the positive photographs from those whose lives have been transformed through food are juxtaposed with some of the other images that highlight individuality through specific food rituals, such as eating alone or only in small amounts, as well as images that focus on religious differences, or photographs of animals or city views, instead of food. These are important acts of resistance and demonstrate ambivalence towards the research aims.

Background:
This presentation draws on data gathered for an Institute of Sustainability Solutions Research (ISSR) collaborative award 2014, ‘exploring food as a ‘lifestyle motivator’ to support wellbeing and life skills in marginalised groups.

This exploratory project involved an interdisciplinary team from a range of backgrounds (PI: Public Health Dietitian, research assistant with an interest in foraging, quantitative research expert, sociologist, social worker, occupational therapist, centre volunteer/gatekeeper and General Practitioner). The aim of the project was to utilise creative and participatory methods of research to gain insight into the food practices, needs and preferences of residents using a city centre homeless centre. At the heart of the project was the ‘photo elicitation’ method developed to enable otherwise silenced or marginalised individuals a means of expression. Thus participants were invited to a ‘photo dialogue’ workshop, and then given cameras to take photographs of their everyday food activities for 10 days. The photographs were developed and used to form the basis of discussion exploring food choice, relationship with food and the potential impact of food-related activities on their lives within focus groups run by the Public Health Dietitian, research assistant and centre volunteer. There was also an exhibition of the participants photographs held at the homeless centre. In addition data was gathered through an online questionnaire with staff from the homeless centre and observational data (photographs) collated by support workers.

References:

Dr Julie M. Parsons and Dr Clare Pettinger
J.M.Parsons@plymouth.ac.uk; clare.pettinger@plymouth.ac.uk
‘Liminal identities’, reflections on resistance and empowerment in researcher/respondent relations when utilising a creative participatory research approach.
Julie Parsons’ and Clare Pettinger’
1 Sociology; 2 Public Health Dietetics; Plymouth University

This presentation centres on interaction between two researchers/presenters involved in a research project that utilised a creative participatory approach: ‘photo elicitation’ in order to empower/engage with users of a homeless centre. The focus of the study is ‘food as a lifestyle motivator’, as some of the participants had clearly turned their lives around as a result of becoming interested in and participating in a range of food activities provided by volunteers at the centre. Yet, for others taking food out of bounds and/or adhering to strict religious food values for example were sources of resistance. Hence, choosing what to eat/not eat, when, where and with whom becomes a means of asserting agency in the face of intense regulation and control of food and mealtimes (and/or other aspects of everyday life).

Of course there are power relationships inherent in all social research practices and participatory research approaches are no less influenced by these dynamics (Letherby 2003, Liamputtong 2007). In this study participants were keen to please and worried about doing “it” wrong. Yet, their photographs provide valuable insights into their individuality and the presentation of the self outside of the label of ‘vulnerable’ and/or ‘marginal’. What emerges is a lack of fit between the expectations and demands of stakeholders towards a group of people that ‘need’ to change, and the highly individualised perspectives of those who are doing the best they can in light of multiple deprivations.

Hence, one of the presenters will ‘speak’ on behalf of respondents through the use of i-poems, which are part of the voice centred relational method (VCRM) that aims to prioritise the voice of narrator above that of researcher, (Mauthner and Doucet 1998). These are created from respondent transcripts and focus on the ‘i’, ‘you’ and ‘we’ statements, which are powerful speech acts embedded in everyday talk. The other presenter juxtaposes the ‘i-poems’ with the use of responses received in an open ended online questionnaire sent to staff and volunteers at the centre.

Meanwhile the photographs taken by participants form the backdrop to the presentation. Here the positive photographs from those whose lives have been transformed through food are juxtaposed with some of the other images that highlight individuality through specific food rituals, such as eating alone or only in small amounts, as well as images that focus on religious differences, or photographs of animals or city views, instead of food. These are important acts of resistance and demonstrate ambivalence towards the research aims.

Background:
This presentation draws on data gathered for an Institute of Sustainability Solutions Research (ISSR) collaborative award 2014, ‘exploring food as a ‘lifestyle motivator’ to support wellbeing and life skills in marginalised groups.

This exploratory project involved an interdisciplinary team from a range of backgrounds (PI: Public Health Dietitian, research assistant with an interest in foraging, quantitative research expert, sociologist, social worker, occupational therapist, centre volunteer/gatekeeper and General Practitioner). The aim of the project was to utilise creative and participatory methods of research to gain insight into the food practices, needs and preferences of residents using a city centre homeless centre. At the heart of the project was the ‘photo elicitation’ method developed to enable otherwise silenced or marginalised individuals a means of expression. Thus participants were invited to a ‘photo dialogue’ workshop, and then given cameras to take photographs of their everyday food activities for 10 days. The photographs were developed and used to form the basis of discussion exploring food choice, relationship with food and the potential impact of food-related activities on their lives within focus groups run by the Public Health Dietitian, research assistant and centre volunteer. There was also an exhibition of the participants photographs held at the homeless centre. In addition data was gathered through an online questionnaire with staff from the homeless centre and observational data (photographs) collated by support workers.

References:
Dr Jennifer Patterson
J.J.Patterson@greenwich.ac.uk
“‘What It Says On The Tin’ – why the patient or the medicine doesn’t do it: Risk Trust and Critical Reflexivity
University of Greenwich

Ulrick Beck’s view of a second modernity is a self-reflexive one that raise issues of trust and credibility in relation to risk and the dominance of science and technology (including medicine) as powerful purveyors and creators of knowledge about risk and risk management. Science and technology therefore become the corporations and bankers trading in a currency of risk as it were in today’s “risk society”. This raises issues of trust, as risks are generated by and form part of the institutions that create such technologies. Additionally, mistrust is compounded by the constraints of modernity around science and public knowledge, as a form of policing that is particularly evident around the borders and intersections between institutions and the public sphere, between research and practice, measured as benefits and losses, physical reactions and individual experiences. Indeed, while medicine is founded on measures of norms in the human body, yet ideas about norms as such, were initially created by measuring what is ‘abnormal’.

This paper applies reflexive modernity as a critique of scientific knowledge through a framework of othering to clinical practice. It considers a number of case histories and considers how the arts can support the unusual, the abnormal and the practitioner (i) in the every day reality of the patient versus the ‘proven’, raising a range of provocative ethical, philosophical and social questions.

Dr Clare Penlington
c.penlington@qmul.ac.uk
Readers’ Theatre
Barts and The London, School of Medicine and Dentistry, Queen Mary University, London

This presentation takes the form of a Readers Theatre (RT). RT is a play-based format, used primarily in the US, in which the players read from a script, and where the focus is on creating narrative via verbal expression (Coger & White, 1973).

Having recently made the move from working in postgraduate to undergraduate medical education, I have found myself having a variety of thoughts about the way students are prepared for their role as doctors at medical school. One of the means I have used to navigate the organisation of a medical school, is view it (and myself) through the lens of psychoanalytic theory, functioning as an experiential and relational system (Diamond & Allcorn, 2009). My interest in applying psychoanalytic theory has grown since I have been training to be a psychotherapist over the last 5 years. One of the thoughts I have found useful to ponder is: if the organisation of a medical school was a person, what kind of psychological disturbances and strengths might that person present with?

In this RT, there are three characters: narrator, psychotherapist and ‘patient’. The ‘patient’ (Rupert) is my attempt at personification of a traditional medical school, and the RT represents the first 10 minutes of his initial therapy session with his psychotherapist, Sara.

The aim of this presentation is to explore some of the idiosyncrasies of medical schools. At a time in which regulation affects every aspect of medicine, my hope is that this Readers Theatre will raise particular questions as to whether a pervasive fear of decay and death is a primary contributor in creating the conditions in which regulation threatens to stultify constructive developments in medical education.

References

Professor Alan Petersen
alan.petersen@monash.edu
Metaphors of risk at the margins of medicine: the market of stem cell treatments

Ulrick Beck’s view of a second modernity is a self-reflexive one that raises issues of trust and credibility in relation to risk and the dominance of science and technology (including medicine) as powerful purveyors and creators of knowledge about risk and risk management. Science and technology therefore become the corporations and bankers trading in a currency of risk as it were in today’s “risk society”. This raises issues of trust, as risks are generated by and form part of the institutions that create such technologies. Additionally, mistrust is compounded by the constraints of modernity around science and public knowledge, as a form of policing that is particularly evident around the borders and intersections between institutions and the public sphere, between research and practice, measured as benefits and losses, physical reactions and individual experiences. Indeed, while medicine is founded on measures of norms in the human body, yet ideas about norms as such, were initially created by measuring what is ‘abnormal’.

This paper applies reflexive modernity as a critique of scientific knowledge through a framework of othering to clinical practice. It considers a number of case histories and considers how the arts can support the unusual, the abnormal and the practitioner (i) in the every day reality of the patient versus the ‘proven’, raising a range of provocative ethical, philosophical and social questions.

Dr Clare Penlington
c.penlington@qmul.ac.uk
Readers’ Theatre
Barts and The London, School of Medicine and Dentistry, Queen Mary University, London

This presentation takes the form of a Readers Theatre (RT). RT is a play-based format, used primarily in the US, in which the players read from a script, and where the focus is on creating narrative via verbal expression (Coger & White, 1973).

Having recently made the move from working in postgraduate to undergraduate medical education, I have found myself having a variety of thoughts about the way students are prepared for their role as doctors at medical school. One of the means I have used to navigate the organisation of a medical school, is view it (and myself) through the lens of psychoanalytic theory, functioning as an experiential and relational system (Diamond & Allcorn, 2009). My interest in applying psychoanalytic theory has grown since I have been training to be a psychotherapist over the last 5 years. One of the thoughts I have found useful to ponder is: if the organisation of a medical school was a person, what kind of psychological disturbances and strengths might that person present with?

In this RT, there are three characters: narrator, psychotherapist and ‘patient’. The ‘patient’ (Rupert) is my attempt at personification of a traditional medical school, and the RT represents the first 10 minutes of his initial therapy session with his psychotherapist, Sara.

The aim of this presentation is to explore some of the idiosyncrasies of medical schools. At a time in which regulation affects every aspect of medicine, my hope is that this Readers Theatre will raise particular questions as to whether a pervasive fear of decay and death is a primary contributor in creating the conditions in which regulation threatens to stultify constructive developments in medical education.

References

Professor Alan Petersen
alan.petersen@monash.edu
Metaphors of risk at the margins of medicine: the market of stem cell treatments

Alper Petersen, Casimir MacGregor and Megan Munie
1 Monash University, Melbourne; 2 The University of Melbourne

Metaphors are ubiquitous in medicine, as they are in other spheres of social life. Although clinicians and scientists tend to think of their work as devoid of metaphorical content, metaphors are intrinsic to their practice. Metaphors are also evident in the narratives of patients, with writers such as Arthur Kleinman, Victor Turner and Susan Sontag highlighting their crucial role in the articulation of the illness experience. This paper considers the metaphors of risk and regulation that manifest at the borders of medicine,
especially in the market of experimental (clinically unproven) stem cell treatments. A wide range of stem cell treatments are currently advertised directly to consumers via the Internet, with providers being located in many countries throughout the world. Further, patients suffering various conditions and/or their carers are balancing risk by undertaking treatments on the basis of information derived from diverse sources, including the Internet, patient communities, and the providers themselves. Scientists and regulators have expressed concerns about the physical and financial risks posed by such treatments and yet their responses are mostly limited to providing information to patients and their families via online resources. By examining the metaphors that shape the representations of stem cell treatments, as manifest in 1) the narratives of patients and carers who have undertaken or contemplated undertaking treatments, 2) the claims of those promoting and providing treatments, and 3) the arguments of those seeking to regulate the stem cell treatment market, one can learn much about the politics of risk and regulation. The paper will identify how particular metaphors of risk are used to establish and police the boundaries between legitimate and illegitimate applications of stem cell science and medical practice and to reinforce a particular definition of ‘the problem’ and how ‘it’ should be addressed. We conclude by discussing the implications of our analysis for rethinking concepts of risk, regulation and resistance in regard to new and emerging treatment markets.

Dr Claudette Phillips
0791631@doctors.org.uk
Poetry in the waiting room – Reviving the healthcare environment
Claudette Phillips¹ and Elizabeth Davies²
¹ South Thames Foundation School; ² Division of Cancer Studies, King’s College London

Healthcare providers have a responsibility to ensure that patients’ experiences are associated with as little distress as possible. However, in recent times of austerity and NHS restructuring it sometimes seems that the experience of the healthcare environment is actually increasingly overlooked.

The rising burden of chronic diseases in a larger and older UK population and the increasing complexity of investigations and procedures have increased pressure on NHS resources and capacity. A palpable sense of strain on health care providers pervades healthcare settings with inevitable rises in patient waiting times and clinical environments devoid of any meaningful cognitive or emotional stimuli.

The 2013-2014 Care Quality Commissions’ annual NHS Patient Satisfaction Survey highlighted that 15.4% of patients were dissatisfied with the length of time they spent waiting in hospital for access to services and were disappointed with the surroundings they encountered.

Aims
In 2004 the UK Arts Council published their review of over 400 pieces of evidence from 1990 to 2004, confirming that art could positively transform healthcare environments. In 2007 the Department of Health (DoH) published their conclusions from the 2005 Working Group – Review of Arts and Health. Poetry and creative writing were recognised as showing significant therapeutic value by creating a positive, calm and healing environment for the wellbeing of both staff and patients.

This presentation aims to discuss how recent literature, projects, and case-studies add to the evidence for the use of poetry to improve the patient experience in healthcare settings. It will consider if there remains scope for poetry to improve the emotional and cognitive wellbeing of patients and reflect on perceived obstacles to the arts becoming a welcomed and enduring feature of the healthcare environment.

Design & Methods
A search of Medline, Embase and PubMed was undertaken. This was supplemented by a search of the Grey literature – including books, NHS Trust publications, and resources from organisations and registered charities associated with poetry in healthcare. There was a focus on evidence and projects emerging since the 2007 DoH recommendations. The evidence was classified and subsequently synthesised to identify significant themes and conclusions of relevance to the impact of poetry on patient experience in healthcare settings.

Conclusions
Considerable evidence exists to suggest that poetry-based projects have an overwhelmingly beneficial effect on cognitive, emotional and even physiological aspects of the waiting experience. Large scale reviews of the type published by the UK Arts Council and the DoH are since lacking, evidence largely comprises small-scale projects and innovations in scattered healthcare settings. Robust economic analyses of the cost-benefit impact of these projects are also insufficient. On balance, however, integrating poetry into waiting rooms emerges as a pragmatic and simple approach towards creating a therapeutic and emotionally uplifting environment for patients. In times of increasing
Legally, in the UK, ‘transsexualism’ has not been a mental disorder since 2002, and gender identity is a protected characteristic in the Equality Act. Why, then, has it been so hard to move to a ‘choice and consent’ process of care? Why are services still located in Mental Health, where up to two years of ‘psychiatric assessment’ – and sometimes much longer – are mandated by practice? At a point at which equal marriage has been achieved, why do trans people habitually experience direct discrimination by the NHS, and why are so few clinicians aware of the risks posed, to them as individual practitioners and to the NHS as an organisation?

This paper briefly traces the manufacture of trans as a psychopathology; considers its status as an ongoing eugenic project; reflects on the response of regulators; and assesses the risk created to the NHS by a new resistance of the trans patient body, as they seek equality and a patient-centred healthcare system.

Hilly Raphael Quigley
Hilly.Quigley@nhs.net; www.oxfordhealth.nhs.uk/cfs-me

Performance: Reflexive reflections
Oxford Health NHS Foundation Trust
Social Sculpture, Oxford Brookes University

As a facilitator/participant in a new group programme aimed at recovery for people with Chronic Fatigue Syndrome (CFS/ME), I was intrigued to explore aspects of the experience and the meaning to participants. Through an NHS internship, I’ve made a phenomenological enquiry using a series of in-depth reflections, in which I’ve interwoven two inner voices. It has developed my understanding and has highlighted a series of findings, in particular, the opportunities for participants to find their own voice.

I’ve developed a performance piece based on four reflections that demonstrates the value of giving time and space to deep and attentive reflections. It conveys the potential for the richness of this process. The pressures of current healthcare provision are stripping away protected time for high quality reflective practice. This performance piece is a tool that can be used in a variety of settings – and my hope is that it can demonstrate the value, and indeed necessity, to encourage, to practice and to teach that reflection is an integral component of good healthcare provision.

Professor Zoë Playdon
Zoe.Playdon@london.ac.uk

1 Survive What? Bear Grylls, Leadership, and the NHS
University of London

The NHS is in crisis and all political parties are touting themselves as providing the only leadership under which it will survive. The metaphor is a familiar one, drawing on an archetypal image of disaster averted by the decisive intervention of a specially gifted individual or group, utilised politically here to position those saved – the electorate – as inadequate, helpless, and grateful.

The same story is played out on Survival Television, where volunteers are placed in unfamiliar locations and eliminated one by one until only the winner ‘survives’. The ‘dangerous wilderness’ posited by these shows are, of course, the familiar homes for the indigenous people who live in them, with the threats faced by contestants resting on either their unfamiliarity with the location, or being manufactured by deliberately imposed pressures. This paper contrasts the approach to leadership taken by the Bear Grylls series Mission – Survive with that suggested by TIK, and asks, what reality lies beneath the rhetoric of survival, for game show participants and for the NHS?

2 Sex, Lies, and the NHS: Relocating Trans
In 2013, the NHS public consultation on new National Service Specifications for Gender Dysphoria received an unprecedented number of responses – 60% of the total of all responses about the new specialised commissioning process – commenting on and complaining about the proposed care pathway for trans people, many of them protesting their continued psychopathologisation. A year later, in 2014, Amnesty International and the European Agency for Fundamental Human Rights added their voices to these concerns about psychopathologisation, while the WHO, prompted by the European Parliament, announced its intention to remove Gender Identity from the psychiatric section of ICD.

Legally, in the UK, ‘transsexualism’ has not been a mental disorder since 2002, and gender identity is a protected characteristic in the Equality Act. Why, then, has it been so hard to move to a ‘choice and consent’ process of care? Why are services still located in Mental Health, where up to two years of ‘psychiatric assessment’ – and sometimes much longer – are mandated by practice? At a point at which equal marriage has been achieved, why do trans people habitually experience direct discrimination by the NHS, and why are so few clinicians aware of the risks posed, to them as individual practitioners and to the NHS as an organisation?

This paper briefly traces the manufacture of trans as a psychopathology; considers its status as an ongoing eugenic project; reflects on the response of regulators; and assesses the risk created to the NHS by a new resistance of the trans patient body, as they seek equality and a patient-centred healthcare system.

Hilly Raphael Quigley
Hilly.Quigley@nhs.net; www.oxfordhealth.nhs.uk/cfs-me

Performance: Reflexive reflections
Oxford Health NHS Foundation Trust
Social Sculpture, Oxford Brookes University

As a facilitator/participant in a new group programme aimed at recovery for people with Chronic Fatigue Syndrome (CFS/ME), I was intrigued to explore aspects of the experience and the meaning to participants. Through an NHS internship, I’ve made a phenomenological enquiry using a series of in-depth reflections, in which I’ve interwoven two inner voices. It has developed my understanding and has highlighted a series of findings, in particular, the opportunities for participants to find their own voice.

I’ve developed a performance piece based on four reflections that demonstrates the value of giving time and space to deep and attentive reflections. It conveys the potential for the richness of this process. The pressures of current healthcare provision are stripping away protected time for high quality reflective practice. This performance piece is a tool that can be used in a variety of settings – and my hope is that it can demonstrate the value, and indeed necessity, to encourage, to practice and to teach that reflection is an integral component of good healthcare provision.
or reckless but the desire for beauty is complex and perceived by many to be beneficial to their psycho-social wellbeing. This is because our appearance provides important information to other humans as to our characteristics, and if aesthetically pleasing can be described as “beauty”. One definition of beauty according to the Oxford English Dictionary is “the quality of a person (esp. a woman) which is highly pleasing to the sight; perceived physical perfection.” This physical perfection is associated with health, physical ability and fertility, which in turn are qualities that can be associated with youth. People are initially sub-consciously and consciously judged on their appearance, and trials have shown bias in favour of attractive people when interviewed for jobs or suitability as potential partners, and receive more social support from colleagues. This may underlie findings that physical attractiveness correlates with happiness and self-esteem, particularly in women, and negatively correlates with neuroticism.

Physical beauty is deeply embedded in our culture and artists have been producing images of attractive people for millennia, producing creations that are considered “masterpieces”. The performing arts often favour people considered beautiful and a common tactic employed by the advertising industry to draw attention to their product is the use of models in a sexually provocative manner, hence the term “sex sells”. Advances in technology mean that images of physical perfection, often digitally enhanced, are reproduced on multiple media including computer and mobile telephone technology, to the extent that a previously rare physical ideal is now commonplace.

The age-old quest for beauty began with cosmetic pigments and hair products, many of which were toxic, and has been furthered by advances in medicine so that newer surgical techniques and materials can be employed to alter a person’s physical appearance. Currently the most common surgical procedure is breast augmentation for women, where silicone implants are placed under a woman’s own breast tissue. Originally a reconstructive procedure following mastectomy, this is now more commonly performed electively to enhance a woman’s natural tissue. This procedure is not risk free, and complications from this include implant rupture and capsular contraction, the former having been the cause of a recent health scare.

Cosmetic procedures are no longer solely performed by surgeons in a hospital setting, but by practitioners of varying degrees of training at much reduced costs. Other common procedures performed by both medical and non-medical staff include subcutaneous filler and botox injections. These can achieve the desired aesthetic results but have been known to cause

---

Sangeetha Saunder
sangeetha.saunder@students.pcmd.ac.uk

Medical School of Rock

Medical student, Peninsula College of Medicine and Dentistry

Peninsula College of Medicine and Dentistry (PCMD) runs a compulsory longitudinal medical humanities special study unit (SSU) for fourth year students. The aim for the students taking part in the “Medical School of Rock” SSU was to form a band to write, record and perform some original music. Five students from diverse musical backgrounds were randomly selected and formed the band “Diet of Terror”. Despite possessing different musical styles and playing an eclectic range of instruments, they were able to create and record two original songs together. This special study unit enabled them to work as a team and to enjoy music, alongside continuing academic pressures.

The presentation will describe the group’s approach to the project and outline the development of the final single. The audience will get the chance to hear the final songs and CDs will be available to buy at the conference, or alternatively can be sampled and purchased on iTunes and Spotify, with all proceeds going to the Freya Barlow Trust charity. Finally the presentation will give an overview of the fourth year medical humanities SSU at PCMD and explore what makes it different from modules offered by other medical schools. It will end with a slideshow of images from this year’s medical humanities conference in Truro.

There will be a live performance on the veena, an Indian stringed instrument, by Sangeetha at the conference dinner on Wednesday 24 June.

Dr Andrew Snedden
Andrew.Snedden@stgeorges.nhs.uk

Risks and regulation at the interface between medicine and the arts, and resistance – the case of demand for cosmetic procedures

St George’s Hospital, London

The arts and medicine interact in many ways, and one of the most obvious is in the cosmetic procedures industry. In the UK this industry has an estimated turnover of £3.6 billion for 2015 according to the British Association of Aesthetic Plastic Surgeons. The desire for cosmetic procedures and their benefits and risks will be discussed, as will the benefits and risks of current regulations.

The need for invasive procedures with their associated risks may seem vain or reckless but the desire for beauty is complex and perceived by many to be beneficial to their psycho-social wellbeing. This is because our appearance provides important information to other humans as to our characteristics, and if aesthetically pleasing can be described as “beauty”. One definition of beauty according to the Oxford English Dictionary is “the quality of a person (esp. a woman) which is highly pleasing to the sight; perceived physical perfection.” This physical perfection is associated with health, physical ability and fertility, which in turn are qualities that can be associated with youth. People are initially sub-consciously and consciously judged on their appearance, and trials have shown bias in favour of attractive people when interviewed for jobs or suitability as potential partners, and receive more social support from colleagues. This may underlie findings that physical attractiveness correlates with happiness and self-esteem, particularly in women, and negatively correlates with neuroticism.

Physical beauty is deeply embedded in our culture and artists have been producing images of attractive people for millennia, producing creations that are considered “masterpieces”. The performing arts often favour people considered beautiful and a common tactic employed by the advertising industry to draw attention to their product is the use of models in a sexually provocative manner, hence the term “sex sells”. Advances in technology mean that images of physical perfection, often digitally enhanced, are reproduced on multiple media including computer and mobile telephone technology, to the extent that a previously rare physical ideal is now commonplace.

The age-old quest for beauty began with cosmetic pigments and hair products, many of which were toxic, and has been furthered by advances in medicine so that newer surgical techniques and materials can be employed to alter a person’s physical appearance. Currently the most common surgical procedure is breast augmentation for women, where silicone implants are placed under a woman’s own breast tissue. Originally a reconstructive procedure following mastectomy, this is now more commonly performed electively to enhance a woman’s natural tissue. This procedure is not risk free, and complications from this include implant rupture and capsular contraction, the former having been the cause of a recent health scare. Cosmetic procedures are no longer solely performed by surgeons in a hospital setting, but by practitioners of varying degrees of training at much reduced costs. Other common procedures performed by both medical and non-medical staff include subcutaneous filler and botox injections. These can achieve the desired aesthetic results but have been known to cause
disability and even death in extreme circumstances. Facial filler injections can cause scarring, oedema or even anaphylaxis and botox use can result in excessive muscle weakness. The risk of complications is highlighted by the case of a lady who presented to a senior colleague’s neurology outpatient’s clinic. She complained of facial pain requiring analgesic medication, and it was only after this was investigated with an MRI scan showing abnormal signal in her subcutaneous facial fat that she mentioned that she had previously had facial filler injections.

In the United Kingdom surgical intervention is tightly regulated, with the rules having been recently consolidated; in comparison the regulation of non-surgical intervention is much less so. A review of the regulation of cosmetic intervention was published in February 2014 making many recommendations. This included extending the EU medical devices directive to cover dermal filler; additionally botox and dermal fillers should be prescribed and administered by a healthcare professional (doctor/ dentist/registered nurse), who should be supervising non-healthcare practitioners administering these products. A central register was recommended in February 2014; currently there is an Independent Healthcare Advisory Services registry for practitioners of injectable cosmetic treatments, but this is not yet mandatory.

Production of these cosmetic treatments and devices to administer require testing before they can be allowed by regulatory agencies such as the EU medical devices directive or the US Food and Drug Administration. The precise requirements are unclear, but presumably these products would require both animal and human testing to satisfy the regulations. This raises the question of whether animal testing for a cosmetic product is ethical. Disfigurement from surgery and trauma can cause profound psychological harm and the manufacturers would argue that developing corrective cosmetic procedures outweighs any animal discomfort and suffering. However testing of products designed to make a person appear younger is harder to justify.

Not all practitioners of dermal filler injection of botox are suitably trained, and many practitioners have improvised, often leading to tragic results. One practitioner was arrested after injecting a client’s buttock with silicone, causing a pulmonary embolus and death.

I would conclude that regulation of the cosmetics industry is worthwhile and necessary, and that it could be regulated more tightly in the United Kingdom. This could be done by enforcing recommendations that have already been made, such as keeping a mandatory register for medical and non-medical practitioners.

Tricia Thorpe
Tricia.Thorpe@bristol.ac.uk

A different take on patient safety: how safe do I feel to talk to the doctor? University of Bristol Medical School

Minority groups such as the homeless, the LGBT community, wheelchair-bound individuals or the hearing or sight-impaired have specific issues as patients and may not always feel comfortable talking to a doctor about their fears or problems.

To widen their understanding of this broader community, second-year undergraduates at Bristol University participate in a week of diversity-related activities. Classroom sessions are lead by members of this diverse community. However, these ‘tutors’, whilst experts in diversity by virtue of their own situation, are not trained to teach and sometimes tend to simply ‘tell’ students everything about their condition with little space for the students to create their own empathic understanding.

Studying the arts and humanities is often believed to help people to access feelings, come to terms with emotions or even just experience vicariously situations and conditions that they have not encountered in their lives. Bearing in mind the need for affective rather than cognitive learning, I devised a workshop for the tutors to help them with ideas for their teaching sessions. These included activities to allow the students to engage with each other and with the tutors on a more personal level, an approach drawn from Drama and calling for some degree of self-revelation.

I will run some of my activities with participants and also invite them to bring along their own ideas for further, arts-based resources – literature, film, poetry, and activities that might help undergraduates to grasp the life issues for diverse members of the community and how these might play in the health-care setting. I will compile a list of suggested resources and to take part in activities.

assume a reparative or corrective role in response to the deficiencies of science. This peripheral position leads to an ambivalence typical of outsider status – an opportunity to defy the status quo, coupled with a desire to merge with the status quo. However, in a perceived or achieved insider role, the medical humanities risk assimilation, serving merely as an ideological rubber stamp that has no genuine impact on the economics or delivery of care while helping stabilize the existing system. How might this tension between adaptation and critique be addressed, if not overcome? In this talk I offer examples of projects undertaken within my institution representative of a critical (outsider) and a collaborative (insider) platform for the medical humanities. While both models offer counter-cultural elements, they each illuminate the problems of the medical humanities’ role within the medical culture. Participants will be invited to challenge the insider/outside framework for the medical humanities and offer counter-models.

2. My life as a medical humanities subversive

The talk will begin with an anecdote describing the challenge for the medical humanities of embracing traditional academic goals and methodologies. One of the hallowed tenets of academic research is to uncouple the autobiographical self from the research material. (Several arts-based research projects are for this reason defiantly autobiographical). My own entry into medicine after formal literary training reflects a tension between counter-cultural impulses and a desire for social integration. These conflicting motivations have their roots in my multicultural family whose motto was “You are a little bit unhappy wherever you are.” Practitioners of the medical humanities in fact all have to confront a similar betwixt and between, of approaching medicine from the outside looking in, wanting to be part of it and wanting to be critical – and no matter what we do, this tension will always be present. (See Insider/outsider status of the medical humanities: Opportunities and Risks). A powerful corporate example relevant here is Gordon Mackenzie’s autobiographical account Orbiting the Giant Hairball. He spent his last years at Hallmark Cards corporate headquarters occupying the role of ‘Creative Paradox.’ This role was a sort of golden handshake – giving him free reign to be as outrageous as he wished to be and at the same time underwriting his obsolescence. Participants will consult a handout based on Shapiro’s work on ‘resistance’ as a role for the medical humanities. Participants will be invited to reflect on the ways in which they affirm and rebel against the institutions to which they belong, and whatever problems this tension entails. And, if possible, to say how they got where they are.

Dr Caroline Wellbery
Caroline.Wellbery@georgetown.edu
Department of Family Medicine, Georgetown University Medical Center

Performance as Pedagogy
University of Southampton

This presentation will explore the risks and rewards of including live performance in a medical curriculum. Evaluations of two performances about testicular cancer and bipolar affective disorder, to year 1 cohorts of undergraduate medical students at the University of Southampton, reveal that live performance increases understanding of patients’ experiences of illness. Furthermore, when people with diagnoses who are also performers communicate their experiences, students’ preconceived ideas about patients and healthcare practice are challenged, as the doctor/patient dynamic is subverted into that of performer/audience and the perspective is shifted. Performance can also facilitate critical and reflective thinking in a way that can inform future practice. However, people with diagnoses performing their experiences to medical students also have the potential to disturb which can create adverse responses, particularly when sensitive issues are explored. Using ideas from theatre alongside the student evaluations, performance as pedagogy in medical education will be analysed and discussed.

Dr Caroline Wellbery
Caroline.Wellbery@georgetown.edu

1 Insider/outsider status of the medical humanities: opportunities and risks
2 My life as a medical humanities subversive

A fake and an authentic talk sit side by side. The fake vs authentic talk is itself an exemplar of the conundrum that is the subject of my talk(s). Thus, for ethical (and in that sense somewhat assimilative) reasons, the fake talk has a real presence as Part 1 of the real talk. With a side-by-side real/fake talk, I can satisfy the conflicting demands of insider/outsider status.

1 Insider/outsider status of the medical humanities: opportunities and risks
2 My life as a medical humanities subversive

The humanities have struggled for relevance for many decades, and this is the subject of frequent laments. The medical humanities have a peculiar place in the orthodoxy and economics of scientific medicine. On the one hand, they are merely a subset of the marginalized humanities culture in general. On the other hand, the medical humanities draw on a strong moral healing tradition. As a marginalized entity, the medical humanities often
The Hauntologies of Clinical and Artistic Practice

By recognising ‘practice as contingent, embodied and ambiguous’ (Schwandt, 2005), this paper will explore the ghosting of both clinical and artistic practices. Practice is intrinsically linked to bodies in space and place, being what we do in a particular time and geography. It is by beginning from here, our own bodies in this place, the place where we currently sit/stand/lie, that we can articulate an understanding of there. Place and non-place (Augè), space and practiced space (de Certeau amongst many), smooth and striated space (Deleuze and Guattari), are all different articulations of here and there, all offering a consideration of the moment in between, something that might be articulated both physically and conceptually by invoking Edward Soja’s ‘thirding’ of space.

It is in this space between that the ghosts of practice lie; this paper will attempt an excavation, or perhaps an exorcism, of the gaps in between here and there, to explore what it is that happens in the moment of creative and clinical exchange. It will speak to ‘the invisibles’ of Della Fish (Fish, 2012), who describes elements, such as reflexive practices, as the unspoken and unnoticed of clinical practice. The rhetoric of ‘best-practice’ is littered with the ghosts of things we used to do, or expect others to do. This paper will consider that which we have forgotten, but still hear the traces of, and what is at risk if we fail to listen to the echoes.

The Quickening [2013]
The Quickening is a text-based film in response to a 14 hour site-specific durational performance piece in Theatre Academy Helsinki, Finland, performed by Joanne ‘Bob’ Whalley and Lee Miller in 2013. It is written in the space, for the space, whilst attempting to resist being tethered to either of these. An articulation between two bodies separated by an expanse of theatre foyer, and their failed attempts to communicate with each other, it speaks of broken things: bones, dreams, sounds, windows.
much better after orthopaedic surgery including dorsal route rhizotomy; early recognition and appropriate intervention of conditions such congenital hypothyroidism or phenylketonuria, lead to protection of neurodevelopment. All are in education and hopefully will continue to live full lives. These children are fortunate through accident of birth, to have had access to treatments that too many premature infants and children still do not have access too, now, let alone so long ago. Elimination of this inequality is the challenge that must be addressed for all children, worldwide.

References

Performance Film of stage play Daniel Mercy
Andrew N. Williams
“We will remember not the words of our enemies, but the silence of our friends”. Martin Luther King, Jr.
“What we’ve got here is failure to communicate. Some men you just can’t reach. So you get what we had here last week. Which is the way he wants it. Well, he gets it. I don’t like it any more than you.” Strother Martin

I am an NHS consultant community paediatrician, playwright and historian and for the last 10 years have undertaken my research in clinical medicine, history and ethics within a Virtual Academic Unit. Some things within medical practice can only be said through a different medium.

This is a performance film of my play ‘Daniel Mercy’. Mostly set in an NHS consultant’s office the play deals with an ongoing truth that is of institutional cover up of child abuse. Based on real life events, ‘Daniel Mercy’ is a modern day allegory concerning Society’s attitude to child protection. The play was first performed by final year University of Northampton drama students and more recently by University of Birmingham Medical students at the Royal College of Paediatrics Annual Meeting. In the post Climbiė/Baby P era, child abuse failings and cover-ups are inevitable. This play is named after the child who is the centre of the activity of this play. I would be happy to discuss with any audience members after the play.

References
1 Washington State University Martin Luther King Program http://mlk.wsu.edu/about-dr-king/quotes/ accessed March 1st 2015
2 http://en.wikipedia.org/wiki/What_we%27ve_got_here_is_failure_to_communicate accessed March 1st 2015

Dr Ian Williams
sleepingdog100@googlemail.com

Comics and the Iconography of Illness
Graphic Novelist, freelance cartoonist and freelance GP. Editor, GraphicMedicine.org

In this presentation I aim to examine the depiction of disease, trauma or suffering in comics and graphic novels, asking how the medium might create new knowledge and contribute to the bank of available images that inform our cultural conceptions of illness and healthcare: what Sander Gilman calls the iconography of disease (1987). The word iconography refers to the use of images and symbols to portray a subject, movement or ideal. In this case the subject is illness and I will focus on the comics memoir of illness, what Green and Myers (2010) have termed the graphic pathography, the direct
descendant of the first autobiographical comics born of the West coast counterculture of 1970s America. These works deserves wider recognition within the healthcare professions and within academia. While comics are knowledge and theory, Graphic medicine should also open a debate with Visual Studies in order to examine healthcare comics from numerous angles. Medicine is constructed around a taxonomy of diseases in which differentiation and categorisation of conditions is conducted partly in visual terms, yet practitioners are often blind to the assumptions made in their mental schemata or textbook depictions of ‘typical’ disease presentations. Visual assessments of the sick are linked to deeply seated and culturally accrued attitudes within the observer that may also be unacknowledged or unconscious. These latent attitudes may be addressed by the consideration and discussion of images and the meanings inherent within them or the reading and appraisal of comics and graphic novels.

Comics artists who portray themselves autobiographically face many decisions in how to portray themselves in sickness, although they may not be aware of the decisions they are making or the effects that those decisions have in subtly reshaping the cultural model of disease and disability. Artists use a variety of innovative and traditional visual codes to express their illness experiences, which may vary depending on whether the problem is manifest, concealed or invisible. Their powerful depictions might be said to belong to the radical, unofficial iconography of healthcare of which the medium of comics is as yet an underused source.

References:
Professor Michael Wilson
M.Wilson@lboro.ac.uk
The Objet Surpris or Overheard Object: Fragmentary Narratives, Digital Technology and Mutual Recovery
Loughborough University, UK
This presentation is less a critical reflection on research completed and more a series of starting points for thinking about research that is ongoing. Its first starting point is the idea of the Objet Trouvé or ‘found object’, characterized in art by Marcel Duchamp, in his use of everyday, often modified, material objects. This idea is then developed into the Objet Surpris or ‘overheard object’ as a way of describing and understanding the fragmentary, partial and incidental narratives that proliferate in everyday exchanges of personal experience and which digital technology now enables us to capture and represent as multi-layered complex narratives. The presentation will then take this concept of the Objet Surpris and apply it to a series of narratives and narrative fragments collected through online communication as part of the ‘Digital Dialogues’ Project, itself part of a five year programme, ‘Creative Practice as Mutual Recovery’ (funded by the UK Arts and Humanities Research Council), exploring the role of creative interventions in supporting mutual recovery by service-users (patients), service providers (medical professionals) and informal carers in mental health situations. During the project, a number of participants were engaged in sharing personal experience narratives in a closed online environment and entered into narrative dialogues as a way of challenging the power relationships and dominant scientific knowledge systems that usually prevail in doctor-patient encounters. Narrative enabled medical professionals to acknowledge their vulnerabilities and service-users their resilience, thus challenging their conventionally assigned identities and statuses, and reinforcing the notion of mutuality. Furthermore, it raises fundamental questions about what exactly is being recovered in such exchanges, what is being told and untold, and the significance of speaking and silence in storytelling exchanges.

Essay
Dr Caroline Wellbery
Mad scientist

The humanities have struggled for relevance for many decades, and this is the subject of frequent laments both nationally and internationally. As recently as this week at the time of writing, the editor of Atlantic magazine, Leon Wieseltier, wrote that ‘the discussion of culture is being steadily absorbed into the discussion of business.’ In 2009, Mark Slouka wrote: “By downsizing what is most dangerous (and most essential) about our education, namely the deep civic function of the arts and the humanities, we’re well on the way to producing a nation of employees, not citizens.” The medical humanities have a peculiar place in this orthodoxy of metrics and productivity. On the one hand, they are merely a subset of the marginalized humanities culture. On the other hand, the medical humanities draw on a strong moral healing tradition. It has been argued that in fact this dual role perfectly suits the medical establishment’s management agenda: no one needs to be accountable – financially or otherwise – to the medical humanities while their presence reassures everyone from the top down that matters of truth, goodness and beauty continue to guide the institutional enterprise. There is concern among medical humanities educators that this instrumentalization “will result in support for the powerful medical status quo and manipulate both doctors and patients into roles of cooperation and compliance.” (Shapiro 2012)

Some scholars have argued that the medical humanities should teach ‘resistance’ to students to prepare them to question rote, and at times harmful, practices within the medical establishment. The discourse on resistance includes exposing the hidden curriculum, questioning practices through critical thinking – and even subversion,
defined as “directly confronting and challenging the dominant status quo”. But very little self-reflection has taken place on the role and responsibilities of the medical humanities in performing resistance. What I have to say builds on Shapiro’s work or forms of resistance in the medical humanities. I will begin with a brief summary of the benefits and liabilities of collaborative medical humanities models that hope to impact on the medical establishment. I then outline my own engagement with the critique of the medical establishment and its practices, and conclude with an inquiry into the possibilities and risks inherent in medical-political activism. In determining the viability of these frameworks for resistance, we must always consider the current relevant goals of the medical humanities, whether resistance is a desirable or appropriate goal and the risks involved in the way this question might be answered, and what forms of resistance are feasible.

A long-standing discussion of the dichotomous nature of medicine as both ‘art’ and ‘science’ sheds a particularly helpful light on the discussion about the role of the medical humanities vis-à-vis the medical culture. In a recent article on the task of the medical humanities, Boudreau and Fiks (2014) suggest that the medical humanities often assume a reparative or corrective role in response to the deficiencies of science. Because science separates the observing subject from what is being observed, according to these models, interpersonal connections and relationships suffer, creating need for remediation or “humanization”. The medical humanities offer their services as doctors to the wounds inflicted by science. For example, each component of narrative medicine—self-reflection, interpretation and listening, and public narrative—strives to bridge the gap represented by the concept of the ‘case’ and the ‘person behind the case’. This mediative role of the medical humanities has been criticized as both acquiescent and helpless. (Poliakinski, Fangerau, 2011) Indeed, it seems as though any attempt to bridge the art-science dichotomy perpetuates this dichotomized model while seeking to overcome it. (Here a brief illustrative discussion of a visual art work by Lin Milligan and interpretation of a short essay by Naomi Fremen). Insofar as the medical humanities are an ‘add-on’ to the scientific enterprise, they are easily marginalized and are always hoping (through their eager practitioners) to be offered a place at the professional table. This outside position leads to an ambivalence typical of outsider status—an opportunity to defy the status quo, coupled with a desire to merge with the status quo. For that reason, others have suggested an integrative model, a sort of ‘fifth column’ medical humanities enterprise that can subvert the system from within. But this model also risks assimilation, as its (at least visible) modus operandi is cooperative. Examples of integrated models include the “asymmetric paternalism” of architectural space as a means of shaping the lived experience of patients (slides with examples) and the University of Durham’s medical humanities project “The life of breath” http://centreformedicalhumanities.org/the-life-of-breath-a-new-project-on-breathlessness-and-copd/, as well as examples given by Boudreau and Fiks. An integrative model may provide an alternative framework for genuine change, but it is telling that much work remains to be done for such a model to be viable within established curricula and patient care systems.

my institution that illustrate the dichotomized model and the integrative model of teaching the medical humanities respectively. While both models offer counter-cultural elements, they both illuminate the problems of the medical humanities’ role within the medical culture. In the first, dichotomous, case, there is a limited forum for dissemination as there is no curricular platform for curricular critique. In the second, integrative case, the limits of social critique are quickly reached because medicine conventionally adopts a narrow view of the disciplinary boundaries that define ‘health’. While the arts and humanities might offer a powerful tool for advocacy, their own marginal status within the medical establishment provides an additional stumbling block to political action and acts of protest.

Dichotomous case: Arts-based research: a student video documentary on the hidden curriculum. My first example is of a dichotomous approach to the medical culture—a critique, an exposure, an opposition. “Resistance” begins with a challenge to the conventions that define research. “Artistic” work is exempt from Institutional Review Board scrutiny because it is not considered research. Yet artistic investigation can be revelatory in areas that may otherwise be difficult to demonstrate. As Jack Coulehan has written: “The narrative world is most alive in the teaching hospital’s hallways and conference rooms and unit stations.”

In a 4-year medical student elective, a student was assigned to investigate aspects of acculturation and socialization in medical education. The student was given readings on arts-based research, and was introduced to a working definition of medical culture as “A routine and pervasive way of doing things that serve the interests of the provider” with examples of physician- and system-centered practices. The student then interviewed medical students in different years of training, which he edited to create a 6-minute documentary, which he titled “The Path.”

Three themes emerged in this documentary:

1) Redirection: Students arrive at medical school with idealistic expectations that are quickly ‘corrected.’ Their hopes and wishes for engaged and effective patient care are replaced with an emphasis on memorization of scientific details, constant testing and grades.

2) Ambition: students are pushed to choose specialties on the basis of future pay and prestige. They are steered away from ‘lesser’ specialties with low remuneration, are told they are ‘too smart’ to waste their time on these specialties and that these specialties have limited advancement potential.

3) Nurture: students are discouraged from pursuing their personal needs. While students are encouraged to pursue their self-interests, ‘hard,’ ‘macho’) self-nurture is considered ‘soft.’ Personal needs are endowed with feminized adjectives (as are the medical humanities themselves) to convey the inferiority of self and experience. As a collage of statements, the video articulates defining themes that prop up the discourse of professionalization in medical education. Arts-based research may be particularly suited to exposing the notoriously invisible components of medical acculturation.

Integrative case: Addressing social issues & pushing the envelope on public health
The medical humanities have accommodated themselves to a convergent role in medical education. (Ridinger 2014) That is to say, they reside within the narrow intersection of humanities and medicine. Within the limits of their particular language, the medical humanities in fact have opportunities to enlarge the scope of meaningful medical education by promoting social awareness and activism. Medical education today remains largely entrenched in technological progress and economic concerns, but increasingly some educators are drawing attention to the health-related social problems smoldering all around us. At our institution, we have inaugurated a quantitative and qualitative study to examine ‘social empathy,’ which we define as ‘the ability to understand people by perceiving or experiencing their life situations and as a result gain insight into structural inequalities and disparities.’ Included in this research is a reflective writing project through which students explore the reach of their empathy beyond that for individual patients, as a means of broadening student’s understanding of their health professional role. As we move to more politically charged issues of global importance, we find ourselves once again at the margin of the curriculum. In an extracurricular project, we are involving students in a human rights clinic to care for torture victims. In addition, we have carried out various projects lobbying for greater awareness of physicians’ responsibilities in speaking out about climate change. Each of these activities has drawn on the affective, divergent elements of visual art and narrative as a way of introducing students to their ethical responsibilities of social engagement. But a major concern remains that the parochial nature of the medical enterprise, in keeping with Slouka’s and Wieseltier’s critique of our cultural focus on science and technology in the service of economic advance, will continue to marginalize efforts to expand the reach of medicine to embrace meaningful cultural change, writ large or small, and the medical humanities may sacrifice impact to the privilege of speaking truths, even when others prefer not to hear them.