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EDITORIAL

The masks we wear: authenticity, vulnerability, and innovation in TB

IN THIS ISSUE, the *Journal* steps out of its comfort zone to present very early and exploratory efforts to change ingrained habits in health care facilities. Publishing pioneering ideas at an embryonic stage precludes us from being able to draw conclusions about impact, but it stimulates debate—a core business of this journal. Both papers highlighted here[1,2] show that the masks that we wear include not only N95 respirators, but also the masks of professional distance, stoicism, authoritative knowledge, and, in the case of tuberculosis (TB) researchers, a studied neutrality or 'objectivity' toward this work.

Parent et al. describe a novel effort to increase recall and uptake of occupational health measures using theatre techniques.[1] Starting from Bourdieu's notion that we are creatures of habit and hierarchy, they invited health care workers (HCWs) to physically depict the dilemmas and tensions that personal and administrative infection control measures can imply. The article reveals the trial and error (and the push-back) that often accompanies attempts to alter the rituals and routines of cosmopolitan health care. Parent et al. imply that by helping HCWs embody their fears and vulnerability with respect to TB, they can make the unspoken discussable and even solvable.

Another intriguing prospect of the paper is the possibility that arts-based approaches might help address a range of stubbornly persistent behaviors. While the failure of traditional 'chalk and talk' trainings as a behavior change pedagogy has been well documented, the death-by-a-thousand-powerpoints teaching method has remained a staple in the TB field. It is therefore not surprising that the infection control (IC) arena is well known for interventions that improve knowledge but not behavior.

Lopez et al. asked individuals receiving treatment for TB or latent tuberculous infection a simple question: 'Is there anything more that you think we should know about you as a person to give you the best care possible?'[2] The apparent simplicity and logic of this question belies a long tradition of directive medical interrogation, designed to get to the bottom of things quickly.

Of course, fear of the open-ended question is not unique to TB health care providers. Health professionals—and even some journal editors—often view qualitative inquiry as casting open Pandora's box, whereby all manner of intractable problems, questions, tangents and effluvia can emerge, eclipsing the precious few minutes allocated per client. Lopez et al. argue persuasively, however, that acknowledging patients' humanity and individuality is both powerful and necessary, not only because it helps to establish the basis of mutual respect and openness upon which an effective treatment plan can be built, but also because recognizing the inherent value of each patient helps reveal our unique contribution too.

Controversially, Lopez et al. also suggest that getting to know a TB patient as a person benefits HCWs by enhancing connectedness, empathy, and personal satisfaction in their difficult jobs. If true, that would be a game changer, for in many settings there is a steep social and professional cost to be paid for providing care for people with stigmatized conditions like TB. To retain a strong voluntary TB workforce, the notion that TB is stigmatized 'dirty work' must be constantly offset by the keen sense that TB care providers are saving lives, and not just 'treating cases'.[3]

Compared to other infectious disease communities, TB is often caricatured as didactic, decorous, and tradition-laden.[4] Whether theatre or open-ended inquiry can produce a sea change in our behaviors or image is still unclear. But the work of Lopez et al. and Parent et al. offers a tantalizing hint that we are indeed significantly more creative, responsive and dynamic than the old stereotype suggests, and certainly willing to step outside our comfort zone if it means ending TB.

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