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HEARING THE PATIENT'S 'VOICE': TOWARD A SOCIAL POETICS IN DIAGNOSTIC INTERVIEWS

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Abstract—In this article we introduce a special practice that we have called the practice of a "social poetics", and explore its nature. The setting is a Primary Care Clinic at a large urban teaching hospital in the northeast of the U.S. As we describe it, the practice is at first conducted by a third person who occupies the position of a "cultural go-between" and who mediates between doctors and their patients in diagnostic interviews. Her task is to be open to being 'arrested', or 'moved' by, certain fleeting, momentary occurrences in what patients do or say. For sometimes in such moments, in our responding to the unfolding motions of their whole body and voice—as they respond to the circumstances in which they find themselves—we can begin to sense that the unique nature of their 'inner world of pain and suffering' is like for them. The practice of a social poetics entails a new, relational attitude to the patient's use of words, an attitude that invites a creative, poetic sensibility, as well as a 'boundary crossing' stance that creates comparisons useful in relating what patients say to the rest of their lives. In elucidating the nature of such a practice further, we draw on the work of Wittgenstein, Bachelard, and Bakhtin. Together, these can lead to a new diagnostic practice that enables those involved in it to create, within the practice itself, both ways of talking that draw attention to the new possibilities for interaction the practice itself momentarily makes available, and ways of talking relevant to realizing these possibilities. Copyright © 1996 Elsevier Science Ltd

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"It's not like it is back home" (Haitian patient in a diagnostic interview).

"Inside every patient, there's a poet trying to get out" (Broyard, 1992, p. 41 [32]).

"... the essential newness of the poetic image poses the problem of the speaking being's creativeness" (Bachelard, 1992, p. xx [21]).

"The way music speaks. Do not forget that a poem, even though it is composed in the language of information, is not used in the language-game of giving information" (1981, no. 160).

INTRODUCTION

In this article, we wish to discuss the role of certain special kinds of 'arresting', 'moving', 'living', or 'poetic' moments occurring in medical diagnostic interviews. Both health professionals and theorists need to attend to these moments of epiphany that occur in the delicate negotiations between their worlds and those of the patient. We shall adopt a relational, dialogical stance toward the study of these often ignored moments, for, if responded to appropriately, patients can be invited to express and to live out in such interviews a relation to their illness meaningful to them.* Thus, in our approach, we see human agents less as a locus of representations, and more as engaged in embodied dialogical practices, i.e. as beings acting practically both in and on the world around them, from within specific relational involvements with others [1–4]. It is this relational focus on people's ways or practices of connecting and linking themselves both to each other, and to the rest of their surroundings and circumstances, that makes our approach here quite novel, rather unusual in fact.

Indeed, it is the nature of a special practice—the practice of a social poetics—that we seek to articulate in this article. As we see it, the task of such a practice is to help us grasp in such living moments, in the emerging 'movement' of what is unfolding before our very eyes in diagnostic interviews, something we have not before noticed. Instead of seeking a universal, cognitive understanding of such events, supposedly revealing of their true nature, a social poetics must 'move' us toward a new way of 'looking over', or participating in, the particular 'play' of unique events unfolding in the conversations between us. Not only must it draw our attention to events that might otherwise escape our notice, but it must also provide us with an understanding of their possible relations and connections to the particular circumstances of

*Our approach here is related quite closely to current work in social constructionism [3–14].

their occurrence. It is only by being able continuously to create new links and connections between events within that 'play', in practice, that those involved in a dialogue with each other can reveal both themselves and their 'worlds' to each other: patients can reveal, not only their 'worlds of pain' to their doctors, but also their own relations, their own moral stance or attitude as persons; they can reveal the ways in which they are still healthy and vital beings persons worthy of human dignity and respect, able to play a part in their own healing [15, 31]. It is in such living moments between people, in practice, that utterly new possibilities are created, and people 'live out' solutions to their problems they cannot hope to 'find' solely in theory, in intellectual reflection on them.

Below, in outlining what is involved in the practice of a social poetics, we shall call on the writings of Wittgenstein [17–20], Bachelard [21], and Bakhtin [22], for all, as we shall show, are concerned in their own different ways with those crucial 'poetic' moments when one is 'moved', 'arrested', or 'struck' by the working of certain words within oneself, and in conversation with others. Because of the nature of our approach, we will move as soon as possible to an account of a particular case. As the character of these moments can only be made visible from within the practice itself, we write in the same manner: from within the practice rather than from a detached analytical stance. For these moments can best be captured in writing as illuminating fragments by being pointed to or gestured at. These moments then become visible in the dialogical practices—in moving between a number of different stances, or boundary crossings—described below.

In setting the stage for the boundary crossings involved, let us point out that you will find at work in the text below, three registers or voices: the medical voice or register (M), working to progressively narrow its focus in order to characterize the symptoms presented by the patient and to make a diagnosis; as well as the voice of one of us (AMK), taking the stance of a 'cultural go-between' (CG-B), attending to 'local worlds' and 'local cultures' in which each participant has something at risk, and concerned with culture as a relational process: that is, with cultures as having to do with the different resources people use to bridge the gaps between them, to relate themselves to each other. There is also the voice of the patient in this case (B)—although we will only mark it when it seems to us that she speaks in her own voice. We should also point out that there are two ways to describe what is going on in the talk between the people involved: (1) as a medical diagnostic interview; or (2) as a relational process—attending to inter-cultural relations that are so local that they shift moment by moment to invite new possibilities of meaning and experience. As we shift from one voice or register to another, we render what was determinate in one indeterminate in the other.

"IT'S NOT LIKE IT IS BACK HOME": AN ARRESTING MOMENT IN PRACTICE

CG-B: The moment in question occurred to one of us (AMK) in the primary Care Clinic of a large urban teaching hospital in the northeast of the U.S., serving a multicultural and immigrant population. In my role as collaborative consultant (a nonmedical preceptor) in a primary Care Clinic I am invited to sit in with residents and their medical patients, to observe and consult on their clinical practice and reflect with the resident and patient present, during or after the interview. Thus, I shift back and forth between participating and observing in a number of different contexts. (1) The initial conversation with the resident—a form of collaborative 'contracting'—what she wants me to observe, or what she is working on that she'd like me to reflect on; my position and the extent to which I will be participating directly with the patient and/or talking with the resident with the patient present. (2) The second context is the interview itself. (3) The third is the resident presenting this 'case' to her preceptor. (4) We then return to the patient and, as previously negotiated, I continue to observe, or to talk with the resident about my reflections, or talk with the patient directly.* (5) After the patient leaves, there is further opportunity to discuss what had preceded in light of the initial questions of the resident.

Thus, I am at the crossroads, navigating worlds of meaning, not only as a kind of 'cultural broker'† between the patient's cultural world and the doctor's, but also at the intersection of two other worlds of meaning: that of the doctor as physician and mine as a nonphysician. I am here at the request of the resident as a part of their training program to learn about doing medical interviewing. I am in the hierarchy but not of it, an invited guest: now an observer, now a participant; now on the margins, now in the center. I am involved in voyages of boundary crossing, navigating worlds of difference; making room for another person, a different point of view or stance; opening up a new space between patient and doctor, between the world of medicine and the larger cultural context, or within the local culture created moment by moment by what is at stake for each participant. My shifting position, betwixt and between, is a moving liminal position with formative but not coercive power—a discursive power to formulate questions of relevance to the interactive process unavailable to the others. A relevance witnessed by medical colleagues occasionally saying: "You ask different questions than I do, where do they come from? I want to understand." It is this shifting, moving, stance, that we feel is the key, in inviting the

*Tom Andersen [23] describes the use of the "reflecting process" in consultation with physicians in Norway.
†Byron J. Good, personal communication.

occurrence of arresting moments into the ongoing talk, or in being able to recognize them when they occur spontaneously in what, until that time, had been a routine conversation.* For without such a special stance such moments are so fleeting they are easily ignored; it recognizes the patient's power to express themselves, to make her world known to us.

These first meetings are not only for diagnosis, they are also 'first meetings' with the person of the patient. We listen for people's first-person voices, and, on occasion, write it as such. For, in the voice of the third person, while there is perhaps a chronicle, there is no story, no narrator, no person, no patient, no physician; just a writing about a patient as an abstract generalization. Thus, aware of these depersonalizing tendencies in the objectifying voice of medicine, my task in all of this is to help interns to become a little more conscious of how their often third-person ways of talking (with and about patients) 'work', as well as to become more sensitive to patient's first-person ways of talking too. And, in the 'play' allowed me, I shift between participating and observing, crossing boundaries between different ways of relating both to the doctor and the patient. My switching of stances renders previously determinate meanings lent by the doctor to the patient's terms, indeterminate; new meanings suggest themselves as I let the patient's words resonate and reverberate within me—a dialogical invitational stance.

Indeed, in failing to notice this, one is easily tempted into treating the words of the patient as only revealing their symptoms. If we privilege the medical voice alone, then what the patient says is located in the body, selectively translated into medical language, and the rest set aside; that is, issues to do with cultural and social process become marginalized [25]. However, if we care to notice other features of the talk in such interviews—not only of the patient but of the doctor too—its tone, its emotional richness or emptiness, its nuance and variation, the rhythm of the speech used, whether it is monotonic and formulaic, whether it is empathic or wondering talk, full of feeling, varying in tone and intensity, whether the person themselves talks, or describes others, in first-person or third-person language, then we can find something else besides symptoms of disease in the interview talk. It is in our capacity to respond to these fleeting moments in extraordinary, rather than ordinary, routine ways that enables us to create a novel form of living contact with them. For it is in those living moments of talk that we can find the patient, their 'world', and what it is like for them, trying in the face of their illness, to live in it.

*"It is all too easy to take language, one's own language, for granted—one may need to encounter another language, or rather another *mode* of language, in order to be astonished, to be pushed into wonder again" (Sacks [24] p. ix).

THE INITIAL INTERVIEW

On the day of the event in question, D, one of the interns, introduced me to a new patient, B, a woman from Haiti. This was to be another routine training session, but the events that occurred were far from routine, and affected me greatly. (In what follows, conversations between D and B are denoted by 'M', the medical register or voice.)

M: D began by asking B:
"How old are you?"
"33."
"What brought you to the primary Care Clinic?", D asked.
"Oh two months ago, I was coughing, deep in my stomach . . ."
"In your chest?"
"Yes."
"Who did you see then?"
"Oh, I will find the letter the Dr. gave me."
"How is it now?"
"It's better, but I still feel something in my chest."
"Congested? Do you cough up phlegm? What color was it?"
(*All legitimate questions to help characterize the symptom.*)

CG-B: As someone both interested in anthropology, and 'positioned' in this interview as an 'outsider', able to be sensitive to other possible responses each might give to the utterances of the other, something in B's demeanor 'touched me'. As I listened to D asking questions to help 'characterize the symptoms', to gather information to make a diagnosis, I couldn't help wondering what B thought was going on. As I listened, I was struck by the rhythm of her Creole accent and how little it varied as she spoke. I wondered where she was from, how long she had been here, and how she was doing.

M: D asked where she was living.
"River Park. I live on the top floor with friends from church living downstairs."
"Do you work?"
"Yes, as a nurse's aide in a nursing home . . ."
B: "It's not like it is back home. It's hard to work there; I'm working too hard."

CG-B: As she said it, there was a marked shift in the intensity of her speech, a slowing down . . . a process punctuated by shifts in her posture . . . a looking down to her left and a sinking-in-on-herself . . . a sense of despair darkened her story. Her saying "It's not like it is back home" seemed suddenly, at that moment, to come from 'somewhere else'. I was occupied by what was not said but gestured. Something gave color and life to the stark symptom picture, something from her life, her culture. I was provoked into wondering, "Where is she from?", "What's her 'world' like?", "How much of the 'stuff' going on in her 'world'—though not articulated here—is a part of her sense of being here, in this world?" Perhaps that is what is preventing her from being able to be fully here, in the world she now finds herself in.

M: D continued, and asked, "What else?"

"Pain from my period which I have two times a month, or every 3 weeks."

Again careful questions were asked to characterize the symptoms: "How heavy is the flow? . . ., on the heaviest day? . . .; cramps? . . .; how long does it go on?" D tried to match language with the patient; if a word was not picked up on by B, D changed it. 'Chronic' became replaced by the words 'long time', and so on.

B described having been to a gynecologist two years ago when these problems began, who had given her Naprosin which she found very helpful. D went on to ask about allergies, then later, if B was sexually active, and B said, "Oh no, I am not married" . . . D shifted back to her symptoms and the logic of diagnosis, by saying that they could certainly do an internal examination to help determine what may be going on.

CG-B: And B again, slightly but yet so significantly that you could not but notice it, shifted her posture, looked down, and said in a soft voice, "Oh, but I am so scared by that"—and in an almost silent aside she added, "In my country it would be so different; the medicine is different. Ah but it would take a long time."

I noticed that D was considered and considerate in her manner, but what struck me more was this response of B's seemingly connected with her saying earlier, "It's not like it is back home." Already attuned to the possibility of her illness having its existence in a whole, much larger but unspoken 'world' of pain and distress, her saying "In my country it would be so different . . . " seemed to be a break in the present regime of significance, to open up a 'gap' or 'discontinuity'. I found myself wondering again about what was not said, but hung, arrested, in the space between us, creating a silence that was anything but silent: "What is her suffering about?" How could I, how could D, respond to it so that she might talk of things not yet said? How could D invite a larger look at her world of suffering, triggered by her alarm over her physical symptoms?

M: "Anything else," asked D?

"I had a TB test but took medication for 6 months."

"Is there anything else concerning you?" asked D

"I have headaches."

She thought, then said, "I don't think it's normal to have such heavy periods."

And again she said, "It's not the same at home; I work hard but not two jobs."

And D asked, "Where is home?"

"Haiti," answered B. "I came here 6 years ago with my father; my family is in New York."

"Would you go back?"

"No, I wouldn't have the same opportunity back there to help my sister and brother. My father brought me here and so it's here I have to stay."

CG-B: I was still left wondering what it is like for her here. And how her life would be different in Haiti, and what is the practice of medicine like there that would be helpful to her, and for us to know. What I had been most struck by was the patient's language, wondering what it had been like for her to be here, what had got her to come? How are the recent shifts in Haiti affecting her and her family? When she had spoken of her physical symptoms and how it would be treated so differently at home, the register of her voice changed, she looked down and became quiet. The flow of her story of her physical symptoms had been punctuated by deep sadness and withdrawal, shown in her whole expression of it, in her voicing, in her gesturing of it. Though tacit, it was communicated to me as a felt sense; it hung in the air and was palpable between us, yet ignored.

And there, the first interview ended. I asked D what she thought of the interview and she said she had noticed that the patient was "not happy about her medical care." I echoed her description and added my concern for her apparent suffering, and, without knowing entirely what it was about, I wondered out loud to D how she might be invited to talk about that. I said I was most struck by the cultural issues here, and pointed out how moved B had been whenever she talked about being at home. We also couldn't ignore, I suggested, the backdrop of recent events in Haiti and how she and her family might be affected. However, D and I had next to meet with D's preceptor, and D had to present the case to her.

THE PRECEPTOR INTERVIEW

M: D to preceptor: "This is a new patient, a 33 year old woman with gynecological complaints, heavy bleeding, painful periods. She wants Naprosin, which she claims effects the flow . . ."

(And D continued with a proper biomedical diagnosis).

CG-B: At one point during D's presentation, I wondered aloud about B's distress. D's response to this was to flip through the medical chart and to notice that the diagnosis of depression was mentioned at least two times. The formal note written in the medical chart at the end of this interview is an exemplar of how the patient's experience is translated into medical language and reduced into symbolic shorthand.* Usually, for the physician, the story is ended with diagnosis; the path is clear about what needs be done and how. For the patient, however, the story may be just beginning all over again, but this time with an uncertain outcome. The process of trying on endings, participating in the process with others, including their doctor, allows the opportunity for coming to terms with what is unknowable, but packed with feeling that may be inchoate or voiced.† Thus, before, and in this first meeting, along with the

*The style of talk during this episode is, of course, in stark contrast to the written style in the final medical chart produced by D for B's case (see Barrett [26] for how a patient's illness is represented in written records).

†Good and Good [27], and Good (1994) [28].

distress presented by the person, or the symptoms presented by the 'patient', is the 'way' in which patients have, or are, embedding their distress (or their 'symptoms') in language. How a story is told can bring the experience back to the patient and into the room, so that, along with all the necessary information available for their doctor, they may recall not only what they experienced, but also the meaning it has had for them. In the process of telling, as the patient accesses more and more, however, the doctor may pick and choose what to respond to, inviting the patient to expand in their own language, or channeling the talk more and more to narrow the focus and translate the patient's own words into the language of biomedicine. In other words, what the patient speaks as a way of articulating, or making sense of, their relation to their illness, the doctor may treat simply as information, indicating a thing or object in the already existing world of medicine.

But the patient's phrase—"It's not like it is back home"—stayed with me. What does this mean to her? What meaning does 'home' have in her own country? How would medicine be different? What kind of help would she receive in Haiti? Could some of it be gotten here? And how is this different when she is, so to speak, on the outside looking in, or even looking back. What is at stake for her in this emerging local moral world, in this 'conversation' about diagnosis? How does this compare with what is at stake for the intern? How does the CG-B navigate these stances to shed light on this multiplicity of agendas, to evoke an atmosphere of invitation and inquiry, and to legitimate them both? What could easily be viewed as physical symptoms or psychiatric diagnosis seemed to me to have a universal quality of distress that I could as yet only sense. But if she could 'show' us how she related to these issues, then, perhaps, she could 'show' us her 'world', what it was like to be her. When we treat conversation as not just a way to give voice to information that has not yet been conveyed, but in a more relational manner, then we find that it is not only a way to generate important questions—by all in the situation—but we may even invite a sense of agency in the patient. That is, the patient can have the experience of what she has to say, as 'making sense' for perhaps the very first time.

Thus, rather than her 'symptoms', I was wondering about very different things: about B's responses and reactions, what she had 'shown' in her 'living out' her part in the diagnostic session. B's part of the conversation held, not just the 'what,' but the 'when', the 'how', and the 'who' of the person she once was, at the time of the onset of her 'distress', but also how it had changed the person she once knew herself to be. How she might be is now inextricably interwoven into her illness. For the time between the first sense that something might be 'wrong', that something is unusual, and the time of naming or diagnosis, is, by its very nature, indeterminate, a liminal state. Here, the challenge for the doctor is to match the patient's symptoms against a heuristic, to move from the specific to the general, to 'translate', or carry across, the patient's story into medical language. Thus her utterances offer instrumental moments, a time in which to match as closely as possible the bits and pieces of the unique language of the patient to the canon of the generalized known. Knowing this, the not-yet-known may be experienced by the patient as not making sense, as being heard by the doctor as 'nonsense'.

But for the patient, the not-yet-known is an indeterminate state that may, or may not, be recognized, and become articulated. But by whom, how, and for what purpose? How might a language be created such that the tacit, the unsaid, the nature of 'her world', could be articulated in her terms, instead of being translated into the already accepted, traditional world of medicine? How might this privileging of ordinary language create a more two-way exchange in which she has as much command and import as the other? What possible 'topics' or 'common places' could we find to create a 'common ground' between us, to create a 'sensed' or 'sensible' space full of 'things' about which both she and we could speak? Thus, I wondered about cultural factors: her being an immigrant, conditions in Haiti, how she was affected by the social and cultural upheaval, and so on. And I noted how struck I had been by how moved she was whenever she talked about 'back home': why had I been moved so powerfully? Something that I did not understand was at work there. And I wondered about what would emerge from following up on B's opening by asking the questions that had occurred to me at that point, how would it be different at home?

THE POST-PRECEPTOR INTERVIEW

In her post-preceptor interview with B, D followed up on questions having to do with B's cultural background, and her concern with how different it was for her here and back home, and with how medicine is different, with remarkable results.

M: D began by asking,

"You spoke of things being different back home ... in terms of medicine ... what do you do in Haiti?"

CG-B: And in the course of the telling, B not just brightened but shifted her whole demeanor and stance, where just before she had appeared depressed and disconnected, now she became energized and present.

B: "... well maybe its not different in the city, in the hospital, they are all the same. But if you go out into the countryside, there are herbs from the forest and Drs. who give massage and herbal wraps. My mother and family massage me. You have to go for three weeks. Here, not just anyone can touch you, they can pray with you, but not touch you."

CG-B: As she relayed the story she'd step out of it every so often to look at us. At first she said, "It is

true, what I'm saying is true." And D looked back and said, "Yes, and it sounds great." This responsiveness served as an invitation for B to go on. One had the sense that if this had been told before, on other occasions, it had met with at best questionable, or no, responsiveness. What was at stake for her had been, in former times at best not heard, at worst disqualified, medicalized, or seen as psychiatric problem.

B: As she continued, she'd again look at us, chuckle and say:

"Nobody would believe it, then, when I tell people this, people could think I was crazy, but I'm not."

"Why did you come to Boston," asked D?

"My father brought me to NY and then I moved to Boston because I was engaged and my boyfriend's family lives in Boston. But we broke up 2 years ago."

"That's hard," said D, "and also not to have your family close by."

"Yes that's when my problem began. And that's when I went to the doctor."

"CG-B: And now, who can you go to if there are problems and you want to talk, or get a massage? You mentioned your mother would give you massage . . ."

B: "Oh, my mother passed away—two years ago . . . In my country, my mother lived next door to someone high up politically, and Duvalier's men came looking for him and instead found his 25 year old son, and shot him dead in front of my mother. She had high blood pressure and immediately fell down, then and there, and passed out."

"And the ambulance—it's not like it is in this country—didn't come for three hours, and she was dead."

"And that was when?"

"Two years ago. And my life has not been the same since."

"I had been at a church retreat. And I sensed something was wrong with my mother, that she was in danger. There's so much; people could think I am crazy for all of this, but I'm not, I'm not. It's just a lot."

CG-B: And as we talked together, she knew *we* didn't think so. It was a kind of conversation which in the telling not just opened the space for new possibilities, but touched each of us in ways that changed us. As she moved from what privately made sense to what also, publicly made sense to all of us, there was a profound shift. What she had feared would be construed as nonsense became a 'shared sensibility'; what had been tacitly felt as a silent suffering, a fear of being judged, humiliation, became in the telling, a story of dignity.

Now, there was a new kind of conversation, one in which she was able to relate her medical problems to her sense of herself as a person and her personal world, one in which her worlds of suffering intersected: from shifts and changes in Haiti and the shock of her mothers' death; to her bodily sense of alarm and need for diagnosis; to her reactions to the technology of diagnostic tests. So when the question of having a pelvic examination came up, she was able to say,

B: "In my country it is important to be a virgin; you cannot marry well without it. And here, I am told, you are 33, you must have this [exam], be a grown up. When I went to the other Dr.—he was Chinese, he understood because in his country it is the same. One time he just showed me these two instruments—one plastic and one metal. I went home shaking, called all my relatives and prayed."

M: D said,

"Oh yes the speculum. They are rather scary looking."

B: "And I came back, and he was so gentle; I didn't feel anything. If I have to have this, will you be gentle?"

CG-B: Now the use of technology and diagnostic procedures became a topic of discussion embedded in important cultural practices and the larger world of her lived experience. And as she left, it was a very different patient, a person, not just more relaxed, smiling, but present, a person with dignity. She knew how to relate what would happen to her, in a way that was in accord with who she took herself to be, in a way that made sense to her, in her world.

Afterwards I asked D what she thought of the meeting. She had a similar sense of amazement and said, "You know, you get so entrenched in the biomedical, not wanting to take too much time, not wanting to keep any patient waiting, that you lose sight of the person. And if it hadn't been for you, I wouldn't have noticed any of this—about the cultural issues, trauma on so many levels."

Although originating in a fleeting moment, the 'relational change' occurring here is to an extent permanent and transferable, in the sense that the patient now feels able within the new relationship formed to speak on her own behalf, while its continuation issues a strong reminder to this doctor of how she wants to practice medicine.

POETIC-RELATIONAL WAYS OF BEING AND TALKING

This, then, is the circumstance we wish to put before you. It is a story in which certain fleeting but 'moving' moments, interspersed among more routine forms of talk, play a central role, a story in which, among other things, a routine medical examination embodying a medical sensibility became a relational rather than an alienating event, in which B came to feel involved and respected rather than objectified and pathologized. On the level of human suffering, her alarm over her physical symptoms and a feared pelvic examination—a small part of what was at stake for this patient became an occasion, perhaps an invitation, to understand a larger world of suffering beyond the consultation room. But how is it that such a fleeting but moving moment as that presented by B's utterance, "Its not like it is back home," can begin to tell us of an other's 'world'? And further, how is it in the telling that these moments can change the very being of the teller (as well as those they talk with)? Yet further, how might the occurrence of such moments be promoted, invited? How might the patient's power to participate in creating a shared world between us be realized? Here, we would like to articulate further the character of the stances and practices involved in being something of a 'cultural go-between', and how the practice of a social poetics might be instituted, by turning in a moment to the

work of Wittgenstein, Bachelard, and Bakhtin. However, we shall turn first to the question of how is it possible to be sensitive to 'poetic' or 'arresting' forms of talk when they are so vague and come, seemingly, 'out of the blue', though embedded in a relational context. How can they be so utterly novel and unique and yet so meaningful at the same time? Indeed, how can such fleeting moments offer such a rich invitation to the world of the patient, while providing a basis for the further articulation of its unique sense and culture in subsequent conversations with us?

In tackling these problems, we can begin by noting that, in any interactive circumstance, activities of two different possible kinds can occur, and that, as a result, there are two quite distinct attitudes or stances that we might take towards people's talk of themselves, their self-talk. (1) We can treat it as we usually do, as an activity in which they as individuals talk to the others around them of something they think or feel to be the case 'about' themselves: they 'report' on their inner states, feelings, ideas, or inner mental representations; and they do this by progressively specifying or articulating their nature, step-by-step, over time. This is to take a disciplinary, representational stance toward their self-talk and to see it as conveying this or that kind of information. (2) We can, however, take a quite different stance toward it, and see it in quite another way: as a part of a living, interactive process in which people as embodied agents are continuously, responsively, reacting to each other in such a way that, even as one person is speaking, the facial and bodily responses of those around them are acting back upon them, to influence their 'shaping' of their talking. In such circumstances as these, we are doing much more than merely talking 'about' things; we are creating forms of relationship, or as Wittgenstein calls them, "forms of life," with their associated "language games"—where, as he says, "the term 'language-game' is meant to bring into prominence the fact that the speaking of language is part of an activity, or a form of life" (1953, no. 23). In this view of speech, our talk is never meaningful simply on its own; our words in their speaking draw their influence very little from our saying them in themselves, i.e. from their supposed lexical meanings, but rather from our use of them at crucial moments, to make crucial differences, in the larger flow of our living, bodily activity into which they are intertwined. It is our local or situated use of our words that is important: in producing in those who experience them certain embodied reactions and responses, they work to make, momentary, practical differences, to create certain embodied, momentary relations and connections between interlocutors. Here, we are taking what might be called a nondisciplinary, relational stance toward people's self-talk, seeing it as providing, not information, but different possible relational opportunities. And this is how we treat B's talk with us: as bodily 'gesturing' or 'pointing' toward something important for her in her life.

It is this relational focus on people's immediate, embodied, responsive reactions to each other's words which is central to our approach here. It is in the way that people's responsive utterances connect, link, or relate them with their surroundings that they 'point' or 'gesture' beyond themselves, toward what their 'world' is for them. That is, it is both in the way in which other people 'show' their 'world' in their fleeting reactions to and understandings of what is occurring around them, practically, and, in the way in which we find ourselves 'arrested' in responding dialogically to their responses, that we are provided with an initial, crucial grasp of their world. Thus, it is in the uniquely expressed, unfolding motions of a patient's whole body and voice in such moments, as they 'respond' to the 'position' in which they find themselves in 'their world', that they reveal their illness's nature, what the singular nature of their 'inner world of pain and suffering' is like for them—if, that is, in further conversation with them, we can continue to relate ourselves to 'their' way of being in 'their' world. For, as Kleinman and Kleinman [29] point out, "We, each of us, injure the humanity of our fellow suffers each time we fail to privilege their voice, their experience" (p. 292).

Yet, such an occurrence is endemic in our professional academic practices, for currently (even in the interpretive social sciences, never mind in their more positivist counterparts), academic authors have always tended to write within a disciplinary–theoretical genre, adopting what might be called a retrospective–objective stance toward those they portray in their accounts. But as Kleinman and Kleinman [29] remark, although such professional accounts have given rise to many important findings—such as the fact that illness or disease processes are culturally patterned into recognizably shared forms— "The professionalization of human problems as psychiatric disorders...is to lose a world" (p. 293). Although authors may often have been involved with their subjects in conversational transactions of a quite personal kind, in writing these transactions, authors write 'about' them as if from a position now outside of these involvements, looking back on them as now finished processes. For their aim in such a style of writing is to provide fellow professionals with information derived from their encounters, thus to contribute toward the development of theories or representations of the subjects in question, theories couched in disciplinary terms. In other words, in this style of writing, they write 'about' other people's experiences in terms quite different from those in which the people themselves might express them. This is how such accounts lose, or render invisible, the unique local context, with its local moral order, in which each ill person lives out their life. Yet, it is just within this unique moral context that ill people organize, express, and experi-

ence their own unique forms of suffering. Thus, if we are to properly understand human suffering, we must in some way deal directly with this first-person embodied and experienced domain. Yet, as Kleinman and Kleinman [29] say, "How social and behavioral science is to transform [this] realm into a suitable subject matter is not entirely clear to us" (p. 294). It is just this realm, we suggest, that is expressed—but only momentarily and occasionally—in the 'living', 'poetic' moments we have outlined above: it is expressed in how the embodied, living responses of patients gesture toward it, and in the direct and immediate sensuous responses that such gestures call out in those around them.

Indeed, we now turn to some remarks of Wittgenstein's [19] on how a work of art (or a poem) conveys a 'feeling'; he suggests that, "In so far as people understand it, they 'resonate' in harmony with it, respond to it" (p. 58). Indeed, in such singular circumstances, he likens the 'movement' of people's thought to the 'movement' in a piece of music, and the music's 'movement' to speech and other human gestural movements: ". . . the theme . . . is a new part of our language; it becomes incorporated into it; we learn a new gesture" (p. 52). But: "Doesn't the theme point to anything outside itself?" he asks. "Yes, it does! But that means:—it makes an impression on me which is connected with things in its surroundings—e.g. with our language and its intonations; and hence with the whole field of our language-games" (1981, no. 175). In other words, a new gesture brings to life new ways of 'pointing beyond' our immediate circumstances, to make new connections and relations with our surroundings. In relation to a world of pain, he remarks: " 'Fare well!' 'A whole world of pain is contained in these words.' How can it be contained in them?—It is bound up with them. The words are like an acorn from which an oak tree can grow" (1980, p. 52). These remarks on their possible musical and gestural nature, give us a first clue as to how to begin to relate ourselves to the 'poetic' character of 'arresting moments'. For another clue, it is worth looking at the very style of Wittgenstein's own writings, which consist of striking similes and poetic remarks—indeed, as he himself remarks, "Philosophy ought only to be written as a poetic composition" (1980, p. 24). But why?

Aware that we often fail to notice the momentary particularities of our immediate circumstances, aware that we tend to see the world just as much through our words as through our eyes, Wittgenstein wants to divert us from describing our particular, practical activities as we think they must be (in theory), and, through his 'poetic' remarks, to draw our attention to "observations which no one has doubted, but which have escaped remark only because they are always before our eyes" (1953, no. 415). This focus on the particular and the practical, and the destabilizing of the disciplinary, not only characterizes the radical nature of Wittgenstein's own approach, but is a part of AMK's practice as a CG-B. For, the very method that Wittgenstein uses in his attempts to break the grip on us, of various, already established forms of life—with their associated ways of talking and regimes of significance—is continually to use words outside the confines of any particular, already established language games: that is, he is continually crossing boundaries! And it is by his vague and indeterminate usages, his comparisons and juxtapositions, the discontinuities and gaps he opens up, that he questions already determined and taken for granted meanings. The actual use of words, their practical, concrete meaning, is their unique use in the context of their occurrence. Thus, it is by his "arranging of what we have always known" (1953, no. 109) into new arrangements, by his "assembling reminders" (1953, no. 127), that he produces a 'poetic image'—a form of talk in which we are 'led' to see possible connections and relations between things that we had not noticed before.

His methods, then, do the opposite of what we might have expected from a logician, philosopher, and intellectual: they first create an indeterminacy where before there were determinate meanings, and direct our attention to something, to new possibilities, that can at first only be 'sensed'. But we can now perhaps see why, given what we said above about the nature of a social poetics, his methods contribute toward our goal: for although they do not provide us with any new theories as to the nature of our words, they do provide us with a new practice. That is, instead of helping us 'find' or 'discover' something already existing, but supposedly hidden behind appearances, they help us grasp something with our very eyes. The problems facing us are solved, "not by giving new information" (1953, no. 109), but by us 'going on' with each other in a new way. His similes draw to our attention things with which we are already in fact conversant, in practice, but of which we need to be reminded. They 'move' us toward a new way of 'looking over' the 'play' of appearances unfolding before us, such that, instead of seeing them as related to each other in terms of certain theoretical prejudices, we see them in terms of the connections and relations they might actually make, the roles they might play in our lives. In their everyday, practical use, people's words work to create, not determinate, explicit meanings, but particular felt or sensed implicit meanings of a unique kind. And the task is—just as one of us (AMK) initiated the further exploration of B's unique use of her utterance: "It's not like it is back home" in the conversation—to grasp the nature of the relational practices involved in such investigations.

To elaborate the nature of the practice of social poetics in yet more detail, it will perhaps be helpful to clarify the 'arresting' nature of such momentary utterances further: for, how can such a simple, brief phrase as this offer an invitation to 'the world' of the patient? And how can its unique sense and its unique

culture be locally articulated and created moment by moment in conversation with us? To clarify both to what in the speech of others and in ourselves we should pay attention, if we wish to attend to 'their worlds', we will find it useful to consider the work of other writers: namely, Bachelard [21] and Bakhtin [22].

Turning first to Bachelard (1991), we find that he raises a question precisely similar to ours in the following terms:

> How—with no preparation—can [a] singular, short-lived event constituted by the appearance of an unusual poetic image, react on other minds, and in other hearts, despite all the barriers of common sense, all the disciplined schools of thought, content in their immobility? (pp. xiv–xv).

Such poetic effects come prior to knowledge, and as such do not provoke judgments of truth or falsity, but they occasion a re-visioning of one's circumstances, a responsivity to something before unnoticed, unacknowledged. And it is this—their capacity within their short-lived existence to provoke or to 'call out' entirely novel reactions, spontaneously and directly, despite all the barriers of common sense, etc.—that makes their nature so difficult (and unusual) to study. For poetic acts, poetic images, constitute, says Bachelard [21], a "flare-up of being" (p. xiv), a unique and specific event whose character, if it is reduced to any already existing schemes of analysis, is lost.

Thus, "By its novelty, a poetic image sets in motion the entire linguistic mechanism . . . It takes root in us. It has been given us by another, but we have the impression that we could have created it, that we should have created it" (p. xix).

Like Wittgenstein, Bachelard discusses our receptivity to such events in terms of resonances and reverberations: for, in irresistibly calling out something from within us of which we were previously unaware, we resonate to such events; and in further responding to our own responding, in reverberating, we relate ourselves to them. As Bachelard puts it: "In the resonance we hear the poem, in the reverberations we speak it, it is our own. The reverberations bring about a change of being. It is as though the poet's being were our being . . . the poem possesses us entirely" (p. xviii). Indeed (as we have already seen with Wittgenstein's methods), it is just because such events offer us "breaks in signification" (p. xxv), i.e. destabilize established meanings, that they also offer us ". . . a new being in our language, expressing us by making us what [they] express; in other words, [they are] at once a becoming of expression, and a becoming of our being. Here expression creates being" (p. xix). This is the power of the poetic: ". . . in its expression, it is youthful language" (p. xv); it can change us in our being by gesturing toward new possibilities; it can provide the 'seeds', spontaneously, for re-connecting ourselves with our surroundings in utterly new and unique ways, independently of any pre-existing systems of knowledge.

Bachelard provides us with many useful 'poetic' phrases, useful images and metaphors, through which to 'see' and to 'grasp' at least some of the important aspects and features of the fleeting phenomena we must confront: especially their uniqueness, their novelty, and their effects upon our own very ways of being in the world. Given the function of Wittgenstein's 'poetic' methods, we suggest that Bachelard's remarks similarly draw our attention to the really rather 'extraordinary' nature of our everyday relations both to each other and to the larger circumstances of our activities. Their function is to change our sensibilities, to make us sensitive to a whole field of phenomena that before have passed us by.

In the same vein, Bakhtin's [22] works—that emphasize the responsive, relational, and dialogical nature of the human communicational processes—will take us into even more surprising and strange regions, and bring to our notice yet further its unacknowledged features. Like Wittgenstein, Bakhtin also takes an everyday, responsive attitude to our talk. Thus for him, the real unit of speech communication is the utterance, as a response to its own momentary circumstances, ". . . its beginning is preceded by the utterances of others, and its end is followed by the responsive utterances of others" (p. 71); and, "regardless of how brief and abrupt, [it] has a special quality of completion that expresses a particular position of the speaker, to which [an other] may respond or may assume, with respect to it, a responsive position" (p. 72), where the special quality of this completion is such that it always 'calls out' or 'invites' the response of another speaking subject. Thus, as such, rejoinders are all related and linked to each other in a dialogic way, as living, responsive relations to each other; utterances always mark out the boundaries between different speaking subjects, different unmerged 'voices'. It is Bakhtin's introduction of living, responsive, dialogic relations between different 'voices' into the movement and structuring of our utterances as they unfold that opens up a vast new realm of phenomena for study. For, "An utterance is never just a reflection or an expression of something already existing outside it that is final and given. It always creates something that never existed before, something absolutely new and unrepeatable . . ." (pp. 119–120). Like Wittgenstein, it is not the repetition of a recognized form that interests him, but our understanding of the unique use or voicing of an utterance in relation to its surroundings.

It is in noting the creative nature of our responsive utterances in this way, however, that Bakhtin brings to our attention something rather strange, something not obviously present in Wittgenstein's work: that, in such circumstances, no person's actions can originate from within them alone, individually. The organizing center that 'shapes' or 'gives form' to what they say or do or experience cannot be located wholly within

any of the individuals involved. 'It' must be located 'outside' the individual concerned, in a 'space of possible relations' between them, and as such, that space always has a unique 'relational movement' to it. Thus, in one's utterances, one gives oneself verbal shape, not simply in relation to those around one, but in relation to the 'languaged space' into which one must address oneself, and that 'space' contains more than those immediately present to each other. Our words create "a drama in which three characters participate (it is not a duet but a trio)" (Bakhtin [22] p. 122). "Each dialogue takes place as if against the background of the responsive understanding of an invisibly present third party who stands above all the participants in the dialogue (partners)" (p. 126). 'It' has the strange property of seeming like another living being, an 'it' or a 'who', like another person, [who] has certain abilities, certain rights, etc., to which one must respond—to which one of us (AMK) felt she had to respond in the circumstance of B's utterance: and it was in the unfolding movements of B's voice that she began to reveal the nature of her 'world of illness' and her 'position' in relation to it.

Indeed, as B intones "It's not like it is back home", an 'it' begins to take shape in the space between us, an 'it' that is not 'hers', nor 'mine', but 'ours'. Filled with all the "various kinds of responsive reactions" she has to her current circumstances, the moment-by-moment movement of her voice and my responses to it begin to shape an 'it' between us, an 'it' with its own 'relational movement', an 'it' that can occasion a sense of what her world is like. So, although the 'invitations' offered by such utterances, the responses they call out, are utterly unforeseeable and occur in only fleeting moments, it is because of the enormous number of interrelated influences at work in their shaping—because of the unique relational movement they manifest as they are bodied forth out into the communal spaces between people—that they can create a sense of a whole 'multivoiced or relational world'. And because of this fractal-like inner richness, even brief, fleeting utterances, or a single, sudden, novel gesture in a certain setting, can invite a whole new shared form of life. This was the effect of B's phrase on AMK: the poetic (poeisis) 'making' of a new 'social world'.

However, our work is not over in simply being momentarily responsive to the 'poetic gestures' in a patient's words; we must also invite their further articulation in our further dialogic relations with the patient. The seeds sown in the space between us must be further cultivated. We shall turn to this task in the following section.

*See Andersen [23] for an account of such dialogical processes of 'reflecting' in family therapy.

CONCLUSIONS: A SOCIAL POETICS IN PRACTICE

We have been concerned, then, with those kinds of circumstances in which people respond to each other, not in terms of a system of pre-established meanings, and especially not in terms of a set of disciplinary or professionalized meanings, but in singular, short-lived, poetic moments. And with how, in those moments, they are able to 'gesture' toward the uniqueness of their lives. We have also suggested that the occurrence of such moments in diagnostic medical interviews can be promoted by the presence of a third-person 'outsider' in the interview: someone who plays the part of a 'cultural go-between' (CG-B), who, in being dialogically responsive to, or dialogically reflecting* on, the utterances of other speakers, reveals new meanings in them not previously appreciated. It is the noticing of the dialogical nature of all our practices that changes our attitude to them completely, and it is in this context that the crucial role of this outsider position must be evaluated. For its creative potential has not yet, perhaps, been properly appreciated, especially in relation to professional cultures, and the bodies of knowledge they sustain.

Currently, in being socialized into such cultures, it is thought that one should completely forget one's own, everyday, common-sense ways of orienting toward one's surroundings, and come to view the world wholly through one's new professional eyes (and words). All the new understandings to which they give rise are, so to speak, not 'creative' but 'productive' understandings: that is, they are understandings that sustain and reproduce the professions basic forms of life. But, as Bakhtin [22] points out, this stance toward the nature of understanding is "one-sided" (p. 7).

> Creative understanding does not renounce itself, its own place in time, its own culture; and it forgets nothing ... In the realm of culture, outsidedness is a most powerful factor in understanding. It is only in the eyes of another culture that foreign culture reveals itself fully and profoundly ... A meaning only reveals its depths once it has encountered and come into contact with another, foreign meaning: they engage in a kind of dialogue, which surmounts the closeness and one-sidedness of these particular meanings, these cultures. We raise new questions for a foreign culture, ones that it did not raise itself; we seek answers to our questions to it; and the foreign culture responds to us by revealing to us its new aspects and new semantic depths (p. 7).

Indeed, as we have already mentioned, speaking from just such an outsider position occasionally provokes such remarks from medical colleagues as: "You ask different questions than I do, where do they come from. I want to understand." In an important sense, then, this is not a fixed 'outsider' position, but a moving, shifting, dialogical stance, perhaps more aptly called an 'outsider/insider' stance. It is this insider/outsider, cultural go-between stance that we feel is the key in instituting a practice of social poetics. However, once the character of this practice is more fully understood, it is of course for doctors

(and other medical interviewers) themselves to learn how to switch their stance around to that of an 'outsider' from time to time, in order to make these much more personal, dialogically responsive contacts with their patients.

As a step in this direction, we shall now attempt to outline some of the central features of this 'insider/outsider' stance and also, to outline how, in practice, such a practice might be instituted: to that end, we shall comment first on both the character of the words and the stance appropriate to such a practice, before turning to the character of the practice itself.

Words: In the practice of a social poetics, we seek ways of grasping previously unnoticed relational moments in the emerging 'play' of events as they unfold in the conversations before us, to give these events new parts to play. In implementing such a poetics, we should, perhaps, first note the attitude to people's words, and to their speaking, it entails. A poetic sensibility in practice creates not only a special sensitivity to the language of self and other, but also to the positions of speakers and their addressees. The stance necessary for a practice of social poetics emphasizes (i) the difference between talking in the first person and talking in the third person, the difference between talking as a participant agent able to affect events and as a mere spectator or observer; (ii) similarly, a shift from 'talking about', to 'talking of' and to 'talking with', re-positions one as talking more from within a particular, still ongoing and open, dialogic moment, than retrospectively, looking back on something already completed; and (iii) using special, non-technical but 'poetic' terms, helps us 'see' the extraordinary (the 'magical'?) embedded in the ordinary.

Thus, speech that is responsive, that is involving, arresting, moving, that oscillates or navigates between different worlds of possibility rather than in a single fixed realm, that leaves gaps or spaces not to be bridged or filled by already determined theoretical meanings, that makes room for others to voice their responses, is the kind of speech that can 'invite' the creation of a 'local culture', with its 'local moral order', in terms of which people both 'suffer' and 'show' their experience of their illness. The kind of language that can do this is language that is conversational and collegial. It is language that is, so to speak, still 'young' rather than fixed and objectifying, looking forward, prospectively, toward novel relational possibilities, rather than looking backwards, retrospectively, toward representations and explanations within old, already existing categories. It makes use of ordinary forms of language and, as such, can be used by anyone; we do not need to be trained in any special uses of words to call out from each other, immediately, the kinds of 'poetic' responses of which we speak; such forms of talk make an opening for what is utterly new.

Stance: If the forms of talk described above are those that invite a poetic sensibility, what stance is required? How should one position oneself in relation to one's addressees? As we have seen, such a positioning requires, in part, a shifting of stances, an ability to conduct what we have called 'boundary crossings'. From moment to moment, one must navigate, negotiate, or move among: (i) different languages or registers, e.g. medical, professional discourse and ordinary language, i.e. the voice of the patient as person and the rhetoric of medical nomenclature, the use of medical diagnostic language that narrows the focus, compared with use of poetic relational language that expands possibilities; (ii) the cultural context and cultural issues including local moral worlds in which what is at stake for each participant is heard or understood, or translated into another domain of discourse; (iii) worlds of meanings so local that they change moment by moment. It is a collaborative stance that seeks to create a 'level playing field', where the voice of the patient is recognized as an equal participant. Boundary crossings by their nature generate multiple levels of comparison—an attitude toward difference that makes room for an 'other', an other person, meaning, stance, or time. 'Gaps' generated by such circumstances invite creative comparisons—such comparisons themselves invite further comparisons [30] (pp. 99–100), and thus further dialogic creations of new meanings ... without end. Indeed, in the 'arresting moments' we have presented to you, the very intoning of the word 'home' contained so many intersections of meaning, was filled with so many responsive reactions to other utterances, that it stopped time and bridged what might be known or sensed with possible meanings within and around it—the single word 'home' contained a collision of the known and the unknown, the given and the created.

'Seeing' such moments, then, creates an opportunity for further elaboration. How can this be done? Strangely, quite easily, for an 'arresting' moment also creates a 'resting' moment for reflection, in which further elaboration may come about through listening for, or by offering metaphors or similes—a voyage into what is not yet known with those who can now become co-participants in the process of meaning creation. Thus questions that can invite creative comparisons can come from within the conversation itself, and invite the patient as a person into a more equal partnership. Typical examples may be seen in those offered in the reflections offered by the CG-B in the interview described above, questions that are then carried into the interview by the resident, such as: "How would medicine be different in Haiti?", "How is her sense of 'home' different here, from the outside looking in, so to speak?" When the intern returned to B, she (the intern) posed the questions that she would not otherwise have foreseen, that shifted her stance and the stance of all of us. It not

only invited B to articulate her world, but created a whole new world. It not only created a break in the official or routine regimes of significance, but also a shift in B's position: she now became a CG-B, guiding us in a comparison of cultures. What had been for her, a fixed, liminal state, a position, literally, as a patient on the margins of a medical discourse, shifted to another, of her as a moving agent. As our positions switched and shifted, she not only told her 'story' but stepped out of it to comment on it—a narrator, a guide as to the meaning of the narrative created in conversation. Privileging the voice of the patient in this way puts the conversation on a more equal footing—a talking *with* rather than a speaking for the patient [16]. Instead of making sense of a patient's behavior by imposing upon it a category system of one's own, one allows their utterances to strike one, as if for the first time.

This practice seems to require, not only adopting the stance, sensibility, and linguistic sensitivities we have outlined above, but also the putting into practice of a very special practice—one that particularly enables those involved in it to create, within the practice itself, both ways of talking that draw attention to the new possibilities for interaction the practice itself momentarily makes available, and ways of talking relevant to realizing these possibilities. Talk of this kind is neither descriptive talk, nor is it theoretical; it is 'metamethodological' in that it works to reflect on our practices in such a way as to begin to articulate what has previously been tacit for us in the doing of the practice. We might call such a practice in practice a 'dialogically iterative' practice, in the sense that, in the course of its own conduct, those involved become better able to articulate, i.e. provide a commentary on, what they are doing in it and why.

But let us end by pointing to the radical ordinariness of our claims here. For, in wanting to draw attention to phenomena "our ordinary forms of language easily make us overlook," we have not in fact gone beyond phenomena that lie before us, open to view. So, although the practices we describe may not be easy to implement (for, like any practice, they require practicing if one is to become competent in them), they nonetheless do not go beyond everyday uses of language. For people use words everyday to draw each other's attention to aspects of their circumstances they might not otherwise notice. We, however, have set our attention directing remarks in a new context, with a new aim: that of making the subtleties and nuances we sense, in dealing with the unique relational moments which are involved in diagnostic interviews, rationally-visible, i.e. amenable to discussion and further practical study. And thus, through such remarks, bring to people's self-conscious awareness, aims, and criteria for their achievement, not previously considered possible. We have, of course, in our own (self-consciously) 'poetic' writing on occasion here, been employing some of these same practices ourselves.

T. S. ELIOT, THE FOUR QUARTETS

At the still point, of the turning world. Neither flesh nor fleshless;
Neither from nor towards; at the still point, there the dance is,
But neither arrest nor movement. And do not call it fixity,
Where past and future are gathered. Neither movement from nor towards,
Neither assent nor decline. Except for the point, the still point,
There would be no dance, and there is only the dance.

POSTSCRIPT

This paper itself, and the process of its writing, constitutes a three-way dialogue between the two authors, and a set of 'its' that also participated in its creation: one 'it' emerged in a conversation between talk of 'theory' and talk of 'practices'; another, in the shifts between the concerns of the academy and those of the clinic; while yet another 'it' emerged in crossing from life within the writing of a text to life within a living dialogue.

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