**The Seeing Place: Talking Theatre and Medicine**

**Abstract:**

A Professor of Medical Ethics and a theatre director, also mother and daughter, talk about health, illness, suffering, performance and practice. Using the lenses of ethical and performance theory, they explore what it means to be a patient, a spectator and a practitioner and cover many plays, texts and productions: Samuel Beckett’s *Not I* and *All That Fall*, Sarah Kane’s *Crave*, Tim Crouch’s *An Oak Tree*, Enda Walsh’s *Ballyturk*, Annie Ryan’s adaptation of Eimear McBride’s novel *A Girl is A Half-Formed Thing*, Duncan MacMillan’s *People, Place and Things* and Henrik Ibsen’s *Hedda Gabler*.

These were selected because we have seen, studied or worked with each and they have continued to inspire us. Secondly, they offer rich and revealing insights into the ways in which meaning(s) is/are both negotiated and contested in relation to health and illness. It is the iterative negotiation of meaning(s) that, it is argued, is the essence of narrative practice, be it in medicine or in the theatre.

The difference and divergence of perception, response and interpretation to dramatic performance can test relationships, be they professional, creative or familial. Yet, the capacity to understand, and embrace, disagreement and uncertainty is vital; fundamental to a flourishing life. For it is by recognising our part in creating narratives, broken and otherwise, that we can begin to recognise the necessary interactionism and humanity of both medicine and theatre.

**The Seeing Place: Talking Theatre and Medicine**

It began at a children’s theatre around the corner. A mother (‘DB’) and her small daughter (‘JB’), went to see *Stardog’s Winter Adventure*. As an introduction to theatre for the little girl, it was not a success. Stardog was an overwhelming character playing big in a small space with even smaller people, so overwhelming that the girl buried her head in apparent fear every time Stardog appeared. Yet, something curious happened: the young girl chattered about that hour in the dark and when she walked past the theatre, the little girl always pleaded for ‘more’. And there was more. Lots more.

The shared experience of theatre has been one of our greatest joys. It imbues the ways in which we relate to our academic specialisms: medical ethics and drama. Theatre provides a lens through which we navigate questions and problems, to explore what it means to be a patient, a spectator and a practitioner. The texts - Samuel Beckett’s *Not I* and *All That Fall*, Sarah Kane’s *Crave*, Tim Crouch’s *An Oak Tree*, Enda Walsh’s *Ballyturk*, Annie Ryan’s adaptation of Eimear McBride’s novel *A Girl is A Half-Formed Thing*, Duncan MacMillan’s *People, Place and Things* and Henrik Ibsen’s *Hedda Gabler* - were selected for two reasons. First, we have either seen, studied or worked with each and they have continued to inspire us. Secondly, they offer rich and revealing insights into the ways in which meaning(s) is/are both negotiated and contested in relation to health and illness. It is the iterative negotiation of meaning(s) that, it is argued, is the essence of narrative practice, be it in medicine or in the theatre.

DB: I return frequently to the Greek meaning of theatre as ‘the seeing place’. The clinic, ward or surgery are also ‘seeing places’. Long before Foucault wrote about the medical gaze, the act of seeing and being seen has been integral to medical care: medicine is where objective observation, subjective interpretation, established sight lines and blind spots collide. It isn’t an accident that hospitals have theatres too. Both the clinical and the theatrical depend on implicit agreement about a shared endeavour which is inherently *human* and *active* (it brings about change in the play itself, in those who perform and in those who watch too). The play and the production create both the internal and external frame through which experiences, events, perceptions and interactions are shaped and interpreted. Medicine cannot be practised without people in roles: patients, doctors, family members and carers. Likewise theatre depends on performance, interaction and the roles played by actors, writers, directors and, of course, audiences.

JB: Yes, I think the idea of a ‘shared endeavour’ is essential to theatrical performance. The sense of active community – a company coming together repeatedly to allow a production to happen – is present in theatre in a way that feels notably different from other creative media.

DB: I wonder if theatre is a more inclusive and collaborative version of a shared endeavour though? The imbalance of power in the medical or clinical encounter is one of the themes that has most informed the ways in which I think about ethics. That is, any discussion of clinical care and its moral dimensions has to recognise that one party in the encounter is more vulnerable, dependent on the professional for his or her expertise, skills and advice. Much has changed, of course, since I began working in medical ethics: recognition of the essential value of autonomy and a patient-centred approach are welcome. Yet, for me, there is a stubborn imbalance that demands attention. How do you think about power when you talk about collaboration or the shared endeavour in theatre?

JB: I think power is a difficult word to use in a production context, mostly because collaboration is *so* essential: everyone in the room has a specific role to play, and these roles must be played alongside every other individual in the team. Theatre is so often more than the sum of its parts: Mike Alfreds points out that this is, in many respects, what separates theatre from other art forms.

DB: Can we go back to ‘seeing’? I think, for me, it is the conceptual crux of why theatre has informed my thinking about medicine. I’ve always been interested in the sightlines of an interaction, whether it is theatrical or clinical, and in how those sightlines inform each other in the different interactions. Theatre and medicine are infused with the co-existence of multiple stories, experiences and perspectives; the ones we notice and, of course, the ones we miss or maybe even choose to miss. Sight lines, literal and metaphorical, shape what is seen and attended to both on stage and in the clinic.

Agency in theatre is much greater than it is in film: the director and the staging might intend for us to look at a particular place or character, but we make choices, moment-by-moment, we choose not only where we look, but what we want, or perhaps can bear, to see. How do you approach sightlines and seeing in your work?

JB: I agree with your point about audience agency in terms of sightlines in theatre. As an audience member, we get to choose who we look at and when in a theatre: rather than looking at the actor speaking, we can choose to look at the reactions of other characters on stage. The 2017 Royal Court Theatre’s production of debbie tucker green’s *a profoundly affectionate, passionate devotion to someone (-noun)* made these choices central to the staging of the play. By placing the audience between two runway stages on either side of the space (a sort of ‘reverse traverse’ staging) on rotating bar stools and having the actors speak over the audience, the choice of where to look was made physical with audience members turning to observe certain sections of the play.

DB: That was such a fascinating production for many reasons, but the staging and concomitant effect on watching and seeing absorbed me for days afterwards. During the performance, I was struck by how rarely anyone close to me seemed to be looking in the same direction. I also noticed that I didn’t tend to watch the actor who was speaking; most the time, I was drawn to the person to whom dialogue was addressed. And because characters remained visible throughout, even when their ‘scenes’ were apparently finished, we could see the effects of all those words – it might only be a glimpse of someone silent in a corner, but it was a sucker punch in its impact. And because we were in the middle of it all, on individual stools that we controlled entirely, the agency of our choices was unavoidable.

JB: I think the agency the audience has in terms of how they watch theatre is particularly revealed in the *National Theatre Live* broadcasts. Here, a director – who is often a different director from the person who directs the staged production – has made a (necessary) series of choices about what is ‘important’ for an audience to see which might well be distinct from what an audience member would choose to watch in the theatre.

In terms of my own approach to sightlines, I am always conscious that good sightlines allow the audience to see the choices you are making and allow them to make their own choices within a performance.

DB: I know we have spoken before about theatre as a place where interactions are both controlled and liberated, but I wonder too if there is something simultaneously inhibiting and disinhibiting about medicine, which emphasises confidentiality, privacy and the creation of a space that allows for disclosure of the most intimate information or concerns. It is endlessly fascinating to me the ways in which the conventions of a medical encounter can simultaneously control how we interact and liberate us to reveal ourselves at our most vulnerable.

I think there is a more fundamental way in which the nature of ‘seeing’ in theatre is particularly resonant for me when I think of medicine and clinical care. Tony Kushner puts it beautifully in Richard Eyre’s collection of essays:

“People always have to see double which is critical consciousness and it teaches you to see dialectically. It teaches you to understand both the manifest appearance of things and also their actual content.” (Eyre: 150)

For me, the ability to ‘see double’ is invaluable in medicine. The necessary distancing that doctors talk of somehow has to be reconciled with remaining human and humane. Much of the discussion about empathy in medicine has been, I think, hinting at this notion of ‘seeing double’. When I interviewed Lesley Jamison, author of The Empathy Exams (2014), I was struck by her suggestion that ‘simulated empathy’ was no worse than an intuitive or ‘authentic’ empathy. She talks too about having the capacity both to flinch and not to flinch. That resonates with me – it is the essential doubling of medicine.

For me, plays like *Ballyturk* which is simultaneously comedic and redolent with loss, and *Crave* where the audience is apparently disoriented but also has a bruisingly clear awareness of suffering, are examples of this ‘seeing double’. When you directed *Crave*, you did it in the darkness with light emerging as the production progressed, was that a form of engagement with the critical consciousness to which Kushner refers?

JB: Oh absolutely. As you said, we made the choice to do the production starting in pitch-blackness with small lights coming on at various points during the play. While the experience of sitting in complete darkness with voices coming out of the space is disorientating, particularly in the first few minutes, the aim of staging the play in such a way was to allow for a total focus on the words of the play. As anyone who knows *Crave* or Kane’s work more broadly will attest that there is a lot in the text itself that is confusing and disorientating, so the aim with this staging was to acknowledge that – to let the audience know that the disorientation was to be expected – but also to allow the focus to be entirely on the words of the play.

DB: It was brilliantly done! A way of form, content and performance coming together that was, to return to my previous thoughts about incoherence and credibility, convincing and liberating. It also made me think about the hospital at night, and also I remembered the times when I was a child and a doctor used to come in the small hours on a home visit. There was a different quality to those encounters which I think was due in part to the darkness. It allows for a further layer of intimacy, perhaps a greater yielding of self and a disorienting sense of vulnerability and aloneness. I’d never thought about it until now.

Your production seemed to owe a debt to Beckett’s *Not I* which I think of as a rich exploration of altered states and, of course, illness is the ultimate altered state. When I saw Lisa Dwan’s rendition of *Not I* also performed in the pitch darkness, I wrote:

“There is nothing between us and ourselves. No distracting or reassuring visual clues that we have a place in the world. All that remains is the blackness. We wait until our eyes adapt – for surely, they will adapt – isn’t that what eyes do? Isn’t adaptation the essence of humankind? But they don’t. We don’t. It is inescapable: our altered state. And then, looming above us in a beam of light, is the mouth. We cannot help but focus. It commands our focus. This disembodied mouth. All that there is in the room is the darkness, the mouth and our thoughts. And so, it begins. Words, sounds, glimpses of sentences tumble out of those bright red lips – a life pouring forth, demanding to be heard. At first, we can’t make out the words. Some are familiar, but some a nonsense. Is it the speed? Is it the accent? We are concentrating so hard; why can’t we understand? And still the words cascade into the darkness and still we search for meaning. We revert to the comfort of clinical categorisation: this is logorrhoea. But how pointless that seems – what is the value of naming but never knowing?

And still the mouth moves and the waves of sound wash over the auditorium. We sense damage. We intuit harm. We no longer need the details – we can feel it. In our altered state, all communication convention is overthrown and we discover it doesn’t matter. If we persist in attending to another, then we will make a connection “

(Bowman 2014)

Your production of *Crave* and *Not I* are examples of creating and attending to altered states, but I wonder if that is what theatre always does, in some way?

JB: This challenge to ‘see someone’ is far more difficult when considering the liveness of theatre: every performance is necessarily different. The shifts of a character don’t only happen over the course of a play but also over the course of a run of performances. Tiny, often imperceptible, changes that naturally occur each night – whether a more vocal audience than usual, an understudy being on, or even something as seemingly insignificant as the theatre being slightly warmer than the night before – can have a substantive effect on the play. When considering these small changes, even in ‘important’ or ‘landmark’ productions of plays, the question of what it is ‘to see’ in a theatrical setting is elusive and makes it difficult to find a language with which to talk about performance.

DB: That recognition of seeing as an active, elusive and shifting process, even a choice, resonates with me when I think about medicine and the clinical. To accommodate the dynamic character of seeing and what is seen seems to me to be an essential element of healthcare. Medicine’s relationship with ‘seeing’ is fascinating. Traditionally, the emphasis on being observant and discerning pathology through close attention is at the centre of effective clinical practice. Yet the notion of choice and change in what is seen are much-less explored. The notion of the ‘neutral’ doctor attending to the patient whose pathology can be revealed by visual acuity does not account for the shifting nature of seeing and being seen in healthcare and the influences on the same. For example, when a patient comes to see a clinician and mentions an experience or symptoms that are beyond what the doctor considers the scope of the consultation, there is a choice to be made about whether the boundaries of the encounter will be extended to prioritise responsiveness over efficiency. Even within the ‘straightforward’ consultation – the simple presentation of self-contained problem that is susceptible to well-established treatment or management – each presentation and encounter will be different as doctor and patient navigate values, language, evidence, risk, agency and resources moment-by-moment, consultation-by-consultation.

I am reminded of what Mike Alfreds says about the importance of presence and freedom in theatre to create an encounter that is true to that moment, performance, performer and audience member. I have thought about this a lot in relation to the clinical encounter. Much has happened to emphasise and improve clinical communication since I began working in medical education. That work has been transformative in giving many medical students and doctors awareness of, and skills in, clinical consultating. Yet, there is something missing if we focus only on ‘the script’ or even the technical aspects of ‘the performance’ without considering or attending to the relational commitment and choices that shape an authentic relationship; the capacity to be present, to be curious about the individual, to be flexible, humane and to work hard to adapt, to respond, to listen with care and to create an encounter that, as Alfreds would say, is ‘true to that moment’. It is an inherently moral choice and one that we probably articulate too rarely in medical training.

JB: Yes, absolutely. Aside from the community of the production team, what is also central – what makes theatre theatre – is the audience: without an audience, there is no impetus for a piece of theatre to take place. Theatre is a medium not only designed to be consumed by others, but usually in groups: when we go to the theatre – whether or not a performance is taking place in a traditional theatre space – we tend to experience a performance alongside other people. Some configurations of theatrical spaces, notably here in-the-round or traverse stages, encourage us not only to look at the performance space but also other members of the audience. When we are watching a performance, we are often being watched or at least acknowledged as an audience member too. Our laughter or silence as an audience member frequently has a notable impact on other audience members and the reception of the play. The public nature of performance is central to theatre. As an audience member, we have a distinct role in facilitating a performance. I don’t think it is accidental that I often talk about the audience having a role to ‘play’. The second someone steps into a theatre, he or she is, sometimes explicitly but more often implicitly, expected to follow a set of normative conventions: we sit quietly; we turn our mobiles off; we clap at the end of the performance. Just as the actors and production team have a role to play in performance so do the audience. The activeness of this relationship is made explicit in much of Tim Crouch’s work where he directly acknowledges his audience, even presenting them with academic theory on their importance in the theatrical setting.

DB : Those miniscule variables and adaptations exist alongside with conventions, assumptions, norms and rules, many of which are assumed, unarticulated and unacknowledged. And then there’s the performative dimension: each party brings both themselves and a commitment to playing their part. There are multiple ways in which those norms and the performative are experienced: audiences, actors, patients, doctors, and relatives all have parts to play without which the interaction cannot exist. You can challenge the norms, mock the conventions and interrogate the performative, as Tim Crouch does in *An Oak Tree* and *Adler and Gibb*, but they persist.

Illness affects lives and people *variously*: the fracturing, the diminuition, the strengthening, the altering, the distorting and the sharpening that can occur, sometimes from moment to moment, but which capture the ways in which illness is never an insignificant experience. Without attending to these underlying truths about the character of illness, its treatment and the care with which we meet its occurrence can never be what we would wish it to be. Although, I also find myself wondering whether care can ever ‘be what we would wish it to be’. I wonder if, maybe, the contradiction, ambivalence, complexity and emotion that follows from illness and its diagnosis at some level may create an insatiable and unpredictable appetite for responses that are ultimately indefinable, perhaps beyond any one professional or clinical service.

Whoever it is, be it a character or a patient, he or she is shifting, misleading, complex, contradictory and partial. We may find them attractive or even repellent – each is challenging – and if we’re honest, we recognise that our perception and response has as much to do with ourselves and our changing identities as it does with the person whom we are charged to see. For me, the emotional or affective response in theatre and medicine is vital. In contemporary medical education, compassion, sensitivity and a facility for connecting with others, especially those who are different or may be difficult, are as integral to practice as theoretical frameworks, clinical skills and biomedical knowledge. In theatre, I think that Mark Fearnow puts it well:

“*Theatre has tended to be a place that accepts people in their brokenness, in their states of rebellion and pain. It is the place for accidents of connection between interior worlds and external realities*.” (Fearnow: 23)Going back to audience and your consideration of their contribution to theatre, the activeness of the relationship is similarly considered now in medical education and training: medical students and doctors are, from the outset, expected to reflect on the nature of their work with patients. Yet, to me, despite Crouch and the empathic turn in medical education, these are encounters, in the theatre and in the clinic, that are inherently interpretive; infused with questions of identity, emotion, mystery, ambiguity, uncertainty and meaning. No amount of training in communication skills will alter that. I like Crouch’s work a lot, but I do wonder about it too. I am not suggesting that patients and, if relevant, family members and carers are directly comparable to audiences, but there is something about the symbiotic nature of the relationship between doctor-patient and theatre maker-audience that I find it useful to interrogate when thinking about the convenant between the parties when we practise medicine because that is what seems to inform duties of care, notions of responsibility and the construction of ‘ethical dilemmas’. Crouch, perhaps more than any other writer has challenged me to think about that relationship differently. What do you think is the impact of acknowledging the audience in the way he does?

JB: The way Crouch acknowledges the audience is strikingly direct – *ENGLAND* almost beginning with the claim “If it weren’t for you [the audience], I wouldn’t be here” (*ENGLAND,* p.13). Crouch uses the acknowledgement of an audience to unequivocally confirm the importance of the audience to live theatre. However, much of his work does this whilst not being quite as ‘on-the-nose’ about it. In *An Oak Tree,* Crouch gives the audience the role of an audience watching a hypnotism in “*a pub a year from now*” (*An Oak Tree,* p.23: acknowledging not only the role the audience plays in allowing a performance to take place, but also giving the audience a purpose within the context of the play. By explicitly recognising the role the audience plays, Crouch hands the audience a set of questions and ideas which can have a life beyond a specific production.

DB: Hmm, I’m still not sure about Crouch’s approach, although it is interesting. I think audiences are intuitively aware of their role and function, each of which may change depending on the production. For example, in both *A Girl Is a Half-Formed Thing* and *People, Places and Things*, the audiences were visibly moved whilst also functioning as a containing force for these stories of destruction from two damaged women. That is fascinating for me when I think about the clinical encounter. The patient is, in some senses, comparable to the audience: the consultation cannot happen without them, yet their role is circumscribed in pre-determined ways. And, as you were saying earlier, there is the question of power [in]balance in the clinical encounter that is different from the theatrical. Few doctors explicitly acknowledge the patient’s role in the encounter itself, although there is a large literature on how professionals tend to respond to patients who, in some way, flout or challenge the expectations and boundaries of their role. I am thinking, for example, of the notion of the ‘heartsink’ patient or the ‘special’ patient or Jeffery’s (1979) seminal paper on ‘deviant patients’ in A&E settings.

JB: That interpretative work and the influence of roles/differing perspectives is integral to theatre directing and might be more explicitly considered than it sounds, from what you’re saying, it is in medicine. So, something I always have in mind in a rehearsal room is how to mine the text for questions, ambiguities and uncertainties to enable us to begin to have some possible answers in the production, whatever the play might be. I think it is essential to realise too that choices made in a rehearsal process are always made from multiple potential choices. Part of the rehearsal process is building up various choices that make sense in relation to one another from an audience’s perspective. However, what is also key is that audiences will interpret things differently from how they were perhaps conceived because they are, of course, bringing their own experiences, ideas, and questions into the theatre.

DB: Can I push you on ‘possible answers’? Say more about what you mean, especially on ‘ambiguities and uncertainties’. I see theatre as having an inherent value because it is concerned with different and contested ways of knowing, being and seeing. So, the concept of ‘answers’ is fascinating.

JB: I think what I mean by ‘answers’ is a series of ideas which make sense within the context of a production: making choices so that people understand *enough*. For instance, texts tend to present a multitude of possibilities in terms of characterisation – a production of *Hedda Gabler* can present Hedda as cold and withdrawn from the start of the play or can show a more significant character shift over the course of the play – and I believe the purpose of a rehearsal room is to work out which of the various possible interpretations work within each production and alongside each other. Similarly, part of working in the rehearsal room is finding a language and methodology to allow actors to be able to portray a character – to be able to do this there is a need to settle on a series of choices (or ‘answers’) regarding the textual questions which allow actors to play a part. Nick Hytner (2017) talks at length about every production only ever being ‘partial’: there is no such thing as a ‘definitive’ or ‘complete’ production, rather each production is made up of a series of choices and decisions, none of which will or can ever be wholly ‘right’ ones but ones that can both work within the context of the text and alongside one another.

DB: Ah, I see. That resonates in terms of clinical interactions where meaning is being sought and negotiated within a complex and ambiguous context, but do we think in terms of finding ‘which of the various possible interpretations work’? I like the notion that meaning is negotiated, whether it is with the text or from the patient’s ‘history’, within the silences and absences and with the overall intention to make sense of the whole. I recognise though that is a preference or a disposition that many would challenge, particularly in the pressured NHS where choices and decisions have to be made, often within an unforgiving timescale. One of the questions often asked of medical ethicists (and one of the objections to my subject by some) is whether it has anything to offer the stretched clinician trying to do a daily job where that which is expected or argued for by ethicists seems unachievable and disconnected from the realities of clinical work. It is a fair challenge; one of the ways in which I am helped to think about it is to consider the ways in which shape and meaning are distilled in theatre: it is necessary, but rarely, if ever, offered as definitive, but as a partial process. It is partial in both senses i.e. it is incomplete (there will be infinite other possible interpretations) and it reflects the values, choices, preferences and ideas of those directly involved in that production at that time.

I confess though that I am a bit troubled by the notion that there is always sense to be made. I think sitting with non-sense is one of the imperatives of theatre and medicine. From the outset, clinicians are trained to sift, restructure and ‘tidy’ narratives. Being open to, and working with, the truth(s) of narrative, which is unlikely to be neat or constant, broadens moral vision, deepens understanding, shapes sensibilities and develops trust. Tolerating, even welcoming, incoherence and contradiction matters, for everyone involved in health and illness which is all of us! Patients, families, doctors and other professionals will all claim, notice, construct, interpret and negotiate narratives when someone is unwell. They will be narratives about people, about the nature of illness, about the diagnostic category, their own understanding and the structure within which illness is experienced and care provided.

When I think of writers who navigate the human condition (and that is what I consider medical ethics to be about rather than the ‘solving’ of dilemmas) I think of Beckett. For me, he captures it eloquently when describing how we can simultaneously see both constancy and change and navigate contradiction and coherence in the line from *Happy Days* “to have been what I always am, so changed from what I was”. For me there is a paradox in that credibility often depends on uncertainty, missteps, messiness, surprise and even abject contrariness. It is that absence of neatness or coherence which makes something recognisable and ultimately believable as a production. Do you know what I mean?

JB: As an aside, I think it is ironic that you refer to Beckett because his stage directions are so tightly-defined and regulated. From a director’s perspective, he seems to attend more to constancy than he does to change, at least in the prospective management of productions.

DB: Yes, and there is a paradox at the heart of theatre like Beckett’s *Not I* and *Happy Days*: the women are restricted, confined and diminished yet the plays radiate urgency, the irresistible force of living, even in the face of chaos or crisis. One of the reasons I think I find Hedda infinitely fascinating is her response to boredom as chaos or even as a crisis. She’s confined too, of course and she too has a drive that is simultaneously inexplicable and inevitable. For me, she encapsulates the complexity, tensions and ambivalence that infuse illness and suffering, both for those who experience it and those who respond to it. The audience or the doctor are challenged: to *see* someone. And in the case of Hedda and many of Beckett’s women, that seeing is difficult.

JB: Going back to your point about incoherence and contradiction, I do know what you mean - life is often characterised by its messiness and uncertainty. When productions capture that, they have what I’d call recognisability. Although, the tension between realism and recognisability is interesting. For instance, I think that when productions try to reproduce ‘reality’ – say when actors stumble over lines, or verbatim pieces reproduce natural speech patterns in performance – it can feel jarring. It is as if we can cope with a certain amount of realism in a theatre, but when it becomes too realistic, it begins to circumvent our expectations. A bit like banana medicine which tastes a bit too much like banana; when something is too realistic in a theatre it can become somewhat unrecognisable.

DB: My point isn’t so much about the heightened realism of performance or the replication of messiness in theatre, but as about the uncertainty of content i.e. that it is open to interpretation and there is work to be done in seeking meaning. And that work is happening because of professional discretion which is where the exploration of medical ethics becomes most interesting to me. I suppose another reason that I picked up on the use of the word ‘answers' is that I am ambivalent, perhaps even verging on suspicious, about those who characterise the theatre, or the arts and humanities in general, as instrumental. It happens a lot in medical education: the notion that reading improving literature or seeing a play will make medical students and doctors ‘better’ people and therefore more compassionate or empathic practitioners. I noticed it in relation to *People, Places and Things*. Colleagues who went to see the play came out suggesting that certain scenes should be included as reading for discussion in teaching sessions on addiction. I don’t mean to be critical, but that seemed like a limited response. There was so much about the production that warrants exploration. For example, the ways in which we saw the protagonist in the context of her life, relationships and experiences extending well beyond the confines of the clinic or the hospital. To recognise that the clinical encounter is but a small part of someone’s story – doctor and patient alike – is, for me, fundamental to understanding what it is to be ill and to care. The ways in which the staging captures the distortions and contested perceptions of both characters and audience challenging us constantly to consider and reconsider our notions of reliability, honesty, complicity and support offer a deepening reflection on not only the presenting problem of ‘addiction’ but the relational context in which it flares and diminishes.

JB: It is always interesting to me what people see as central to a story or a production. Often when discussing plays with other people, the ideas of what were the ‘important bits’ of the play are different. Part of what a director does with their team is try and find where the key parts of narratives and stories are and allow those to become central to the production. However, audiences are a diverse bunch of people, which allows for interesting conversations! Perhaps its enactment in medicine is around what practitioners might think of as the ‘important’ bits of a consultation?

DB: Yes, and one of the challenges of taking a literal and biomedical approach to seeing and interpretation is that it is easy to overlook the ambiguous and the contradictory. Maybe it also privileges presence via discernible clinical signs and well-articulated symptoms. The ‘important bits’ in medicine are, of course, crucial to the success and effectiveness of the consultation. Teaching sound history-taking, consulting and examination skills helps, as does the experience of spending time with patients, but there are more fundamental requirements too which I would describe as ethical dispositions. First is the capacity for moral imagination – a facility to recognise and attend to other perspective(s) via attention, commitment, curiosity and yes, care. Secondly, the capacity to accept and to hold multiple ways of knowing in a single interaction. In medicine, the objective and the subjective, the inductive and the deductive, the emotional and the rational, the problem and the mystery, the individual and the general, the physical and the spiritual, the factual and the theoretical and the personal and the professional all come together in one consultation. Thirdly, the discernment of meaning is itself a moral act: storyteller and listener are making choices that shape the questions and responses that flow from that story. And of course, it may be in the spaces – in what is not said – that meaning also exists.

I think a lot about absences in theatre and in medicine. In many, perhaps most, situations, there will be influential absences. They might be people, but they might be losses of other kinds – of a reliable mind or body, of an aspiration or of an identity (actual or desired). *A Girl is a Half-Formed Thing* and Aoife Duffin’s extraordinary performance was one of the most memorable encounters I have had in a theatre: I think the principal reason, for me, was that it demonstrated the ways in which attention to the effects and significance of those absences is central to negotiating the present and the future. Similarly, *Ballyturk* is infused with absent experiences and others: we don’t always know who or what, but the loss is palpable. Same with *Crave* which is infused with longing for something or someone, even where it may be considered destructive or damaging.

I’m struck by how many of the plays we’ve chosen to discuss concern absence: whether it is a loss of person, identity, security or even self: all our choices are, in some way, preoccupied with the missing and the absent. Why might that be?

JB: Probably because absences allow for a more interesting response as an audience member and maybe as a director and probably as an actor too! The productions and plays we have chosen to talk about are those which have left me bubbling over with questions and comments, and I think it is probably something to do with the nature of absence as ephemeral and intangible. When gaps and spaces are consciously left in a production we are naturally led to ask more questions not only of a production but also of our own response to a production.

JB: Although we observe and watch all the time – Rancière took issue with the way in which spectatorship is often painted as somehow different to what we do every day – there is a difference in being an audience member where we are conscious (sometimes even conscious of being conscious) of watching a play and our role as a spectator. So yes, theatre both manages to alter states, but also draw direct and explicit attention to that altered state.

DB: Maybe that altered state is what also allows us to begin to see and know in different ways. Ways of knowing in medicine preoccupy me. Many ways of knowing collide in the clinical encounter: biomedical, social, emotional, rational, quantitative, qualitative, inductive, deductive, generalizable, particular, existential, physical and so on. Yet, the risk is that, for all kinds of reasons, clinicians privilege particular ways of knowing over others, leading to the potential for what Havi Carel and Ian Kidd (2014, 2017) have described as ‘epistemic injustice’ after the political philosopher, Miranda Fricker (2007).

This is why, for me, theatre matters to medicine; it is a counter to epistemic injustice. Theatre offers more nuanced and attentive ways of knowing. Kohn (2011) has written about the value of theatrical ways of knowing in medical education, describing how it is particularly valuable for fostering ‘flow knowing’ (relational, communicative and context-specific) and ‘whole knowing’ (intuitive, instant and encompassing). I’ve encountered it often, most recently in some of the work I did with *The Donmar* on Nick Payne’s play *Elegy* which I’ve written about elsewhere (Bowman 2017).

I’m interested that in the consultation and the clinical setting, doctors may be drawing overtly on particular epistemologies and ways of knowing – say the scientific, the rational or perhaps a ‘model’ of knowing that has been taught in medical school such as the biopsychosocial – In medicine, patterns, typologies and categorisation abounds. Situations are repeated and classified. Yet also in that room, whether it is acknowledged or not are multiple other ways of knowing. Emotions, memories, comparisons and normative assumptions about medicine are also at work. Healthcare requires attention to both the objective and the subjective, to the naturalistic and the abstract and to the self and the other.

And it is because it is a professional encounter – like that in the theatre – there is potential for a particular affective engagement and distance. Just as with Hedda, a doctor can experience the distress of a patient’s story but do so in the containing frame of the clinic. Yet, that particular space and distance are complex: serving as both protective, perhaps even necessary, and potentially dehumanising. It is the challenge of clinical work: to recognise both the likeness and ‘this-ness’ of an interaction. It is the conundrum of having a professional role and I often think about this duality in relation to actors who “create the amazing double reality of being themselves in this performance space at this moment and simultaneously being other people in another place at another time; being both here now and there then.” (Alfreds 2007: 13).

I’ve always been interested in the way you talk about working with actors to create a performance, particularly when we’ve discussed the need, or not, for immersion in character. Tell me how you’ve approached that ‘self and other’ duality in recent work you’ve directed.

JB: I find the work of the actor fascinating. It is a puzzle I continue to try to figure out, both as a director and as an audience member. Conceptualising and negotiating the distance between actor and character is something with which I continue to grapple, no matter what sort of theatre I am making. When I was directing *Hedda Gabler,* the actor playing Hedda found it difficult to reconcile Hedda’s behaviour with her own personality. Much of the character-based rehearsal process was finding a way for the actor not only to be able to understand, in some way, Hedda’s motivations, but also to demonstrate those motivations within the production. We had to find a way for the actor to engage with Hedda whilst drawing on her own responses to Hedda’s behaviour as a way for her to navigate the required duality of being herself playing someone she couldn’t initially recognise. There is something important in reducing the gap between actor and character in the safe space of the rehearsal room to free an actor to present the character before the audience recognisably within the context of the production.

DB: That makes sense to me when I think about working with medical students and doctors to explore that duality and the conundrum of being oneself but in a role that can seem overwhelming. I have a particular interest in what enables or prevents doctors from speaking up or resisting when they are asked to do something they believe to be unethical in practice – a phenomenon known as ‘ethical erosion’. I have increasingly come to think that space for rehearsal, scripts and improvisation – giving people the opportunity to practise ways of challenging others in a medical hierarchy – is integral to building effective responses to ethical challenges.

Which makes me ask: how do you see rehearsal and its relationship to performance?

JB: I going to return to Crouch’s play, *An Oak Tree.* As you know, the central conceit is that an unrehearsed actor takes the stage alongside a fully-rehearsed actor to perform a conversation which becomes a meditation on grief and identity. That conceit allows an audience to see what happens in a rehearsal room. Over the course of the play, the audience sees the transformation from an actor confronted with a new text and unfamiliar situation into a character. The scarce direction given to the actor during the place reveal the way rehearsal allows characters and ideas to emerge from a text and to flourish.

I think the most important part of the rehearsal process is creating a space in which ideas can be explored and, crucially, where things are allowed, even expected, to go wrong. Often, I have an idea which, when an actor to tries it, doesn’t work. Rehearsals too have a certain duality. First, they are the engine for the practical aspects of a production: blocking is done; lines are learnt. Secondly, and more interestingly, rehearsal time allows texts to be interrogated and for ‘choices’ to be negotiated. But, having said that, it is the liveness of theatre that I find exciting and that is the thing that makes the difference between rehearsal and performance. However much rehearsal time you have, you never quite know what’s going to happen and that’s exciting.

And talking of rehearsal and being ready, but not over-prepared for performance, I need to get to the dress rehearsal for *Attempts on Her Life*. . .

DB: Ready to break legs?

JB: Poised to be broken!

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