

# Pointe of no return: perspectives on dancer-clinician communication

*I explore the complex interplay between dancer identity and dancer-clinician communication in the context of illness or injury, drawing on qualitative interviews with former professional dancers whose careers were prematurely ended. I highlight how systemic power imbalances in the dance ethos foster habitual deference. Many dancers feel misunderstood and unheard by clinicians unfamiliar with their unique needs. The narrative approach reveals the profound biographical disruption caused by career loss, compounded by inadequacies in conventional approaches to medical consultation. The study underscores the importance of empathetic, bilateral communication and advocates for reform in the dance profession and clinical education, proposing that dancers be empowered with better knowledge of their bodies and that clinicians cultivate greater understanding of dance-specific issues. Ultimately, the article calls for a reimagining of Dance Medicine as a collaborative, prestigious field capable of addressing the nuanced challenges faced by this specialised population.*

## Keywords:

Dance injury, Dancer-clinician communication, Dancer identity, Dance training, Dance Medicine, Clinician Empathy, Biographical narrative, Biographical disruption, Power imbalances in dance

## Introduction

The study on which this paper is based forms part of the research for my doctoral thesis, and presents an interpretive, qualitative, perspectival view of three widespread problems in dance and in the medical treatment of ill or injured dancers. I discuss systemic imbalances of power which permeate the dance profession, effectively conditioning dance students to a default habit of subservience, a learned state of mind which manifests both in their work and in the physical and psychological experience of career-changing injury or illness. The distress of

such dancer-patients is further compounded, by a ‘spoiling of their identity’<sup>1</sup> through incapacitation of their physical instrument, and simultaneously through what they see as incomprehension of their specific needs and problems among the clinicians treating them. A third complication arises from the effects of the tenacious dance identity, which preoccupies most former dancers long after they leave the profession.

I draw on Bourdieu<sup>2</sup>, Merleau-Ponty<sup>3</sup>, and Charon<sup>4</sup> to propose potential mitigatory interventions in academic clinical education, dancer training, and the dance profession. I hope, with this research, to enable dancers and their clinicians to reach, hear and help each other.

## Methodology and Methods

My aim is to explore possible ways to mitigate discrepancies between a conventionally positivist clinical view of injury and treatment, and dancers’ perceptions before, during and after consultation. Having weighed the ontology of participants’ medical conditions against the subjective, auto-transformational quality of biographical narration, I needed to find an epistemological balance between the empirical reality of illness or injury, and the interpretivist orientation of the dancer-patient, each within their own separate but related ambits of distress and survival.

Alvesson and Sköldbberg<sup>5</sup> are helpful here:

‘Before proceeding with a distinct approach to methodology we relate it to, and ground it in, a broadly accepted thesis in philosophy of science; that how we interpret phenomena is always perspectival, and that so-called facts are always theory-laden.’

(p.3)

Their view resonates with that of Bruner,<sup>6</sup> writing of truth in narrative:

‘Narrative "truth" is judged by its verisimilitude rather than its verifiability.

There seems indeed to be some sense in which narrative, rather than referring to "reality," may in fact create or constitute it... ’ (p.13)

I am reminded of Nietzsche,<sup>7</sup> who regarded empirical reality with some scepticism:

‘So what is truth? A mobile army of metaphors, metonyms, anthropomorphisms – in short an aggregate of human relationships which, poetically and rhetorically heightened, become transposed and elaborated, and which, after protracted popular usage, pose as fixed, canonical, obligatory. Truths are illusions whose illusoriness is overlooked.’

I carried out this research between 2020 and 2025, when I was working on my doctorate in the Department of Primary Care Health Sciences, under the Medical Sciences Division of the University of Oxford. Having secured approval from the ethics committee of my University, I circulated recruitment posters calling for volunteers, to ballet companies, schools, publications, physiotherapists, and social media. This was purposive sampling of a specific population. Selection criteria stipulated a minimum participant age of eighteen, fulltime professionally-oriented ballet activity which had been prematurely terminated by illness/injury, willingness and availability to participate, provision of informed consent, and

absence of issues which might preclude participation. Forty-one people volunteered by email -- I excluded volunteers who did not meet the stipulated criteria. The final sample consisted of twenty women and three men whose careers had ended as a result of illness or injury. Their ages ranged from twenty-one to sixty-two (median age thirty-seven). I provided complete verbal and written information on my aims, procedures, and methods, secured their written consent, and explained their freedom to withdraw from the research at will, without obligation. I assigned each participant a pseudonym, archiving the details of their actual identity in encrypted form.

In order to explore the illness/injury from the patient's perspective, I used extended Biographical Narrative Interview technique. I approached the research abductively, holding almost completely unstructured interviews, with occasional open-ended prompts to facilitate, where necessary, a participant-driven unpacking of their narrative. Participants related their life-story, their career, and how their illness/injury affected them. I viewed their responses inductively, subsequently bringing reflective deduction to bear on the mass of their collected primary data across the sample. This interpretive approach, appropriate to analysis of narrated experience, is characteristic of qualitative methodology. For research of this type, it would not have been practicable to deploy positivist, quantitative methods, generally considered suitable for measurable, empirical data, often in respect of large samples. Instead, I concentrated on hermeneutically foregrounding participants' spoken words, giving primacy to their related perceptions.

Interviews were conversational in tone, yielding deep, rich narrative data, and the accounts evolved and developed with each telling -- attempts to fix 'historical events as they happened' would have been both unlikely to succeed, and irrelevant. My focus turns, instead, on interviewees' perceptions of the events they relate. Such interpretation of co-created meaning evokes Ricoeur,<sup>8</sup> van Manen,<sup>9</sup> Merleau-Ponty,<sup>3</sup> and other phenomenologists -- for

example, Merleau-Ponty's perspectives of a shipwreck on the shore, a view which continually changes as he approaches the vessel. For Merleau-Ponty, perception, unconstrained by empirical reality, is a constantly developing phenomenon, mediated by location, timing, and constructed preconceptions. Ricoeur,<sup>8</sup> too, suggests that a narrator's successive interactions with discrete interlocutors indicate historical narrative to exist in flux, perpetually relocating and changing shape.

Over a period of about 18 months in 2020 and 2021, I recorded online conversations with ex-dancer volunteer participants in Canada, the United States, Australia, New Zealand, Germany, Scandinavia and the UK. In the first, I introduced myself, and explained the study. In the second (main) interview, participants recounted early dance memories, training, careers, injury/illness, interaction with clinicians, and the sequelae. I scheduled this interview soon after the first one; for most participants the interval ranged from ten days to a month. The time between Interviews Two and Three was six to eleven months, which gave me a longitudinal insight into their developing perspectives. Interview Three functioned as a rounding-off, to answer remaining questions, revisit salient points, and thank them for participating. In total I recorded nearly thirty-four hours of conversation. Three participants were obliged to miss Interview Three – one was newly bereaved, one was in hospital, and one was convalescing from extensive surgery. Having already recorded copious data in Interview Two, I found that data collection had by then reached saturation point; I therefore felt able to dispense with these three participants' farewell conversations. Primary data thus consisted of sixty-six unstructured, recorded interviews. Participants recounted the impact of career loss, and how it affected their dancer identity, nurtured and reinforced throughout their dance lives. Important, since they could no longer call themselves dancers, was how, following that alteration, they perceived their identities and futures, and how they adapted, with varying degrees of success, to a non-dancing existence.

As the sample within which I work might be said to resemble a kind of vocationally-based ‘tribe’, (to which I myself belong), this research contains elements of an ethnographic, even autoethnographic character. Inasmuch as I share common ground with these individuals, my awareness of our mutual experiences was, *de facto*, likely to define and steer my research design and data collection. A different researcher, interviewing the same participants from a different standpoint, would perhaps have elicited different results. This is both a strength and a point for discussion in the assessment of limitations. It is, nonetheless, integral to such research. I must nonetheless make clear that, although I have known the dance world for many decades, I knew none of the participants, nor, to my knowledge, had any of them ever met any of the others.

I began transcribing manually, but soon switched to Otter.ai transcription software, approved by my University. I listened reflectively and repeatedly to the recordings, transcribed them, and corrected the results, removing or disguising details which might identify participants, then sent each interviewee their main transcript for feedback, a technique known as member-checking.<sup>10,11</sup> They all judged the resulting verbatim texts accurate and reliable, and approved the transcript – some offered additional reflections, which I incorporated into the data set for analysis. This triangulation reinforces the rigour and transparency of my findings. I archived pseudonymised transcripts as line-numbered Word documents, analysing them iteratively and recursively, discussing findings with my supervisors and refining concept, then formulated the outcomes graphically, to reveal frequency and patterns of thematic similarity. This supervisory team consists of a GMC-registered medical doctor and former international athlete with experience of providing medical advice to elite athletes, a literature scholar (trained as a classical dancer) with specialisms in narrative medicine and the translational medical humanities, and an academic experienced in qualitative research methods, with particular emphasis on observational and

ethnographic work, and extensive dance experience. This team has constantly reviewed my work, ensuring adherence to best ethical and academic practice.

My original plan had been to use NVivo software for pre-analysis collation of data. It seemed, however, that the narrative richness of the primary data was reduced by the programme's inflexibility and the implicit pressure to manipulate spontaneous conversational material into forms and shapes for the sake of the system. I here impute no fault either to the software or to its producers; nonetheless, the required reconceptualisation of my plan seemed disproportionate to projected benefits, and I found myself agreeing with Robson and McCartan<sup>12</sup> over the potential disadvantages to reliance upon such programmes. I used thematic analysis<sup>13</sup> as described below by Riessman:

‘A typology of narratives organised by theme is the typical representational strategy, with case studies or vignettes providing illustration.’ (p.2)

I started by organising topics into category-based lists, tabulating them to identify recurrence of themes across multiple interviews, and grouping related interview extracts together, theme by theme. I deployed illustrative techniques enabling optical and spatial appreciation of thematic relationships across the primary data. Working iteratively back and forth from these tables, I converted the data, first diagrammatically, then into what I called mind-maps, finally deploying the One Sheet Of Paper (OSOP) technique.<sup>14</sup> OSOP technique is also known by some researchers as Very Large Dining-Table (VLDT) analysis.

## Results

Rates of injury in dance have been found to reach 97% annually<sup>15</sup>. Unless the healthcare professionals whom dancers consult happen to be familiar with dance, they may tend by default and training to view ill or injured performers primarily as matrices of standard biomedical issues, treatable by conventional methods like other patients who come to them. It is of course likely that most of the medical conditions suffered by my participants would have displayed some features typical of non-dancing patients. In the clinical context, however, dancers differ markedly from non-dancers. They manifest atypical, *genre*-specific anthropometry, obsessive professional identity, lifelong emotional investment in dance, marked competitiveness, dietary anomalies, high pain threshold, and habituation to gender/power imbalances. Their profession and their physique are the fruit of long, intense training. For elite performers such as these, injury may entrain serious, even catastrophic professional consequences. Many dancers, conditioned to defer to authority, may be awed by medical expertise, and therefore reluctant to give the impression of lecturing clinicians on dance-specific connotations. Instead, they may instinctively respect, and give way to, authority, as they have been taught and obliged to do throughout their lives.

Buckroyd<sup>16</sup> explains this phenomenon:

‘... It is rare to find a studio/gym where the teacher/coach is not an absolute authority with a very clear hierarchical control over the students.’ (p.12)

Relative levels of social capital<sup>2</sup> and perceived status between clinician and dancer are thus uneven. Too often, this status gradient, and the concomitant imbalance of what Fricker

calls ‘epistemic esteem’,<sup>17</sup> result in mutual incomprehension and inadequate dialogue, and may lead to treatment failure, impaired or limited movement, even career loss. I have witnessed numerous dancers, attempting to explain professional implications of their condition to clinicians unversed in dance. It is important here to clarify that, in my view, no blame devolves upon the medical profession. The situation arises from mutual misunderstanding, and it is precisely this communication gap which forms the focal point of my research.

Some themes recurred right across the sample. Certain of these: background, training, injury, clinical interaction and its sequelae, the violent reshaping of identity and subsequent (frequently frustrated) attempts at finding a means of survival are common to most or all of my participants. Nearly all spoke, too, of the influence of their families (principally their mothers), encouraging them into a growing love of dance, reinforced by socialisation into the dancer identity, as classmates and colleagues bonded into a community of practice<sup>18</sup> resembling a surrogate family, coalescing around shared passion. Their training required ten to twelve years of concentrated study, long, hard hours, high learned tolerance of pain, and ability to cope with the physical, social and mental demands of dance. They mentioned the heavy temporal and physical demands of schooling, their increasingly crowded schedules, intense, highly physical, perfectionistic striving, dedication to exalted aesthetic ideals, pressure for thinness, and the sense of being members in an elite team, joyously capable of physical feats beyond the reach of most non-dancers. Simultaneously, however, they recalled pain, anxiety and maltreatment, power imbalance and gendered inequity, both in training and subsequently in their careers. They remembered fierce rivalry too, as they sought approbation from teachers, Artistic Directors, and choreographers, a struggle rendered more intense by scarce employment opportunities in their underfunded profession.

Following years of preparation to perfect the requisite dance skills, coping at the same time with normal schoolwork and the challenges of adolescence, they emerged into a highly competitive jobs market. Those who gained contracts entered the regimented life of the professional dancer, requiring intense work, rigid discipline, mental resilience and the ability repeatedly to deliver feats of virtuosity, often despite diet restrictions. Some knew little of the bodies upon which their livelihoods depended. Eventual injury could be severe, the likelihood of professional incapacitation high, employment prospects circumscribed, and the associated social, emotional and existential toll, daunting. For most, having since childhood known only dance, premature, involuntary career termination entailed significant biographical disruption. Identifying as dancers, they knew and wanted no other work. Following traumatic injury or illness, deprived of livelihood, friends, identity and context, they felt disoriented and helpless.

This is exemplified in the narrative of one participant, Katherine. Following a rehearsal accident, she explained repeatedly to clinicians how the damage had been done, and the debilitating limitations which it imposed. In her perception, no-one really listened, and she felt that her description seemed to be ignored. Her clinicians appeared not to value her account, nor could they identify or heal the injury. They took two years to diagnose a musculoskeletal insult more usually sustained by elite sportsmen. By then, Katherine had lost her livelihood, her self-concept, her friends, her house and her possessions, and found herself trying to survive in the unfamiliar, non-dance world of unskilled employment. She believes that, with prompt diagnosis and treatment, a full return to performing life might have been possible (there have been several documented examples). The two-year hiatus rendered this unachievable and Katherine's top-flight career was finished – in order to survive financially, this acclaimed ballerina had to resort to unskilled work which she perceived as banal and alien to her character. Many interviewees related similar instances of clinicians, neglecting to communicate with the specialist patients before them, and falling back on the conventional

diagnoses, treatments, and processes which had been engrained in them during medical training. For the performers, to manage alone in a non-dance world with only dance skills was frightening; some felt their lives had ended. As one told me:

“I can remember thinking at the time... it felt like I had died. Where are you a separate entity from the dance? You’re not sure you are.”

Another interviewee, recalling her loss, said:

“... it was my identity, really. So when I had to quit, it was a real identity shift. And that was that was the hardest part.”

Others were, figuratively speaking, paralysed by indecision – one former dancer, a year after the event, recounted:

“... I really wonder, you know, lately, as I said, like, how much of me actually doesn’t want to do it anymore? Or how much of me already for a long time, didn’t want to do it? But I just did it. Because, I mean, that’s what you do, you love that, you do it... I’ve had what, like a year now, a bit more than a year, you know, digesting and doing whatever. Now, it starts to happen like this. I’m like, okay, so ... because I was very confused. I was like, why don’t I like it anymore? ... So now I need to get acquainted with the part of myself that just doesn’t want to do it.”

A further stress factor was the brevity and insecurity of dance contracts. Professional companies rely on uncertain government funding and sponsorship. Budgetary unpredictability often impedes long-term planning, restricting production choices, and limiting numbers of performers who can be engaged. Recently-graduated dancers audition every year, but there are seldom funds for many new contracts; most auditionees fall by the wayside, exacerbating the competitiveness and rivalry which are already endemic in schools and across the profession. Budget constraints preclude maintenance of a pool of reserve performers; dancer injury and absence therefore necessitate urgent choreographic adaptations, overtime rehearsals or engagement of substitute artists, all expensive. It is relatively easy, within contractual limitations, for companies to dismiss an incapacitated performer within a short time, and replace them from among the many talented, unemployed graduates on the market; this reinforces dancers' sense of insecurity. Performers tend, therefore, to conceal injury, working through pain as though all were well.<sup>19</sup> Competitiveness, concealed pain, the emotional and physical load of constant rehearsal and performance, meagre salaries, and job insecurity, are causes of habitual stress; the deleterious health effects of this on dancers are well documented.

Yet another problem manifests in the prevalence of reported abuse throughout the training, professional activity, injury, treatment and subsequent life of dance people. (I do not refer here to sexual abuse, although that, deplorably, is also commonly reported). What seems disturbing, especially in point of long-term developmental effects, is the potency and ubiquity of power differentials in evidence. Many children and young people in dance schools are systemically influenced and persuaded by a combination of peer pressure, incentivisation, implied risk of rejection, and proselytising, aimed at convincing them to adopt the ideal of

“becoming a dancer”. All of this comes at a sensitive and turbulent stage in their development, when their infatuation with what they are encouraged to perceive as the magic realm of dance becomes embedded in their minds, altering their view of themselves and their place in the world. The suggestibility of young, inexperienced people embarking upon, as they believe, a ‘quest’ for the realisation of their fantasy, may render them vulnerable to physical and psychological harm.

As Buckroyd<sup>16</sup> reminds us:

‘A central premise ... is that young dancers, by definition, do not have a fully developed sense of self ... At that stage of life, identity is strongly invested in the body and the developing sense of mastery of it. For teenage girls particularly, the sense of self is near identical to their sense of their bodies and physical selves.’ (pp.2-3)

Van Staden, Myburgh and Poggenpoel<sup>20</sup> are among many researchers who have warned of the results of the ostensibly benign encouragement of students’ *idée fixe*:

‘... the profession had strongly influenced their sense of self, relationships with others, and future-orientation. The findings of the pilot study are important for what they suggest about the tendency of classical dance to stimulate the setting of externalized goals that may lead to self-destructive behaviors such as eating disorders, depression, maladaptive perfectionism, and problems with career transitions.’ (p.20)

Following the unsuccessful treatment the had received, incapacity from illness/injury ended the careers of my participants. Unable to follow their lifelong vocation, unemployed and, in their view, unemployable, deprived of the only profession they knew, they felt impelled into an unfamiliar existence, without relevant, transactable skills. To reconstruct themselves as non-dancers was painful, arduous, and, for some, only partially achievable.

## Discussion

Most participants hoped and expected to discuss their condition and its implications with understanding, collaborative healthcare professionals, yet found their narrative apparently discounted. In place of rapid healing and speedy return to dance, the outcome known as “restitution narrative”,<sup>21</sup> they faced clinicians unused to their peculiarities, who seemed neither to appreciate their professional predicament, nor to understand how to diagnose or treat them.. Empathic<sup>22</sup> clinician-dancer communication seems to have been lacking.

Discussing one of the root causes of this problem, Mattingly<sup>23</sup> points out that:

‘Narrative studies of patient/doctor communication have addressed power through examination of a subordinate [patient] voice which is in contest with a prevailing and powerful medical voice. Analysis of interchanges between doctors and their patients often show patient narratives as neglected or reorganized through the doctor’s ‘medicalizing’ discussion. ... ‘Doctor talk’ often emerges as a kind of anti-narrative speech act ... which gains its perlocutionary power precisely through a set of discursive moves which suppress personal narrative, such as adoption of the passive voice and consequent elimination of agency’. (p.12)

As Murphy<sup>24</sup> reminds us:

‘Medical people have a penchant for looking primarily at the biological aspects of health, considering state of mind only when their diagnostic skills fail ... ’. (p.143)

These two quotations seem to imply that medical incomprehension of dancer priorities, combined with an apparently top-down medical mindset, would effectively impede communication between clinicians and their frequently tongue-tied dancer-patients.

Nettleton<sup>25</sup> understood the predicament experienced by these performer-patients:

‘There is a tension here then, between the way the body is experienced or *lived* and the way the body is observed or described by “medical experts”. In those circumstances where the voice of the body is silenced the person is likely to become alienated from those who aim to “practice” upon his or her body.’ (p.54)

As Dotson<sup>26</sup> argued:

‘...to communicate we all need an audience willing and capable of hearing us.

... the feeling that persons or objects arouse in us as projections of our feelings and thoughts. It is evident when “I and you” becomes “I am you,” or at least “I might be you”.... Doctors prefer dichotomies: right or left, up or down, physician or patient, you or I. Medicine is, however, both science and narrative, both reason and intuition.’  
(p238, pp7,14)

For these dancers, every day without dancing represented loss; they feared for roles, professional status, their contracts, their identities, the edifice of their lives. What they needed (but did not find) was the systemic literacy which Launer<sup>27</sup> recommended to medical practitioners:

‘... sensitivity not just to the problem but to everything and everyone else who might be involved as well. Some people describe this as ‘taking the helicopter view’. Others describe it as seeing yourself as part of an enormous dance.’ (p.11)

Launer’s quotation<sup>27</sup> evokes the concept of Narrative Medicine,<sup>4</sup> underlining the fundamental centrality of patient’s stories, the need for bilateral patient-clinician comprehension, shared decision-making and mutual support. Bilateral comprehension is germane to my research, a crucial mediator of the malaise afflicting dance at educational and professional levels. The issue recurs with striking frequency throughout the profession. For people unaware of the strength and tenacity of the dancer identity, (and perhaps especially so for clinicians, who necessarily prioritise empirical evidence) it may seem strange that a patient, prevented by incapacity from following one profession, cannot easily accommodate the doctor’s recommendation to retrain for a different occupation. Dancers, however, define

themselves through dance.<sup>28</sup> Dance is what they do, and for many, it is all they know. The reasons for this are rooted in the dance ethos.

Waumsley & Katz<sup>29</sup> note that,

‘As athletes’ sense of identity is strongly associated with their sporting prowess, serious injury can be experienced as threatening to who they are as people and not just as athletes. Consequently, psychological recovery post-injury needs to support the athlete in re-establishing a sense of worth and value as a person ...’ (pp.181-182F)

Buckroyd<sup>16</sup> agrees:

‘It is generally acknowledged by those working with career professionals that loss of identity is one of the most devastating aspects of transition (Pickman, 1987; Greben, 1989; Horosko, 1982; Leach, 1997; Hamilton, 1997) ...’. (pp.192-193)

... Years of training and rigorous apprenticeship prepare the dancer for a profession that is relentless in its demands, scarce in its material rewards and fiercely defended by those involved in it. Dancers dance for the love of it, but the performing life is intense, insecure and short. When it comes to an end, either by personal choice, physical limitations or injury, the dancer faces a difficult challenge.’

Finkenauer *et al* <sup>30</sup> make clear that:

‘ ... people’s sense of self is inextricably intertwined with their body ... changes of the body should therefore be experienced as changes of the self.’ (p.35)

It seems therefore logical to suggest that one important objective in the medical consultation should be to illuminate for clinicians why, at a deep, personal level, the dancer cannot easily change jobs for a life devoid of dance. Jerome Bruner,<sup>31</sup> referencing Donald Spence in a passage on narrative truth, reflects on clinical perceptions of patients’ lived convictions:

‘Such narrative truth, screen memory or fiction though it might be, succeeds if it captures the patient’s ‘real’ story, if it somehow manages to capture within **its** code the patient’s **real** trouble.’ (p.166)

To tell a dancer whose career has disintegrated, that they should simply cut their losses and move on without further ado, is to offer a suggestion likely to meet with bewildered resistance. Oliver Sacks<sup>32</sup> quotes a stanza from Matthew Arnold’s *Grande Chartreuse*, which might be borrowed to describe the plight of these dancers. In the critical instant, they find themselves, figuratively speaking:

“.... between two worlds, one dead, the other powerless to be born ...” (p.93)

There have, nonetheless, been several recent, encouraging developments. For example, a gradual restructuring of pre-professional dance training is being implemented in some of the major schools. Excellent work is being done by the National Institute of Dance Medicine and Science, with three Dance Medicine clinics in the NHS. First-class dissemination happens every year in the Dance Science Research Symposia at the University of Wolverhampton. Dance Science (often combined with Sport and Exercise Science) is now offered at undergraduate level by nine UK universities, and at postgraduate level in nine. Five of the six larger UK dance companies employ their own permanent clinical staff. These positive developments are underpinned by a small but growing body of recently published research<sup>33,34,35,36</sup> into some of the problems I have discussed above. Progress, then, is being made -- quantity and accessibility of Dance Medicine provision remain, however, short of what is needed, and there is still work to be done to develop Dance Medicine at scale within academic clinical education.

## Summary

Their dance mythos drives students into the prolonged, arduous undertaking of a professional career, with few chances of success, for which they sacrifice much of their childhood, adolescence, and their social, metabolic, endocrine, musculoskeletal, psychological, and financial wellbeing. For most, the quest to become classical ballet dancers ends in failure. The select few who succeed, despite achieving their cherished goal of entering the profession, may nonetheless lose their career after relatively few years. I suggest that part of the solution would lie in enhanced education, the education of dance teachers who, having themselves endured similar physical and psychological maltreatment, may tend to perpetuate the practices which made them miserable, by passing on their burden to their students. Ballet training might benefit from being fundamentally recast as a facilitation, an opening of doors,

a revealing of possibilities, not (as at present) a rather strict novitiate through which salvation is granted only to the few.

Equally important would be for dance students of all calibres to be educated in the structure, care and maintenance of their own bodies and minds. It ought not to be normal to see, as I have too often seen, injured performers with only rudimentary concepts of their injury, how and why it happened, what can be done to alleviate it, or how recurrence might be prevented. I would suggest that dancers need different, more effective, imaginative, and appealing biomedical instruction during their training, from which they might emerge as fully-rounded people, capable of reasoned, informed discussion and choice about their bodies, their careers, their life options, their place in the world and their sense of self-worth. An injured dancer should be able to converse with a clinician on terms of mutual respect and bilateral comprehension.

By the same token, the medical profession could help by making space in its institutional world-view for curiosity, humility, and willingness to explore this specialised, atypical, expert patient population, to learn from the concentration of knowledge, energy, capacity and desire which is sitting, distressed, before them in the consulting room. I suggest that there could and should be a wider, deeper dissemination of the subtleties, challenges and potential triumphs inherent in the specialism of Dance Medicine, currently the niche interest of relatively few enlightened individuals, (often granted room under the umbrella of their more affluently-funded cousins in Sports Medicine). I believe Dance Medicine to be capable of becoming a prestigious and universally admired branch of clinical activity in its own right – certainly there is a potentially large client base, with no shortage of demand for this rare discipline.

## Practical and Clinical Applications and Implications

I should wish to propose the following mitigatory interventions at both educational and professional levels, to alleviate the current distressing situation of these specialised patients:

- To avoid the clinician-dancer communication gap I have mentioned, academic clinical education should encourage teaching of empathy in this and analogous situations, modelled on the precepts of Medical Humanities. Study and application of Narrative Medicine should be widely disseminated, connected to provision of training in Dance Medicine, at generalist and specialist levels. To this end, Medicine needs to work closely with dance institutions, with whom comprehensive, collaborative plans for this underserved discipline could be created and implemented.
- Dance training should be reconfigured to take account of the empirical situation within the profession. Inasmuch as evidence confirms that most students will not win contracts, vocational training should emphasise preparation for alternative, non-performing careers in and around dance (for example, dance research, history, notation, design, choreography, film, therapy, teaching, nutrition, psychology and so on). Education for dancers on their professional options in an inevitable post-career life should become universal across the sector. Practical help and support during career transition should be available to freelancers and solo performers, as well as company members.
- Motivational climate in training schools should, by default, be task-oriented, rather than goal-oriented. Imaginative, energetic, comprehensive biomedical instruction should be provided. Timetabling should accommodate psychosocial, developmental and nutritional issues associated with puberty and adolescence. Body objectification and gendered imbalance should be addressed, and the personality cult around

individual dancers denatured and disarmed. Pressure for thinness, pressure to excel, to compete, and to ignore pain, sacrificing sleep, health and equipoise for a misguided infatuation with the dancer identity, should be removed from the equation. Analogous issues should also be addressed within the profession itself, reducing systemic power imbalances, relieving psychological and physical pressure on dancers, and ensuring benevolent pastoral oversight of the wellbeing of dancers and staff.

- Funding, whether government or commercial, should support widening of the gamut of performance options, oriented towards enhancing public appetite for the art form, broadening its appeal and audience base, so as to increase funding, and enhance attractiveness and viability of commercial sponsorship; this would expand employment opportunities in the sector, and reduce the competitive anxiety associated with current scarcity of contracts .

Ideally, this type of concept should lead to a new, dedicated line in medical education, multidisciplinary, translational and adventurous, embracing orthopaedics, physical therapy, psychiatry, linguistics, social science, nutrition, comprehensive dance knowledge, education theory, philosophy, patient-led research, sociocultural politics, rehabilitation and much more, effectively forming a new synthesis, and resulting in what might be called the Medical Humanities of dance.

## Limitations

I remind the reader that although dancers in all *genres* may share similar problems across the entire sector, I here focus principally on classical ballet dancers. I concede the following limitations to this work: The sample excluded narratives of successful dancer-clinician interactions -- research design concentrated specifically on negative clinical outcomes. (There are, no doubt, many stories with happier endings – my aim, however, has been to discover the

reasons for the unhappy ones). The small sample size precludes generalisation, however for such in-depth research, time-consuming both in data collection and in analysis, large samples are generally not considered practicable. Use of a single researcher might be seen as a limitation, potentially compromising impartiality, however triangulation, in the form, both of member-checking with participant approval, and of consensual deliberation with supervisors, counteracted this risk, enhancing rigour and transparency. In fact, my familiarity with life in professional dance enabled the free collection of copious rich, deep data in a manner which would have been difficult for a researcher without lived, experiential dance knowledge, to replicate.

### Future recommendations

It is my hope that this study may form the basis for educational interventions for dancers and clinicians, providing transferable insights for future research into communication between ‘unusual’ patients and medical professionals, with the aim of enhancing their mutual awareness and communication. I should welcome future research into the practicability of options for these reforms, as well as studies into the feasibility and long-term potential of my suggestions for restructuring availability and public perception of dance performance, to consolidate and extend funding, greatly expand employment opportunities across the sector, and to enhance quality of life for dancers and those engaged within the institution of dance.

## Declaration of Conflict of Interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article’.

## Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

## ORCID ID:

Jeremy Leslie-Spinks <https://orcid.org/0000-0003-4169-0522>

## References

1. Goffman E. *Stigma: Notes on the management of spoiled identity*. Simon and Schuster;2009.
2. Bourdieu P. trans. Nice R. *Outline of a Theory of Practice*. Cambridge University Press;1977.
3. Merleau-Ponty M, trans. Smith M. *Phenomenology of perception*. Routledge & Kegan Paul Ltd;1962. ISBN: 0-415-04556-8.
4. Charon R, DasGupta S, Hermann N. *The principles and practice of narrative medicine*. Oxford University Press New York;2017. ISBN: 9780199360192:
5. Alvesson M. & Sköldbberg K., 2<sup>nd</sup> ed. *Reflexive Methodology: New Vistas for Qualitative Research*, Sage. London;2009.
6. Bruner, Jerome. "The narrative construction of reality." *Critical inquiry*, 1991;18(1):1-21.

7. Nietzsche F, *On Truth and Falsehood in an Extra-Moral Sense §1*, Translated from the original German by Ronald Hayman in *Nietzsche*, Phoenix. London;1997:21-22.
8. Ricoeur P. The Human Experience of Time and Narrative. *Research in Phenomenology*.1979;9:17-34. <http://www.jstor.org/stable/24654326>
9. van Manen M. *Researching lived experience: Human science for an action sensitive pedagogy*. Routledge;2016:xiv.
10. Birt L, Scott S, Cavers D, Campbell C, and Walter F. Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, 2016;26(13): 1802-1811.
11. McKim C. Meaningful member-checking: a structured approach to member-checking. *American Journal of Qualitative Research*. 2023;7(2):41-52.
12. Robson C, McCartan K. *Real world research.*, 4th ed. J. Wiley & Sons;2016. ISBN 978-1-118-74523-6 (pbk).
13. Riessman CK. Narrative Analysis. In: Kelly N, Horrocks C, Milnes K, Roberts B, Robinson, D. eds. *Narrative, Memory & Everyday Life*. University of Huddersfield; 2005. 2005:17. <http://eprints.hud.ac.uk/id/eprint/4920/>.
14. Ziebland S, McPherson A. Making sense of qualitative data analysis: an introduction with illustrations from DIPEX (personal experiences of health and illness). *Medical education*. 2006;40(5);405-414.
15. Rivera DC, Alexander JL, Nehrenz G, Fields BJ. Dancers' perceptions of injuries. *J Music Dance*. 2012;2(1):9-12.

16. Buckroyd, J. *The Student Dancer: Emotional Aspects of the Teaching and Learning of Dance*. Dance Books, London;2000.
17. Fricker M. Evolving concepts of epistemic injustice. In *The Routledge handbook of epistemic injustice*. Routledge;2017:53-60.
18. Lave J, Wenger E. *Situated learning: Legitimate peripheral participation*. Cambridge University Press;1991.
19. Anderson R, Hanrahan SJ. Dancing in pain: pain appraisal and coping in dancers. *Journal of Dance Medicine & Science*. 2008;12(1):9-16.
20. Van Staden A, Myburgh CPH, Poggenpoel M. A Psycho-Educational Model to Enhance the Self-Development and Mental Health of Classical Dancers. *Journal of Dance Medicine & Science*. 2009;13(1).
21. Frank AW. *The wounded storyteller: Body, illness & ethics*. University of Chicago Press;1995.
22. Spiro HM. What Is Empathy And Can It Be Taught? In Spiro HM, McRea Curnon MG, Peschel E, St. James D, eds. *Empathy and the Practice of Medicine* Yale University;1993. ISBN: 0-300-05918-3.
23. Mattingly CF. *Healing dramas and clinical plots; the narrative structure of experience* Cambridge University Press. Cambridge;1998.
24. Murphy R. *The Body Silent*. JM Dent & Sons Ltd., London;1987
25. Nettleton S. The sociology of the body. In: *The Wiley Blackwell Companion to Medical Sociology*. 2021:103-124.

26. Dotson K. Tracking epistemic violence, tracking practices of silencing. *Hypatia*. 2011;26(2):236-257.
27. Launer J. *Reflective practice in medicine and multi-professional healthcare*. CRC Press:2022.
28. Wainwright, Steven P., Clare Williams, and Bryan S. Turner. "Fractured identities: injury and the balletic body." *Health*: 2005;9(1):49-66.
29. Waumsley JA and Katz J. Using a psychological model and counselling skills in sport rehabilitation. In: Arvinen-Barrow M & Walker N, (Eds.)*The Psychology of Sport Injury and Rehabilitation*. Routledge, Abingdon, 2013:181-182F.
30. Finkenauer C, Engels RCME, Meeus W & Oosterwegel A. Self and Identity in Early Adolescence : The Pains and Gains of Knowing Who and What You Are. In: Brinthaupt, Thomas M., and Richard P. Lipka, eds. *Understanding early adolescent self and identity: Applications and interventions*. Suny Press, 2002.
31. Bruner, Jerome. *Acts of meaning: Four lectures on mind and culture*. Vol. 3. Harvard university press. 1990:111.
32. Oliver Sacks, **A Leg to Stand On**, Picador, London:1991:93.
33. Andrade, P., & Thomson, O. P. Must The Show Go On? A Qualitative Study Exploring Barriers And Enablers To Manual Therapists' Care Of Dancers. *Journal of Dance Medicine & Science*. 2024;28(4):256-266.
34. Keay, N., Lanfear, M., & Francis, G. (2021). Clinical application of interactive monitoring of indicators of health in professional dancers. *medRxiv*, 2021-09.

35. Outevsky, D., & Berg, T. Dancer education beyond the conservatory: the health education benefits of pre-season screens for a professional ballet company. *Research in Dance Education*. 2022; 23(1):37-59.
36. Kinney, S., McCrystal, T., Owen, M., Stracciolini, A., & Meehan III, W. P. The effect of physical therapist involvement in the diagnosis and treatment of youth and adolescent dancers' injuries. *Journal of Dance Medicine & Science*. 2018;22(2):81-83.