**Elspeth Graham, 'Geraniums (red) and delphiniums (blue)': trauma, ethics, and medical communications**

**Abstract**

More official complaints about medical treatment in the UK relate to poor communications than to wrong diagnoses. This article, in considering the importance of communications training for clinicians,

 is structured into three sections. From use of a story that introduces the idea of miscommunication and trauma in the first section, the article moves, in the second, to a theorisation of trauma as a concept, addressing issues of intersubjectivity, the relationship between embodied and psychological being, and ethics. The third section then engages directly with medical communications training, exemplifying a particular literary-studies approach to matters of communication.

**Keywords**

Medical communications, intersubjectivity, trauma, literary studies, medicine and meaning, medical ethics, medical education

**Conflict of Interest**

The author declares that s/he has no conflict of interest.

**'Geraniums (red) and delphiniums (blue)': trauma, ethics, and medical communications**

In the UK, more formal complaints investigated by the General Medical Council (GMC) relate to poor communications than to wrong diagnoses. While clinicians may primarily worry about diagnosis and treatment, the number of patient complaints about 'communications' and 'respect' almost equals the total number of complaints about all aspects of clinical treatment combined, and 'communications' comprises the fastest growing category of complaint overall.[[1]](#footnote-1) This article considers communications training for clinicians, looking at the assumptions, impulses, difficulties and enablements that come (for both clinicians and patients) out of the recent shift away from a disease-focussed emphasis in the role of clinicians to one that is more patient-centred. But it approaches the issue of medical communications obliquely, not by working from the media-studies and social-scientific communications theory that already informs much current medical training, but by bringing to bear the insights of a literary-critical approach. The article juxtaposes three different ways of thinking about communication and meaning that are characteristic of literary analysis: telling a story; theoretical reflection on the concept of trauma which comes out of the story; and textual analysis of a medical communications textbook. Each of these methods of analysis is contained in a separate section. Combined, these aim to produce three different perspectives on the subject of trauma in the same way that the panels of a visual triptych offer a series of views or variations on a theme. The article, working in this way, explores the nature of those connections and disjunctures between bodily experience, interpersonal relationship and verbal language that are highlighted by theories of trauma which, although deriving originally from medicine, have become important in literary studies and might be seen to have a bearing on issues about communications and why they matter so much.

In using methods associated with literary studies, this article aligns itself with the substantial body of work on narrative medicine that has emerged in recent years.[[2]](#footnote-2) And, in moving between three different sorts of literary methodology, it exemplifies the fluid nature of literary study, a fluidity that perhaps parallels that of medicine which has been described as 'traditionally...magpie-like in its selection of theory, ideas, knowledge and skills' (Bowman et al. 2013). Although the identity of literary studies, or literary criticism,[[3]](#footnote-3) as an academic discipline from its nineteenth-century inception until the 1970s might conventionally have been seen to cohere around the study of canonical literary writings (the Great Tradition or the literary classics), the fiercely fought debates of the 1970s and 80s led to a broadening of its content and methods. Today, even if a prime focus is on recognisably 'literary' writings, its objects of study may also include *all* that is written or represented in verbal language – and even that which is produced through other symbolic systems: those of the visual or kinaesthetic, for instance. Correspondingly, its characteristic methods or approaches are equally open.[[4]](#footnote-4) Literary Studies in the past few decades has been prone to recurrent 'turns': the historical turn, the ethical turn, the affective turn...and so on. Through these gyrations it has both incorporated aspects of the methods and knowledges of a range of disciplines (history, philosophy, anthropology, psychology, neuroscience...) and examined its relationship to them. What remains constant in Literary Studies, however, is a central concern with the ways in which meanings are produced and with a mode of 'reading'. This way of reading typically involves an 'opening' to the meaning of a text and a subsequent unpicking of the ways in which that meaning has been created, whether through analysis of how the 'words on the page' (or other symbolic forms) operate through their denotations, connotations and combinations, or through exploration of the history, context or implications of a culturally shared idea that is inherent in the text, or produced by the process of reading. Literary reading involves an attentive receptivity and responsivity – an active passivity – in relation to a text, plus reflexivity and contextual knowledge in relation to the ideas or feelings produced by, and informing, the text, the responses of its reader, and the wider culture in which each exists. In the same manner, Literary Studies increasingly engages with its sibling discipline, Creative Writing, in awareness of the reciprocal insights offered by producing writing and by analytically responding to writing. So, this article – in using, in its different sections, creative writing, analysis of the concept (trauma) that emerges from the story told, and textual analysis, or response to 'words on the page', as typical literary-analytical methods – aims not only to exemplify what literary analysis might further offer to the developing field of medical humanities, but also to explore reflexively something of what characterises, and is at stake, in the *relationship between* humanities and medical disciplines.

**I Fragments of a Life Story**

1930: A ten-year-old boy has forgotten who he is, or where he belongs. The kitchen table is cleared and scrubbed. Dressed in striped pyjamas, the boy lies on it. His mother stands by. A doctor settles a jar on a chair, places a pad soaked in chloroform over the child's mouth and nose. He removes the anaesthetised child's tonsils. This works. The boy's memory returns.

1956-57-58: The little boy has grown up. He has won scholarships, made life-changing, shaming mistakes, fought in a war, killed a Japanese soldier, seen – at close range – his dearest friend shot. He never talks about any of this. He has married, lost a son and gained a step-daughter, another son and another daughter. His daughter is three, then four, then five. He reads her stories in bed. This is a favourite:

There once was a Dormouse who lived in a bed
Of delphiniums (blue) and geraniums (red),
And all the day long he'd a wonderful view
Of geraniums (red) and delphiniums (blue).

A Doctor came hurrying round, and he said:
"Tut-tut, I am sorry to find you in bed.
Just say 'Ninety-nine' while I look at your chest....
Don't you find that chrysanthemums answer the best?"

The Dormouse looked round at the view and replied
(When he'd said "Ninety-nine") that he'd tried and he'd tried,
And much the most answering things that he knew
Were geraniums (red) and delphiniums (blue).

The Doctor stood frowning and shaking his head,
And he took up his shiny silk hat as he said:
"What the patient requires is a change," and he went
To see some chrysanthemum people in Kent.

[...]
The Dormouse turned over to shut out the sight
Of the endless chrysanthemums (yellow and white).
"How lovely," he thought, "to be back in a bed
Of delphiniums (blue) and geraniums (red.)"

[...]

The Dormouse lay happy, his eyes were so tight
He could see no chrysanthemums, yellow or white.
And all that he felt at the back of his head
Were delphiniums (blue) and geraniums (red).

*And that is the reason (Aunt Emily said)*
*If a Dormouse gets in a chrysanthemum bed,*
*You will find (so Aunt Emily says) that he lies*
*Fast asleep on his front with his paws to his eyes* (Milne 1925, 67-70)*.*

In the early summers the man and his daughter plant geranium cuttings in crusty clay pots. He wears his old Indian Army breeches; she wears her fawn cardigan with red cherries round the neck. The smells of bruised geranium leaves and wet John Innes No 1 fill the air. They stomp round the garden chanting, 'Geraniums red and delphiniums blue'.

2008: The man has had a stroke. He is in hospital, confused, part-blind, speaking in jumbles where mittens are trousers, babba-little-littles are grandchildren. He has diarrhoea. A nurse comes up to him with a laxative liquid. He clenches his lips. She grabs his chin and forces the rim of the plastic pot into his mouth. The man pushes her away, spits out the liquid and shouts, clearly for once, 'You bitch.' His daughter witnesses this. She explains he does not need a laxative. She is told that the man has a difficult personality. The man, day by day, becomes more frenzied: sometimes, wordless, banshee-like, he wails; other times, clenching his teeth, jabbing his finger, he demands, 'Take me home. Take me home. Take me home.'

He tries to escape in the night. Climbing over his bed rails, he falls, is chastised and returned to bed. He now stops moving, or speaking: he becomes rigid and blank. He dissociates.

2012: The man, very frail, lives with his daughter. They struggle through the days together in the narrow world of his darkened room: television; armchair; commode chair; hoist; neat piles of dressings and creams, tubes and pads; the green, waterproofed, slat-railed bed that imprisons him in his sleep. His daughter has promised he will never go to hospital again. She moves him and lifts him; she feeds him; she clears up his 'accidents', wipes his bottom, washes his body, shaves him, cuts his hair and his nails; she empties his catheter; she tends his pains and his sores, his frights and his sadnesses. The man and his daughter laugh a lot.

One day the man complains of a sore gum; the daughter sees he has a broken tooth and calls out a dentist. The dentist looks in his mouth. She does not look into his face; she does not address the man. Loudly and clearly from the far side of his bed she tells the daughter she wants someone else to look at him: he will have to go to hospital. The daughter explains about hospitals. Staccato, monotone, the dentist says she suspects this may be serious; she holds up the man's tongue to display his mouth; she says a hospital may need to do a biopsy; she explains, as to the uncomprehending, what a biopsy is. The dentist repeats all of this... then again... and over again; the daughter, immobilised, is unable to silence her, unable to make her speak to the man.

That evening, the man decides to die. He tries not to eat, or drink, or take medication again. For twenty days he smiles at his daughter and his visiting son. One time he murmurs, 'I can't speak any more.' But then, another day, breath soft as the touch of a moth wing, he whispers, 'I barely exist.'

The next day he starts to breathe hard, rattling. And that night he dies.[[5]](#footnote-5)

**II Trauma and Ethics: the history, implications and contours of trauma as a concept**

So, here is a story, a life story that is about language and the body and relationships. Like all auto/biographical writings it claims a direct relationship to the experience and actualities of a lived life. But it is also self-conscious about itself as a *story* that is constructed, fashioned. The inclusion of the children's poem, a second story, within the main narrative draws attention to this constructedness, at the same time as it suggests that fear surrounding medical misunderstandings of what matters to an individual might be – or have been – culturally broader than that belonging to the one man whose particular experience is evoked here. Then, at the level of its content and structure, we might see the story as being punctuated by moments of traumatic repetition, first triggered by an unknown childhood experience that has evaded, or rather disabled, memory and the processes of representation. How this initial, unknown trauma producing memory loss, in conjuncture with the experience of the physical shock that stimulates the return of memory, is perpetuated in successive scenes of interaction that catalyse returns to the psychic terrors, flights and physical reactions of the original experiences structures the story, as does reference to the stages of transmission of traumatic affect from father to daughter. If its ending could suggest transcendence through the paradox of achieving self-determination at the threshold of death, the core of the story brings together bodily suffering, assaults on embodied identity, denials of full subjectivity, and a variety of recoils from agency, language and memory. In all of this, the story speaks of gaps in communication between people and of gaps between aspects of an individual's identity, especially those occurring between bodily and language-based senses of selfhood.

The purpose in telling this story of an individual – and in invoking the idea of trauma – isnot to blame, nor to imply that past or present healthcare practices are routinely violating. Rather, what this article suggests is that in any practice crucially centred on relationship, particularly a relationship that involves, to a greater or lesser extent, responsibility and an imbalance of knowledge, power and levels of vulnerability (teaching, caring, parenting..., and perhaps most intensely of all, medicine and healthcare), the potential for trauma is a ghostly background presence. So, reference to trauma here works to introduce a shift from the individual to the abstract, to set up the concept as a magnifying lens through which we might analyse the dynamics of a *system* and of unexceptional, everyday practice in order to further scrutinise issues of medical communications. Equally, a focus on trauma in the opening sections of this article serves to establish a problematic that has been exchanged between medicine and literary and cultural studies, that is invisibly present in some medical-humanities writings,[[6]](#footnote-6) and that may tell us something of the relationship between these different disciplines and practices.

Trauma: the concept, its import and history

If trauma began as a medical concept (in seventeenth-century medical treatises it refers specifically to physical wounds 'from an External Cause',[[7]](#footnote-7) a meaning retained in some areas of medicine today), this bodily meaning accrued psychological meanings throughout the nineteenth and twentieth centuries, so that it is now this psychological meaning which is most commonly recognised.[[8]](#footnote-8) The notion of psychological trauma has been absorbed into a number of disciplines that identify a shared set of component factors that delineate the experience of trauma. The presence of trauma can be recognised if:

* a person has suffered extreme distress produced by the experience – or the inherited effect or the witnessing – of an event or situation that involves threat of: death, serious physical injury or shattering of the integrity of the self, plus an immediate response involving intense fear, helplessness or horror;
* these combined factors effect an overwhelming of normal, bodily, psychic, cognitive and expressive systems, so that the experience cannot be processed;
* the event is therefore persistently re-experienced, and there are equally persistent symptoms of increased arousal, at the same time as, paradoxically, there is an avoidance of stimuli associated with the trauma, and a numbing of responsiveness;
* there is continuing entrapment in cycles of repetition and flight: somatisation as symptom (rather than somatic discharge of stress) and avoidance of symbolic articulation, or ineffectively repeated, empty articulation. (Adapted from DSM-IV-TR [1994; 2000]; DSM-V [2013])

The generally accepted characteristics of trauma listed here relate to a particular form of experience that may lead to the manifestation of a series of painful and disabling responses, simultaneously physical and psychological. These constitute, at the level of the individual, a diagnosable 'disorder', or disruption to a homeostatic alignment of boldily, psychological and symbolic systems. But, in line with a methodology that sees illness or dysfunction as offering a route into understanding normal functionality, the idea of trauma as an identifiable disorder produced by a disequlilibrium of crucial aspects of human functioning can bring to light the 'normal' inter-relational ordering of those very systems. Seen in this way, trauma becomes a conceptual site where – through their disarticulation – component aspects of the essentially human may be identified. Trauma highlights the relationship between inner experience and external impacts; it also has a transmissible effect. And it is precisely because trauma involves the unravelling of relationships between somatic, emotional, cognitive and signifying processes, that it offers rich insights into what it means to be human. The multidimensional nature of the concept has allowed abstraction from the experience of traumatised individuals to produce trauma as a paradigm for interrogating the nature of what makes up human subjectivity as a universal.

 Trauma as a concept, then, brings together micro-level, personal experiences (such as abuse in childhood or sexual abuse) with mass experience of broader environmental or historical cataclysms, particularly the twentieth century's massive wars and genocides, and major natural disasters. It situates itself at the interface of thought about individual humans with particular histories and collective human groups embodying and enacting historical process. This multiple quality of trauma as a concept also means that, in the history of its circulation and refinement over the past century or so, it has been variously focalised, seen from the perspectives of disparate disciplines which privilege different component strands, but which recurrently return to a consensual understanding, in spite of these differences. Recent work, for instance, in epigenetics and epigenomics[[9]](#footnote-9) (a field that is, at last, dissolving nature/nurture and mind/body binarisms in scientific thought) has tentatively provided a demonstration of the heritable effects of trauma amongst mammals. In particular, a much-cited 2013 study of mice who were given electric shocks in an environment redolent with acetophenone (a chemical with a distinctive scent, similar to cherry blossom and almonds) found that not only they, but also subsequent generations of their offspring, had a measurably significant aversion to this smell (Dias and Ressler, 2013).[[10]](#footnote-10) The familiar idea of trans-generational traumatic affects begins to be biologically substantiated through empirical, epigenetic work. And, perhaps more directly and confidently, modern neurobiological investigations of the bodily process of trauma have identified ways in which a rapid response circuit is triggered in the brain by a traumatising experience. This involves a bypassing of the amygdala/hippocampal circuit and ensuing processes, through which, in other situations of lesser threat, meaning comes to be ascribed to the experience, allowing it to become integrated into a person's sense of their own history (Hopper et al. [2007]; Hayes et al. [2011]; Lanius et al. [2011]). So, through the development of imaging technologies, neurobiological accounts have begun to be able to identify neural and chemical correlates to the features of trauma (or, in a more diagnostic register, Post-Traumatic Stress Disorder) identified in descriptive and analytic psychological accounts. And all such accounts owe a debt to Freud. He, himself, suggested that, one day, biological understanding would be able to explain aspects of the human that his own science of psychoanalysis sought to illuminate. But because we have not yet fully arrived at that day, it is still in Freud's writings we find the most comprehensive articulation of the complex of processes involved in trauma with which, as Cathy Caruth puts it, Freud had a 'passionate fascination' (Caruth 1996, 3). The history of trauma as a concept is, to a large extent, the history of a conceptual inheritance from Freud.

It was, famously, Freud's turning away, in his early work on hysteria, from a simple model of direct cause and effect between childhood sexual abuse and adult neurosis that led to his development of a more nuanced understanding of the relationship between external events and internal phantasies, and from this to produce the whole system of ideas about the organisation of psychic processes in the human that he named psychoanalysis (Strachey 1977, 17). That it is trauma, however, that underpins the development of his thought, has led post-Freudian psychoanalytic theorists such as Jean Laplanche to retrieve from Freud a general sense of the complexity of the relation of external event to internal processing of the impact of that event, a relationship that tells us something more general about human experience in the world. Laplanche suggests:

[Freud's original] theory explained that trauma, in order to be psychic trauma, never comes simply from outside. That is, even in the first moment it must be internalised, and then afterwards relived, revivified, in order to become an internal trauma...

First, there is the implantation of something coming from outside. And this experience, or the memory of it, must be reinvested in a second moment, and then it becomes traumatic (Caruth interview with Laplanche 2001, 2).

This second (mental or internal) experience then becomes retroactively projected back on the first (externally produced) experience. A feedback loop between external event and psychic process is created. It is this which produces the characteristically repetitive, non-progressive, non-integrated, quality of traumatic affects.

There is another aspect of trauma that establishes it as universal process in the formation of the human psyche, and not only as a particular experience of some individuals. Laplanche formulates this further aspect of trauma through his notion of the 'traumatically enigmatic signifier', a term that complicates the relationship between internal and external causality in a different manner. Here, trauma is seen as affecting all infants in relation to the other, 'the concrete other, each other person, adult person, which [sic] has to care for the baby' (Caruth interview with Laplanche 2001, 5). Because the adult(s) caring for the baby cannot know everything about themselves, they transmit to the child messages that they are unaware of, that are strange even to themselves. Such messages constitute the 'traumatically enigmatic signifier' sent to the infant who is constitutionally unable to respond to it. This is a message that 'wounds' the baby but, in Laplanche's formulation of Freud, simultaneously triggers the baby's building of an ego, or sense of 'me', in order to cope with the invading strangeness. In such a way, the wound, the trauma, of the strangeness of the other is structurally necessary to psychic development.

If such thought can be taken from Freud's early work, further intense speculation about the dual nature of humans, at once biological and psychological, was similarly driven in his late work by his continuing preoccupation with trauma. Writing in the aftermath of the Great War, he recurrently returned to the idea of a death drive, a concept that brought together for him a cluster of concerns: how to conceptualise the human capacity for destruction that the war evidenced; the nature of the trauma experienced by soldiers; and the more general implications of mortality (1964; 1955). In *Beyond the Pleasure Principle* he takes the biological as his starting-point: the fundamental tendency of all organisms towards return to an inorganic state. This primary drive towards death, he then suggests, works in tension with the ego which, as a secondary psychological agent, aims to preserve life, and to disavow the certainty of death, even while being aware of its inevitability. But the bodily and the psychological are connected: the primary processes of the biological body inform, and bear on, the 'mental' or secondary processes through the agency of the instincts which 'represent the somatic demands upon the mind' (1964,148). These need to be subjugated, contained, if we, as humans, are to enter into social life and, indeed, to function in the characteristic way of humans (through the dynamic relationship between the conscious and the unconscious which produces memory and a sense of history; rationality; and the capacity for language or symbol formation [1955, 62]). The idea of trauma here provides a springboard for Freud into thinking about the centrality of death to human experience in a way that allowed him to hypothesise a general relationship between the bodily and the psychic in the human.

So, Freud's thought in these areas provides a model of human situatedness between bodily realities, psychological systems, and systems of meaning. And central to the experience of being human is a constant dialectic between external impacts and internal processing. For Freud, humans are essentially split beings. Between the somatic and the psychic, the internal and the external, there are profound gaps; traverse of these gaps involves negotiating a series of paradoxes. (And it is, of course, psychoanalysis as the 'speaking cure' that offers a possibility of bringing primary and secondary processes into alignment, and of articulating the internal and the external, in cases of their disequilibrium, through talking to a properly-receptive other person, so creating a new relationship between a self and all that is beyond that self, by means of language's constant negotiation of speaker and addressee, 'I' and 'You'.)

In the last few decades, the concept of trauma (as developed from both Freud and more recent approaches), particularly its suggestion that human subjectivity is predicated on negotiation of gaps and paradoxes, has been adopted by social scientists, philosophers and cultural and literary theorists, at first in the context of identity studies and Holocaust studies, and then more broadly. So, while in the fields of psychiatry, psychotherapy and psychology, attention to features of individual trauma has led to development of a proliferation of therapies that intervene in trauma's characteristically cyclic, but non-progressive, oscillations between body, emotion and symbolisation, from different angles (the bodily, the symbolic, the neurological),[[11]](#footnote-11) the application of ideas about trauma, both in its particular and its universal forms, has led in the humanities and social sciences to a radical re-configuration of fundamental disciplinary assumptions in the past two decades. As Roger Luckhurst puts it in *The Trauma Question*, the trauma paradigm has now, 'come to pervade the understanding of subjectivity and experience in the advanced industrial world' (2008, 1). Particularly influential has been the idea that trauma reveals to us an aporia, a radical uncertainty, at the centre of our thought, knowledge, and systems of representation. This aporia occurs as the effect of the paradoxes inherent in ideas of trauma and arises, inevitably enough, in relation to language itself. The linguist Ruth Wajnryb, for instance, speaking of family deaths in Treblinka, during the liquidation of the Vilna ghetto, and in a concentration camp in Estonia, writes in *The Silenc*e, her analytic meditation on the effects of this history:

 Tragedy so devastating sweeps away everything in its path – and more, even the capacity to represent it. The home I grew up in was bathed in a silence wrought by trauma. Yet because silence transmits its own messages...I grew up apprenticed in the skills of inference and versed in the language of the oblique. I became literate in the grammar of silence (2001, xi).

Not only does trauma present us with the paradox of a meaning-producing absence of language, but in its dissociations, its non-integration of memory and emotion, its avoidances and disarticulated repetitions in the form of flashbacks and re-experiencings, it has been seen to complicate ideas of how we live in time and through memory (and so, has troubled concepts of identity itself).

It is in the context of such perceptions that many influential thinkers have seen trauma as questioning the very basis of our structures of knowledge or as a concept which can be used to develop and challenge inherited thought.[[12]](#footnote-12) The philosopher Catherine Malabou, as a recent example, through a critical extension of Freud's thought, has focussed on the nature of ruptures in subjectivity created by brain lesions and degradations, or what she terms 'the negative plasticity' of the physical – the neurological – brain (Malabou 2012a; 2012b). And Slavoj Žižek, partly responding to her work, has applied it to social ruptures. Exploring the nature of the post-1980s world, he speaks of a common 'post-traumatic subjectivity', a culture of the 'Wholly Other', the 'psychically mute'. This is evidenced for Žižek in the experience of individuals but also speaks, again, of our shared, contemporary condition (Žižek 2008; 2011, 292-314). Trauma has become an overarching concept, now including within its scope the experience of illness, of brain damage, of global political, economic and cultural events. The idea of trauma has become integral to delineating subjectivity itself. It serves simultaneously to underpin, and to question the basis of, our systems of knowledge and understanding; it offers a paradigm which tests not only concepts of history and truth, and of narrative time, but also of language and systems of representation.

So, for literary and cultural theorists, who take as axiomatic the notion that humans are definitively creatures of meaning, the trauma paradigm has produced intense questioning about the ruptures in, and the limits and the absent centre of, our systems of thought, knowledge and representation. Indeed, the mobile meanings of trauma – its shifts from the realm of symbolic language to the body as a meaningful but incomprehensible site, with its replication of symbolic silence, its fragmentation and its repetition in its own stalled and repetitive language of symptom – and trauma's overall signalling of a breakdown in our ways of processing and making sense of things, have come to focus fundamental questions about the nature of knowing as well as being. And if trauma is always to do with the dual nature of humans as bodily beings and beings dependent on producing meaning through symbolic representation,[[13]](#footnote-13) encoded also as memory and identity, it is also definitively related to the*inter*subjective. Language and structures of meaning are always produced between subjects, between 'I' and 'You'; selfhood is achieved and life is lived in relation to others.

Ethics

All notions of trauma recognise that it is initiated by an assault from outside the self, often (although not always) from human others. Trauma comes about from a cataclysmic disruption of the inter-relationship, including the intersubjectivity, that is at the core of our being. So, central to establishment of the trauma paradigm has been a branch of philosophy that seeks to produce a model of ethical inter-relationship at a personal level, but that also goes beyond this, further producing an epistemological model which avoids the implications of those western systems of knowledge and understanding, most particularly totalising and reifying systems, that were able to produce the historical trauma of the Holocaust, and that continue potentially to produce other denials of full subjectivity. Such a philosophy is interested in the possibility of a structure of knowledge that does not involve objectification by mastery, that does not, through its forms of knowing, possess its objects. In this sphere, the work of Emmanuel Levinas has been particularly influential.[[14]](#footnote-14)

Levinas was a Lithuanian Jewish philosopher who took French nationality in 1931. During the German invasion of France in 1940, Levinas' military unit was captured, and he was imprisoned in a forestry commando unit for Jewish prisoners of war, Camp 1492 near Hanover. In one of the brief, personal, hermeneutic meditations contained in the collection *A Difficult Freedom,* Levinas describesan episode from his imprisonment that succinctly summarises the core of the thought he developed after the end of World War II (Levinas 1990, 152-53). He tells us here the story of the 'wandering dog', Bobby, who used to come into Camp 1492 each day. The overall experience of prisoners in the camp, Levinas writes, was a denial of their humanity, a degradation, a 'stripp[ing]...of [their] human skin', to the status of animals ('We were subhuman, a gang of apes'), or to the language-less non-human:

A small inner murmur, the strength and wretchedness of persecuted people, reminded us of our essence as thinking creatures, but we were no longer part of the world...We were... beings without language (Levinas 1990, 153).

It was the actual non-human animal, the dog Bobby, who, in greeting them each day in the familiar way that a dog greets a human, provided the only recognition of their humanity: 'He would appear at morning assembly and was waiting for us as we returned, jumping up and down and barking in delight. For him, there was no doubt that we were men' (Levinas 1990, 153). The dog, as validating other, restored to them, in a small way, the humanity that had been denied.

It is the relationship between the self and others (or in an abstract formulation, the Other), that preoccupies Levinas in his post-war philosophical thought. He takes the work of another Jewish philosopher, Martin Buber, as a starting point. Buber, in attempting to identify what characterises a fully dialogic encounter, distinguishes the subject-object relationship of I-It from a fully intersubjective I-Thou relationship (Buber 2004). Working from Buber's distinction, Levinas reformulates questions about full intersubjectivity as the question of how it might be possible to live in the permanence of a 'face-to-face encounter with the other' (Levinas 1969). For him this involves not adherence to a set of rules, or behaviours, but an ‘inexorable and constant exposure to alterity’ (Nealon 1998, xi). For Levinas, it is in a dialectic between self-recognition and encounters with the other that our being is produced. These encounters, if ethical, focus on the quiddity, the particularity, of being. At the same time, they involve recognition that an other cannot ever be known: 'others' cannot be lumped together, as other, nor can they be seen just as a reflection of the self. Any other exceeds all *idea* of the other that the self can conceptualise. Levinas' preoccupation with the 'face' and with the 'skin' of the self and the other, throughout his writings, precisely expresses his notions of expressed and experienced particularity (embodied in the face) and of the importance of what is at the interface between self and other (the skin which demarcates and bounds, which identifies the self to the world, which holds inside and outside in relationship, but which is permeable, which is living).

Since otherness, whether personal or abstract, is never reducible to the categories of the self or of knowledge of the world, Levinas’ notion of ethical responsibility implies not a form of liberal caring, based on perception of the equality of the self and the other, but a commitment to a simultaneous recognition of the quiddity of the other – in the sense of his or her or its particularity – and of the fact that it exceeds recognition. So, the aporia, the gaps and paradoxes, identified at the heart of traumatic formations and systems is here reformulated as the paradox of the Other: in an ethical relationship, one should strive to recognise the particularity of the other at the same time as recognising that the other is always unknowable. (And, further, it is this recognition of the lack of totality in what can be known, the blank of not knowing, that produces the self. The self is marked out and recognised against a coinciding recognition of the infinity of what is not, and cannot, be known.)[[15]](#footnote-15)

Using the trauma paradigm, then, as a case study of a multidimensional concept that has been exchanged between scientific and humanities-based thought has had several aims. It picks up on the problematic established through the story that forms the first section of this article. There, issues of the complex nature of a life history and experience, and of gaps in, and disjunctures between, aspects of being and selfhood were thematically figured through recurrent attention to the oral as a bodily site variously associated with speech and language, with ingestion, and with particular bodily ills and treatments. The story, in alluding to these various aspects of orality, presents the mouth as a place of bodily opening, a gateway between inside and outside, that is crucially involved in negotiating inter-relationship and personal agency. The mouth is shown as a body part that is simultaneously subject to its own suffering and disease, functionally involved in producing various degrees of agency through the production of sound or full speech, and a prime site of acceptance or rejection of what comes from outside – food, drink, or medication: offerings of the other. Reference to the oral in the story here served as one way of suggesting the inseparability of mind and body, as well as the way that individual selfhood or subjectivity always depends on the interpersonal.

Theorisation of the concept of trauma, developed in this second section of the article has then aimed to explore these same elements of human experience and selfhood in a more abstract manner. It has suggested that considering the trauma paradigm is one particular way of understanding the fragility of our human equilibrium between the bodily and the psychic, while also emphasising the importance of a recognition that our being is produced in our inter-relational, particularly our intersubjective, experience. It has aimed, equally, to say something about the idea that the relationships that produce us are personal and immediate, but that the effects of them may also be also transmitted or inherited. Further, it has brought into play the idea that, because trauma is both manifested in the lives of individuals, but also speaks to our common humanity, we need to be alert not only to how we relate to those who may have experienced trauma, but to recognise that the forms of relationship appropriate to traumatised individuals are also forms of behaviour appropriate in all human relationships, since we are all, always, potentially traumatised. Similarly, the theories described here insist that we are all, always, implicated in a dialogic encounter: there is no neutral or detached position from which we may relate to others, either at personal, or at epistemological, or at practice-based, levels. What is suggested is that every utterance and act, however mundane, depends on a syntax connecting 'I' and 'You', so that in every utterance and act we refashion ourselves, those selves fundamentally produced as an effect of 'I' in relation to its others. This need for attention to syntaxes of connection applies, beyond the personal, to ways in which relationship is encoded in the systems of knowledge, and the systematised practices, through which we act on and engage with the world and one another. And if central to the idea of trauma is the notion of uncertainty and gaps, the question this might raise for us now is how we address a very particular gap: that between such a formulation of an ideal of intersubjective relationship and the operational practicalities of the everyday medical encounter.[[16]](#footnote-16)

**III Medical Communications and the Calgary Cambridge system: a reading**

Since the 1970s there has, in fact, been growing recognition that the quality of inter-relationship between patients and healthcare workers crucially affects medical success, conceived managerially as both 'patient outcomes' and 'outcomes for doctors'.[[17]](#footnote-17) The consequent changes that have, in recent decades, put communication skills at the core of medical training acknowledge the difficulties for both practitioner and patient of the medical consultation, predicated, as it must be, on the complexities inherent in matters of embodied and signifying intersubjectivity and in the heightened context of intimacy between strangers.[[18]](#footnote-18) A shift away from a purely disease-focussed and objectifying emphasis in the role of clinicians to one that stresses narrative, context and interrelation is, in seventy per cent of British medical schools, and in much continuous professional development training for primary care and other practitioners, based on what is often known as the Calgary-Cambridge method.[[19]](#footnote-19) This is outlined in two highly influential textbooks by Jonathan Silverman, Suzanne Kurtz and Juliet Draper:  *Skills for Communicating with Patients* and the companion volume, *Teaching and Learning Communication Skills in Medicine,*[[20]](#footnote-20) both first published in 1998, which have, as the prefatory materials in later editions suggest, 'quickly found a global readership' (Silverman et al. 2005, vi). These textbooks represent, then, an attempt to integrate thought about signifying practices and inter-relationship into the mainstream of healthcare.

As their titles suggest, the approach formulated in these manuals is emphatically skills-based.[[21]](#footnote-21) Acquisition of the advocated skills is to be achieved through experiential-learning techniques. The model is systematic, and it elevates communication as one of four central aspects of clinical competence: knowledge-base, physical examination, and problem-solving ability are the others. Its goals are pragmatic. One of its introductory boxed summaries (Silverman et al. 2005, 8) reads:

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| --- |
| **Box 1.1 The prize on offer from communication skills training is improved clinical practice** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |
| * Communication is not just 'being nice' but produces a more effective consultation for both patient and doctor.
 |
| * Effective communication significantly improves:
 |
| * + accuracy, efficiency and supportiveness
 |
| * + health outcomes for patients
 |
| * + satisfaction for both patient and doctor
 |
| * + the therapeutic relationship.
 |
| * Communication bridges the gap between evidence-based medicine and working with individual patients.
 |
|  |

A few paragraphs later a further central aim is articulated:

Together the skills that we identify support a *patient-centred* or *relationship-centred* approach that promotes a collaborative partnership between patient and health professional. (Silverman et al. 2005, 9)

And shortly after, the first of a much-reproduced series of boxes outlining the structure or framework of what the authors refer to as the medical 'interview' is introduced. But, if these opening statements and charts primarily establish the method and aims of the books, it is evident that they also establish a series of unspoken implications, some contradictions, tensions, and, here again, paradoxes. In reading these textbooks *as* *texts*, it is these tensions and paradoxes that are immediately striking.

First, and perhaps most importantly, the emphasis on skills, functionalism and the pragmatic, underplays the radicalism of the manuals. The elevation of communications to one of the four competencies of the practitioner represents a major paradigm shift introduced to medical training over the past twenty years. The very inclusion of a realm of expertise concerned with the production of meaning as crucial signals a quite different formulation of the role of medicine from that of the Enlightenment-evolved, empiricist, objectifying, taxonomically-structured, social-hierarchy-driven, often authoritarian or judgmental, thought and practice of the past. Here, signalled by these introductory statements and charts, as well as in the textbook's wealth of detailed suggestions for implementation of this model, is a conceptualisation of medicine that promises to be contextual, fully dialogic, intersubjective and democratised. Yet, the (perhaps necessary) timidity with which such a paradigm shift is announced, as well as some of the tensions and impossibilities which might be seen to inform the model, are similarly signalled by these introductory statements and charts. If the emphasis on skills here might be seen to give actualising form to the abstract ideals described in the second section of this article, and to enable practitioners to avoid the sorts of interpersonal denials or misapprehensions suggested in my opening story, such an emphasis might also show itself as working to obscure its relationship to such ideals, to mask its own radicalism. It may also betray the very anxiety against which it is seeking to work.

Box 1.1 serves as an instance of the mode that the texts use and how we might read the tensions inscribed in them. A consultative 'interview' is inevitably fraught. For a patient there is a concern or a need, whether major or minor, that exposes and bears on his or her being, that has to be made comprehensible to a stranger (or relative stranger); for a practitioner there is the need to comprehend, to make responsive decisions about action, to help and not to hurt, not to compromise the nature of the other's being, and to be interested – even in the tedious and routine. For both parties there is often the arbitrariness of encounter; there are constraints of time and of what, within a number of clinical, policy-related, economic and process-based contexts, is possible. What is at stake is always potentially great. For the medical practitioner as perpetual host to these encounters and respondent to the needs of others, it is the security of training with its proffered knowledge and its repetition after repetition of practice and procedure, the intuition brought about by experience, and the certainties produced by institutional contexts and protocols that both enable and protect against an otherwise intolerable burden of responsibility and incumbent anxiety.[[22]](#footnote-22) This need for containment of anxiety is visually represented here in Box 1.1, as throughout *Skills for Communicating with Patients*, by the box format itself. Sharing a mode that favours flow-charts, lists and boxes with management treatises and other, more general teaching and learning manuals used in the field of Education, these texts work to schematise time-limited encounters, to provide a sure path through the uncharted terrains of uncertainty and unpredictability. To initiate this path-finding, Box 1.1 establishes aims in order to establish purpose, a rationale, or '[t]he prize on offer'. But these aims also suggest a number of complex, and possibly contradictory, agendas.

Reference to 'not just "being nice"', at the very start of the book's exposition of its rationale and method, is particularly arresting. The phrase initially seems to hover between signifying 'not *only* being nice' (suggesting a starting point of niceness and then something beyond that) and 'not something as banal, trivial or sentimental as niceness'. But the plunge into colloquialism, the shift in tone typographically marked by the use of inverted commas (' "being nice" '), in a sentence otherwise characterised by a Latinate vocabulary, encourages the reader to privilege the second of these understandings of the sentence. The waspish tone produced by the scare quotes then works to suggest a background resistance of some practitioners to this entire communications enterprise. So, by invoking criticism in this manner, in the very introduction to the method, the whole communications model is subtly established as antagonistic. Then, by seeking to identify itself as something more 'evidence-based' (Silverman et al. 2005, 8 and passim),[[23]](#footnote-23) more productive of professional success, and therefore more legitimate, than 'being nice', this also implies a hierarchy of values in which 'being nice' is ranked as unscientific, unskilled and not instrumentally valuable. And, from this, a whole history of the construction of social and professional values might begin to surface behind these words: matters of the specialised against the popular or everyday; notions of 'soft' skills and 'hard' skills and with this, perhaps, the gendering of skills; issues of the empirically-testable against the phenomenological, and so on. Yet the text's emphasis on setting out its advocated process and skills, rather than on sustained argument and analysis, does not allow for anything more than assertions or subtextual barbs, as here, to convince. In such a way, a simple summarising phrase in a box invokes, from its tone, a range of issues that inform the model but are not directly articulated or reflected upon.

Similarly, the sub-points to the third bullet point in this box, for all the lightness of expression, are saturated with implied, but unvoiced, ideological and epistemological assumptions:

|  |
| --- |
| * Effective communication significantly improves:
 |
| * + accuracy, efficiency and supportiveness
 |
| * + health outcomes for patients
 |
| * + satisfaction for both patient and doctor
 |
| * + the therapeutic relationship.
 |

'[A]ccuracy, efficiency and supportiveness' refers to a range of factors. '[E]fficiency' might raise questions about economics, political policy, institutional and ideological issues driving health provision (in the UK,for instance, the current context of a full state provision that is sliding into a new world and mixed economy of privatised-NHS provision, with its blend of paternalism, authoritarianism, consumerism and market-competition).[[24]](#footnote-24) The word 'accuracy' might signify the necessity of accurate diagnosis and appropriate treatment – and all of the epistemological, ideological, ethical and economic issues that underpin these matters. And 'supportive' raises a further cluster of questions about the basic role of the clinician, the needs and desires of patients in all their heterogeneity, and the variant theories, ideologies and opinions that bear on this relationship. Questions about the whole complex issue of how we understand the meaning of illness and the role of health professionals, both in relation to illness itself and in relation to particular individuals, are raised by this slight phrase. This is picked up in the final sub-point. Here, the reference to a therapeutic relationship, even more strongly, begs questions about feasible and desirable relationships, and raises theoretical and methodological questions dating back to, at least, Balint's work in the 1950s.[[25]](#footnote-25) And what is not listed here may also be significant. Advocacy of the importance of good communications is not linked to any complex model of how body and mind interconnect. Good communications are represented as desirable in responding to social change and as a tool to augment existing medical practice, rather than as deriving from a wider reappraisal of the role of medicine in relation to the nature of humans, both embodied and meaning-dependent, that defines the needs, possibilities and experience of both practitioners and patients. So, even a brief reading of this summary box serves to suggest how the pragmatism encoded in the form itself of the textbooks, as textbooks, underplays the complexity and range of issues involved. If the elevation of communications to a core skill, equal in importance to technical skills, is a radical move, changing inherited thought about the ownership of illness and the knowledge-systems that produce medicine as a discipline and practice, these books embody that radicalism, but – in spite of emphatic assertion of the rightness of their model, and thorough referencing to a scholarly literature – do not articulate it (Kurtz, 52). The approach is covert.

Conversely, however, it also seems at times, that while *Skills for Communicating with Patients* advocates a new approach based on a notion of a practitioner-patient partnership, its own structures and methods, as well as details of its own articulation, tend to replicate the very structures of thought and relationship that it works against. Small slippages of language, as in any written text or any utterance, reveal tensions, contradictions and unexamined assumptions. For example, the phrase, '*calibrate* the patient's emotional state' [Silverman et al. 2005, 50, my italics] suggests the opposition of scientific rationalism, embodied by the clinician, to inchoate feeling and passivity as a potential characteristic of the patient, and perhaps even carries, in the embedded metaphor, a notion of emotion as bullet, reinforcing the stereotype of practitioners as affect-averse. Or, the use of Standard English in practitioners' utterances, but a variety of quasi-dialect forms for some patient utterances replicates old-fashioned socio-occupational demarcations. And it would be possible to multiply these readings of textual moments. The generic pull of a long tradition of case-study writing exerts its force here. The intertextual imprint of past medical teaching texts is inevitably evident. And it would be possible to interrogate other effects of the texts' style and habits of articulation in a similar way. Or, from a different perspective, certain implausibilities of the model might be explored: for instance, can anyone ever understand someone else's 'ideas and beliefs' about anything from an exchange of a few minutes, however intense that exchange is (Silverman et al. 2005, 20 and passim)? That, in these texts, the clinician-patient encounter is largely discussed in isolation from its informing environment, rather than as a gestalt made up from a series of interactions with other clinicians, nurses, patients, receptionists, care workers, porters, administrators and so on that occur within the particular syntax, spatial and sensory, of designated buildings, and which are mediated through past experiences, broader cultural representations and immersion in institutional cultures,[[26]](#footnote-26) might be noted as an effect of the texts' specific training-purpose. (It derives as well, perhaps, as a broader epistemological inheritance, from the practice of isolating objects of study, of 'specimen logic', in the early natural sciences [Neri 2011, xii-xiii]).

But although *Skills for Communicating with Patients* does not incorporate consciousness of its own assumptions and habits of thought in laying out its model, it is, in more discursive sections, self-aware about some of these tensions, contradictions and difficulties. The issues of power and agency that are unremarked in the main part of the book are summarised in the section, late in the text, 'What recent trends in society have influenced medical information giving?' And, although socio-cultural change is here linked to specific issues about information, it is clear from statements such as 'Patients do not now accept the concept of an unbridgeable competence gap' or '...the paternalistic relationship between doctor and patient is increasingly viewed as anachronistic' (Silverman et al. 2005, 155) that there is recognition of the implications of the democratisation of culture here, even if it is not fully worked through in the construction or articulation of the model. Because this is a practical manual, legitimising itself through its instrumental appeal, reference to thought about why and how past practices came about, or to non-instrumental reasons for change to inherited forms of practice are sidelined. But it is the texts' simultaneous awareness and repression of forms of understanding that do not correspond to their practical agenda that produce their tensions, awkwardnesses and fractures.

*Skills for Communicating with Patients*, then, might be seen as a transitional text. In giving serious attention to the dynamics of medical consultations, and in raising skills in inter-relationship to a core competence in healthcare disciplines, it addresses, in its own pragmatic way, the central issues raised in different forms in earlier sections of this article. By putting relationship at the centre of medical practice, it implicitly acknowledges matters of intersubjectivity and offers the possibility of a practice alert to the ghosts that haunt it, trauma or hurting others, when relationship is awry. If the implications of this for all aspects of practice have not been worked through, this will increasingly occur as – or if – recognition of the importance of dialogism becomes embedded. But a central paradox that inheres in the production of this model raises more complex questions. As the reading here suggests, the Calgary-Cambridge system creates its own authority and legitimacy precisely through its self-articulation as a system. This is its strength. It can be learned and taught as a procedure. It corresponds in mode to ways in which medical students have been taught to think elsewhere in their curriculum. But this very systemisation and instrumentality may also work to inhibit understanding. *Skills for Communicating with Patients* teaches learners what to do, and to an extent, *how* to communicate. But it offers no understanding of why this is important beyond notions of efficacy. Any notion of the role of medicine in the playing out of a shared humanity is beyond the bounds of this text. And the book is about communication. As such, it is concerned with matters of process, with ways in which transmission of meaning can be facilitated, rather than with meaning itself. [[27]](#footnote-27) The model of signification that underlies the teaching of this text is that prevailing in the social sciences which are, by their nature, concerned with analysis of institution, policy, regulation and process. The idea of giving attention to meaning, in all its complexity, elusiveness and radical uncertainty, that often informs humanities disciplines (varieties of history, literary study and other analytic and interpretative disciplines) shadows, but is not brought into the daylight of, this text. The manuals' attention to communications as a system, rather than to forms of knowledge concerned with how meanings are produced, becomes, in this way, an issue of epistemological differences. It raises questions about the nature of encounter and exchange between medicine and humanities disciplines, which return us to the issues set out earlier in this article. It might be argued that medicine as a discipline whose practitioners need to act decisively, to take responsibility, to have confidence in their own judgment, and to offer confidence to patients, needs firm parameters. Closed systems may seem attractive. Humanities scholars and practitioners, on the other hand, whose work is predicated on a notion of the slipperiness of meaning and on reflexivity about the nature of thought itself, often tend to favour open systems and modes that interrogate and destabilise thought, privileging instead the uncertainty perceived as integral to being. If medicine's task is to mitigate the effects of life's uncertainty and of human vulnerability, how might it acknowledge through its everyday practice the profound uncertainty that is central to all of our lives and all of our thought, while at the same time managing the effects of such an aporia?

The Calgary-Cambridge method, ambitious and genuinely radical, offers to reduce the possibility of medical interactions creating or replicating traumatic situations for individuals, such as those suggested by the story at the beginning of this article. In doing so, it marks a step forward in a process of rethinking the medical encounter in new way that has begun, but has not ended. If it is to become a generative – and not a fixed or totalising – system, it must evolve through self-recognition of the implications of its own content and dynamic, and through continuing openness to other modes of thought. And, if we take seriously the ideas about embodied and signifying subjectivity that emerge out of engagement between the humanities and medicine (and exemplified earlier in this article in the tracking of a single concept – trauma), a great deal more than is currently on the agenda in the medical humanities might be produced out of further dialogues between disciplines. The disciplines might speak more fully to one another through their likenesses and across their differences of method and purpose. Medicine and a humanities discipline such as Literary Studies, for instance, share a difficulty that arises from issues of ownership, expertise and communication. Literature – everything that is, and can be, written or represented – belongs to everyone with a competence in the language in which it is produced, but there are specialised students of literature who have their own methodologies, terminology and values in relation to the analysis of meaning. Likewise, health and illness are matters that belong to everyone, are common to all humanity, but clinicians are specialists in identifying and treating illnesses. How to manage encounters between immersion in specialised knowledges and everyday participation in communal knowledges might be an area of particular engagement between the disciplines. In a different way, fuller dialogue between the practices might modify the tendency of some humanities thinkers to lose sight of the materiality of being by over-privileging the realm of meaning, by fleeing into a solipsistic and barricaded world of ideation; medicine might temper its tendency to reification, its uneasiness, at times, in relation to conceptual thought, or to the complexities produced by a notion of the human as *homo significans.* Properly engaged dialogue might bring about a fuller understanding of the nature of meaning for embodied subjects: an understanding that is predicated on thought about how to acknowledge meaning's elusiveness, yet to navigate its ambiguities and vagaries without losing the capacity to act.

Medicine is altering rapidly. We are at the threshold of a changed paradigm where new variations of questions about embodied, inter-relational and signifying subjectivity need to be asked. (The ethical tensions between the massifying processes of public health education, screening and population-wide data collection, on one hand, and the drive towards ideas of patient-practitioner partnership or developments such as personalised medicine, on the other, might serve as one example. The implications for embodied subjectivities of the use of new technologies in cyber-medicine might be another.) Current and emerging developments in technology and knowledge systems demand complex new thought about the old question of what it means to be human – and such questions are, inevitably, at the heart of both medical and humanities-based disciplines. In the encounter zone between disciplines, these issues could be considered in fully interrogative manner. Rather than each disciplinary group borrowing, magpie-like, a content from the other, as in some current medical-humanities work, engagement in the space *between* medicine and the humanities might allow more disciplinary reflexivity. In a Levinasian fashion, such an approach might open up possibilities of thought about how to look into the face of the other not only in individualised patient-doctor contexts, but also in interdisciplinary contexts. Recognising what can be known and done, what should be known and done, and what exceeds knowing and doing, might not only create a possibility of ethical relationship with others, but might allow us more fully to recognise ourselves: what we are and what we might be.

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1. For statistics and commentary on patients' complaints considered valid for investigation, see GMC Report (2012, 21; 61-62). Cf: 'Complaints about unsatisfactory communication are the second largest category of complaints dealt with by the Health Service Ombudsman'. NHS England (2010, 17). The GMC is the regulatory body for doctors in the UK. [↑](#footnote-ref-1)
2. Examples include a fairly early collection by Greenhalgh and Hurwitz (1998) containing chapters by some literary scholars and concerned throughout with dialogue between disciplines, including literary studies; and Jurecic (2012), written from a literary scholar's perspective, representing a recent growth in directly literary attention to medical issues. [↑](#footnote-ref-2)
3. The terms 'literary criticism' or 'textual criticism' used in this article do not imply judgment of a text in the manner of, say, a theatre or book review in a newspaper. These terms are used within the academic discipline of Literary Studies, as synonymous with 'textual analysis', to describe the activity of interpreting and analysing a textual object. The word 'text', as used in the discipline, refers to any object of study, verbal or otherwise. [↑](#footnote-ref-3)
4. In the UK, The Quality Assurance Agency for Higher Education states in its Benchmark Statement for university English (Literature) degree programmes: 'English is a versatile academic discipline characterised by the rigorous and critical study of literature and language. It is concerned with the production, reception and interpretation of written texts, both literary and non-literary...' (2007). [↑](#footnote-ref-4)
5. This story is extracted from the author's unpublished auto/biographical account of family lives. [↑](#footnote-ref-5)
6. Although the title of Arthur W. Frank's *The Wounded Storyteller*, a classic text of the medical humanities, might suggest an engagement with thought about trauma, it contains, in fact, no sustained reference to it. Allusion to trauma remains implicit in Frank's text, in the references to a range of post-modern thinkers whose writing is underpinned by, or in concord with, the contemporary trauma paradigm and its epistemological implications, as well as in his central question: consideration of how to describe 'stories as told through the body'. (1995, 2). [↑](#footnote-ref-6)
7. Blankaard (1684, 151): '*Troma*, is a Wound from an external Cause'. Browne, (1678. 10-11), referencing Galen and making, '...a brief and generall Division of Wounds...' distinguishes '*Trauma*' from other forms of wound such as an ulcer [ulcus or ἑληὸς]; a fracture [catagma]; or a spasm [spasma]. [↑](#footnote-ref-7)
8. For a particularly lucid history and overview of the concept of trauma, see Luckhurst (2008, 1-15). [↑](#footnote-ref-8)
9. A working, consensual definition of what is meant by an 'epigenetic trait' was formed at a conference at New York's Cold Spring Harbor Laboratory in 2008, as a: 'stably heritable phenotype resulting from changes in a chromosome without alterations in the DNA sequence' (Berger et al. 2009). [↑](#footnote-ref-9)
10. While there has been scientific excitement about this, there is, of course, some scepticism, as the process has not yet been established at a molecular level. Although this experiment has led to speculation about the heritability of emotional responses to experience and the plasticity of germ cells in humans, there is, as yet, no fully accepted demonstration of this. For a representative, influential article on the implications of human epigenetics (not in the specific context of trauma), see Kaminsky et al. (2009). [↑](#footnote-ref-10)
11. See Ehlers et al. (2010) and Foa et al. (2009) for critical overviews of therapies currently evaluated as effective and Levine (2010) on body-centred trauma therapy. [↑](#footnote-ref-11)
12. See Lockhurst (2008, 5-15) for an overview up to 2007. [↑](#footnote-ref-12)
13. For a recent attempt to integrate mind and body in relation to meaning, making connections between cognitive science and study of language, meanings and the aesthetic, see Johnson (2007). On the relation of body and selfhood in medical transcripts and narratives, see, for instance, Charon (2006, 85-104). [↑](#footnote-ref-13)
14. Cf. Frank (1995, 14-15; 176-82). In spite of his not referencing thought on trauma directly, Frank similarly invokes Levinas' thinking in order to ponder matters of pain, the communicability of suffering, and of the inter-human. [↑](#footnote-ref-14)
15. Here Levinas is critically diverging from Heidegger's concept of *Dasein*, or Being, which originates in the experience of being-in-the-world, but is focussed through reflexive self-recognition crucially achieved by awareness of death, and most particularly of '[t]he fact of dying for and by ourselves [which] is what gives the self authenticity, making it a "being-toward-death." ' (Levinas 1989, 3) For Levinas, infinity resides within the human, rather than in the surrounding nothingness that Heidegger's thought presents as the 'complement' of being. Laplanche's notion of the function of the 'traumatically enigmatic traumatic signifier' in triggering ego development, mentioned earlier, parallels Levinas' thought here. [↑](#footnote-ref-15)
16. The word 'encounter' is borrowed from the terminology of travel writing studies where the 'encounter' signifies what occurs in the 'contact zone', a phrase coined by Mary Louise Pratt to denote the point or place of meeting between those who are radically other to one another and where there is an asymmetrical power relation (1992). The word 'encounter' is also commonly used in relation to Levinas' thought. [↑](#footnote-ref-16)
17. The UK's General Medical Council crucially describes the relationship between patients and medical practitioners as a partnership (2013a, Domain 3, paras 46-52; and 2013b). Niall Dickson, Chief Executive and Registrar of the GMC, commented on the publication of this second document: '... it is meant to be a constructive document which reflects the evolving nature of the doctor-patient relationship. Patients increasingly expect to be and are partners of that relationship. It was important that as well as simply setting out to doctors what we expect from them, patients should be aware of what we are expecting from doctors, so that is why we have decided to produce this booklet’ (Soteriou 2013). [↑](#footnote-ref-17)
18. For an elaboration of the implications of this, see Phillips and Bersani (2008) who see conventional models of intimacy as being never safe from violence, since humans find difference unbearable. Roth (2008), reviewing *Intimacies* and quoting Phillips, writes: '"For Bersani, pleasure is not an enhancement of the ego as it masters the world. Pleasure is a shattering of the ego as it encounters the world." What does this splintering have to do with intimacy?' Roth suggests that in *Intimacies* the authors 'explore new modalities of affection and relation that would not repeat old repressions and poisonous violence. These would be new intimacies that embrace shock and fragmentation, that seek out self-shattering rather than repair and redemption. Bersani and Phillips call these "impersonal intimacies".' Questions of the im/possibility of avoiding violence are, of course, at the heart of this article. [↑](#footnote-ref-18)
19. The name relates to the home universities of two (the medical two) of the three authors. This work of naming could itself be seen to enact a depersonalisation: from authors as individuals to institutions as legitimating points of origin. [↑](#footnote-ref-19)
20. These are intended for use in training student doctors. Offshoot, adapted versions are used in the training of nurses and other healthcare workers. [↑](#footnote-ref-20)
21. As a vocational and practical subject, medicine has always had a central skills-acquisition content. The history and implications of the recent turn to a new utilitarianism (and the development of quantifiable skills in all areas of education, in a context of recent questioning of the 'value' of the arts and humanities) is addressed in Bate (2011, 5-13) and Small (2013). The related and fraught question of whether medical-history teaching to medical students should foster professional identity on one hand, or involve critique of current and past medical claims, on the other, is discussed in Kushner and Leighton (2013). [↑](#footnote-ref-21)
22. Menzies Lyth (1960) influentially analysed anxiety and institutional structures in relation to nurses in the 1950s. Recent re-evaluations of her work have mapped both the continuance of such anxieties and institutional defence processes and aspects of change in contemporary institutions. [↑](#footnote-ref-22)
23. See Greenhalgh (1998) on 'evidence' and narrative in medicine. [↑](#footnote-ref-23)
24. Such a blend of tones and positions is apparent, for instance, in Care UK's patient leaflets.

 Introduced by the statement, 'A younger, better educated patient may take a more assertive role...', issues of consumerism are briefly discussed by Silverman et al. (2005, 179), largely in the context of disempowerment of practitioners and diminution of expertise and in contrast to a paternalistic model where it is a patient's agency that is denied. [↑](#footnote-ref-24)
25. The title of Balint's influential book, *The Doctor, his Patient and the Illness* (1957), encapsulates neatly the ideological underpinnings of patient-practitioner relationships of that era, not only in its overt patriarchalism, but in its attribution of full identity and agency to the practitioner and the illness – '*THE Doctor*'; '*THE Illness*' – and its representation of the patient, *'HIS Patient'* [my capitalisations] only as a possession or effect, someone whose being is constructed purely in relation to the doctor and to illness. The words 'Doctor' and 'Illness', rhetorically linked through the rhythm and structure of the title, and bracketing the patient, produce the patient as a site on which the doctor engages with his agonist, illness. [↑](#footnote-ref-25)
26. One particular aspect of institutionalisation (with a range of ideological implications) that affects medical students is identified by Greenhalgh and Hurwitz (1998, 13): 'It has been shown that, somewhere between the first year and the final year of medical education, undergraduate students exchange a native facility for eliciting and appreciating patients' narratives for the learned expertise of constructing a medical history.' [↑](#footnote-ref-26)
27. The decision to end national implementation of 'The Liverpool Care Pathway' for dying patients, after an independent review for the UK Government, was based on recognition of the inadequacy of a generic procedure in the case of care for individuals at the end of their lives. This might stand as an extreme example of the dangers of teaching procedures without facilitating understanding at a deep level (Department of Health, 2013).

 It is, initially, surprising to humanities scholars to find that degree-level, and even graduate, medical students are taught from textbooks, rather than being asked to assemble their own thought through structured, critical study of primary texts. Different disciplinary notions of knowledge acquisition and of understanding are at play here. [↑](#footnote-ref-27)