

Managing suspended transition in medicine and law: liminal hotspots as resources for change

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Abstract

This paper explores occasions where professionals in law enforcement and medicine find themselves trapped amidst the paradoxical demands of diagnostic/investigative practice. By juxtaposing research into the experiences of police officers charged with interviewing children who are the alleged victims of sexual abuse, and clinicians tasked with diagnosing and managing contested cases of thyroid disease, the paper develops an understanding of such practice paradoxes as occasions of stalled transition, or *liminal hotspots*.

Drawing on a process theoretical understanding of liminality, the analysis explores the personal, experiential and affective efficacy of the epistemological framework that both practices share. While liminal hotspots denote paradox stalemates,

the paper argues that they are also responsible for recurrent instants of temporary affective unsettledness, and as such can provoke novel thinking and agency towards innovation in practice areas notoriously resistant to change and improvement. Systematizing this property could turn them into resources for change. (147)

Keywords: Liminality; Liminal Hotspot; Medicine; Law; Thyroid Disease; Diagnosis; Interviewing Child Witnesses; Paradoxes; Suggestibility; Process Theory.

Introduction

Van Gennep (1909) originally defined liminal occasions as temporary phases of transition people undergo, as they move between different types of order, position, or identity (e.g. 'rites of passage'). Turner revived the concept giving it an ephemeral but existential/experiential quality as the "'quick'" of human interrelatedness" (1969, p. 127), conducive to the development of new structures and forms of relating. During such liminal occasions the implicit order that normally structures conduct does not apply resulting in the experience of being suspended in a "betwixt and between" (Turner, 1969, p. 95) situation. In this sense liminality characterises occasions of transition between any given form of (social) process, and constitutes a sphere of non-exclusion where both/and, neither/nor apply all at once. Alongside Paul Stenner and Monica Greco we position the concept of liminality within a process ontological

framework, differentiating between *liminal occasions*, i.e. transitions between different forms of social processes; and *liminal hotspots*, i.e. occasions of stalled transition, the experience of being “trapped in the interstitial dimension between different forms of process” (Greco and Stenner, *this volume*). For the purposes of this paper we use the concept of *liminal hotspots* and explore it based on Motzkau’s work on suggestibility as a liminal resource (Motzkau, 2007). This work captured such phenomena as practice paradoxes exposing pragmatic and conceptual ‘voids’, or gaps, in the operations of professionals working at the intersection of psychology and law, and thereby constituting rhythms of problematisation (Motzkau, 2009; 2011). This approach also resonates with Clinch (2009) that explored ‘treatment gaps’ emerging where evidence based- and patient centred logics of care collide.

This paper aims to explore, in depth, the nature and dynamic of such gaps, voids or liminal hotspots as they take hold within two different practice fields, and how they are experienced by practitioners who end up having to manage them. In doing this we wish to add to the understanding of liminal hotspots, while further mapping their analytic, practical and methodological value.

Liminal occasions in Law and Medicine

The paper is structured around two examples. The first example draws on research by Motzkau (2007). It explores the experiences and practices of police officers in England/Wales, charged with gathering testimony and evidence from children who are the alleged victims of sexual abuse. Where in the past it was custom not to hear young witnesses (they were considered unreliable due to their immaturity), a new 'child-centred approach' now stipulates hearing their evidence. Yet at the same time wariness about their reliability and potential suggestibility/manipulability persists. This turns children into ambiguous witnesses, whose evidence police officers can neither dismiss nor disambiguate. In practice it stalls children's transition towards becoming reliable witnesses (for or against) an allegation (victimhood), leaving them suspended as both/neither. Officers in turn struggle to manage this ambiguity as they become trapped amongst the colliding demands for investigative impartiality and child-centredness.

The second example is based on research by Clinch (2009) and explores the experiences and practices of clinicians who diagnose and treat hypothyroidism in the UK. Here issues emerge where fixed diagnostic parameters based on blood tests do not correspond with patients' experience (particularly where they report symptoms where blood tests indicate subclinical pathology or no pathology at all). Where in the past such a discrepancy might be dismissed (e.g. by attributing it to patients' imagination), a recent shift towards 'patient-centredness' now compels clinicians to take patients' reports/experiences seriously in diagnostic and treatment decisions. Amongst

uncertainty (and inability) of treating something that is not clinically significant, and concerns that appreciating symptoms might suggestively feed somatising patients' imagination, the diagnostic process stalls. Rather than transition towards a position of health or illness patients remain suspended as both/neither. Each case differs and individual responses may vary but the principle paradox facing clinicians who confront and manage this ambiguity is the impossible choice of administering (what they consider) inappropriate treatment for the wrong reasons, or dismissing patients' suffering, thus violating their clinical ethics and patient-centeredness.

Both of these examples play out within highly complex, emotionally charged, real life contexts that are known to challenge professionals, and that have serious, often life changing implications for those concerned. The details of this are explored in more depth elsewhere (Motzkau, 2007a; 2007b; 2010; Clinch, 2009). Exploring the examples alongside each other while adopting a liminal gaze, allows us to gain a more general perspective of how liminal hotspots operate and are experienced, without denying the important differences between the cases and practice contexts. By making visible the epistemological frameworks at play and tracing the parallel dynamics of processes and stalled transitions, we hope to gain a detailed picture of the shared issues practitioners face. By illuminating the dynamic that underpins liminal hotspots, we also explore how they might act as a potential resource for change in these, and similar other situations of stalled transition. We suggest that liminal hotspots can provoke novel thinking and

agency towards innovation in practice areas notoriously resistant to change and improvement.

To frame our exploration we would like to highlight two commonalities in the epistemological framework underpinning both practices: the liminal role of suggestibility and the bifurcation of nature within modern scientific epistemology.

Suggestibility and the modern territory: practices of the body versus practices of the mind

Both medicine and law operate within what Stengers (2009) has called the modern territory. They follow the logic of western thought where the appreciation and evaluation of truth/evidence is predicated upon the distinction between the subjective (mind/experience), and the objective (matter/body). This framework is based on what Whitehead (1927-8[1985]) criticised as modern sciences' bifurcation of nature into 'objective causal nature', i.e. hard incorruptible matter, and 'subjective nature', i.e. fickle/corruptible experience. Accordingly contemporary epistemological orthodoxies of scientific practice imply a split into practices of the body (matter), and practices of the mind (subject), with the latter considered of inferior factual value.

Suggestibility also emerges as a key factor embedded within these practice situations. When attempting to correctly gather and evaluate evidence (legal/medical),

what practitioners struggle with, and attempt to manage, is the constant threat of suggestibility; the fear that the truth of disease or abuse they are trying to evidence/discount, cannot be reliably extracted from the body, and might become compromised, obscured or contaminated by the malleable minds of children or somatising patients in the diagnostic/investigative process. Suggestibility injects ambiguity into the question of 'how we know ourselves and others reliably', and how we communicate and evaluate such knowledge in the context of relevant epistemological and practice frameworks (science/medicine/law). Where these frameworks are designed to disambiguate information by ordering it alongside practices of the mind and the body, suggestibility has a track record of challenging or short-circuiting such distinctions, signifying their volatility and recurring collapse.

Since suggestibility first featured as a topic for the nascent discipline of psychology it presented a paradox. Being 'suggestible' was on the one hand considered an expression of manipulability and irrationality (McDougall, 1911), a characteristic of an inferior mind, attributed to women, children and colonial subjects. On the other hand, the 'ability to be suggestible' was considered the most fundamental characteristic of the human mind, the *sine qua non* of human existence, accounting for the possibility of learning as well as for that of affection and social cohesion (Sidis & James, 1919). Within this paradox suggestibility exposes the intrinsically liminal issue of how we relate (being permeable/perceptive) while maintaining our integrity/authority as

autonomous beings; how we know, while continuously compelled to reaffirm such knowing in relation to external frameworks, ourselves and others. Motzkau (2009) termed this the 'paradox of the psychosocial'. In the early 20th century this paradox was obscured through the privileging of the definition of suggestibility that posits it as a characteristic of an inferior mind. This definition gained traction over others as it fitted with the then dominant paradigm of the modern sciences and confirmed the boundaries that had just been drawn up between the disciplines (medicine, biology, psychology and sociology). Yet, wherever it emerged, suggestibility continued to betray the modern territory, troubling bifurcated knowledge practices, and in this sense constituting a liminal resource (Motzkau, 2009).

Law: child witness practice in suspended transition

Over the past three decades child welfare/protection services in the UK have periodically been in crisis and subject to repeated far reaching reforms, and critique of the ineffectiveness of such reforms, in the light of the recurring need for serious case reviews and persistently low conviction rates for cases of sexual exploitation, abuse, rape and neglect (Spencer and Flin, 1993; Motzkau, 2007a; Plotnikoff and Woolfson, 2005; Radford et al, 2011; Featherstone et al, 2014). Here it is important to note that the question whether and how children should be heard in regard to welfare/justice

proceedings concerning them, and what weight should be given to their evidence/account, has a long and chequered history that is closely linked to the re-emergence of suggestibility as a research topic in psychology (Motzkau, 2010). Until the late 19th century in most industrialised countries children (under 10s but often including those under 14/15 years of age) were not considered reliable court witnesses. In England/Wales children were restricted from giving evidence as witnesses in criminal courts by 'corroboration laws' (requiring an adult eyewitness to corroborate children's statement). The law was abolished in 1988 as a result of growing awareness for the prevalence of sexual violence against children, and the insight that corroboration laws made the prosecution of a crime as secretive as child sexual abuse virtually impossible (Spencer & Flin, 1993). Further, in 1990 the UK signed and ratified (1991) the UN convention of children's rights (General Assembly of the United Nations 1989), which specified that children needed to be heard in all matters concerning their own welfare and justice.

By the early 1990s children were admitted as witnesses more frequently but courts in Northern America and parts of Europe (e.g. England and Germany) saw a number of high profile miscarriages of justice in child abuse cases. These hinged on evidence given by children, who had been questioned in a highly suggestive manner by well intentioned but overly zealous investigators and/or parents (Ceci & Bruck, 1995; Bell, 1988; Bull, 1998; Steller, 2000; Lee, 1999). These cases attracted wide media

attention and sparked a sudden and intense research interest in children's suggestibility. Suggestibility, which had not featured in research agendas for almost half a century, now re-emerged as synonymous with children's dubious memory performance and manipulability (Ceci et al, 1994). This again undermined perceptions of children's credibility as witnesses, while the notion of suggestibility added a fresh layer of ambiguity to the already complex work of investigating child abuse.

First, while concern about children's reliability as witnesses persisted, the presupposition had changed. The issue was no longer children's presumed lack of moral maturity and consequent propensity to lie or fabricate (i.e. immaturity of the mind/soul), but now an immaturity of the body, a physiological immaturity, was considered responsible for them being 'unreliable containers' of memory. *Second*, suggestibility introduces a sense of volatility and inadvertent contagion, which is hard to predict or control, showing children as ambiguous dispensers and volatile interactants. Given children are not considered reliable arbiters of their own memory/experience, external criteria/practices were needed to stabilise and verify what they reported. *Third*, this turn to physiological immaturity highlighted children's general vulnerability, and by 2000 this triggered calls to again bar children from giving evidence; but now this demand was made in the name of childrens' protection, as the experience of giving evidence was considered harmful (Motzkau, 2010).

This brief outline provides a sketch of the emergent and shifting societal frameworks and discourses that constitute the liminal hotspot emerging around child witnesses. Now taken seriously as witnesses, the system demands for them to speak, but at the same time it remains uncertain as to how they can be heard, what the consequence of their speaking should be, and what weight to give to their evidence. This leaves child witnesses suspended between speaking and silence, justice and protection: When they speak up within justice processes, this speaking produces ambiguous evidence; when they remain silent out of choice or in the name of their own protection, justice processes are unlikely to proceed, which in turn undermines child protection if it means perpetrators cannot be prosecuted. Unable to transition out of their position as alleged victim/ambiguous witnesses they can remain suspended amongst doubt (including self-doubt) over their potential experience of victimisation; an experience of suspense that in itself is likely to be profoundly traumatising while undermining coping and personal development. What does this mean for those who encounter and end up having to operate around this liminal hotspot?

Managing children's ambiguity: police officers' liminal hotspot

To address the demands of the 1989 UN convention of children's rights, and in response to the continuous crises in child protection, legislators in England/Wales have since the 1990s embarked on a sustained programme of reforms. These include the introduction of special measures designed to enable children to provide evidence admissible to criminal courts, while accounting for their intellectual/developmental immaturity and vulnerability to suggestion, as well as aiming to mitigate potentially adverse effects of giving evidence (Motzkau, 2007a).

The most distinctive measure introduced is the video recording of investigative interviews (first formal interview police conduct with a witnesses), alongside special guidelines and training for police officers who conduct interviews. The video recording(s) are passed on to the prosecution service for consideration as evidence. If the case goes to court the video can be shown in court to replace a child's evidence-in-chief, sparing them at least one of several potential court appearances (they may still be called for cross-examination). The interview guidelines have changed over time and training differs across the country, but generally officers learn about children's vulnerabilities, specific questioning techniques, the importance of rapport building, and are alerted to the dangers of suggestion.

We argue that this response to child witnesses' ambiguity constructs this ambiguity as a matter of the body: capturing and preserving the child's statement as soon as possible on video addresses the problem of children's memory as if it was

indeed a matter of extracting contents swiftly from an unreliable container (brain) before they degrade with time (are forgotten) or are corrupted by internal processes within the child's mind. Further, the guidelines and training reflect the idea that collecting this content requires special care and skill, as it could be contaminated in the process (e.g. by suggestion). In this sense the framework that organises this practice is modelled on a forensic discourse of 'hard' evidence akin to the way physical traces would be gathered and secured to provide safe/admissible evidence. Herein interviewing is set up as a practice of the body, implicitly likening it to a skilful collection of items from a container. In this sense, the special measures (video interviewing etc.) constitute a 'ritual' that frames the liminal occasion of the interview, and provides tools for officers to manage child witnesses' ambiguity, to make them 'reliable witnesses' (be it for or against an alleged incident). Yet, looking at practitioners' accounts of this practice in process a more volatile dynamic emerges.

The excerpt below originates from research into child witnesses practices in England/Wales and Germany (Motzkau, 2007b). The data shows an exchange between a training officer (TO) and a police officer (PO) on a training course in England. The training officer has just clarified the overall agenda for the interview: it should be a neutral and open minded inquiry into what happened, in short, as they collaboratively agree, an 'ethical search for the truth'.

TO: [...] but at the end of the day we want to know what's happened regardless of whether it's what we want to hear or what we don't want to hear really (1) it's ahm (2) what's the [??] terminology? (2) ahm ethical search ahm ((PO2: search for the truth)) search for the truth (1) that's how we describe it

PO: that is right and it has to be ethical (1) you you (1) I think we've all' it again everybody must have fallen foul of being encouraging and they're just like you say tell you what you want to hear (1) and you go back with that and then you sort'f look at it in the cold light of day and you think (.) ouchh °it's completely wrong° (1) and you've also been in court when you are sitting watching your video thinking ohh °god did I say that?° and you are being encouraging and it's supposed to be relatively cold (2) but sort of you've got to be friendly enough to get the information

The concept of an *ethical search for the truth* relates to the neutral stance that defines investigative practice, prohibiting personal interest or preconceived ideas to avoid suggestion. This alludes to the modern scientific stance of the 'disinterested observer' and experimenter who must not be seen as the author, but merely the passive receiver/observer of evidence that in turn 'speaks for itself' (Haraway, 1988).

The excerpt illustrates what can be termed the ‘rapport paradox’. To communicate we need to be open/attuned to one another. This goes both ways and here rapport, considered particularly important for child witness practice, means a friendly interviewer attuned to children’s potential needs and misunderstandings, taking an interest in their case. It is hoped that this will create a receptive child witness who trusts the interviewer enough to cooperate and offer information while being able to clarify misunderstandings. In an everyday context this is unproblematic, but as part of the ‘ritual’ encounter of the video interview this process collides with the process of disinterested, safe collation of evidence. Officers have learned that where children are concerned it is precisely the attunedness/cooperativeness that provides fertile ground for suggestion. While one might suggest officers should find a balance between ‘friendliness’ and ‘coldness’, the excerpt illustrates that in practice this is difficult, as there is no direct measure for too much, or too little rapport. Indicating that this is a commonly experienced paradox, the police officer highlights how “everybody must have fallen foul of being encouraging” during the interview, ending up with children “just saying what you want to hear”, and realising once the video is submitted that “it’s completely wrong”. Further, the stakes are high as far as officers are concerned, because in the account of the police officer it is always a post-hoc evaluation of the interview that is felt to reveal its inadequacy. This means that, regardless of the true/potential suggestiveness of their interviewing, even perceived suggestiveness may undermine the

impact of a child's evidence. For the police officer it is the spectre of a prospective audience and their potential gaze, that makes him cringe as he assesses his performance with their eyes "sitting in court watching your video thinking 'ohh god did I say that?' and you are being encouraging".

Rather than tackle or remove children's ambiguity, the special measure involving video recording amplifies ambiguity by enabling a direct transmission of the interview situation into a later contexts. In this way it broadcasts the collision between the process of good interviewing and that of generating good evidence. This in turn makes the collision not just visible to later audiences but also particularly tangible for officers, while leaving them unable to resolve it. They are themselves caught in a liminal hotspot vis-à-vis child witnesses, suspended between processes of caring/relating in order to 'conduct the interview well' and processes of performing the stance of the disinterested observer who skilfully allows evidence to 'speak for itself' ensuring its integrity. Rather than being managed, the effects of children's ambiguity, and thereby officers' own emergent liminal hotspot, communicates itself to the officers via the omnipresent but vague threat of suggestibility.

For officers the liminal hotspot is only temporary though, because their practice as such does not stall or collapse, it proceeds while they experience the hotspot and are then forced to find ways of glossing over it to move on regardless. But this comes at a cost. Looking at the way this data expresses their experience of practice in process, we

notice the affective dimension of this liminal hotspot. Here the officer's allusion to temperature is interesting as it highlights how he frames the interactions in relation to a modern scientific understanding of 'cold hard facts' versus 'friendly/warm/subjectivity'. The officer talks about the "cold light of day" that will reveal an interview's inadequacy; or later, refers to being "relatively cold" when outlining the stance the interviewer should take to get hard evidence. At the same time the personal affective tension felt as they experience the collision of processes (and collapsing frameworks) is expressed as visceral embarrassment, illustrated by groaning (e.g. "ouch") or exclamations (e.g. "oh god did I say that"). Evidently this is not something they can push aside easily. It resonates with them as they feel the 'heat' of the paradox via the impossibility of conducting their 'search for the truth' in an ethical, cold and at the same time warm and friendly manner, driven by the firm commitment to do right by child witnesses who are bound to be confused and anxious regardless of the nature of their case. The resulting 'damned if you do damned if you don't' scenario means officers might approach interviews with the expectation that there is no way to get it right. Often they might err on the side of caution, operating defensively, with interviews being conducted 'by the book', in a 'cold' formulaic fashion that is unlikely to generate much detail. Low expectation of their own efficacy also means this work is considered unrewarding while carrying high risk and personal cost. As a result there is high

attrition in this area and some officers report deliberately de-skilling themselves to avoid being called up (Motzkau 2007a, 2007b).

While carrying out their duty, officers preside over the repeated paradoxical collapse of their own practice in the process of performing it. This happens because the criteria and principles that organise what is set up as a practice of the body short circuit with, or are invaded by, the practice of the mind they meant to control/exclude. While officers can gloss over it and move on within the legal process, it affects them emotionally, through repeated exposure, and shapes their expectation of their efficacy and professionalism.

Medicine: Diagnostic practice in suspended transition

Millions of people, largely women, all over the world suffer a seriously impaired quality of life and even early death because of undiagnosed, misdiagnosed or under-treated hypothyroidism. They are denied treatment, told they have chronic fatigue syndrome, which can't be treated, or not given enough hormone or the right type of hormone to make them better. This situation borders on an abuse of civil rights and gender discrimination. How many men would be told symptoms are all in your head? (Thyroid UK, 2013).

This statement from a recent petition calling better treatment for hypothyroidism stands in stark contrast to the opinion held by many medical professionals tasked with diagnosing and managing thyroid disease in the UK (Clinch, 2009). For instance, in an account by a Consultant endocrinologist interviewed as part of an ethnographic study of a NHS thyroid disease outpatients clinic, it is stated that the diagnosis and treatment of thyroid disease “should be easy” as thyroid function “either goes up or it goes down”. From this perspective it is a simple and clearly identifiable pathological process that is easy to diagnose and treat (in the case of hypothyroidism via a synthetically produced thyroid hormone replacement that is taken orally).

Hypothyroidism is a common endocrine disorder that effects 1-2% of the population in iodine replete countries, is more common in older women, and ten times more common in women than men (Vanderpump, 2011a). Hypothyroidism occurs when the thyroid gland can no longer produce sufficient thyroid hormones (thyroxine and triiodothyronine). As the thyroid gland controls metabolism throughout all cells in the body, the symptoms of hypothyroidism are wide-ranging, presenting as non-specific and insidious, which makes them hard to communicate and quantify. Ranging from fatigue, weight gain, sensitivity to cold, physical/mental slowness, hair loss, dry skin, low mood, loss of libido and fertility problems, they do not just point to many other pathologies, but are also identical to adverse experiences any healthy individual might encounter at one time or another as a result of life’s challenges.

First described by Queen Victoria's personal physician Sir William Gull in 1873 (Gull, 1873), historically the disclosure of symptoms by patients and the observation of clinical signs by clinicians was crucial for diagnosis of hypothyroidism. Yet, in the early 1960's the first rudimentary thyroid function test (TFT) was developed, which has become the diagnostic gold standard (Association for Clinical Biochemistry et al, 2006). The drive for diagnostic technologies such as the TFT has helped transform diagnostic decisions from, what came to be considered, capricious affairs guided by the potentially flawed mind and judgments of clinicians, into decisions based on the scientific evaluation of reliable diagnostic evidence (Berg, 1999). Moreover, in the case of diagnosing hypothyroidism, this transition from eminence-based to evidence-based medical decision making also clears up what was perceived as another threat to a sound diagnosis: the subjective evaluation and report of the notoriously insidious and non-specific symptoms and signs of hypothyroidism by patients. Thus current best practice guidelines for the diagnosis and management of thyroid disease state that a diagnosis can only be made with certainty through a TFT, which compares present hormone levels to a 'normal range' ascertained from a reference population of healthy individuals.

The changeable role and prominence of patients' experience and clinicians' interpretation in the process of diagnosing thyroid disease mirrors the shifting value of patients' voice/experience in the history of medical consultation more generally. Jewson

(1976) declares that from 1770 onwards, as medicine aligned itself with the natural sciences, the 'sick man' began to disappear from medical cosmology. Significantly this process resulted in a transition from symptoms being viewed as the "raw materials from which pathological entities of medical theories were constructed" (Jewson, 1976; p. 624) to being considered unreliable evidence, indicative of the fact "that the fundamental realities of pathologies' are located in "microscopical events beyond the tangible detection of patients and practitioners alike" (Jewson, 1976; p. 629). This cosmological transformation is reflected in the development of diagnostic techniques for hypothyroidism where symptoms have gone from being considered 'the disease' to a weak form of evidence that may or may not suggest the presence of pathology. This in turn fundamentally changed how clinicians and patients related to another. In response to this emergence of the cosmologies of hospital and then laboratory medicine, over the course of the 19th and 20th century, the patient and their experiences increasingly became considered a problem obfuscating the clinical gaze and jeopardizing the accurate diagnosis of pathology.

However, in line with the emergence of neo-liberal technologies of governance that regulate the vitality and conduct of populations at a distance (Rose, 2006), the health systems of advanced western liberal societies have in the late 20th century come to adopt a patient-centered, or choice based, logic, of health care practice (Mol, 2009). This logic posits that patients should be supported and encouraged to become

knowledgeable about, but also responsible for the maintenance and maximization of their own health. Through a range of health care policies (e.g. NHS, 2012) and shared decision making techniques (May et al. 2006; Edwards and Elwyn, 2009) patients are now enabled, and compelled, to choose ways of managing their health in partnership with healthcare workers. As a result of these developments the patient has reappeared as a figure that is considered central to the clinical encounter. Good diagnostic practice now requires that patients' experiences of symptoms are heard and considered as part of reliable diagnoses, effective treatment and care.

Returning to the specific case of thyroid disease it is, on the one hand, clear why clinicians today might consider the diagnosis and treatment of hypothyroidism 'easy': the TFT is seen to offer an easily obtained, objective, incorruptible truth of disease (i.e. independent of patient experience and clinicians' interpretations). On the other hand, the recent emergence of patient-centredness has re-emphasized the role of patient experience and voice for the diagnostic process, undermining clinicians' ability to solely rely on the TFT; this adds ambiguity particularly where TFT results and patient experience do not match. The ambiguity is illustrated by the recent emergence (since the late 1990s) of a sizable and vocal minority of patients and sympathetic clinicians who feel that TFTs, and the population based reference ranges of healthy/unhealthy function that calibrate them, may be inaccurate and are relied on too heavily resulting in failure to diagnose and manage the disease in some patients (see Owen and Lazarus,

2003; Vanderpump, 2003; 2011b; Walsh, 2002; Wiersinga, 2011 for an account of this debate). These interlocutors claim that a reliance on blood tests and the low evidentiary status ascribed to reported symptoms ignores the suffering of patients who sit on the borders of (or even within) biochemically defined 'normal' levels of thyroid function, but who still experiencing serious symptoms. This is why some patient groups argue that established biomedical knowledge practices had resulted in a form of structural violence, refusing treatment to those who need it (see introductory quote).

This captures the liminal hotspot these patients find themselves in. They are suspended and cannot transition to a position of illness or health; they are caught amongst processes that (as in this case) declare them healthy (TFT) and their experience of illness. This would have been true prior to the introduction of patient-centredness, when patients are likely to have remained silent about their incongruent experience. But now the fact that patients' experiences are explicitly demanded, while their role remains unclear, seems to perfidiously add to the intensity of the hotspot. That is, in the eyes of practitioners it might be a patients' insistent reporting of symptoms, that confirms the clinical invalidity of these reports and the subsequent interpretation that they are proof of a psychological rather than a physical problem (Daggert, 2000).

Further, looking at practitioners' reflections we can see that placing patient experience alongside biochemical markers also complicates the diagnostic encounter from their perspective. Where in the past patients within the thyroid reference range

who reported symptoms could be ignored, or repositioned outside of the remit of medical expertise, clinicians now have to take account of what patients say. Yet, as with child witnesses, concern about the validity and consequences of such accounts persists as the modern scientific framework that underpins medical knowledge practices has not found a way to accommodate them. In the following we will explore in more detail how clinicians manage diagnostic encounters where evidence –based and patient-centred logics of care collide.

Managing patients’ ambiguity: Clinicians’ liminal hotspot

When confronted with this collision of processes clinicians often resort to elaborate re-framings of evidence to discount patient experience. According to one clinician interviewed for Clinch (2009) patients who report symptoms incongruent with the TFT are “nutters” “who are desperate for a physical label”. He suggests that they tend to have “a lot of psychopathology” around them, thus their ‘thyroid like’ symptoms are not caused by an underlying organic pathology, as proven by their ‘normal range’ blood tests. This clinician disambiguates the paradox presented by clashing processes of clinical decision making by undermining the validity of patient experience.

This method of managing ambiguity again leaves patients suspended between health and illness, still taking their insistence as proof of their somatization (Greco,

1998). But as outlined above, herein patient-centredness appears to add to the perfidiousness of the suspense. Patients are promised that their experience will be taken seriously, heightening their expectation of being heard, but where clinicians' retreat into the modern territory again undermines this promise, potentially compounding their despair, and fueling their suspicion that there is something wrong which is not being recognized.

For clinicians the move towards patient-centredness, and the subsequent retreat into the modern territory as a means of managing it, comes at a cost. Reflecting on consultations in which the incongruence between TFT and patient experience becomes apparently unmanageable, one clinician interviewed indicates that his aim during these interactions was basically "escaping alive". This clinician also reflected that he felt like he is never going to be able to give these patients "what they want". This provides a first glimpse at the liminal hotspot clinicians are finding themselves in as part of this practice. Further, this frustration, discomfort and apparent giving up on professional ethics (that command helping patients) in the face of an insurmountable paradox, resonates with the experience of police officers.

The following excerpt from research data (Clinch, 2009) indicates that there are more nuanced ways to address the colliding processes of evidence-based and patient-centeredness. Here a Consultant, who runs a secondary care thyroid clinic (UK), outlines a more involved, positive, but also complex and risky approach to managing

patients' ambiguity. By differentiating three levels of practice, the strategies available to mediate the ambiguous relationship between 'the truth' of hypothyroidism (as a discrete pathological entity) and the experiences of this truth by individual patients (through symptoms), are multiplied.

There's something about measures of disease (1) they need to be matched with (1) it's judgement (2) they need to be matched with patient preferences. Well, the way I think of this is that if I'm writing a national guideline, you have to be very black and white in what we say so that's what I call the macro level, ie, you're talking about a big population. You can then go down to the micro level, which is you in your own hospital and what you might do here, as you might [unclear] and then the nano level is what you do with an individual patient in your office. So, I do different things, at three levels so there are things that I would do in a one to one that I almost keep between me and the patient, I would never broadcast because I know no-one else across the company has done that. But, I do have strict rules, I don't give T3 and I don't natural thyroid extract so I keep those rules, but anything else, a lot of the time it's all psychology and I'm thinking, well, I know that moving their TSH from three to one will make no difference but I'm going for the placebo effect. [...]

The problem with the placebo effect, you might say well, why don't we just use it then is that it's [...] it's not sustained. So, if you have a bad relationship with your

husband and you attribute that to your thyroid status, if you correct that thyroid status and you believe this will [inaudible]. If you have a bad relationship with your husband, a year or two later it's going to reappear so I just think there's something fundamentally wrong in a sense, fooling a patient for not making them address what is the issue.

Here the clinician breaks down the levels, or modes, of engagement. He differentiates between processes dictated by the objective scientific register of clinical practice guidelines (macro level), processes of the actual practice within his hospital (micro level), and processes of interaction that occur between him and individual patients (nano level). Operating very differently at each of these levels (“...I do different things, at three levels”) offers more opportunities to take patients' experiences seriously, while apparently remaining within the biomedical frameworks of evidence based decision-making. The ambiguity between the processes is addressed by severing the link between 'macro-level' scientific criteria and processes within his clinic. This enables the clinician to go a long way with what the patient wants ('...but anything else, a lot of the time it's all psychology...'), even if 'going for the placebo effect', to ensure there is a 'match' between the 'measures of disease' and 'patient preferences', which he considers important to help patients, as he outlines at the beginning of the excerpt.

Yet, these maneuvers are extremely intricate and risky. By using the term ‘patient preferences’, rather than maybe ‘reported/experienced symptoms’, the clinician implies that patients make a choice to feel unwell by interpreting various physical sensations as the symptoms of hypothyroidism. While appreciative of their experiences, this still undermines the diagnostic validity/relevance of patient experience. But rather than having to dismiss patients as ‘nutters’, and resigning to not being able to help them, this clinician manages inclusion by carefully positioning patients as customers whose preference he respects while maintaining his clinical authority. This allows patients’ experience to feature in the diagnostic/treatment process while at the same time implicitly devaluing it to maintain the superiority of the scientific medical diagnostic framework which guarantees the clinician’s own authority. This is underlined by the clinician’s indication that a degree of secrecy is required, as he confides not wanting to ‘broadcast’ what might go on in his “office” (“...keep between me and the patient, I would never broadcast...”), implying this might undermine his authority and role in “the company”. Further, the term “placebo effect”, indicates that the clinician does not consider matching patients’ preferences as biomedically justified, but sees it as a way of prompting patients into feeling better. That is, by prescribing thyroxin and “moving their TSH from three to one” (both within the normal range of biochemical function) patients feel that they are being taken seriously, and as a consequence, might improve. Concomitantly, he can guard the scientific integrity of an objective and

biochemically articulated version of hypothyroidism by not prescribing a dose of thyroid hormone replacement that will risk patient's thyroid function operating outside of the biochemically articulated 'normal range' of healthy function.

Still, the clinician's oscillations illustrate his own suspension amongst the colliding processes. He ultimately states that this kind of fix is 'not sustained'; and consequently he is troubled by the fact that there is something 'fundamentally wrong' with 'fooling' patients as it distracts from potential real problems and might even make things worse. This clinician then is suspended between his own conscientiousness and attempts to stick with patients and their experiences, and his adherence to what he considers the biological truth of thyroid disease, which makes him doubt that 'fooling patients' is actually doing them a favour.

No matter which approach they chose (overt or subtle bifurcation) clinicians are exposed to their own liminal hotspot. The objective processes guided by practices of the body are invaded by practices of the mind they can neither control nor dismiss. The concern that clinicians' appreciation of patients' incongruent experiences might make them worse resonates with the idea of contamination and suggestion. As with the rapport paradox, clinicians may worry that their attempts to understand, alleviate and absorb the distress they encounter, might also contaminate the evidence further in the sense that it makes it harder for patients (or clinicians) to find what they would consider the actual origin of distress.

Clinicians encounter their liminal hotspot regularly, but each time it is temporary. They find ways of ensuring practice itself does not stall, by glossing over and working around it. But unable to actually manage the ambiguity, this positions clinicians in a ‘damned if you do damned if you don’t’ scenario they cannot brush aside easily. The liminal hotspot recurs regularly and working around it comes with the emotional cost of experiencing patients’ despair while knowing the help offered inevitably falls short of patients’ needs or might even make them worse (e.g. continued somatization)

Liminal hotspots as resources for change

Our aim was not only to draw attention to the characteristics and experience of suspended transition, but also to illustrate how new forms of process are already emerging through the work of practitioners who inhabit these notoriously intractable practice situations.

Both our examples illustrate how moves towards child- and patient-centredness have contributed to amplifying the ambiguity between mind/body (subject/matter) leading to a proliferation of liminal hotspots. Yet, changes in practice resulting from child/patient-centredness have meant that the ambiguity does not rest solely with child witnesses/patients anymore. The fact that children and patients are not required to participate in the practices discussed here, means that encountering and managing

ambiguity has become an intrinsic part of practitioners' personal/professional duty. As a result liminal hotspots form part of practitioners' own professional experience. While practitioners find ways to overcome any functional collapse and keep practice moving, we can see that in both cases this comes at a personal and emotional cost. Figuratively speaking practitioners are left to absorb some of the 'heat' (Greco and Stenner, *this volume*) generated by the liminal hotspots they regularly find themselves in.

Yet, as we can also see, they have nowhere to put that 'heat'; it generates what we could call a 'homeless affect' (Kofoed and Stenner, *this volume*) in the sense that for police officers the personal interest in the case/child that is required for the 'rapport' of care, is also strongly discouraged by the ethic of objective disinterest. So the commitment/urgency they feel for doing their best for witnesses has no systematic use or outlet within this practice; and neither has the frustration about feeling 'set up to fail'. The same applies for clinicians who have nowhere to direct the dissatisfaction with being compelled to listen but unable to hear. The repeated and routine exposure to that 'heat' and the cumulative impact of experiencing the resulting homeless affect, makes it difficult to ignore the hotspots, making them tangible and personal (e.g. one clinician talks about feeling that all he wanted was 'escaping alive'). This could go some way to explain why some abandon the practice altogether or take a formulaic approach (for an overview see HM Crown Prosecution Service Inspectorate and HM Inspectorate of Constabulary, 2014), while those who remain are likely to grasp for some kind of

response (as indicated in our excerpts). We argue that in generating this unsettledness the liminal hotspots are also resources for change, opening up a space for creative or even subversive dynamics to emerge and take hold. While societal change has made it impossible not to listen to child witnesses/patients, it is the resulting encounter of professionals with their own liminal hotspots that generates the personal urgency/dynamic that drives (potentially creative) rifts and shifts in practice.

To illustrate this we return to the second data excerpt. Looking at the clinician's account we cannot know how far he considers the diagnostic encounter around hypothyroidism a paradox, that is, given his disclaimer about his approach being just a 'placebo' we might conclude he remains firmly anchored in a modern scientific framework. But, as the data illustrates, he is not comfortably anchored there anymore. Despite there being no formal pressure to do this, he feels compelled to invest considerable effort into the disjointed operations he describes as working on different 'levels', in an attempt to attune the interaction allowing a more complete inclusion of patient experience, even if just to a certain point (i.e. not publicly and framed by the placebo disclaimer). Further, he does this despite declaring that it is 'not sustained' and ultimately a flawed approach that does not get at what he considers the 'truth' of the matter. We argue that it is the discomfort, or unsettledness, generated by the 'heat' of the liminal hotspot, that makes him inclined to oscillate between dominant and other potential (not quite formed) processes or modes of diagnosis and care. It is the liminal

hotspot that creates the urgency that drives this. Crucially, in doing this, the clinician allows a version of the diagnostic encounter to occur that sits awkwardly with the traditional approaches, and in doing so, opens it up to the realm of potentiality.

We do not wish to suggest that he consciously invites, or generates, such potentialities, but the mere occurrence of the encounter under changed parameters allows, in the instant, new ways of relating to occur and matter (whether or not these are realised or perceived by those participating). Looking at the excerpt we can see that what emerges, for a moment, is the possibility of an ontologically different hypothyroidism, one based on a more integrated perception of the patient as a concurrently experiential and physiological being. Further, from our analytical viewpoint, his reflections inadvertently summon the possibility of a truth of thyroid disease that is accomplished through the encounter, as a result of relational dynamics, rather than a distinct object that is captured by a biochemical test. These are not things the clinician says in excerpt two and we do not claim he does; but these are emergent potentialities that can be glimpsed by examining the fringe practices he allows to occur as a response to being suspended between colliding forms of process. We argue that potentialities of an alternative process of diagnosis and health care emerge in that they can be meaningfully speculated about, and in this sense edge towards reality, even if at this point only by virtue of being identifiable in our analysis; as noticeable ripples in the diagnostic encounter. A central merit of analyzing liminal hotspots then is the

identification and amplification of such emergent (if temporary) potentialities. Taking such an analysis back to participants (e.g. clinicians) for discussion, and suggesting alternative views on what they are (inadvertently) already doing, could create circumstances under which such alternative modes of understanding and conducting practice, are appreciated systematically and become reality. Given practitioners, in our and other contexts, are already unsettled within their traditional professional approaches, they are likely to be open to such reflections.

In the face of intense patient protest this might seem an intangible step. Further, issues around professional hierarchies and the dominance of existing guidelines may undermine the efficacy of such new ideas and the manner in which they can be shared. Yet, as we can see reflected within the clinician's experience (see excerpt 2) the unsettledness is significant; his position towards the whole issue seems ready to shift but it is not clear where to; he is not just routinely experiencing the normal diagnostic framework as volatile, but he is also regularly operating outside of it. Clearly he is not going to re-write the clinical practice guidelines tomorrow, but it is likely that a number of other practitioners, all exposed to this liminal hotspot, are also beginning to grasp for alternative approaches to knowing and doing hypothyroidism, thereby opening up spaces for emergent potentialities as well, generating momentum for change/dissolution within, that could be amplified and nourished. This 'opening up' and 'unsettling' is the

generic characteristic of liminal hotspots that needs highlighting and exploiting systematically, and that can be observed similarly within child witness practice.

In the case of police officers this temporary emergence of alternative potentialities is more difficult to observe, as it is more implicit. This is because officers operate at the bottom of their practice hierarchy, in a context that is, for good reasons, highly regulated and transparent, so they have little room to explore new approaches and feel it is risky to do so. (In contrast to this the patient/doctor interaction is protected by confidentiality rules.) Yet, research interactions (Motzkau, 2007b) have shown that repeated exposure to the liminal hotspot, makes some officers aware of the importance of aspects they are meant to suppress; e.g. realising that all witness evidence is in good part a collaborative product of the interview encounter, no matter whether it is based on the witnesses' true experience or the inadvertent (or deliberate) result of coaching. This is a step towards seeing the truth of 'witness evidence' less as a 'stable object to be found', and more as a relational (yet robust) expression of an actual experience that is allowed to emerge as a result of good interview collaboration. Being able to see their role as active, while non suggestive, could improve officers' confidence in creating rapport and conducting interviews, while the need for more training and support might become evident. This idea is not new. It already resonates within the police officer's account of the rapport paradox in excerpt one, and in a past practice of involving social workers directly in the gathering of evidence (which has fallen out of use). Further,

recent high profile cases of historic child abuse have also (for the first time) resulted in recognition of the personal cost of this work for police officers, suggesting more support and supervision are needed. This seems a minimal step, but highlights the astonishing fact that so far interviewing a child about sexual exploitation was considered a normal part of PCs routine practice envelope.

It is clear then that the potentialities expressed within liminal hotspots, and the possible shifts facilitated through research, analysis and feedback into practice, are not grand reforms or reversals of practice. They are gradual shifts enabled by the systematic exploration and amplification of already unsettled practices and building on the readiness of practitioners who are already aware of-, and troubled by, the persistent incongruences in their practices.

Outlook: Towards a liminal methodology

The discussion of liminal hotspots' efficacy as resources for change is corroborated by other research into suggestibility's efficacy as a liminal resource, producing practice voids akin to the hotspots examined above (Motzkau, 2009; 2011). In this paper we have detailed the features of liminal hotspots as they emerge and are experienced by practitioners in process; how they open volatile spheres where rules of dominant processes do not apply, and that are conducive to producing new ways of relating, in

turn generating a dynamic that can compel practitioners to operate at the fringes of their own fields. While liminal hotspots generate the affective unsettledness and urgency that pushes practitioners to seek alternative modes of operation, it is the systematic analysis of such hotspots that might, if communicated carefully back relevant interlocutors, amplify and facilitate gradual and productive shifts in practice. That is, is by amplifying, or even summoning, glimpses of alternative understandings that are already implied within practice. Such ‘pattern shifts’, as Greco & Stenner (*this volume*) call them, cannot be minutely planned for or predicted, but they can be discovered, facilitated and nurtured as we hope to have demonstrated. Such approaches need further development and research into methodologies that can systematically reveal, amplify and propagate the properties of liminal hotspots is required to fully realise their efficacy. This could mean to either collate and amplify them (where they are found within practices), or deliberately stage them within practices to generate these dynamics. Motzkau (in progress) is currently developing a version of such a methodology, termed ‘researching practice as process’ (see also Lee & Motzkau 2013). Clinch (in progress) is using the concept of liminal hotspots to explore and manage the difficulties and tensions experienced by interdisciplinary teams of Life Sciences researchers tasked with understanding the relationship between the social and biological factors that impact on health.

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