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Arts and Humanities

**Visualising and communicating illness experiences:
drawing, the doctor-patient relationship and arts-health
research**

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Preamble

Martha Turland and I have been developing research into the manual clinical drawing practices within the UK health system since 2013. This single-authored paper emerged as a lateral exploration of some of the contexts and methodological considerations involved in designing our joint clinical drawing research studies. It is based on ideas initially aired at the Visual Methods Symposium in 2015, but substantially extended and revised. Details of Lyon and Turland's research interests and activity can be found at:

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The illustrations in the textbook (all drawn and lettered by Sister Mary Joseph Praise) had a simple quality, as it done on a napkin; no attempt was made at getting proportion or perspective right, but they were models of clarity.

Verghese 2010: 61

Introduction

Manual drawing and sketching occurs in many areas of UK health care. It is deeply embedded in daily routines across a wide range of roles and specialties, and at different hierarchical levels. It takes place in General Practice and across a range of specialisms and services in hospitals, from dementia wards to cardiothoracic outpatient clinics. Drawings are made, for example, in pathology labs and on endoscopy units (see Figures 1 and 2). These handmade drawings are created against, or perhaps despite, the backdrop of computer screens, professionally-designed digital or printed medical illustrations and 3D models in contemporary consultation rooms. The manual clinical drawings are often selective, schematic or sketchy, significant in the moment of their making and consigned to the wastepaper bin at the end of a conversation. Some are kept on medical records, or retained by the patient as a personal object.

There are no statistics on the prevalence of manual clinical drawing as a practice. As far as can be ascertained, it is not a practice carried out by all health professionals. But

anecdotal evidence and research currently taking place¹ suggests that this type of drawing occurs routinely, often informally, between patients and health professionals. Manual drawing is also a fairly regular part of the communication between one health professional and another, for example, in recording physical examination results or operative procedures. Such drawing takes place to explain care needs and sometimes in order to reach a common technical, diagnostic understanding.

Yet the epistemic value of these drawing practices, which weave throughout the health system, appears not to have been formally established or documented. There are departments of medical photography in hospitals but scant recognition of the role and function of manual drawing as a communication act (or as part of a communication act). Electronic patient record systems may not be designed to hold manual sketches made as part of the doctor-patient exchange unless paper-based drawings are converted into digital format. This would require an additional process of scanning or, in theory, a need to discard drawings that might previously have been kept. A search of the research literature so far indicates that this type of manual clinical drawing is barely acknowledged as a phenomenon.

The research that Martha Turland and I are involved in looks at when, why and how these manual clinical drawing practices occur, and with what impact on both health professional and patient. We are focussing on a visual practice that barely features in the research literature and which has produced very little meta-language. It resides in the embodied moment of the health professional-patient consultation: what Sieff refers to as the 'fragmented', 'point-in-time encounters' (Fischer and Eraut 2012). Communication within the health system, particularly the consultation between health professional and patient, has a complex, plural nature. In Fischer and Eraut's report for the Health Foundation, they highlight that although "the consultation is a single category, in practice it carries multiple purposes and multiple meanings. It can be and is organized around

¹ Taken from Lyon and Turland's first publication from their study into health professionals perceptions of clinical drawing practices, accepted for publication 2016.

Exemplar manual clinical drawings



Figure 1. Exemplar drawings of slide sample and cells, of the type produced in discussion with trainees and/or medical students. Made by the Consultant Histopathologist during a research interview. Lyon and Turland, 2016, accepted for publication.

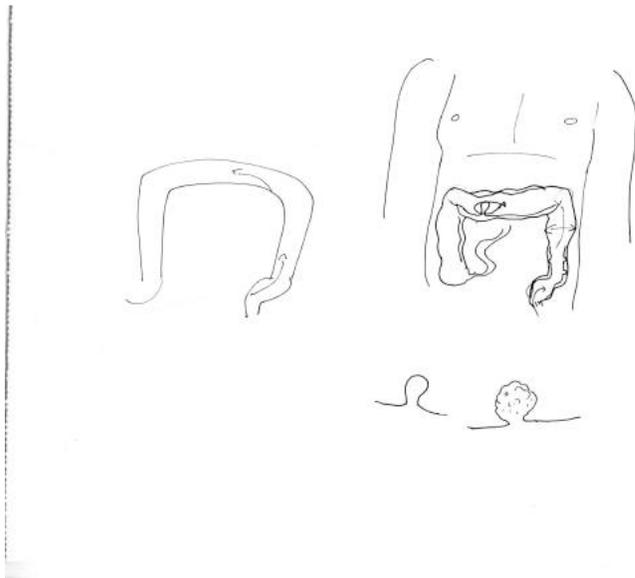


Figure 2: Exemplar drawings of the large bowel and detail of polyps, of the type drawn by a nurse for a patient on an endoscopy unit. Made by a Research Nurse during a research interview. Lyon and Turland, 2016.

multiple different driving principles, or unstated notions of what those involved think they are doing.” (2012 10) Consultations might invoke, for example, whether explicitly or subconsciously, public discourses about health needs and priorities, including societal fears and panics about health issues (such as in relation to child vaccination: see Guillaume and Bath 2015). At the same time they are concerned with individual patients’ intensely private and personal experiences and anxieties about their own bodies.

As qualitative researchers with broadly ‘arts’ backgrounds, there are further challenges in considering the doctor-patient consultation. In attempting to build a theoretical and methodological base for our studies we need to be mindful of where we place our own experiences of being ill and of being a ‘patient’. We have had, of course, to communicate about our own health and that of those close to us. The health system is not a distant object of investigation and our experiences of it resonate with, influence and impact upon our research. At the same time we are, in some senses, interposing ourselves into a different disciplinary sphere. We are aiming to conduct research within a professional world very ‘other’ to the art school in which we are based; we understand that we may be seen as ‘other’ by those working in clinical environments, even whilst focussing on themes, problems and methods of mutual interest. The business of ‘belonging’ to a particular disciplinary or professional domain, or a specific group within it, is no minor issue; educational theorists have for example long recognized the significance of membership of ‘learning communities’ (Lave and Wenger 1991). Language, in particular, is a major part of the training process for doctors (as it is for arts professionals) with ‘linguistic socialization’ extending beyond “technical terms into learning specific tribal uses of otherwise everyday terms – marking the inner circle of a discourse community.” (Fischer and Eraut 2012: 13) Some of these terms of tribal usage can be appealing and helpful to some whilst being baffling or rebarbative to others: in the arts and education, the terms ‘practice’ and ‘mark-making’ are used and viewed as self-evident and indispensable, whilst causing incomprehension in some other settings. Similarly the medical use of, for example, food metaphors, is complex. It can be appreciated as rich and evocative in many ways, as here in a fictional account of a doctor’s pleasure in the verbal cornucopia available to him:

Take the food metaphors we use to describe disease: the nutmeg liver, the sago spleen, the anchovy sauce sputum, or currant jelly stools. ... you have the strawberry tongue of scarlet fever, which the next day becomes the raspberry tongue. ... And that's just fruits! Don't get me started on the nonvegetarian stuff!

Verghese 2010: 223

Yet in those unused to such usages, the connection between food and disease might be unwelcome and proliferate unwanted symbolic associations and an individual would require some knowledge in order for the implications of a particular image to be understood (an area considered in depth by Sontag 1991). Once acclimatized and assimilated, our sense of belonging to professional and linguistic communities often becomes naturalized, semi-visible to us, yet such affiliations suffuse the way we speak, our values, assumptions and modes of operating profoundly (Paquette 2012).

At the time of publishing this paper, the issue of how to bridge communities located respectively within arts and health paradigms, specifically the art school and the NHS, has been brought home by the rejection of an application for NHS ethical approval to carry out a planned study of clinical drawing practices. This pilot qualitative study was to have tested the suitability of methods, with informed consent, that included observation and recording of consultations in which drawing took place between doctor and patient. This, then, is not 'arts-health' research in terms of proposing an arts intervention or deploying a graphic format to represent consultation experiences and issues in the way that authors of graphic medicine novels and graphic pathographies do (although much in this research and article is owed to the theory and creative-critical space that has been created by this field). It is arts-health research in posing questions that emerge from, and are relevant to, both arts and health domains of knowledge and practice: why are manual drawings made between doctor and patient; what form do they take; what impact do they have? The methods proposed were designed to capture the 'point-in-time' nature of the consultation, aiming to establish grounds for further research about whether such practices were positive or not, in what way, and who for. Having met with a mixture of interest, encouragement, incomprehension and, ultimately, ethical refusal

to proceed, we are in the process of redesigning our research. We are in particular refocussing our efforts by reflecting on our own language use, and working more deeply with patient groups and clinical collaborators. There is much learning to be done on our part in terms of researching in clinical settings, and part of this is reflecting on the experience of seeking permission from the NHS: an experience that foregrounded the problematic nature of gaining access to the consultation, especially as non-clinical researchers, and of presenting a case for qualitative research into an existing manual, visual communication practice between health professionals and patients.

In this paper, then, triggered by the experiences outlined above, I briefly explore two contexts that embody different approaches to understanding illness experience and the doctor-patient consultation. This is intended to be an impressionistic reflection on these approaches and the methodological implications that can be drawn out: it does not claim to be a formal or comprehensive review. The first section discusses selected approaches and findings in examples of academic literature on the doctor-patient relationship and the clinical consultation; and the second section considers instances of visual (and to some extent, textual) explorations of health communication and illness, including from graphic medicine. The authors and artists discussed in both sections are concerned with the communication of illness experiences, particularly within the doctor-patient consultation. To some extent they draw on slightly different ontological and epistemological positions, and certainly use different traditions of 'argument' and representation. Taken as a whole, however, there are a number of points of connection and positive implications for arts/health research inquiries, including for the as yet little understood visual communication practice of manual drawing in the consultation. For the purposes of the rest of this paper, I am using 'doctor-patient relationship' to refer to the one to one relationship between a patient and a health professional of any type. Whilst noting Fischer and Eraut's caution about colluding in 'upholding a clear ring round doctoring' (2012 13), this is not intended as a subsuming or negating of the value of other health professionals, but is offered as the simplest formulation for this particular paper.

The doctor-patient relationship and the clinical consultation

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

Hall et al 1981, cited by Ha and Longnecker 2010

So the consultation is a conversation going on with two sets of potential anxieties in the room, each party having only partial visibility, across a chasm, of the other's predicament.

Fischer and Ereaut 2012: 24

Part of the context for research into clinical drawing is the strong cultural and social significance of the doctor-patient exchange and the 'consultation' communication in particular. The consultation, as communicative interaction between doctor and patient centred upon the principle of trust, can be seen as part of an ancient tradition of healing encounters (Porter 2003). In contemporary terms, this encounter is fraught with political, social and cultural pressure and change in relation to the role, status and terms and conditions of doctors. There are also significant shifts in the discourse of patient choice and access to information. In the academic and professional literature there has for some time been a focus on the idea of 'patient-centred care' (see discussion by Richards and Coulter in *BMJ* editorial of 10 February 2015). Yet in a comment by Fischer and Ereaut, the irony of which will not be missed, those patients that participated in their study 'had not really heard of the policy shift towards patient centredness and they do not really know that is going on for the doctor.' (2012: 29)

In the quote at the beginning of this section, taken from a 2010 literature review of doctor-patient communication in which medicine is framed as creative and 'magical', the interpersonal dynamic of the doctor-patient relationship is placed firmly centre-stage. The review goes on to describe 'effective doctor-patient communication' as a 'central clinical function' and to say that a "more patient-centred encounter results in better patient as well as doctor satisfaction". In the same breath, however, it notes the 'brutality of medical training' that 'suppresses empathy'. This is linked to debates about

the impact of medical education systems on students both in terms of cognitive requirements (the 'stuffed' or overloaded curriculum) and emotional demands even of supposedly more 'learner-centred' approaches, in the face of which individual students may develop different, not necessarily patient-focussed strategies (Watmough, O'Sullivan and Taylor 2009; McLean, M. and Gibbs, T. J. 2009). Once qualified, doctors are routinely required to navigate complex interpersonal situations, in which miscommunication can have serious consequences. What surfaces in this review is that whilst good doctor-patient communication is recognised as a very important clinical function, the medical education system is sometimes seen as containing obstacles to the production of doctors with good communication 'skills'. In a 2013 literature review on how patients want their doctors to communicate in primary care (Deledda et al 2013), the authors point to a more methodological problem: that there was a 'heterogeneity of definitions and measures' of good communication and a 'gap' between 'quantitative and qualitative findings' to be addressed in future research.

In a 2014 article about a qualitative study in the field of chronic pain by Zanini et al, the authors describe their purpose as "to strengthen the conceptualization of the patient perspective by identifying aspects that, from doctors' point of view, are important to address during a consultation to build a partnership with patients". The researchers argue that identifying the doctors' insights is necessary in order to 'operationalise' the concept of the patient perspective and in their introductory section, note that:

Despite the emphasis of the literature on the value of the patient perspective, the concept of the patient perspective is unclear, as are the aspects of the patient perspective that need to be addressed in the consultation. Indeed, the notion of the patient perspective remains vague and fragmented.

Zanini et al 2014

During a period in which political and academic emphasis is being placed on the patient point of view, and patients themselves are tending towards taking a greater part in their care, there are indications in the articles discussed above not only of the slipperiness of

capturing the 'patient perspective' from a theoretical and methodological standpoint, but the difficulty faced in accommodating and responding to both patient and doctor perspectives. Zanini et al's focus on the doctor's view of the patient perspective attempts to consider how the two points of view can be integrated. The article concludes that "there is a partial convergence of interests between patients and doctors with regard to the aspects that they think are important to discuss, namely, the burden of the health condition on patients' life, patients' expectations, and patients' preferences for treatment". Emphasis is needed not only on the principle of the active involvement of patients but also "the value for doctors and patients to engage in argumentation, defined as the communication process of exchanging points of view with the aim of resolving a difference of opinion." (Zanini et al 2014).

There is a growing body of theory and practice that suggests alternative strategies and viewpoints on the problem of the doctor-patient consultation exchange. Within medical humanities, Charon and others in the narrative medicine movement have argued for a shift in how doctor-patient communication is understood, suggesting that it needs to be focussed to a far greater extent on the act of listening to the way patients present their narratives (Charon 2008). Charon explores, from the position of medic and literary scholar, the importance of being receptive to patients rather than applying learned consultation 'skills' in a formulaic way that may not take into account individual variation, mood and need. This is a point deftly emphasized by Green's reading of Wertz's graphic novel *The Infinite Wait*:

For me, the panel that resonates most truthfully is one where Wertz's physician compassionately places a hand on her should and asks how she's feeling. Wertz's response reveals much about the complexity of doctor-patient communication: "Uh-oh, unnecessary touching and terms of endearment? This can't be good..."

Green 2015: 82

As Squier points out, Charon's work has had impact within the medical school curriculum and offers many points of resonance with scholarship into visual

representations of disease and illness (Squier 2015: 45). Publications and teaching in the growing field of graphic medicine have brought attention to a wide range of perspectives and Myers has argued that graphic pathographies have helped medical students understand the perspective of the patient, although possibly to the neglect of other perspectives. Although fewer, there are also graphic novel representations of the experiences of health professionals, including the narrative of a GP's struggles with his own mental illness and vulnerability in a tightly-resourced and high pressure health system (Williams 2014). The growth of comics scholarship and its interest in medicine brings with it a turn, in the words of Squier, away from 'an implicit endorsement of the practitioner's emphasis on medical treatment to a critical incorporation of the care-giver's or patient's experiences, including the social determinants of health and well-being' (Squier 2015: 48). It also provides the opportunity to develop narrative and visual literacy relevant not only for 'students of medicine but for practicing physicians as well' (Green 2015: 69). In the next section, I will briefly explore some contemporary examples of visual representations of this experience in a little more detail.

Visual approaches to health communication and illness experience

All too little will be said of the personal side: how people have experienced sickness and how it has affected their lives. But sufferers' responses to being ill or incapacitated, and to the threat of dying loom over this book as an ever-present shroud. The dread of disease, potential and actual, the pains of acute complaints and long-term ailments, and the terror of mortality number among our most universal and formidable experiences.
(Porter 2002: Preface)

I have selected here three very personally-situated visual approaches to illness and doctor-patient communication, to consider the insights they afford and the implications of using this approach. Many patients, some of whom are also professional artists, have used drawing: some as a creative response to illness, some as a strategy to enable themselves to be 'heard' within clinical communication scenarios and some as a visual method, using their experiences as a starting point to explore health-related research questions. Some of these are or might be grouped within the field of graphic medicine.

The first example is the author and illustrator Nick Wadley. Wadley's book *Man + Doctor* (2012), also published in the Guardian books online gallery (2012), describes his compulsion to draw throughout an experience of serious illness; to draw about that illness and the care he received (Figures 3 and 4). This need to draw extended to his surfacing from a period of time he had been a coma. His drawings are annotated with brief verbal comments placed outside the image frames, a graphic novel/comic strip trope. These seem to ask for the reader-viewer to dwell on his quietly stated but poignant perspective on his care:

I made countless drawings about lying on consultants' beds, being prodded by consultants' fingers. These are the first encounters with that peculiar sense of intimate confidence in someone who forgets you almost as soon as you leave the room ("Next!")
Wadley 2012

For Wadley, drawing seems to be an inevitability, an instinctive or compulsive act but also a way to investigate the experience of the doctor-patient 'encounter'.

Daily ward rounds are a processional display of deference to the surgeon. You may remember the question you wanted to ask this god. You probably won't remember his answer.
Wadley, 2012

Whilst this urge or instinct to draw is in itself not particularly surprising, given he is a professional artist, it raises wider questions about the use of, and the facility offered by, the drawn mark. In this quotation, Wadley's articulation of the impulse to draw is particularly telling:

The passage between waking in the recovery room and waking again in the ward is one continuous haze of drugged semi-consciousness. From this state spring the intense alliances with caring nurses, who know how much and what you need within reach at night, where you want pillows, tissues, pencil and paper, a spare bottle for urine – all matters of life and death. The nurse who understands is your close ally. Nowhere

outside the theatre of man + doctor do such concentrated personal dramas have so short a run.

Wadley, 2012

Here, the turn to pen and paper and the materializing, visualizing practice of manual drawing might be related to Heidegger's notion of 'readiness-to-hand', which McGuirk usefully highlighted in relation to drawing as the "situated, engaged and transparent way we encounter things through their use", as opposed to the more "theoretical and objectivist attitude" or 'presence-at-hand' (2011: 220). This situated and engaged use of the drawn mark, in which drawing materials are part of the array of essential objects during the concentrated personal drama of acute illness is not, I would suggest, exclusive to the professional artist. Whether the tools or medium involved is the eminently 'low-tech pencil and paper, or the more high-tech tablet drawing application and touch-sensitive screen, there is a vernacular turn to mark-making that is a means of encountering things. The practices of manual drawing between doctor and patient that are the origin of this paper may, indeed, be put forward as another, differently contextualized instance of this.

In my second example, Dr Jac Saorsa, philosopher and artist, describes how she uses her artistic practice "as a vehicle to understanding the existential experience of illness" (<https://drawingof.wordpress.com>). Described both as a campaign to increase understanding of the condition and a celebration of the women themselves, she has produced a body of work from a residency in Tanzania, in a unit for Obstetric Fistula, where she drew extensively. Her drawings include images of the women arriving at the unit, focussing attention implicitly on questions of at what point we turn from citizen to 'patient' (or in Sontag's terms, from the kingdom of the well to the kingdom of the sick). The women arrived often in a state of pain, shame and alienation to present themselves for treatment. Saorsa drew the waiting area, she drew the women in their pre- and post-operative states and the spaces and equipment of the clinic (Figures 5 and 6).



Figure 3. Examination by Nick Wadley, 2012



Figure 4. The Ward Round by Nick Wadley, 2012

In a blog that accompanies her images, Saorsa writes that these drawings are a 'meta-language':

The focus of my work in the area of art and medicine has become the creation of what I call a 'meta-language', a form of communication that goes beyond both the verbal language with which the patient tells her story, and the visual language manifest in the drawings I make that are based on my experience of and response to these stories. The meta-language becomes itself a 'voice' that can communicate across the boundaries of convention and taboo, and articulate suffering so that, in dialogue with the drawings, the viewer is invited to engage and understand at a profound, intuitive level.

Saorsa 2014, 'About' page of Drawing Out Obstetric Fistula

Saorsa presents her work as a continual dialogue between artist and patient and between artist, patient and viewer. Using drawing workshops with the women of the clinic as well, she sets out to foreground, define and enter a space where language seems to fail, to bring out aspects of the women, their specific condition and predicament to wider attention. From Saorsa's perspective the drawings become the meta language for experience itself. The women of the Tanzanian clinic project are presented to a wider public through the creative and cultural filter of an artist, academic and counsellor, yet the images and text of the blog use these questions of distance and voice, authenticity and representation, as central to their subject matter.

Finally, the third example. In 2012, I carried out a project with my University of Brighton colleagues Patrick Letschka, Tom Ainsworth and Inam Haq, investigating professional understandings and uses of drawing. We developed a methodology we called 'conversational drawing' and ran a single conversation scenario, which we filmed (Lyon et al, <https://vimeo.com/77975872>). In the resulting wide-ranging discussion between the individuals we recruited, senior critic in furniture design, Chris Rose, and hand surgeon Donald Sammut, the latter talked about how he drew both to provide explanations to patients and their families, and to prepare for operating. In one clip, Sammut described

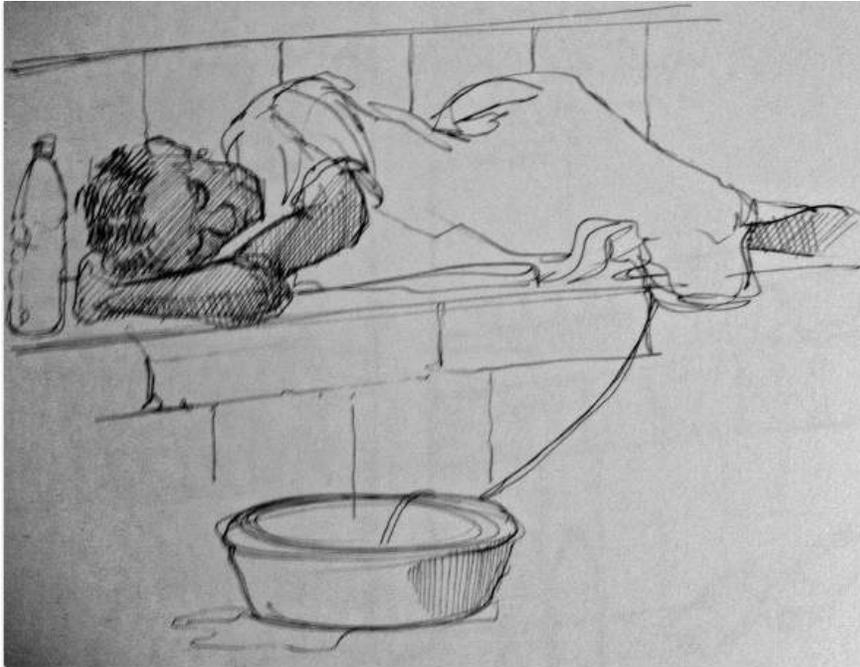


Figure 5. Jac Saorsa, image from blog post 'In the Banda', 19th January 2015.



Figure 6. Jac Saorsa, image from blog post 'Ward round and portraitures', 14th December 2014.

drawing for a particular patient, a six year-old boy who was accompanied by his parents. In Sammut's account, as he drew and the shape of the boy's hand emerged on the page in front of them all, there was a moment when the boy recognized, with complete delight, that the marks on the paper represented *his own* hand. This, I would argue, is connected to what Milner described as an 'embodied form of knowing that traditional education of the academic kind largely ignores' (Czerwec 2015: 151). The significance of this story was not only in the child's response but in the surgeon's satisfaction that his drawing had communicated something significant to his very young patient. As Sammut told this story in the research video, he mimed the beaming face of the child. In the course of the conversation with Rose, Sammut described and demonstrated how his drawing process could be functional and technical in preparing to operate, yet he also showed how it afforded a means of communicating information that did not rely on abstract or technical knowledge. Another interpretive angle might suggest that a surgeon who can use drawing in this way is creating a transformation: the abstract notion of surgical competence becomes transubstantiated. Through observing the process of drawing, the patient has the felt, embodied understanding of the physical presence of the dexterous, surgeon's hand. The act of drawing is, perhaps, no longer purely an explanatory practice but an invitation to the patient to relinquish control of their body, to have faith. The patient recognizes, through the marks being made, that the drawing is not just of *a* hand, but of *their own* hand: there is a materialization of the temporary intimacy between doctor and surgeon and an unambiguously clear acknowledgement of the personal in the communication.

The multimodal consultation and arts-health research: connection and collaboration

The visual examples I've referred to above explore connections between drawing, communication in its cognitive and affective dimensions and bodily experience. They suggest that dimensions of knowledge and experience that are difficult, if not at times seemingly impossible to articulate in words alone, can at least be partly opened up through the drawing process and, to some extent, through the resulting drawing itself. As one means of framing and communicating illness experience, these examples seem to

me to have something important to offer. On the one hand they underline, as does the graphic medicine movement in general, that illness and treatment is often experienced personally and culturally as emotional and intensely visual, and that visual means and methods of representing and exploring illness can be developed, encouraged and deployed to benefit health professionals and patients. On the other hand these visual representations point to the significance and complexity of the consultation exchange between patient and doctor. Whilst only one of the visual works discussed above was set up explicitly with the intention of being 'research', all of the examples offer important experiential insights and add to the debate about how different perspectives can be accessed, brought together, integrated and acted upon. The images propose that the communication of illness experience can be as deeply visual, gestural and haptic as they can verbal, and that these are dimensions that need to be brought more fully into the research process and research thinking.

The drawing practices that Martha Turland and I are in the process of exploring still have the aura of taking place in the unexplored interstices of doctor-patient exchanges: they have a liminal quality. They cannot be replaced easily by verbal language, they may not 'fit' the newer formats for record-keeping and they are not taught or discussed under an agreed set of terms. Yet there is reason to suspect that for those involved in making these drawings or being drawn for, they are meaningful. This type of drawing takes place in and around many different forms of interaction, from the type of eye contact made to bodily posture, speech and gesture. In the consultation, doctor and patient are temporarily bound within an often difficult process of meaning-seeking and exchange in which all the senses, potentially, come into play; here the theories of Kress (2010) on the multimodal nature of meaning-making processes, 'texts', in daily life are enabling: 'Texts – spoken, gestured, written, drawn, mimed and any combination of these – are the means of making some of these complex meanings material.' The use of visual imagery in a complex consultation context is currently the subject of PhD research by Padfield at Slade School of Fine Art, collaborating with Zakrzewska (plus colleagues and patients in University College London Hospitals) in the field of chronic facial pain. Here, rather than looking at routine existing practices, Padfield is exploring

the extent to which created visualisations might play a constructive part within the doctor-patient relationship. In her findings so far there is an implication that such visual and imaginative tools do not necessarily simply help individuals represent their experiences (such as pain) but that they have an impact on the shape and nature of the communication exchange itself, on creating more space for the patient perspective within the consultation. Innovative and collaborative arts-health research such as this has the potential to access the interstitial zones of the doctor-patient relationship for the potential benefit of both.

As researchers, whether arts or science-based, we need to pick our way through this web of meaning-making practices that constitute doctor-patient consultation experiences and perspectives. Framing clinical consultations as multimodal and multiperspectival offers us a constructive and nuanced way to approach the social, performative, ambiguous and sometimes sheer messy context of clinical communication, and the often unacknowledged, embedded visual practices that take place within it. Within this framework, a greater focus on visualizing experience and on visual forms of communication in the consultation could be a very important part of a broader effort to investigate and share experience and knowledge from both 'sides' of the doctor-patient equation.

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