UNIVERSITY OF SOUTHAMPTON

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School of Health Professions & Rehabilitation Sciences

Working with the Body in the Medical Curriculum

by

Angela Fenwick

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ABSTRACT

FACULTY OF MEDICINE, HEALTH & LIFE SCIENCES
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Doctor of Philosophy

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Medical students learn the knowledge and skills required to undertake the practice of medicine and how to operate within its culture or cultures, through the medical curriculum. Since the 1950s, an extensive literature on the professional socialisation of medical students has explored how students are socialised into becoming doctors and how their attitudes to patients are developed over time.

My research focuses on the ontological status of the bodies that students encounter in the medical curriculum: dead and dissected, unconscious and conscious. It uses the two constructs of the medical body – passive and object – and the everyday body – active and social – to explore the relationships between students and these bodies, in an attempt to find an approach which recognises the complexity of these interactions. It is my contention that the curriculum does serve to support the notion of the medical body in a variety of ways and that certain normalised educational practices reinforce this. However, the everyday body is present for students in various situations: for example, when they make a social connection with a patient.

Attention to the ontological status of the bodies that students interact with is important because it influences the way that the body is treated. If a student needs to negotiate access to a patient's body, how they go about this will be affected by the status they accord the body: negotiating access with a person whose body is considered to be passive is likely to take a different form from a negotiation with someone whose body is viewed as active and interacting. The introduction of policies and procedures which aim to improve interactions between patients and students, need, therefore, to be understood in the wider context of the status of body in educational encounters and in medicine.

Students must find their way through an uncomfortable and complex tension between using bodies for their own ends and, at the same time, respecting these bodies. I propose that this tension be openly discussed and that the contingent nature of both students' and patients' bodies need to be acknowledged. Encouraging a view of the patient's body as everyday – as a social 'educating' body – through more active involvement of patients in students' education, might be one way to counter, or interrupt, the unnecessary transformations to the medical body.

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List of Abbreviations

BM4	Bachelor of Medicine 4-year Graduate Entry Programme
BM5	Bachelor of Medicine 5-year Programme
BMJ	British Medical Journal
CLAS	Centre for Learning Anatomical Sciences
DoH	Department of Health
DR	Dissecting Room
EPC	Early Patient Contact
GMC	General Medical Council
IVF	In-vitro Fertilisation
MiP	Medicine in Practice
NHS	National Health Service
PM	Post mortem
POM	Practice of Medicine
PR	Rectal examination
PV	Vaginal examination
REC	Research Ethics Committee
SoM	School of Medicine

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Last, but definitely not least, I thank all the students who participated in my work and for their openness and willingness to discuss sometimes difficult and sensitive issues.

Preface

For the past eleven years, I have worked as Lecturer in Medical Education in the School of Medicine at Southampton. My roles have been various in this time. Currently, I am Deputy Director of the new graduate entry Bachelor of Medicine (BM4) programme in the School. Whilst undertaking this thesis, I was joint course co-ordinator for the Practice of Medicine course and then Clinical Skills and Family Study, both of which aimed to help students make links between early patient contact and their more theoretical studies. I was also pastoral tutor for three years taking a pastoral support and progress role for a cohort of students. Other differing roles that I have undertaken have involved initiating or supporting curriculum development and evaluation projects.

My interest in this work stems from when I first started working in the medical school and my realisation that the reason why I felt an outsider in the School was the way that I viewed certain things. It took me a while to realise that I didn't always share certain taken-for-granted assumptions. Very early on, a colleague was talking about 'clinical material' for a lecture and I wasn't quite sure what he meant. I had assumed he was referring to some sort of preserved body specimen but, when I asked another colleague about this, she said that he had actually been referring to a patient.

I think things have changed somewhat over the years, not least because of events such as Alder Hay and Shipman; but, of course, I have worked within a medical culture for sometime now and I too need to guard against seeing the familiar as the 'normal'.

It took me quite a while to get used to touching my patients. Touch was so personal and invasive. While my hands could comfort, they now had the ability and even the obligation to hurt as I searched my patients' bodies for clues to the diseases ravaging within. As a second year student I still had no on-going responsibility for patient care. The exam was solely about my touch, and the stories I heard were destined only for my write-up. I felt that I violated these patients, forced a learner's hand on their bodies under the guise of a white coat. But every week I mustered up my courage, marched into a hospital room, and introduced myself to a new patient. I was rarely turned away.

Rothman, E. L (2000) *White Coat: Becoming a doctor at Harvard Medical School.* New York: Perennial (p.49)

In Frank [cadaver in the dissecting room at Brighton and Sussex Medical School] everything is squashed and unclear and covered in a kind of black felt that comes out in pieces bearing the impression of the pericardium. It turns out to be blood. At his death, something, in the heart or in one of the heart's great vessels, must have burst: the chest cavity is full of clots. 'Oh god, I feel so sorry for him now,' someone says. 'No, it's alright, that's not a bad way to go,' the demonstrator says. 'It would have been fast and it wouldn't have hurt.' 'But wait a minute: that means *he died of a broken heart!'* 'Don't be so silly,' says Professor Watt.

Harrison, S (2004) Diary. *London Review of Books* 5th February, 2004 (p.5)

Chapter 1

Literature Review

Introduction

In January 2001, the inquiry into events at the Alder Hey Children's Hospital published its findings. The report addressed both a general and a specific complaint in relation to the retention of body organs after post mortems. First, there was a concern that, within the medical profession, it was general practice to retain organs without the informed consent of relatives or next of kin. Specifically, at Alder Hey, it was believed that the Professor of Pathology, Richard van Velzen, had been stockpiling organs without obtaining consent for their removal and then subsequently not using them.

The inquiry did find evidence of malpractice in relation to Professor van Velzen and he has subsequently been 'struck off' by the General Medical Council (GMC). However, in relation to the general practice of retaining organs without informed consent from relatives or next of kin, the inquiry found that the practice was, in fact, against the terms of the Human Tissue Act of 1961. The report concluded:

> In our search we discovered the long-standing practice of organ retention without consent. The practice arose from a sense of paternalism on the part of the medical profession which served to conceal retention in the supposed best interest of parents. Such practice was misconceived and was bound to cause upset and distress when, inevitably, it came to light. (Redfern et al, 2001: Epilogue 15.1).

The reason given for the lack of informed consent for organ retention by the medical profession was, therefore, that doctors, albeit in a paternalistic fashion, were trying to act in the best interests of patients or patients' families. The taking of organs was considered justifiable by some because these organs would be used for research and teaching. The debates that took place around the time of the inquiry centred around differing perceptions of the body. There was a difference between, first, the views of people who felt that the organs were in some way emotionally linked to the person to whom they once belonged; and, secondly, those who believed that once a person was dead, their organs were essentially just parts of the body, carrying no emotional attachment. The fact that doctors were acting without informed consent was a shocking discovery for some, but others did not quite know what all the fuss was about, especially if they held the second view about body parts. Amongst the concerns was a sense that doctors treated body parts with little concern or respect and, therefore, had in many instances not seen the need to consider any emotional attachments, including how families might feel when they discovered what had happened without their consent. An example of this type of approach was reported in the Alder Hey report:

> Some of the remaining documentation reveals a lack of respect and a failure to appreciate the circumstances which led to the donation or taking of human material. Two entries relating to material which has not been retained refer to fetal material of 9 weeks' and 45 days' gestation respectively. The comments next to each entry read 'Inflated monster. Humpty Dumpty' and 'Neck deeply lacerated. Pull it to pieces sometime and reject'. Such entries do the researcher no credit. They are shocking and disrespectful. (ibid: 21.9).

Around the same time as the Alder Hey inquiry, the general public was learning that after the Marchioness disaster, which took place in 1989, the coroner ordered the removal, *in situ*, of the hands of the people who died. These were then taken to the laboratories to be used to identify the bodies. Lord Justice Clarke's Non-Statutory Inquiry into the Identification of Victims reported in March 2001. The inquiry was the result of 10 years campaigning by the Marchioness Action Group for some explanation for the removal of hands without the consent of relatives and, in some circumstances, the failure to return these body parts to the families for burial. The inquiry found that there was no justification for the removal of the hands and this act had taken no account of the family's feelings; moreover informed consent for the removal or retention of the hands had not been sought. There was no reason why dental records could not have been used to identify the bodies of those who had died in the disaster.

The Coroner, Dr Paul Knapman, justified the removal of the body parts to be in the best interests of the families, indicating another parallel with Alder Hey, that of the adoption of a certain paternalistic attitude in which the doctor knows what is best for others:

> I judged that what the relatives of those who feared the loss of a loved one wanted was a swift and certain identification. To have acted

> otherwise could have added a week's uncertainty for those families (Vasagar, 2001).

Whilst the Coroner may have thought that he was acting in the best interests of the families, Lord Justice Clarke gave a different perspective on the situation:

> (…) the evidence has demonstrated the distress that was caused when the families discovered that the hands of 25 of the deceased had been removed and, then, in three cases, not returned to the body. Moreover, I doubt whether anyone present will forget the moving statement made by Mrs Garcia when she returned to the inquiry having learnt that her daughter's hands had been left in a freezer in the mortuary for three years and that they had been disposed of without her knowledge or consent. I hope that this inquiry and the publicity which has attended it will help to ensure that nothing like it ever happens again. (Non-Statutory Inquiry into the Identification of Victims Press Release, 2001).

How did the medical profession get to a situation in which these two incidents could have occurred at all? Why didn't doctors seek informed consent for their actions and why did they not think that families might wish to know what they were burying when they buried their dead? It is my view that the body and body parts in both instances were viewed in very different ways and accorded a different ontological status by different people. For example, the lack of consent sought for organ retention was not just on account of doctors being paternalistic towards their patients but also because what they considered the body to be and represent was different from what the relatives of the dead children saw their body parts to symbolise for them. The way you react to, and treat, body parts is likely to be very different if you see them as essentially inanimate objects, rather then taking the view that they have symbolic meaning and still represent the human being to which they belonged. Difficulties arise when the subject of the body comes into view, leading to an uncomfortable tension between an objectified body and a living or once lived sentient body. Reconciling the two in a medical context is problematic and it is this tension between the two that my research explores, in relation to students' encounters with the body in its various forms in the medical curriculum.

It is my thesis that the body in medicine is often objectified and that the medical curriculum can act to reinforce an ontological view of the body as essentially a passive object. This might be seen to be less problematic when a person is dead but as is revealed in the above two examples, it may act as a reflection of how medicine sees patients' bodies with attendant consequences. When the patient's body is accorded object status that is reflected in encounters between students and patients, it sets up dilemmas for students: How do they negotiate access to work with patients' bodies? How do they deal with situations when patients, with their bodies, are all too present? How can they challenge normalised practices? The very act of using the body in medical education is problematic. My argument concludes that patients must be more effectively engaged in students' learning in order to help counter the view of the body as object and to contribute to a more equal two-way interaction between doctors and patients being seen as the norm, but this too is not without its problems.

In the following sections I attempt to give a broad overview of some of the key literature pertinent to my study. However, as the work is interdisciplinary, it is not intended (or possible) for this to be an exhaustive account of all the relevant literature. Rather, I have set out to give an overview of some of the key theoretical positions in relation to my thesis and to identify issues which can be explored in greater depth and can be related to the analysis of my data.

Body Constructs

The question of what I mean when I refer to the, or a, 'body' was a recurring theme during my research and remains problematic to a certain extent: a comprehension of the body was, and still is, an elusive goal. A resurgent interest in the body in sociological literature was helpful at times and unhelpful at others because of the plethora of types of body that are referred to; for example, in a recent edited collection, *Real Bodies* (Evans & Lee, 2002) there are chapters on the dressed body, the pregnant body, and the sexualised body.

The 'body' now appears to be an explicit and central topic in sociological discourse and in particular in medical sociology (Williams & Bendelow, 1998). This was not always the case: classical sociologists, on the whole, dealt with questions relating to urbanisation and industrialisation and reacted against, or disregarded, the influence of genetic or physiological factors in the social world for fear of biological determinism (Turner & Samson, 1995).

Shilling (1993) outlines four reasons for the emergence of the body in sociological thinking. The first arose from feminist writers in the 1960s who campaigned for fertility and abortion rights alongside the need for women to take back control of their bodies from men; women's bodies were identified as a site of oppression related to a host of issues including, for example, sexuality, violence, fertility and the sexual division of labour (see, for example, Corea, 1985 on reproductive technologies).
A second factor was precipitated by the change in demographics towards an older population during the last century. Advances in medicine have meant that people in the west have higher life expectancies than ever before. Western (consumer) culture has elevated the status of the young body, whilst at the same time more people are living longer and experiencing chronic rather than acute illness. That hospitals have large numbers of older patients is particularly pertinent to my study, as medical students are likely to encounter more older people's bodies as they undertake their clinical experience.

Thirdly, there was a shift in the structure of western society in the second half of the last century: from a society that produces goods to one that consumes goods and services, including the consumption of leisure and pleasure. According to Shilling (ibid.: 35): "(...) the body in consumer culture has become increasingly central and has helped promote the 'performing self' which treats the body as a machine to be finely tuned, cared for, reconstructed and carefully presented through such measures as regular physical exercise, personal health programmes, high fibre diets and colour-coded dressing." The notion of the developing self, expressed through an increasing trend towards individualisation, can be identified with the project of the body (Synnott, 1993).

The final factor has been a growing concern about what constitutes a body if the external physical body can be altered, for example through plastic surgery. The internal body can also be changed by organ transplants and the increasing use of artificial materials; hence the notion of a bionic body or the cyborg (ibid.).

Turner (1996) believes that the body has been conceptualised within the developing literature in, essentially, three ways. The first views the body as a set of social practices; in particular, Bourdieu thought that the body could be understood by examining the different experiences of different occupational groups in society. A second viewpoint sees the body as a set of signs that convey messages and meaning, for example taboos. Martin's work (1989), in which she contrasted the metaphors used about the female reproductive system with more positive ones used for the male system, showed that the latter were used to express male power and success. The third, similar to the second, sees the body as a set of signs which reflect social or power relationships. This approach can be seen to reflect the work of feminists who see the body as a site of male power: the body is constructed as a site of patriarchal power relationships.

Building on this latter conception is the social constructionist viewpoint that the body cannot be separated from its historical contexts and that it is, therefore, inextricably linked to society, being constructed in different ways by different groups: "In every epoch, bodies exist only in context. They form the felt equivalent of the age, in so far as age can be experienced by a specific group. In most periods women seem to have different bodies from men, serfs different from those of the lord." (Illich, 1986:1326). Moreover, Synnott (1993:1) asserts that a key element of the constructive nature of the body is its symbolism: "Our bodies and body parts are loaded with cultural symbolism, public and private, positive and negative, political and economic, sexual, moral and often controversial, and so are the attributes, functions and states of the body, and the senses." Our bodies are physical yet social (see also Douglas, 1973).

The notion of the 'medical body' as a particular category of the constructed body in society permeates the literature (see, for example, O'Neill, 1985; Good, 1994). In *The Birth of the Clinic*, Foucault (1973) outlines how eighteenth century medical practice culminated in a new perspective on the body seen through the 'medical gaze' of the doctor; thus, by the beginning of the nineteenth century, the way the body in medicine was read or perceived had changed. I shall explore this making of the 'medical body' in a later section but at this point I want to identify its possible characteristics. The notion of the medical body is different from how and what we perceive the body to be outside medicine:

> Within the lifeworld of medicine, the body is newly constituted as a medical body, quite distinct from the bodies with which we interact in everyday life, and the intimacy with that body reflects a distinctive perspective, an organised set of perceptions and emotional responses that

> emerge with the emergence of the body as a site of medical knowledge (Good, 1994:72).

The contrasting body mentioned by Good – the one which we encounter in everyday life – is referred to by Evans (2001) as the 'familiar' or 'everyday' body and I have used the latter term in my work. Evans outlines the key difference between these two conceptions of the body and I have summarised these in Table 1 below.

Medical body	**Everyday body**
Object of enquiry	Enquiring object
Passive/inert	Engaged/involved
Source of data	Mysterious and private
Object of experience/biological organism	Mode of experience
Standardised/general	Individual
Fact	Symbol
Complex of functions	A form

Table 1: Differences between the medical and everyday body
(Adapted from Evans, 2001)

The body seen through the medical gaze is, therefore, one that is passive and objectified, from which medical or scientific knowledge is gleaned. The body that is familiar in everyday life – the everyday body – is, by contrast, an active, self-determining entity through which life is experienced. The everyday body encompasses an individual's identity and, as an enquiring and active body, has agency.

The distinction between the medical and everyday body parallels that between the Cartesian body and the lived body (Leder, 1992). The Cartesian body can be seen as the physical object body separated out from the mind and, therefore, also from a person's intentionality and agency – the mind/body split. This notion that the body is split between the material body and the thinking mind, which has its roots in enlightenment thinking, lacks attention to the lived body (the subjective experience of the body). In German, the body has two meanings: *Korper* which refers to the objective, exterior body and *Lieb,* the subjective, experiential body which can incorporate an understanding of how people experience health and illness (Turner, 1992). Merleau-Ponty (1962) believed that body and soul were inextricably linked and that we live our experiences through our bodies' relationship with the world: the concept of embodiment:

> The body is the vehicle of being in the world, and having a body is, for a living creature, to be involved in a definite environment, to identify oneself with certain projects and to be continually committed to them. (1962: 82).

The notion of the 'self' can be seen to be separate from the body; for example, in symbolic interactionism, the self is founded on the notion of the mind/body split and is understood through interactions with others and consciousness (Turner, 1996). However, separating out the self from the body is problematic in a society in which the physical body is seen as a central component of how we view ourselves:

> In contemporary society the self is (...) a representational self, whose value and meaning is ascribed to the individual by the shape and image of their external body, or more precisely, through their body image (ibid.: 23).

The concepts of the lived body or the everyday body must therefore encompass any notions of self: I am my body.

In medicine, the patient may present their experience of their illness (the lived body) but then the doctor, through the medical gaze, transforms the patient's body into an object body (Toombs, 1992). I use the concepts of the medical and everyday body in my study as frameworks for my thinking. The concept of the everyday body is useful because, if the medical body represents the status of the patient's body, it acknowledges the pre-and post-patient status of their body.

Body Dimensions

Implicit in the ontological differences between the medical body and the everyday is the potential difference in power relationships with other bodies: the concept of the body as object, which can be controlled, is reflected in the medical body. As Turner (1996:63) notes: "The body as an object of power is produced in order to be controlled, identified and reproduced". Foucault (1979) made a distinction between control of the body at an individual level – disciplining bodies – and at an institutional level: the regulation of populations. Individual bodies can be disciplined by different professional groups, for example medicine, and populations can be controlled by the all-seeing eye – the panopticon. Medical science acts as a link between the two levels, enabling individual bodies to be controlled by the medicalisation of their bodies.

Turner's 'model of bodily order' (see Fig 1 below) reflects differences between the body at population level and at the individual level; and between the internal body, its physical environment and the external body, or how people represent themselves to society. He then draws on the four Rs:

- Reproduction of populations over time
- Regulation of bodies in space
- Restraint of the interior body
- Representation of the exterior body in social settings

	Populations	**Bodies**	
Time	*Reproduction*	*Restraint*	Internal
Space	*Regulation*	*Representation*	External

Fig 1: Turner's Model of Bodily Order
(Adapted from: Turner, 1996:108)

I find this model useful for considering the different dimensions in my work; for example how individual patients and students represent their bodies and how they are represented; the role of restraint (of desire) in the encounters between students and patients; or how patients' bodies are regulated by medicine. However, the model is somewhat abstract and it has been criticised for its focus on bodily order at the level of society, with the individual body being represented as disembodied (see, for example Frank, 1991; Williams and Bendelow, 1998).

Frank (1991) illustrates how the body can be seen to exist in relation to three dimensions: corporeality – the physical flesh; discourses, which map and reflect bodily practices through actions and speech; and institutions. His analytical approach to bodies attempts to provide a more 'bottom-up' approach to understanding the body.

Thus institutions can be understood through body discourses and actions, "since the actions of bodies are already orientated to institutional contexts" (ibid: 49). I have represented these three dimensions in Figure 2 below.

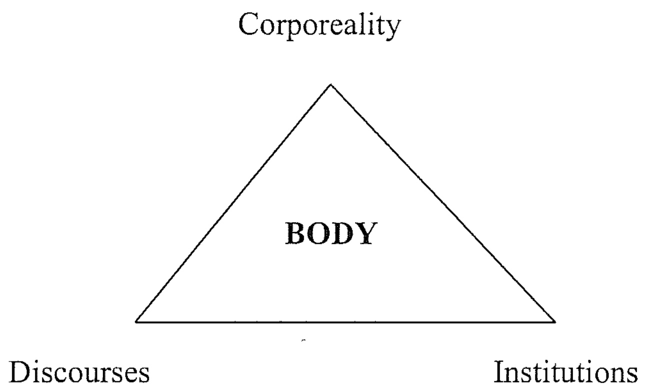

Figure 2: Three dimensions to the body
(Adapted from Frank, 1991)

I agree with conceptualising the body as socially constructed; however, I think it is also important to recognise the physical nature of the individual body that may indeed be viewed in different ways but nonetheless has a definite reality. I think this is particularly apposite in relation to the context of my work in a medical school looking at students' encounters with physical bodies. Frank's attention to corporeality as one of the three central dimensions is useful in this respect.

Frank drew on Turner's work and on Giddens' structuration theory (1986) to develop his "Typology of body use in action". (Figure 3 below)

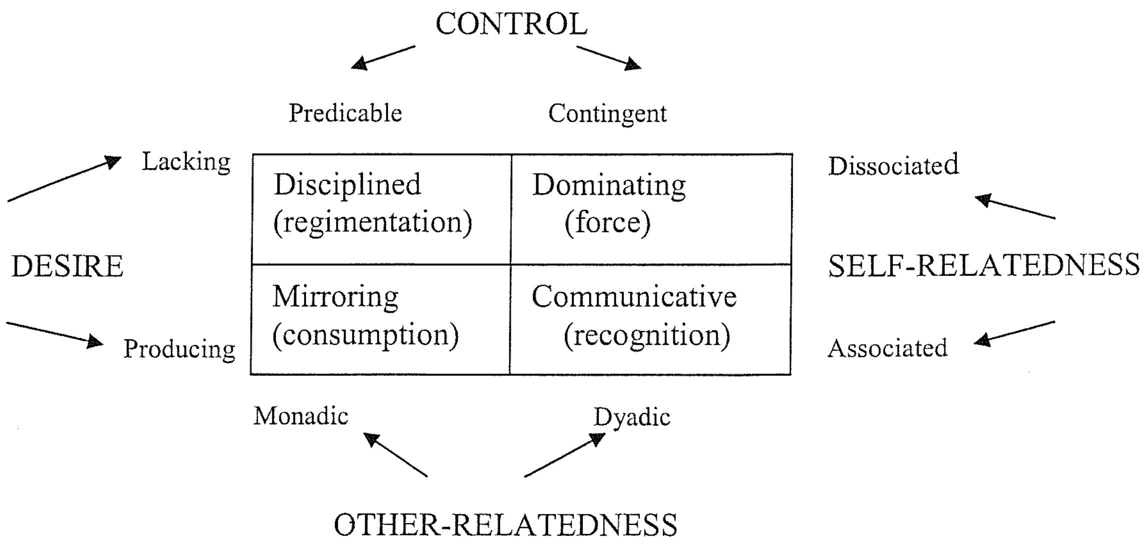

Figure 3: Frank's Typology of body use in action
(From: Frank, 1991: 54)

This involves the consideration of actions and uses. He outlines four body actions and these each raise questions about body uses:

1. Control: Is it predictable or contingent?
2. Desire: Is it lacking or producing?
3. Self-relatedness (relationship with own body): Is it associated or dissociated?
4. Other-relatedness (relationships with other bodies): Is it monadic or dyadic

The model then incorporates four types or styles of body use – disciplined, dominating, mirroring and communicative – for which the questions about actions can be asked. For example, the disciplined body tends to be predictable, lacking in desire, monadic in its relations with others and dissociated from itself. An "idealization" – that of the communicative body – might reflect contingency and desire, and would work by recognising others and itself in relation to others. In the medical context, therefore, this can be applied to the doctor/patient interaction: "the ill want not only to be cared for in their physical needs, but to be recognised in their condition, or, for this condition to be recognised as being fully human" (Frank, 1991: 87).

The issue of contingency is one of the central aspects of Frank's thinking:

> What exist are bodies, which have their own internal contingencies and live in an environment which is more contingent still in its effect on them. When bodies encounter each other, there is a problem of aligning individual contingencies and coping with new mutual contingencies which arise in the interaction. This is a problem of order, but that word suddenly places us looking down on bodies, instead of experiencing what are their own problems of contingency and alignment. I prefer instead to think of the problems as those of communication (ibid: 91).

There is, therefore, a tension between contingency (recognising diversity) and the appropriation of the body; for example, the dominating body reflects an appropriation of the body, whereas the communicative body reflects a state in which individuals and institutions would seek to engage with others and encompass diversity. The discussion of this juxtaposition forms a framework for considering an ethics of the body.

Frank's model is a useful framework to review in my research because it is starts from body actions rather than body systems. Since I am exploring students' encounters with bodies, my starting point is students' descriptions of their actions. It is also useful to consider whether the body is disciplined or whether the use of the body in the medical curriculum reflects a model of communication or domination, contingency or appropriation. These concepts also serve to illuminate or add additional depth to the constructs of the medical and the everyday body.

Both Frank's and Turner's models acknowledge the different dimensions of the body and, as Turner (1996) argues, a theoretical approach is required which acknowledges these different dimensions, using ageing as an illustrative example:

> A radical criticism of gerontological categories could argue (...) that age is socially constructed in such a way as to express dominant power relations and that the deconstruction of age is an important feature of social criticism. However, these arguments have little or nothing to do with the phenomenology of ageing as an individual and social process of bodily transformation. The notion that age is socially constructed does not require us to deny that ageing as a biological process involves the decline in physical ability, the emergence of grey hair, a decline in skin texture, an increase in the brittleness of the skeletal structure, and eventually a decline in mental ability (ibid., 1996: 30).

The Making of the Medical Body

I now want to consider developments that shaped how the body is viewed in medicine: the making of the medical body. The role that the human body has played in the development of medical knowledge and the role of the body in the interaction between the doctor and the patient are both relevant here.

The body and the development of medical knowledge

I do not intend to set out a comprehensive history of how the body has contributed to medical knowledge but I will outline some important developments. Our understandings of the structure of the body have been developed through the discipline of anatomy, which has a long history tracing back to ancient Egyptian embalmers and artists. Galen's anatomical texts, produced in the second century and based on dissections of animals, served as the main medical texts for understanding the human body for over a thousand years. They were unable to be challenged, because of the ban on human dissection, until the resurgence of human anatomy in renaissance Europe when dissection was permitted in many secular European universities. During much of this latter period anatomists and artists were sometimes indistinguishable (for example Leonardo da Vinci, 1452-1519) from one another (Duffin, 2000).

A key figure in this resurgence was Andreas Vesalius (1514 - 1564), who produced a series of books which made up the influential text *De humani corporis fabrica* (from 1543) containing artistic representations of the body, in life-like poses set against natural scenery, and body parts based on his own dissections of the human body. Vesalius' achievements encouraged other anatomists and artists to look more closely at the structure of the human body and further discoveries were made over the next two centuries, which focused on the 'normal' structure of the body. These findings were used to understand more about the body's functions in the developing field of physiology; for example William Harvey's (1578-1657) discovery of the circulation of blood in 1628.[1]

The eighteenth century enlightenment period, characterised as the age of reason in which observation was seen as the basis for scientific understanding, gave new impetus and credibility to scientific pursuits in which anatomy and the act of dissection could be seen to play a key part. Essentially, the newly developing experimental sciences were concerned with the pursuit of progress, represented by the quest to control nature, in which religious viewpoints could be interpreted as being anti-science.

As Duffin (2000) asserts, the newly acquired understanding about the human body, gained through human dissections, was slow to influence medicine to any great extent. It was not seen to have any practical application, precisely because of the lack of attention to abnormal structures or diseases, of which very little of what we understand today was known. In what is sometimes called the 'classical' period of medicine in Europe – prior to the Enlightenment – medicine was essentially practised around a system of 'monism' that ascribed one cause to all illnesses and hence more or less the same treatment was usually recommended. The theory of humours was one type of monism: four humours were linked to the four elements and any imbalance was seen to

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[1] Although William Harvey is widely accredited with this discovery, Ibn Nafis accurately described blood circulation in 1268.

cause illness. The approach to the body and its treatment was essentially holistic in so far as imbalances were considered to be related to disturbances of the mind and body. The role of the doctor was to listen to the patient – at their 'bedside' – taking account of their interpretation of their illness when considering diagnosis and treatment (Porter 1997). A patient's illness was, therefore, seen to be related to their own experience and how they reported it to their doctor rather than being analysed by any reference to the internal structures and workings of their material body. During the eighteenth century medical science was focused on the classification of patients' symptoms; that is what they presented to doctors: "consequently nosography became a chaotic compendium of syndromes extrapolated from the patient's subjective experience of 'feeling poorly'" (Jewson, 1974: 371).

However, by the nineteenth century, scientific medicine was established most forcefully in post-revolutionary Paris and 'bedside' medicine was no longer in fashion; patients could be best observed in large hospitals, "vast infirmaries affording boundless access to the sick poor, or what tellingly became commodified as 'clinical material'" (Porter, 1997:308). The advent of late eighteenth/early nineteenth century hospitals is what Foucault (1973) has called the Birth of the Clinic: hospitals were organised in such a fashion as to facilitate maximum observation which allowed the patient's body to be disciplined.

Here, then, we can see the roots of how the patient body became objectified in medicine and a shift in focus that saw the patient as playing little or no part in their disease or treatment.[2] Patients' own accounts were seen as subjective and unreliable and, therefore, of little worth in the act of diagnosis. The aim was to understand as much as possible about disease by observation and measurement. The best observations were those that could be gleaned from the dead body through pathological anatomy (or morbid anatomy) which enabled different diseases to be identified and classified.

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[2] An illustration of how this impacts on the present day is the practice of referring to patients by their disease, for example: 'the murmur in ward 9'. Although one doctor has told me that this practice is not conducted out of lack of respect for the individual, rather it is used as a means to avoid breaking a patient's confidentiality. Whilst there may be an element of truth in this, there are perhaps other ways to approach the problem. I have also heard colleagues refer to patients as 'clinical material' when patients have been bought into a lecture as I outlined in my preface, although this was some time ago.

The dead body would reveal the secrets of life and disease. As Bichat, a Parisian anatomical pathologist, wrote in 1801:

> (...) for twenty years, from morning to night, you have taken notes at patients' bedsides on affections of the heart, the lungs, and the gastric viscera, and all is confusion for you in the symptoms which, refusing to yield up their meaning, offer you a succession of incoherent phenomena. Open up a few corpses: you will dissipate at once the darkness that observation alone could not dissipate (quoted in Foucault, 1973: 146).

For Foucault, then, modern medicine was founded not on the live patient's body but on the dead. The way that clinicians described an individual's disease or illness, the language they employed, would reflect the fact that knowledge had originated from the dead body. According to Foucault, death became "*embodied* in the *living bodies* of individuals." (ibid.:196).

With the advent of technological advancements like the stethoscope (Laennec in 1816) and the use of the technique of percussion, doctors were able 'get inside' a patient's body whilst they were alive and uncover 'signs' of disease which could be linked to the growing body of disease classifications (clinico-pathological correlation) in the clinical examination. There were, therefore, scientific justifications for touching. The stethoscope allowed the doctor to access a patient's body whilst keeping a distance. The classical approach to medicine was essentially hands-off: probably because it was not socially acceptable for male doctors to touch female bodies. As the middle classes and poor entered the hospital in the nineteenth century the stethoscope enabled a physical distance between doctor and patient to ensure the middle classes' respectability and recreate the necessary social distance from the poor (see for example Porter, 1997 and Sterne, 2001). Thus, as Sterne (ibid.: 120) notes, the practice of auscultation facilitated "a framing of the listening event, a structuring of the doctor-patient relationship according to clear physical and social roles, and a particular preference for instruments".

The profession had moved to a position in which physical signs of disease were used as the means of diagnosis accompanied by a pathology that was based on the basic sciences of anatomy, bacteriology and chemistry. Doctors 'took' histories from patients to gain 'subjective knowledge' about their symptoms and carried out an examination to gather 'objective knowledge' about the signs; however, a patient's own narrative about their illness was no longer the primary route to diagnosis as knowledge gained through examination became the more acceptable route. The purpose of treatment was to overcome the physical causes of disease (Newman, 1957).

The ability of doctors from the late eighteenth century onwards to objectively observe patients is what Foucault termed the 'medical gaze'. The "medical gaze embraces more than is said by the word 'gaze' alone. It contains within a single structure different sensorial fields. The sight/touch/hearing trinity defines a perceptual configuration in which the inaccessible illness is tracked down to the surface, and projected virtually on the dispersed organs of the corpse." (Foucault, 1973: 164). The live body became an important part of the clinical diagnosis as "it is the body itself that has become ill" (ibid.: 136), although this was still predicated on knowledge obtained through dead bodies.

By the end of the nineteenth century, the invention of the microscope linked medicine to the laboratory where experiments like those that revealed cell pathology and bacteriology were in their infancy. Continual advancements led to increasing specialisation and, during the twentieth century, medical science was underpinned by a whole range of scientific (biomedical) disciples.

In the doctor-patient relationship, detachment was equated with objectivity: doctors could not reliably diagnose a patient's illness if they could not distance themselves emotionally. William Osler (1849-1919), the so called 'father' of modern medicine, advocated an approach to doctor-patient relationships in which doctors should remove any subjective bias which might affect their reasoning process – and this included controlling their emotions (Halpern, 2001)[3].

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[3] Lawler (1991) in problematising the body in the practice and theory of nursing comments that nurses are also expected to show no emotion. She emphasises that it is not the same as being 'emotionless' and believes that the trend towards an increasing scientification of nursing will mean a further distancing of nurses from their patients' bodies. Gadow (1980) also expresses concern that the scientific objectivity is at odds with the caring role of the nurse.

The use of the body to establish knowledge

Where did the dead bodies that were used to build medical knowledge come from and whose bodies were they? Foucault does not seem particularly concerned with this question and, whilst acknowledging the existence of a history of grave robbing because of opposition to the act of dissection, seems to deny that this was the case in reality.[4] The reasons for refuting the existence of the practice are twofold: first because he believed there was little public opposition and secondly, because he believed there was, in fact, no shortage of corpses: "Morgagni had no difficulty in the middle of the eighteenth century in carrying out his autopsies; nor did Hunter, some years later (...) So there was no shortage of corpses in the eighteenth century, no need to rob graves or to perform anatomical black masses; one was already in the full light of dissection" (Foucault, 1973: 125).

Richardson (2000) in her historical account of dissection in Britain tells a different story and reveals how the Anatomy Act of 1832 was passed because of a concern about the practice of grave robbing by 'resurrectionists'. Anatomists paid the resurrectionists for the delivery of bodies for dissection and, according to Richardson, this practice was commonplace by the 1720s. The only 'legal' bodies available prior to this time were those of criminals whose bodies, as part of their sentence, had been designated for dissection. These were, however, limited to a small number per year and were not enough to meet the demands of the anatomists and their students. Prior to 1832, therefore, legal dissection was associated with punishment for serious crime (for example, murder). The resurrectionists stole bodies from paupers' graves which tended to be populated by people from the workhouses whose pit burials afforded easier access. The anatomists' practice of flaying ensured that bodies could not be identified. As Richardson points out, cultural views about death were influenced by religion and superstition; there were strong beliefs that the body and soul remained joined for a period after death during which time a person was considered neither dead nor alive (ibid.). Having one's body stolen and dissected during this time, could, therefore, be viewed as being tantamount to being skinned alive. However, such beliefs were seen, by the growing 'enlightened' community, as irrational and anti-scientific.

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[4] France, may of course, have had different experiences in relation to resurrectionists.

Richardson paints a grizzly picture of the commodification of dead bodies prior to the 1830s:

> Corpses were bought and sold, they were touted, priced, haggled over, negotiated for, discussed in terms of supply and demand, delivered, imported, exported, transported. Human bodies were compressed into boxes, packed in sawdust, packed in hay, trussed up in sacks, roped up like hams, sewn in canvas, packed in cases, casks, barrels, crates and hampers; salted, pickled, or injected with preservative. They were carried in carts and waggons, in barrows and steam-boats; manhandled, damaged in transit, and hidden under loads of vegetables. They were stored in cellars and on quays. Human bodies were dismembered and sold in pieces, or measured and sold by the inch (...) No longer worthy of respect, the body of each of these people became a token of exchange, subject to commercial dealing, and then to the final objectification of the dissection room (ibid.: 72).

The Anatomy Act of 1832, whilst attempting to present itself as a piece of enlightened legislation – benefiting science and in the name of progress – seeking to outlaw the practice of the resurrectionists, ended up serving up more dead bodies to anatomists and medical students. The Act included a provision for any 'unclaimed' bodies to be used for dissection; however, unclaimed bodies were most likely to be from workhouses or hospitals for the poor sick (ibid.). The fact that these bodies tended to be from the poor is no coincidence. The bodies of the rich or well off, dead or alive, were accorded more status and respect. Ignoring the existence of social structures, or thinking that they were not relevant in the pursuit of science, resulted in the fact that one of the founding disciplines of medicine was build on the exploitation of the poor and the commodification and exploitation of their dead bodies.

If the practice of medicine was predicated on the dead objective body it is perhaps not surprising that it is sometimes characterised as being inhuman and lacking feeling. As Leder points, out this presents a paradox for medicine:

> After all, the dead body is frequently the symbol of failure and termination of the therapeutic project. The business of the doctor is to attend the living, not the dead, and to preserve life in all but extreme circumstances (Leder, 1992: 17).

Institutional Power in Medicine

Criticism of the practice of medicine and the medical profession is nothing new. In the eighteenth century, Hogarth used his work to depict the doctor and his practices in various guises, none of which were particularly flattering. The final picture, The Reward of Cruelty, in his series, The Four Stages of Cruelty (1751), famously illustrates a public dissection of a criminal. As Porter (2001: 49) comments:

> So upon what is the President – or Hogarth – sitting in judgement: the felon or the business of anatomy? And what precisely is there to choose, this moral twist invites us to ponder, between murderous malefactors and dissecting doctor?

Doctors were depicted as 'quacks' dispensing medicine of a dubious nature that could do more harm than good. (See, also Hogarth's Drs Rock and Misaubin in A Harlot's Progress.) The nineteenth century saw a rise in respectability of doctors and their practice alongside the developments in medicine outlined above. This trend was epitomised by the Medical Act of 1858 which set up the General Medical Council (GMC) as the body which would register all doctors and control their training, marking the increasing professionalisation of the practice of medicine. Doctors in the Victorian age might be depicted as men of science engaged in reforming activities for the social good (ibid.).

It was this growing professionalisation of medicine that became the subject of criticism a century later. Friedson (1970) believed that it was not in the interests of professions to share their knowledge and skills with outsiders, as to do so would mean that their services would soon not be required; it was in their interests, therefore, to maintain control over all aspects of their service. The medical profession was characterised, particularly in the 1970s and 1980s, as a powerful institution that caused harm rather than one that was trying to relieve suffering; and, in addition, it was accused of 'medicalising' everyday problems. (See, for example Oakley, 1984 on the medicalisation of pregnancy and Gabe and Williams, 1986, on the prescribing of tranquillisers for women.)[5] This trend towards medicalising people's lives was also

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[5] Interestingly these issues have now been incorporated into the medical literature. The BMJ produced a series of articles on 'non-diseases' in 2002. See, for example: Clark (2002) on the medicalisation of dying; Johanson, Newburn & Macfarlane (2002) on the medicalisation of childbirth.

seen as a way in which the profession was able to gain more control over people's lives, in effect, empire building or 'medical imperialism' (Illich, 1977). Some radical feminists, like Corea (1985), took this argument one step further and saw the use of reproduction technologies in medicine as another way in which men could gain control over women's lives.

Strong (1979), whilst acknowledging that such criticisms provided necessary checks and balances for the profession, cautioned against adopting simplistic arguments against medicine, in particular because they underestimate, or ignore, the benefits that it can confer and because medicine cannot be represented as a homogeneous profession. Williams (2001), in his recent review of Strong's work, also highlights the fact that there is now a current trend towards the de-professionalisation of medicine; for example the rise in litigation against doctors; the increasing use of complementary medicine; and the blurring of boundaries between the role of the doctor and the role of other health professionals. Medical professionals may also be losing some of their independence, for example through the growing power of non-medical managers in the NHS (Hunter, 1991).

Moreover, Osborne (1994:29) cautions against a certain 'sentimentalism' within anti-medical perspectives, by which medicine is seen as having little regard for people and alternative models are idealised as "humanistic, caring, individualizing, preventative, progressive, person-centred, phenomenological, ideographic, or whatever."

A further problem with a professional dominance model of medicine is that it can have a tendency to underplay, or treat as passive, the role of the individual. Individuals can gain knowledge about their conditions and choose alternative approaches because they are dissatisfied in some way with medicine. The growth in the use of complementary medicines and self-help groups can be viewed as examples of where individuals have done precisely this (Kelleher, 1994).

There is also a growing body of literature focusing on the notion of power as something that is not centralised around particular groups of people. This has interpreted the practice of medicine from a perspective that draws on Foucault. Rather than adopting an essentially Marxist view that power is essentially repressive, can be possessed by particular groups of people and operates from a powerful centre downwards, power is seen as essentially productive, is exercised and not possessed, and flows from the bottom up (Sawicki, 1991). Sawicki, in an alternative approach to Corea's (1985) mentioned above, subjects reproductive technologies to this type of analysis and acknowledges that, whilst they may reinforce existing power relationships between men and women, they also open up possibilities such as questioning established ideas about infertility and the whole concept of natural 'motherhood'.

Disciplinary power is exercised through individuals to normalise certain practices and can confer both benefits and disadvantages. This type of power is represented by Bentham's panopticon – a building in which everyone can be seen by a central observer (the all-seeing eye) – which ensures that people discipline themselves, even when they are not under surveillance. Medicalisation of everyday problems can be reinterpreted as the creation of new forms of disciplinary power and surveillance: an extension of the medical gaze into people's everyday lives. Nettleton (1994) outlines how the mouth was increasingly medicalised and how disciplinary power was exercised through increasing attention being paid to daily rituals relating to teeth cleaning. Although this growing disciplining of the mouth might be seen as being in dentists' best interests, one can also see some benefits in having a 'healthy' mouth.

Countering the Medical Body

Attempts to 'humanise' medical practice can be seen to reflect the conflict between the medical and the everyday body, or between the body as object and the body as subject. This is exemplified in calls for doctors to adopt a more whole person approach to the care of patients, which takes account of the patient's experience and feelings; in effect to pay attention to the everyday body.

The body has always been central to the practice of medicine, which has the physical objective body at its centre, as disease was considered to be located in this body.[6] The bodies at Alder Hey and in the Marchioness disaster can be seen to have been viewed, by the medical practitioners involved, as disembodied, possessing no emotional

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[6] To avoid confusion, I have steered away from discussing the mind as the subject of psychiatry in this work.

meaning. In addition, the live body can also be seen as being disembodied within medicine. In some respects the very notion of needing to think about one's body because it needs attention in some way renders it an object (Radley, 1997) – I have a body. However, according the patient body the status of the medical body has consequences for patients. According to McDonald and McIntrye (2001:237):

> Disembodiment, through the objectification of bodies in medical or technical discourse, serves, we would suggest, to undermine the essential experience of the patient, but also interferes with the meaning-making process that accompanies, for many, the experience of illness or disability.

This disembodiment can be illustrated through a number of different medical practices; for example Anspach (1988) looked at the language used during case presentations.[7] In her discourse analysis, she found that case presentations had four characteristics, all of which contribute to objectifying the patient's body and to underplaying the role of their experience of illness. These were: separating the biological processes associated with the disease from the person, leading to a de-personalised account; using the passive voice in reports and removing the agent of an activity (this is standard scientific discourse), for example "the patient was admitted…."; using medical technology rather than a person as the agent of an activity; and, finally, treating patients' accounts of their illnesses as subjective viewpoints lacking status.

Mishler's (1984) discourse analysis of the medical interview (or history taking) showed how the encounter was structured in such a way as to restrict a patient from telling their story within what he calls the inherent tension between the 'voice of the lifeworld', which reflects the patient's narrative, and the 'voice of medicine' which is focused on the doctor's agenda. The latter tended to dominate the encounter but the tension remained throughout. Similarly, Waitzkin (1989) showed how doctors suppress the patient's voice through inattention to contextual information which doctors deflect by offering technical solutions and advice on adjustments to daily living. Whilst doctors may feel they are unable to deal with such contextual information, Waitzkin links these

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[7] The case presentation is the process of presenting to either peers or more senior clinicians. Case presentations form part of clinicians' work and the ability to deliver a case presentation competently is seen as an integral part of professional practice and is, therefore, important in medical education. The patient is usually physically removed from the student and others listening to the case presentation.

interactions to structural issues of control: "The exclusion of social context from critical attention is a fundamental feature of medical language, a feature closely connected to ideology and social control" (ibid.: 232).

Such work illustrates how people's 'subjective experiences' have made a (re)appearance in the practice and criticism of medicine. In 1977, Engel, then a Professor of Medicine and Psychiatry, brought together a number of concerns in an influential paper outlining the shortcomings of a professional knowledge of disease which was separated from any social or psychological context (Engel, 1977). Engel proposed that the biomedical model should be adapted to take into account the social and psychological dimensions of disease as well as the 'scientific' as, without the former dimensions, patient care would be compromised. This model, whilst challenging the status quo by outlining the importance of people's subjective experiences in the 'business' of medicine, advocated that they be incorporated into the essentially scientific model. Others have criticised Engel's biopsychosocial model for retaining a value-neutral view of science and attempting to turn people's experiences into objective facts (see, for example Shotter, 1993).

However, the attention on people's subjective experiences may have other, perhaps unintended consequences. Armstrong notes "Steven's *Medical Diagnosis* of 1910 offered 3 pages out of 1500 to the 'interrogation of the patient'" (Armstrong 1984: 738). As I outlined above, the role of the patient was to speak for their illness or pathology in order that the doctor could make the correct diagnosis. Armstrong charts the growing tendency, during the twentieth century, for medical texts to include more questions for doctors to ask about a patient's history. This was particularly the case after the mid-twentieth century, when a rise was also seen in an interest in psychological illness and an associated interest in individuals' 'social spaces' such as their anxieties. This can be viewed as medicine incorporating patients' subjective experience into their practice or, as Armstrong believes, as another way in which medicine extends the medical gaze into hitherto uncharted territory.

The irony may be that increasing calls for a more humane approach to medicine in the second half of the last century, which have spearheaded initiatives like the development of a 'patient-centred clinical method' (Stewart et al, 1995), may have served only to medicalise what Armstrong calls the “social spaces between our bodies” (Armstrong, 1984: 739).

The patient-centred clinical method requires a doctor to conduct a consultation, interweaving knowledge about the patient’s disease and their illness (i.e., the patient’s experience) in order to come to an agreed decision about treatment. In this method, however, a differential diagnosis – most likely diagnoses – is developed from asking and listening to answers to questions that relate to ‘disease’. So, although the patient’s experience is taken into account, the information seems not to be directly relevant to the diagnosis of the disease; rather, it is used to help agree on a management plan (Stewart et al, 1995). The social and psychological aspects of illness are considered important primarily because they help the doctor to practise a more ‘humane’ and acceptable form of medicine; but knowledge about the disease remains objective and patients’ interpretations of their experience remain subjective.

The concept of patient-centred medicine can be seen as a means to counter criticisms by using an emancipatory discourse to make doctors’ role appear more holistic and enabling the medical profession to maintain its powerful position. So a focus on the objective physical body and its disease could also be viewed in an alternative, more positive, light.

The Medical Curriculum and the Body

The developments in medicine and the challenges to its practice are reflected in the undergraduate medical curriculum. In 1889, the John Hopkins Medical School in Baltimore was established and this School was the first to organise medical education in a systematic way: the professors of the various disciplines of medicine, surgery, obstetrics and pathology ran the teaching units. In 1910, Abraham Flexner produced his influential report on medical education that became the blueprint for twentieth century medical curricula both in America and the UK. Flexner was convinced that medical students needed a thorough grounding in the natural sciences and the split between pre-clinical (sciences basic to medicine) and clinical aspects of the curriculum, which still exists today, emanated from his report. Science was seen as the key to progress and, for the first two years of the curriculum, medical students would essentially be taught by scientists not physicians. Flexner's recommendations excluded the incorporation into medical education of alternative approaches which were seen as unscientific quackery (Kennedy, 1981; Porter, 1997). Kennedy (1981) points out that the approach to teaching about health was essentially interventionist: students would learn about what medicine could do and what drugs were most appropriate. This was underpinned in the US by huge amounts of private funding for medical science and education.

The recommendation for the pre-clinical/clinical divide was formally adopted in Britain as a result of the Goodenough report in 1944. It also spearheaded the introduction of subjects like social medicine, psychiatry and child health into the medical curriculum (Milnes Walker, 1965). These were gaining recognition as relevant subjects for medicine as interests in patients' social spaces gained ground as outlined above. The increase in specialisation was also represented in the developing medical curriculum: clinical components were organised around attachments in the specialist areas. The Goodenough report also instituted the GMC as a validating body – ensuring quality of medical education – for medical schools but also ensuring professional control of the medical curriculum.

It should be noted that not everyone agreed with the predominance of the biomedical sciences in the medical curriculum. In 1933 a pathologist, Sir Andrew Macphail, wrote:

> I am well aware that in these days, when a student must be converted into a physiologist, a physicist, a chemist, a biologist, a pharmacologist, and an electrician, there is not time to make a physician of him [sic]. This consummation can only come after he has gone out into the world of sickness and suffering, unless indeed his mind is bemused by the long process of education in those sciences, that he is forever excluded from the art of medicine (quoted in Porter, 1997: 533).

By the time the GMC recommendations for undergraduate medical education appeared in 1993 under the title of Tomorrow's Doctors, some medical schools were attempting to break down the pre-clinical/clinical divide by incorporating problem-based learning curricula in which students studied both clinical and scientific aspects of cases throughout their training. Others were organised around body systems in the first two years and essentially retained the divide. The recommendations focused around external factors which influenced medical education; for example a growing recognition about the following: that disease is not just a concern of the individual, public health is also important in determining treatment and planning for services; that the majority of medicine is now practised in the community setting rather than the hospital; that there is an increasing demand for non-traditional or complementary medicine; and that doctors need to communicate effectively with their patients.[8]

Unsurprisingly, the medical curriculum has been the focus of interest for researchers outside the profession. Early work, particularly in the US, was concerned with how the medical curriculum contributed to the professional socialisation of medical students. For example, Merton et al (1957) focused on how medical students were effectively ‘student physicians’ and how their training facilitated this role. *Boys in White* (Becker et al, 1961), explored the role of student culture in determining students’ actions. This culture encompassed the ‘best’ ways that students saw for dealing with patients, staff and other medical students. For example, students’ views about patients differed but appeared to draw on a set of practices relating to being a medical student. Students viewed patients who had a ‘real disease’, that is one with an identifiable pathology, as being the best patients because they felt they could learn the most from them. ‘Interesting cases’ were those (patients) who could teach students something they didn’t already know and so cases differed from student to student. The following extract illustrates this point:

> Prentice and Farmer were discussing who ought to get the patient they had just been shown in the clinic. Farmer said, “I’d kind of like to have him because I haven’t had a haemorrhoid case.” Prentice said, “Well, I’ve had two so I’m not particularly anxious to have another one. We can just trade. I’ll take the next one.” Farmer said, “Gee, that’s nice of you.” Prentice said, “Oh, that’s all right. It wouldn’t do me much good to have another one (ibid.: 330).

Rather terrifyingly, this extract reminds me of the commodification of the body for dissection before the 1832 Anatomy Act discussed by Richardson, above. However, it also highlights how students’ educational needs (or the way that these are presented or perceived) may conflict with a requirement to show concern and respect for patients and their bodies (see also Hicks et al, 2001).

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[8] Tomorrow’s Doctors was updated by the GMC in 2002 but there is little substantive difference between the two reports.

Lief and Fox (1963) introduced the concept of 'detached concern' again linked to the professional socialisation of medical students: the curriculum served to socialise students into an attitude of detached concern for their patients, the "process by which students gradually learn to combine the counter attitudes of detachment and concern to obtain the balance between objectivity and empathy expected of mature physicians in the various kinds of professional situations they encounter" (Fox, 1988: 56). They studied students' activities in both the pre-clinical and clinical years and also identified the training as training for uncertainty.[9] Fox (1988) writes how students' experiences of autopsy (post mortem in the UK) promote an emotional response of detachment. During the autopsy, certain rituals – for example washing hands, rolling up sleeves – alongside referring to the body by a number rather than a name, served to de-personalise the activity. Detachment was further reinforced by attention being focused on the medical science related to the autopsy and engaging students in an intellectual activity. Discussion amongst students about the autopsy did not tend to include any emotional responses, helping to maintain detachment. Students had to find a balance between this detachment (seeing things objectively) and being concerned for their patients. This process forms part of socialisation into the profession and acts as a preparation for their engagement with patients. During the clinical years, students are socialised into the use of a language that portrays detachment (Lief and Fox, 1963) paralleling Anspach's (1988) work outlined above.

When comparing the socialisation of medical students in 1950s America with practice in the 1970s, Fox paints a rather idealised version of what she terms the 'new medical student' who she hoped would be the doctor of tomorrow. This new medical student would not objectify the body of their patients and would have scant regard for the traditional 'detached concern' model of medical practice:

> A "detached concern" model of relating to patients is not one the new medical student admires or would like to exemplify. Rather he [sic] places the highest value on feeling with the patient. Although he recognizes the need for maintaining some objectivity in this relationship, he does so with regret. For him, he says, to feel is to be human and compassionate; it dignifies and heals; and the more one feels the better.

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[9] Atkinson (1995: 115) has criticised this focus on the theme of uncertainty in medicine by Fox and others as being sociologically reductionist and has posed an alternative view that knowledge and experience in medicine are seen as "warrants for certainty".

> However scientifically and intellectually inclined he may be, the student believes that it is all too easy to distance oneself from patients (and from one's own humanity) by approaching the problem for which they seek the doctor's aid in an overly conceptual or technical way (Fox, 1988: 100).

This rather 'rosy' picture was painted at a time when the biomedical model of medicine was being challenged in an attempt to humanise medicine, showing how the calls for the introduction of patient-centred clinical method were mirrored in curriculum developments; for example, the increasing attention to the teaching of psychology and sociology applied to medicine and the introduction of communication skills training. The introduction of problem-based learning can also be seen as a way in which curricula were attempting to reflect a less disease and more patient-orientated approach. Fox is, however, advocating a view of medical education in which the everyday body is seen and acknowledged.

Two more recent additions to this literature, Carter (1997) and Giegerich (2001) follow medical students, again in the US, during a period of anatomy classes. In both cases, the full body dissection was followed by a memorial service for the bodies that served to remind students of where the body they had been working with had come from. Carter, a literature professor, sees students' learning on the body in anatomy as necessary preparation for their work with bodies of living patients: work with dead patients provides the necessary training in detachment. Once again, knowledge about the dead body is seen as the model for knowledge about the live body. However, rather contradictorily, Conrad (1988: 325) does acknowledge that this 'necessary' detachment with dead bodies may not be an appropriate approach to adopt with patients' live bodies:

> To some extent this de-personalization is an occupational hazard for medical practice, but much of the subsequent medical education serves to extend this attitude unnecessarily to living patients.

Hafferty (1991) also focuses on the dead body and the Dissecting Room (DR) in the medical curriculum and its use as part of the emotional socialisation process of medical students. His work showed how medical students perceived and reacted to the body in different ways but, the more reminders that the body was human, the more likely it was to provoke anxiety (the "human referent"). He also explored how the medical school transmitted the norms and values of medicine to medical students and how students took on professional roles, much as Merton had written about; and how students developed coping strategies particularly in relation to the work-load, similar to that outlined by Becker. Part of the socialisation process was the suppression of emotional responses:

> (…) all were aware at some level that under certain (but largely undefined) circumstances, a public display of empathy and corresponding personal anguish was frowned upon within the culture of medicine. Introspection and reflection are terminal diseases in medical school. In the eyes of one first-year student, there is no place in doctoring for personal understanding (Hafferty, 1991: 191).

Thus the students must suppress their own self or everyday body as they train to be doctors (see, also Smith & Kleinman, 1989).

A recent insider/outsider account from the UK is Sinclair's Making Doctors (1997), in which he charts medical students' socialisation into medicine through an education and training that enables students to develop four dispositions: Experience, Knowledge, Status and Responsibility. Physical examinations can be seen as gaining experience, in what he believes "is a matter of learning to recognise what there is to be found, which (as in the DR) means knowing what you're looking for (…). The techniques of examination are frequently taught and students are urged to practise them again and again, so as to learn to recognise abnormal 'signs' of disease from the normal" (1997: 202). So the patient's body is a medical body represented by signs of disease and it is these signs that students are encouraged to be interested in and to practise looking for. Other aspects of the patient's body are out of sight and we can see again how the medical curriculum might serve to encourage the objectification of a patient's body.

In 1988, Light criticised the focus on socialisation and social psychology in the research, which underplayed the institutional or structural aspects of medical education. The focus on humanising medical education through the introduction of humanities, communication skills and early patient contact had not led to "evidence that seeing patients sooner or discussing literature makes clinicians more sensitive to patients" (ibid.: 312). Bloom (1988: 294) sees the humanising agenda of medical education as "little more than a screen for the research mission which is the major concern of the institution's social structure" in an attempt to explain the resistance to change.[10] Misher's and Waitzkin's work outlined above confirm this view, along with the importance of attending to political aspects of medical encounters (see, for example Waitzkin, 1991). Hafferty does identify ways in which wider social issues are played out in the DR; for example, issues related to gender and age: "Although the age of the cadavers at death was unknown to students, virtually all bodies seemed old, even "ancient" and the older the cadavers looked, the less human they became" (Hafferty, 1991: 194).

Atkinson (1997) observed medical students undertaking the clinical parts of the curriculum in his book, *The Clinical Experience.*[11] His research attempted to reveal what happened 'at the bedside', which had been seen as a taboo subject only open to insiders (see, for example, Crooks, 1974).[12] He illustrates how the bedside encounter is a central act in the 'drama of the clinic' and how it plays its part in the production and reproduction of a culture of medicine and medical education, which treats patients as 'clinical entities'.

Insider accounts or autobiographies have been written by doctors themselves; for example: Klass (1987) who likened the DR to the initiation process for priesthood; and Konner (1987) who expressed a view that medical education was constructed so as to prevent concern for patients; and that there was no space to discuss feelings of discomfort when, for example, examining someone of the opposite gender. Rothman (2000), in another such account explored the tension between too much and too little intimacy with patients.

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[10] Although this was written about the situation in the US states 15 years ago, it resonates with today's financial agenda in UK Universities which are driven by the Research Assessment Exercise (RAE).

[11] 1997 is the date of the second edition of this book by Atkinson, originally published in 1981.

[12] Interestingly, I sometimes struggled during my research with the notion that perhaps I was not qualified to comment on students' experience, precisely because of my status as an outsider.

Rationale for the Research and Research Questions

In my introduction, I outlined the differences in response between the medical practitioners and the families of the dead to the use of the dead body. One interpretation was that they each saw the body in different ways. As Richardson's work, outlined above shows, this difference is also played out in historical accounts of the use of the body in medicine. Lupton (2003:50) notes:

> (…) there is historical evidence of a schism between the conceptualization of the dead body in medicine and that of the lay person; the former viewing the body as a commodity and teaching tool, the latter continuing to invest the corpse with respect and fear.

I was interested to explore how these differences in how the body is conceptualised affect how medical students work with the body, both alive and dead. The medical curriculum, as work on professional socialisation has shown, serves to introduce medical norms and practices to students and their medical education is, therefore, likely to help form students' understandings about the nature of the body in medicine. How the body is conceptualised by students is likely to have consequences for how patients and their bodies are treated.

My primary concern in my research was to explore how students work with the physical body. In particular, I was concerned with the complexity and tensions that surrounded their encounters and how these affected their interactions with patients. I attempted to uncover how they reconciled some of the tensions between these different views of the body bearing in mind that medical students span two worlds: that of the lay person early on in their studies and that of the doctor as they progress further into their programme. I was also interested in how the medical curriculum at Southampton University might serve to support or discourage students objectifying the patient's body, students' reactions to these educational requirements and the place of their agency. [13] Furthermore, I was keen to use the findings from the research to suggest practical implications and possible ways forward.

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[13] I use the work 'curriculum' in the broadest sense to cover both the stated/formal course or programme as well as the 'hidden curriculum', that which is embedded in the environment in which the stated curriculum takes place and "being more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques" (Hafferty & Franks, 1994: 865).

Students encounter the body in different forms throughout the undergraduate medical curriculum: as dissected or recently dead; as an anaesthetised, unconscious patient in the operating theatre; and as conscious patients. These have acted as organising frameworks for my work.

The design of the research has developed over time with a first exploratory phase enabling me to refine my research questions by gradually focusing on specific areas of interest. At the end of the first phase the following emerged as my major research questions:

1. What is the ontological status of the different bodies that medical students encounter during their medical education?

2. How do medical students experience and work with dead bodies and unconscious and conscious patients' bodies; and what affects the ways that they approach and interact with these different bodies at macro and micro levels?

3. How do students deal with the tension between working with the body which, on the one hand, they may need to objectify or view in its component parts and, on the other, to view as the body of a person?

4. How does the medical curriculum support or contribute to this tension?

In my next chapter, I provide and discuss the rationale for the way that I approached exploring and attempting to answer these questions and the methods I used.

Chapter 2

Methodology & Methods

In this chapter, I begin with a summary of my research which includes the key aims of each phase and an outline of the research design. I then turn to ontological, epistemological and methodological issues of relevance to the research, which are followed by a section which details the research methods I used throughout the work. I finish this chapter by revisiting some methodological issues which arose during the study.

Summary of the Research

My research was organised around four different phases, each designed to contribute to an exploration of my research questions, which are stated at the end of the previous chapter. Phase 1 set out to help me, primarily, to identify my research questions and begin to identify some key issues. It involved a longitudinal study with the same group of students from years one to years three of the curriculum. Phases 2, 3 and 4 then aimed to address aspects of the research questions in different contexts. Phases two and three involved interviewing fifth year and third year medical students respectively, and phase 4 was concerned with the analysis of key curriculum documents and texts. Table 2 below summarises the 4 phases, their main aims and the relationship between each of the phases and my research questions.

Phase	Aim of the phase	Research questions
1	To develop and clarify research questions by exploring students' encounters with 3 different physical bodies in the medical curriculum: dead and dissected, conscious and unconscious patient body over a three year period. To carry out an in-depth exploration of students' encounters with dead and dissected bodies.	Development of the research questions and beginning to address questions 1-4
2	To carry out a focused in-depth exploration of students' encounters with the conscious and unconscious patient body in their fifth and final year.	1-4
3	To carry out a focused in-depth exploration of students' encounters with the conscious and unconscious patient body in their third year.	1-4
4	To identify the different ways that the body, and how they should interact with it, is represented to students through texts.	1 & 4

Table 2: The four phases of the research

I shall discuss the methods used and the rationale for their use in more detail later on in this chapter; however the primary research method I employed was in-depth interviews and the data generated from these was supplemented by documentary analysis of key documents that students are referred to throughout the curriculum; Figure 4 illustrates the main research activity of each phase of the research.

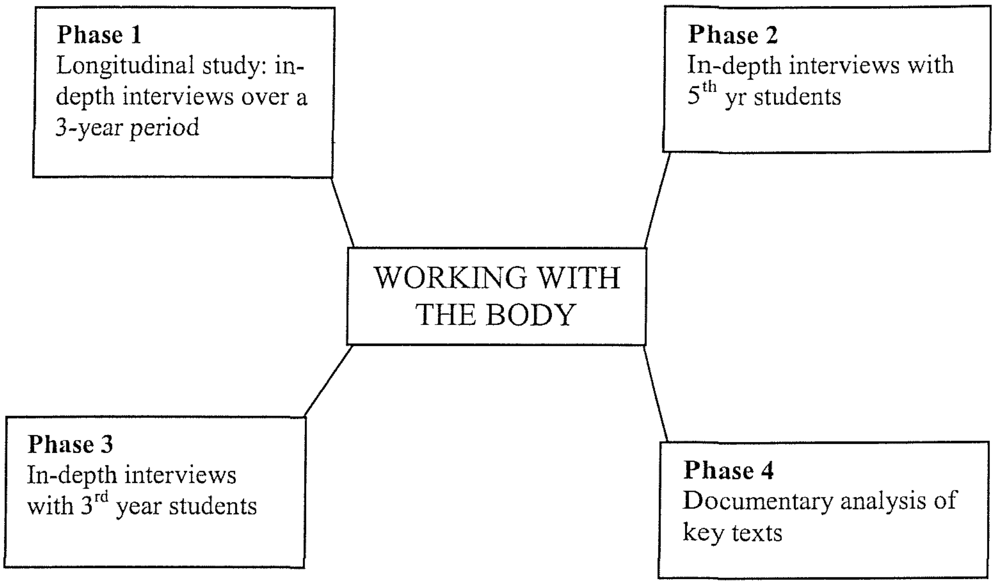

Figure 4: Outline of research design: methods used in the four phases

Ontological, Epistemological and Methodological Issues

This section sets out to consider my research in the light of the three main components of any research project: ontology, epistemology and methodology, making up what Denzin and Lincoln (2000) refer to as the paradigm or interpretative framework. (See Figure 5 for summary.)

ONTOLOGY	EPISTEMOLOGY	METHODOLOGY
Ideas/theories about the world and area of study.	Set of questions to ask about the area of study.	Different ways in which the questions can be answered.
What is the nature of what I am studying?	What can I know about what I want to study?	How can I know about what I want to study?

Figure 5 : The three components that make up the framework for a research project

During the time I have spent on my thesis I have travelled full circle in terms of how I have approached these issues. I began the work with a fairly pragmatic view about questions such as: What is it that I want to know about? and How can I know about it? As I began to consider these questions in greater depth I found myself attempting to try to fit my thinking and my work into a particular category: for example, the need to adopt a constructivist approach or to avoid a positivistic approach to my work. However, I then worried when I felt I was not being consistent or that a different epistemological position, like post-positivism, appeared appropriate for particular aspects of my work. Seale (1999: 25) helpfully reminded me that philosophical differences should be "resources for thinking" rather than "problems to be solved". It is in this light, then, that I attempt to discuss the different positions and aspects of them that are appropriate for my work.

Cohen et al (2000) adopt Burrell and Morgan's scheme for thinking about the three components of research and this is a useful starting point which I have adapted in figure 6 below.

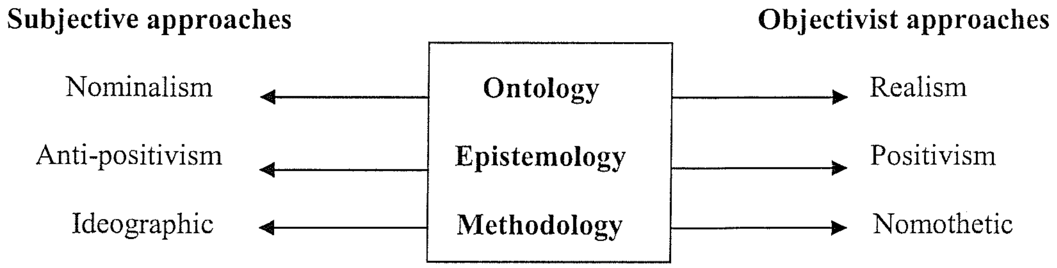

Figure 6: Different dimensions for three components of research
Adapted from: Cohen et al (2000)

Essentially the scheme identifies the extreme ontological, epistemological and methodological positions within the subjectivism/objectivism dualism that permeates thinking about the nature of social reality. Objectivist approaches could crudely be interpreted as explanations for society which have an independent existence (realism), can be known objectively (positivism), and which consist of structures and institutions which determine individual and group actions. In contrast, subjectivist approaches arise from an understanding of society which cannot be separated from the individual's consciousness (nominalism) and therefore can only be known through the subjective actions of, and interactions between, individuals (anti-positivism). Objectivist approaches can be seen to adopt methodologies which are designed to determine generalisations; whereas subjectivist methodologies focus on the interpretation of individual behaviour (Walsh, 1998a; Cohen et al, 2000).

My work is concerned with exploring medical students' encounters with the body in various settings: how they interact with different bodies and what social or structural aspects influence their interactions. I am, therefore, interested in the nature of the body that students work with; how students work with the body; how what they do may impact upon the settings and structures in which they work (agency); and how these in turn influence students' interactions (structures).

In attempting to explore how students work with the body, it is essential to acknowledge the complexities that surround the notion of the 'body'. Western conceptions of how we view bodies since the eighteenth century, particularly in the field of medicine, have been founded on both Cartesian and positivistic views of the world in which the body can be seen as an objective physical reality existing independently from the mind; in effect, then, the construct of the 'medical body' can be seen as a Cartesian stereotype. In *The Treatise of Man* Descartes likened the body to a machine: "I assume their body to be but a statue, an earthen machine" (quoted in Watson, 2000). The medical body can, therefore, be fixed if we know the 'correct' cause (aetiology) and apply the 'correct' treatment. However, within such a viewpoint the body and mind are not just separate entities; there is also little interaction between them. This separation has led disciplines to focus on different entities: medicine and the natural sciences have been concerned with the realm of the objective body, whilst the humanities covered the subjective mind (Turner, 1992).

Objectivist approaches, although very different from each other, also have their foundations in a positivist approach to reality and knowledge and thus are founded on a similar ontological and epistemological viewpoint and, dating back to Comte (1798-1857), reflect a naturalistic view of the social world which can be known and discovered through systematic observation. The acquisition of knowledge, as in science and medicine, is predicated on the Cartesian principles of measurement, reason and objectivity. Knowledge about the 'natural' world, because it is seen to exist independently from human beings, is regarded as value neutral. Such knowledge, when uncovered through the use of scientific or other systematic methods, can be considered the objective truth; the world and social reality can be controlled, observed and measured to reveal its secrets. Once something has been objectively defined using this process, reason can then be applied to make generalisations (or to construct universal laws) and predictions about the truth.

'True' knowledge then, within a Cartesian and positivistic paradigm, is that which can be objectivity known, is generalisable and exists independent of the knower. Knowledge is not subjective and is not influenced by either the 'subject' of the research or the researcher. Hence, if I was writing up research using such a paradigm, I would not expect – or be expected – to write up how my actions or thoughts as a researcher influenced the process and the outcomes. If I adopted a positivistic approach to my work, therefore, the physical body which I am attempting to explore would only have meaning as an objective physical entity and my understandings about students' interactions with the body would not necessarily encompass students' individual actions and experiences. Any research approaches that I adopted would be more likely to be quantitative in nature and would be systematically applied to reveal a 'truth' that could be reproduced by others if they carried out a similar study.

The major problem with this approach, in the study of the social world, is that it assumes that human behaviour is predictable, controllable (in order to enable the researcher to study it) and measurable. One reason why objectivist approaches may focus on structural aspects of society is precisely because human actions and motivations are unpredictable – subjective – and therefore cannot be controlled and measured. For example, functionalism has its foundations in a notion which asserts that societies exist in order to carry out specific functions or needs. Parsons, one of its leading exponents, was concerned with developing a theory for understanding society in which three components – culture, social systems and personalities – are integrated within an ordered society. Personalities relate with each other and act (predictably), both according to practice and tradition and to their allocated position within the social system (Cuff et al, 1998). Parsons' theories have been criticised for a number of reasons: not least because they are predicated on the assumption of an ordered society in which people function in predictable ways. An additional reason, however, which can be applied to other functionalist thinkers, is that 'society' tends to be accorded attributes like 'needs' that can really only be applied to individuals, and yet individual agency is not the focus within this approach (Giddens, 2001).

Subjectivist approaches, on the other hand, have attempted to overcome these potential limitations by focusing on explanations of social actions and interactions and their meanings, whilst eschewing generalisations and predictions in favour of the search for meaning and the interpretation of unique situations. Within such interpretative frameworks, social actions can be understood not by trying to control the setting, but by studying events in their natural setting (naturalistic inquiry) and adopting more qualitative methodologies. Within these approaches, the subjective individual experience is given priority but, in order to make valid knowledge claims, this experience and its interpretation need to be seen as objective knowledge in some way (Schwandt, 1998). In effect, then, whilst these approaches might be classified as anti-positivist (see Cohen above), they are a variation on the theme of positivism and could be classified as post-positivist.

Two examples of interpretative theoretical approaches are phenomenology and symbolic interactionism. Phenomenology has a long tradition: in the 1920s, Schutz questioned the assumption that we should rely on science and scientific methods to construct knowledge, rather than using any other means such as common sense to help us make sense of our lived experiences (Cuff et al, 1998). Phenomenology is concerned with describing and analysing people's individual experiences of their lives, the objective truth about which can be found within people's consciousness rather than externally. Society can be understood through people's shared understandings and experiences. Symbolic interactionists rely on three major assumptions in seeking to explore people's actions. First, how people act is dependent on the meanings that the things/people they are acting on, have for them; secondly these meanings come from the social interaction between people; third, these meanings are modified through interpretation. Truth arises through actions. The world is, therefore, understood through the study of individuals' behaviours and interactions (Schwandt, 1998). Such research tends to adopt a grounded theory approach in which theory is derived directly from empirical data using a clearly defined set of procedures, systematically applied.

In phenomenological and symbolic interactionist thinking, the Cartesian split between mind and body is also undermined: the two are seen to be inextricably linked. Hence the notion of the 'lived body' in phenomenological thinking which I referred to in my previous chapter: "The notion of the lived body rejects this conflation [between mind and body]. It holds that the body of a living thing has an essential structure of its own which cannot be captured by the language and concepts used to explain inanimate nature" (Leder, 1992: 25). Within a phenomenological discourse the body is embodied, as Toombs (1992:51) explains: "At the level of the lived body I do not "have" or "possess" a body, I *am* my body". To reiterate, the body and self are one and it is through bodily senses that one experiences the world.

These two theoretical approaches are relevant to my research as they are concerned with deriving meaning from individual experiences and from interactions between people: my work seeks to understand students' experiences with different bodies and the interactions they undertake in different contexts. Moreover, attention to the 'lived body' is necessary because adopting a purely Cartesian view of the nature of the body would bind me to its conceptualisation as essentially 'medical'; rather than enabling me to incorporate the further construct of the 'everyday'.

Both positivist and interpretive approaches have been censured by critical theorists for their lack of attention to the politics, ideology and power relations within which social action takes place. For example, focusing on a group of individuals' experiences may lead a researcher to understand and interpret meanings within a particular social context but such understandings need also to be understood in the light of repressive structures and practices in society. For Habermas (1972), a leading exponent of critical theory, 'worthwhile' knowledge can be 'technical' (positivist) and 'practical' (interpretive) but must also be 'emancipatory':

> Its intention is not merely to give an account of society and behaviour but to realize a society that is based on equality and democracy for all its members. Its purpose is not merely to understand situations and phenomena but to change them. In particular it seeks to emancipate the disempowered, to redress inequality and to promote individual freedoms within a democratic society (Cohen et al, 2000: 28).

Critical theorists might adopt research methods such as ideological critique or action research. Whilst critical theory adopts a discourse of emancipation which, I think, is unlikely to be realised in practice because of structural constraints, it has relevance to my work in that part of my research seeks to identify how the different views of the body impact on patients. I hope that my work may have practical and political implications for the use of the body in the medical curriculum and it is for this reason that I am interested in approaches that may change the way that patients' bodies are used in medical education.

One further research tradition that I will now address is constructivism. Dualisms such as subjectivist/objectivist approaches to social reality or everyday/medical bodies are seen as essentially irrelevant in a post-modern world in which knowledge and structures are viewed in terms of individual power and discourses. A postmodernist position would question the pursuit of any objective knowledge because knowledge can only be socially and historically situated: what might be seen as the truth in one historical context would not be in another (Kuhn, 1970). The world can never be separated from the knower and so all knowledge becomes subjective; there can be no objective truths. The world is not out there ready to be uncovered or understood; rather it is constructed in the minds of individuals in order to make sense of the world. Multiple realities or truths exist in the signs, practices and discourses that we construct. How knowledge is constructed and what is viewed as valid knowledge is dependent on the norms and practices of the society in question: that which is seen as valid today might not be tomorrow. Groups of people, for example scientists, agree and share their constructions of knowledge claims; all knowledge, therefore, becomes relative and subjective (Guba & Lincoln, 1998). Social constructionists believe that our constructions are influenced by social structures and processes. An extreme position to take up would be the contention that the body does not exist as a separate, natural entity as it cannot be separated from cultural influences:

> There is no such thing therefore as the purely 'natural body', the body that may be separated from society and culture. This is not to argue that the material world or 'real' phenomena such as pain, disease, or death do not exist. Rather it is to contend that we can only ever know, think about, and experience these realities through our specific location in society and culture (Lupton, 2000).

A 'weaker' social constructionist position would be one in which bodily experiences are merely influenced by society and culture (ibid., 2000).

A relativist approach to social reality has its own drawbacks: if everything is relative, how can we know anything and, therefore, how can we make decisions about what is morally right or ethical? One further consequence is that, if one adopts an extreme position that nothing can be known outside our own subjective constructions, then there can be little point of undertaking research other than research into ourselves; and in fact some autobiographical research arises from this viewpoint. Whilst such methodological research might be interesting, and I believe aspects of my 'story' form an important part of my research, on its own it will say very little about students' experiences of their encounters with the body.[1]

My discussions so far have focused on four major paradigms of research and the underpinning beliefs relating to these are summarised in Table 3 below.

Component	**Positivism**	**Post-positivism**	**Critical theory**	**Constructivism**
Ontology	Knowable 'real' reality; naïve realism	'Real' reality but knowable only imperfectly and probabilistically; critical realism	Historical realism – virtual reality shaped over time by different values	Relativism – constructed realities
Epistemology	Objectivist; 'true' findings	Modified objectivist; critical tradition; probably true findings	Subjectivist; value-mediated findings	Subjectivist; created findings
Methodology	Experimental; verification of hypotheses; mainly use of quantitative methods	Modified experimental; falsification of hypotheses; may use qualitative methods	Dialogic/ dialectic	Hermeneutic/ dialectic

Table 3: Underpinning beliefs for four paradigms of research.
Adapted from: Lincoln & Guba, 2000: 168

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[1] Of course a counter argument would be that I should not then be trying to represent students' voice unless I involve them directly in the process of research but undertaking to do this would still not resolve the essential problem.

An important issue implicit within much of the above discussion is that of the relationship between agency and structure, between micro and macro levels of influences on social actions. The central question is whether society is formed through individuals and their social relationships (agency) or whether these relationships facilitate the formation of autonomous external institutions (structure) that then determine the actions of individuals (Walsh, 1998b).

Research traditions have tended to focus on one or the other (ibid.): the problem of subjectivist approaches is the strength of objectivist approaches and vice versa. Within objectivist approaches individuals are subsumed by their social situation, as we cannot be seen to live independently of our social context. Such a viewpoint is deterministic in that the social system determines how individuals operate in the world. Social relationships serve to create social facts that make up the structures and institutions of society. Different theories are used to explain how society's structures operate; for example, simplistically, within Marxism, the way that social relationships are organised is seen to be dependent on the means and processes of production. A shortcoming of such theories is that they appear to underplay the role of the individual in making choices about actions and interactions, and objectify structures separating them out from the individuals who operate within them (ibid.).

Opposing such theories are those that put agency at the centre of their inquiry: individuals make up and construct the societies they live in. People are seen to act according to their own interests and values. The problem with these theoretical approaches (of which symbolic interactionism and constructivism are examples) is that it is difficult to deny that when people act on their own or together there is something external to them which organises and influences the way they or the group operates. For example, two colleagues and I cannot change the culture of medicine just by making choices or performing certain actions; and anyway the fact that we might want to change it implies some external reality. To understand the complexities of culture I cannot just study individuals who operate within it. In order to understand their actions I also need to understand the structures and institutions within which they are working and the different roles, hierarchies and forms of domination that exist within these. Different theorists have attempted to resolve the tension that exists between agency and structure; for example Giddens' (1986) structuration theory and Bourdieu's (1990) genetic structuralism. Both have been criticised for failing to do what they set out to in this respect (see, for example Swingewood, 2000).

All the different traditions and approaches outlined above have their strengths and weaknesses. Whilst I believe that we construct meanings, and these are influenced by the social and cultural context, I do not adopt an extreme view of this position in which everything is constructed and nothing exists independently of our constructions. I think it is difficult to study how students objectify or otherwise view the body without taking into account the dominant scientific discourse and the culture of medicine within which the medical curriculum is located; and I think I cannot research students' experiences and interactions without believing that these, and the interpretations that I attach to them, have some meaning.

I have adopted a qualitative methodological approach as I am not setting out to quantify or measure students' actions, but to try and understand them in the context of medicine and the medical curriculum and to attempt to provide an explanatory framework for students' encounters with bodies. However, although my research is not underpinned by any one particular research paradigm, I have adopted a post-positivist/critical perspective whilst acknowledging that aspects of social reality are socially constructed. Adopting an "eclectic perspective that approaches the same research problems from different theoretical and methodological angles" can be seen as a strength (Lupton, 2003: 21), and as Layder (1998:176) points out:

> Analytic approaches which presuppose that social reality can be understood by reference to some single unifying principle or feature, such as discourses, reproduced practices, figurations, intersubjective meaning, actors' reasons and motives, the duality of structure, must be abandoned since they embody and represent incomplete ontologies which lead to tendentious forms of analysis.

In this next section, I turn to the discussion of some of the key methodological issues which form the background for decisions that I made about undertaking the research.

Methodological Issues Related to my Work

Choice of methods

Although the majority of data generated within my research was through one-to-one in-depth interviews, I did consider a range of other possible methods to employ. Conducting focus group interviews with students would have enabled me to include a larger number of participants in my data sample; however I was aware that the area for discussion was quite sensitive in nature and I felt that interviewing on a one-to-one basis would provide students with a safer environment for them to discuss and disclose information about their work with the body. Undertaking observational methods were another option that I considered which again had advantages and disadvantages: one clear advantage is that I would have been able to observe students working with the body in practice; however I think my status as a lecturer would have impacted on the encounter and perhaps influenced the way that students behaved in the 'natural' setting. In addition, I felt my presence in the clinical environment had the potential to be intrusive and the observational data would not necessarily reveal how students felt about their activities, how they viewed the bodies they encountered or the difficulties and tensions they faced. A mixture of both in-depth one-to-one interviews and documentary analysis of key texts had the potential to be most useful in terms of generating data which would then help me to explore my research questions.

Interviews

Some commentators have noted the rise of the 'interview society' (see for example Miller & Glassner, 1997) in which there is an increasing tendency for the interview to be chosen both for research purposes and for other activities generally – as, for example, the prevalence of the use of the interview within the media. This necessitates thinking through the purpose of using this method which is not without its critics as interviews can be seen as a form of 'face work'[2]:

> The participant is answering in this way in order to perform certain interactive functions, for example appearing to be a good interviewee, or using expressions in order to convince the interviewer that he or she, the respondent, is an expert on this topic. (Smith, 1995:10)

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[2] See Goffman, 1969

As I wanted to explore how students experienced working with the body and how they negotiated their way around the tensions and contradictions they encountered, one way of being able to understand the complexity of their different activities and to explore how different students reacted to them, was to talk to students themselves in an interview setting. I started from the assumption that what students discussed with me in the interview was based on a 'reality': they may be re/constructing and interpreting their experiences as they talked to me about them (and I in turn interpreted what they said), but these interpretations were at some level meaningful. In effect, this is the only position I believe I can adopt, as to think otherwise would be to undermine the student's voice and to render it not meaningful and of little use to the research. As Miller and Glassner (1997:105) comment: "we have suggested that narratives which emerge in interview contexts are situated in a social world that exists outside the interview itself."

Mason (1996: 38) outlines three characteristics of qualitative interviews: a fairly informal style similar to a conversation or discussion; being centred around the themes or topics that the interviewer wishes to cover; and based on an assumption that the interaction that takes place within the interview generates the data. This notion of the interview as guided conversations or "conversations with a purpose" (Burgess, 1984:102) is problematic in that interviews differ sharply from everyday conversations when they are clearly based around the researcher's agenda. As Kvale (1996: 126) notes, there is a "definite asymmetry of power: the interviewer defines the situation, introduces the topics of the conversation and, through further questions, steers the course of the interview." Such semi-structured interviews are sometimes referred to as "focused interviews" (Merton & Kendall, 1946) or "exploratory interviews" (Oppenhiem, 1992) and use an interview schedule to guide the interview.

Documentary analysis

One of my research questions asks how the medical curriculum supports or contributes to the tension between working with the medical and the everyday body. I chose to include some documentary analysis in my research design as I was aware that the texts the students used were likely to represent or reinforce a view, or views, of the body and, therefore, might affect their encounters with bodies.

Slater (1998) outlines two key methodological approaches to the analysis of 'cultural objects': content analysis and semiotics. Content analysis was initially used for the analysis of newspapers at the beginning of the twentieth century (Robson, 1993). It is essentially a quantitative methodology, which is underpinned by a positivistic approach to data and its analysis:

> The central aim is to render issues of interpretation as controllable and non-contentious as possible in order to move quickly on to the more 'scientific' process of counting things (Slater, 1998: 235).

Essentially, the researcher must identify 'recording units' which might be words, paragraphs, amount of space given to a particular area etc., with associated categories for analysis. This allows the researcher to then count up the number of times the category arises in the chosen recording unit; that is its frequency. There are a number of limitations to this approach: primarily it can be viewed as a blunt tool to measure social activities which are both complex and immeasurable (ibid.), and this is in part, I believe, why categories tend towards the lowest common denominator. The claim that it is an objective approach to analysis is, therefore, open to challenge.

Adopting an approach based on semiotics has an advantage over content analysis in that it is clearly founded on interpretive methodologies. It is underpinned by Saussure's structural linguistics in which meaning is seen to be derived through a system of signs. Put simply, words derive their meaning from their relationship with other words in a system. Hearing or seeing the word 'body' is meaningless on its own without considering what conceptual meaning/s underpin it; for example the 'body' could be described as the physical shape of a human being if I am referring to the human body in its corporeal sense. The former is the 'signifier' and the latter, conceptual understanding, is what is 'signified'. Meaning is understood to be derived from the relationships between the two which are culturally and socially determined. Thus language is perceived as a social construct. Research using a semiotic approach looks at how signs relate to systems. So, for example, a literal reading of a piece of educational text on clinical examination would describe what it was about; a reading at a greater depth would attempt to interpret the text in relation to the cultural and social systems within which it has been produced; for example what does it tell me about the status of the patient's body that is represented and why this might be so.

Discourse analysis draws on semiotics and the notion that language has particular uses for particular ends. Discourses, here, might relate to "patterns of words, figures of speech, concepts, values and symbols" and are texts which describe particular people, groups of people, activities etc., in order to give them meaning (Lupton, 2003: 20).

There is an underlying assumption that texts (or indeed other cultural objects) can give meaning to aspects of social systems and that we can therefore understand or 'read' the social activities or the social world through them. Whilst I do believe that texts can be useful indicators of the meaning of the social world in which they exist and which they represent, this is also problematic. As Mason (2002) points out, they cannot directly represent reality precisely because of their constructed nature and because the researcher is usually analysing the text in isolation from the author and their intentions. She recommends adopting a critical and sceptical reading of documents used for analysis, constantly considering the context and purpose of the documents and, where possible, using them to contextualise data gathered through other methods, (see also Robson, 1993).

Data analysis and theory building

One of the purposes of carrying out research is to build or confirm theoretical ideas or concepts (Mason, 1996; Silverman, 1993; Strauss and Corbin, 1990). An argument against the building of theory from research could be mounted, particularly if the theory so derived is then used to oppress the people who were being studied or to suppress their voice/s. This is particularly relevant when researchers engage people who are from different cultures – anthropological studies – or people who have less status and power than themselves in their research. This is not necessarily an argument against developing theory *per se*: rather it is a call to be reflexive about the consequences of one's research (Reinharz, 1992).

Mason (1996) outlines three main approaches to theory building:

1. *Deductive reasoning.* Within scientific or positivistic paradigms of research this is often held up as the 'gold standard'. The researcher has a research design (often called a 'protocol') at the start of the work which includes a series of hypotheses that they would like the research to prove or disprove. The hypotheses are based on a theoretical position and so the research develops existing theory by strengthening, weakening or illuminating it.

2. *Inductive reasoning.* An alternative view of theory building is one in which theory is derived from the data and so data collection and analysis comes first, explanation and theory second. The classic example of this approach to research is grounded theory.

3. *Abductive reasoning.* In this approach, theory is generated alongside data generation and data analysis and each feeds in to the other simultaneously.

In reality it is unlikely that any of these approaches exist in a 'pure' form. Scientists move backwards and forwards between theory and data; and, for example, grounded theory approaches include a need to be 'theoretically sensitive'. I do not consider it is possible to approach research a-theoretically or to conduct research without theoretical ideas feeding into the analysis and explanations. Research is not carried out in a vacuum and the fact the researcher brings their own preconceptions and biases to each piece of work is one of the problems of a 'value neutral' positivistic approach to research. As Layder (1998: 22) comments: "Even a researcher who claims his or her theory is unaffected by theoretical assumptions would, unavoidably, be making a theoretical claim in this regard".

Given this debate, it is useful to outline the approach that I think is most appropriate for my research. Despite the proliferation of qualitative research using grounded theory and its use to signal rigour in analysis, (see Barbour, 2001), I have chosen not to use this approach as outlined by Glaser and Strauss (1967) or Strauss and Corbin (1990). As I discussed earlier, I wanted to address both agency and structure in the research and because my starting point was students' own accounts of their experience, I was aware my analysis may more easily raise issues of agency rather than structure. Grounded theory approaches might be more likely to compound this problem because of their focus on agency and the weaker link they provide to explore structures and institutions in society (see, for example Layder, 1998).

Mason (1996) does not give a name to her approach to analysing and theorising. Her recommendation is for the researcher to continually ask questions of the process that is being undertaken and to be ready to answer these questions about the research. She is concerned with the need to be transparent about the research process and intentions: data collection, sorting, organising and indexing, producing analyses and explanations being the major processes involved.

Layder (1998) has developed a method he calls 'adaptive theory', drawing on aspects of grounded theory alongside already existing, extant theory. He is attempting to develop an approach to theorising that can encompass both agency and structure whilst acknowledging both the subjective and objective nature of reality:

> Adaptive theory attempts to reconcile the idea that many features of social life must be explained in terms of actor's meanings and subjective understandings with the fact that other aspects of social life have more in common with natural phenomena and must be explained in more 'objective' scientific terms. Social phenomena, like structures, processes, settings and resources (as well as the mechanisms that facilitate them) must not be confused with human behaviour and activity even though they are directly implicated in it (ibid.: 140).

His notion of 'objectivity' is not the same as positivistic notions of the 'truth'; rather, he contends, that social structures can exist independently of individuals and their interactions. This I agree with, as discussed above. The adaptive theory approach, therefore, sets out to take account of subjective individual experiences and social interactions whilst acknowledging that these operate within a wider social context: all actions take place within a 'social setting' – a university, a medical school, a family – which is underpinned by norms, values and power relations, and because of this I think it is appropriate for what I am trying to explore.

The method involved in adaptive theory is concerned with linking individual or group behaviour to 'systemic phenomena' – social structures, organisations, power relations, ideologies. If a researcher concentrates on behaviour without taking into account these systemic phenomena then it is difficult to decide what behaviour is relevant within the wider context of the research and where to stop interpreting any behaviour: in other words the ability to be discriminating. Linking behaviour to systemic phenomena and considering how relevant each is to the other "has the effect of applying the brakes to the 'saturation' or 'carpet' generation of theoretical concepts" (ibid.: 154).

Adaptive theory results from the interaction between emergent research data and extant theory. The latter can be of two types: general (for example, Foucault's theory of power) and substantive (relating to a particular area, for example medicine). It is, according to Layder, relevant to "research focus (...) that concerns the interweaving between (...) 'social settings' and the 'situated activities' that take place within them" (ibid.: 156). My work is about students' activities within particular contexts across the medical curriculum.

The approach essentially involves undertaking the following activities after data collection:

1. *Coding relevant areas of data.* There are different types of codes: pre-coding or provisional codes which are likely to be changed or subsumed into other codes are identified early on in the analysis; core and satellite codes which then lead to the identification of possible concepts and may emerge directly from the data or be imported from the theoretical literature (orientating concepts).
2. *Identifying different types of concept.* This involves identifying what aspect of social reality the concepts refer to (or concept-indicator links). See Table 4 for a summary of what these cover.

3. *Writing theoretical memos.* As in grounded theory approaches, these are the researcher's notes that ask questions about and discuss the nature of the developing codes and concepts.

4. *Generating an adaptive theory.* The theory developed needs to be both grounded in the data and influenced by extant theory.

I found this approach to analysis and theory building towards the end of phase one of my research, after which I attempted to draw on Layder's framework in a bid to explore and link the role of both agency and structure in my theoretical explanations.

Type of concept	Aspects of social reality
Behavioural (ie description of some form of behaviour)	For example: • types of participant (e.g. student, consultant, GP) • social activities • nature/quality of interpersonal relationships - their meaning and interpretation
Systemic or structural	For example: • reproduced social relations, practices, positions – the setting and contexts of behaviour: bureaucracy, markets, types of organisation • underpinning power relations
Bridging or mediating (covering both interpersonal and structural aspects)	Behaviour that bridges the gap between agency and structure; i.e. grounded in behaviour but linking to structure; e.g. behaviour of those who are in control; interactions influenced by structures
General or theoretician's	Any of above but linking to general theory

Table 4: Concept-indictor links in adaptive theory
Adapted from: Layder (1998: 85)

Judging the Quality of Research

Qualitative research has sometimes been criticised for lacking rigour or lacking the expression of it; for example Bryman and Burgess (1994: 224) comment that it was difficult to tell how people who contributed to their collection of research articles came up with their issues and ideas. Mason (1996: 5) also notes that: "Qualitative research should be systematically and rigorously conducted. I do not think that there are any excuses for a casual or ad hoc approach to qualitative research." Further, as Silverman (2000) notes, we should not distinguish between qualitative or quantitative research in this respect.

Given that research is carried out for consumption by others, it follows that we might need some sort of criteria from which to judge whether the outcomes of research should be seen as useful or not – is it good or bad research? However, this in itself is problematic: if I am working in an essentially positivistic paradigm of research, what I view as valid knowledge is likely to be different from that selected if I work within a social constructionist paradigm, precisely because we have different ontological and epistemological viewpoints. As a result, attempting to define criteria that can be used to judge research is fraught with problems.

Within positivistic, essentially quantitative, paradigms of research, the outcomes of research are generally judged according to how the researcher has dealt with issues of reliability, validity and generalisability of methodology and findings. Reliability here refers to the ability to reproduce the same result or measurement on another occasion, using the same research method or instrument. Within a scientific discourse, research outcomes need to be the same no matter how many times one or many researchers repeat the research, as the purpose of the research is to produce objective knowledge. The criterion of validity is concerned with whether or not the research is actually measuring what the researcher claims it be measuring: for example, a reader might ask whether the method/s used were appropriate to prove or disprove a particular hypothesis. Finally, the criterion of generalisability would be used to ascertain the extent to which research findings can be applied from a smaller population to a larger one – objective knowledge should be capable of being applied to a larger population than the sample used in the research. This leads to a requirement that the sample chosen is representative (statistically) of a wider population. However, such criteria seem inappropriate to judge the quality of research carried out within alternative paradigms that are focused on human behaviour, are more interpretive, or see knowledge as contingent or socially constructed.

During the 1980s, Guba and Lincoln (both constructivists) attempted to address this issue and refer to the need to judge the 'trustworthiness' of research. In 1982 they believed that all research could be judged according to four generic criteria – truth-value, applicability, consistency and neutrality – but that different types of research would need different specific criteria. These are summarised in Table 5 below.

Guba and Lincoln then went on to suggest a series of activities to help in satisfying the criteria and these are summarised in Table 6 below.

Generic criteria	**Naturalistic criteria**	**Questions to consider in interpretive/ naturalistic inquiry**	**Equivalent positivistic criteria**
Truth value	Credibility	Is my research credible; for example do the participants in my research think that my analyses and interpretations are believable?	Internal validity
Applicability	Transferability	Is the information given in my research write-up sufficient to enable me to make some judgements about transferability of research findings?	External validity/ Generalisability
Consistency	Dependability	Is there some stability in my findings, discounting predictable or unpredictable changes over time?	Reliability
Neutrality	Confirmability	Can I show that my findings relate to the data?	Objectivity

Table 5: Guba and Lincoln's criteria for judging naturalistic inquiry (1982)
Complied from: Guba and Lincoln (1982)

Naturalistic criteria	**Activities**
Credibility	• Prolonged engagement at a site • Persistent observation • Peer briefing • Triangulation • Referential adequacy materials (supporting docs, films etc) • Member checks (respondent validation)
Transferability	• Theoretical/purposive sampling • Thick description
Dependability	• Use of overlap methods (triangulation) • Stepwise replication (divide up research among inquirers) • Dependability audit (audit trail of methodological steps)
Confirmability	• Triangulation • Practising reflexivity • Confirmability audit (each findings can be traced back through analysis to original data)

Table 6: Ways to satisfy criteria for judging naturalistic inquiry
Adapted from: Guba & Lincoln (1982)

However, the problem with their approach, as Lincoln herself (2002) acknowledges, was that they really just changed the terminology and, despite subsequent attempts to add to or change these criteria, (see, for example Guba & Lincoln, 1989), the very existence of fixed criteria contradicted an ontological and epistemological approach that believed in multiple realities and contingent knowledge. The paradox that I outlined earlier is apparent here: applying the logic of a constructivist approach to research would mean that there really is no way to judge whether research is good or bad, whether one approach is better than another, because effectively 'it depends' on your perspective: it is all relative.

This paradox, has, in fact, led to what has been known as the crises of representation and legitimation in research, (see for example Seale, 1999). Lincoln (2002) attempts to deal with the problem by proposing certain 'emerging criteria' which are 'relational'; but it is, unsurprisingly, unclear how these can actually be applied in practice. Meadows and Morse (2001) also eschew using set criteria for the same reasons; they suggest research be judged according to whether it has added something to existing knowledge, and good research would contribute to at least one of the following: theory, methodology or an understanding of a phenomenon. However, the limitation of this approach is they do not outline how I, as a reader, can make judgements about whether there has been any sort of contribution and, moreover, what the quality of this contribution might be.

What follows is the emergence of two approaches: on the one hand, an approach to research which is essentially anti-criteria in relation to quality and, on the other, one that advocates the following of rules and meeting criteria (Seale, 1999). The latter, I think, is often apparent in qualitative research in health care. Barbour (2001) reiterates this in an article about the use of what she calls "technical fixes" or "checklists" to guarantee rigour: what she has also termed 'technical essentialism' (Barbour, 2003). She believes that, recently, five of these technical fixes are enjoying popularity amongst qualitative researchers and the groups/organisations that fund such research. These are: purposive sampling, grounded theory, multiple coding, triangulation and respondent validation.

Looking in more detail at one of these can illustrate some of the dilemmas associated with certain assumptions. Multiple coding is used to ensure reliability: different researchers (or the researcher and an 'independent' other) code the data independently and then come together to reach agreement about the codes and emerging themes. There are two points to raise here: one, as Barbour points out, is that agreement is complex; and two, interpretations may change over time. Work she cites by Armstrong et al (1997) showed that different researchers, although they may come up with similar themes, might vary the way they package "coding frameworks". In addition, Mauthner et al (1998) found that researchers' interpretations shifted as they revisited data. Neither of these is very surprising: for the former, why should we expect different researchers to conceptualise actions/phenomena in the same way; and for the latter, it would be strange if I did not change the way that I viewed and interpreted data over time, especially as I got deeper into a subject and perhaps refocused my concerns. This is, in fact, what happened as I progressed through the study. The point, therefore, is that whilst the technique of multiple coding may elicit helpful discussions and encourage a thorough and more critical approach to research, it does not *ensure* reliability. The researcher always needs to account for what they are doing: "what matters is that a systematic process is followed and that this is rendered transparent in the written research report" (Barbour, 2001: 1115).

Given my overall approach, I think there is a need to be pragmatic here as both approaches have their limitations. Mason (1996) sticks with the three criteria of reliability, validity and generalisability and adapts them to be relevant to judge the quality of qualitative research; and, in addition, she focuses on the need to be transparent about what has been done. She asks researchers to consider three questions from whatever perspective they are operating within and argues that these need to be answered in order to convince oneself and others that the research is worth considering. Acknowledging theoretical underpinnings of research should enable different researchers to answer the questions in different ways but each still should be able to convince others through their different answers. These questions are summarised in Table 7 below.

I think the approach that Mason adopts – retaining the same criteria used to judge scientific method but, at the same time, reinterpreting their meaning in the context of qualitative or interpretive research – is one helpful way to approach the difficulties inherent in this process, because the terms are familiar for most researchers. However, the term 'generalisability' could be seen to be misleading and I prefer her reference to the ability to make 'wider claims' or to the extent to which the research has 'wider resonance' (Mason, 1996:152).

Question	Subsidiary questions
How can I demonstrate that my methods are reliable and accurate	• Are my data collection methods and analyses appropriate to my research questions? • Can I show that my findings relate to my data?
How can I demonstrate that my analysis is valid?	• Am I explaining what I claim to be explaining? • What is the logic behind my choice of data collection methods? Have I tried to approach the data from different angles? • How did I carry out my analysis and how did I interpret the results? Why is my interpretation better than others' are? Have I given a reflexive account of my position?
What kinds of generalisations or wider claims can I make on the basis of my analysis and explanation?	• What type of generalisations can I make – empirical or theoretical? • Are my claims based on a rigorous analysis? How am I testing and developing my explanations?

Table 7: Mason's questions relating to reliability, validity and generalisability
Compiled from: Mason (1996)

Aldridge (1993) also acknowledges the problem with the neatly constructed 'research account', (which, like my thesis, follow a rational pattern of literature review to discussion) which belies the messy process of research and the actual order in which research takes place and which are then disembodied from the researcher. Whilst I agree that this tidying up of research leads to a constructed research account, I do think that what I have to say is based on some notion of students' reality, as I have argued above, and that all I can do is be as transparent as possible despite the messiness of the research process that I undertook.[3] Lincoln (2002) also raises the need to outline the relationship between the inquirer and the participants in the research and I have undertaken to explore this in the last section of the chapter as I do agree that researchers cannot just suspend their values and thoughts in the conduct of research.

Apart from this reservation, I intend to adopt Mason's framework, drawing on some of the activities that Guba and Lincoln suggest to explore the quality of my own work. Some of these aspects I have covered already in this chapter, but I will return to them again at the end of this chapter.

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[3] I think this is particularly problematic with the presentation of analysis. Appendix D gives an example of my thinking from codes to concepts but has inevitably been tidied up to a certain extent.

From Methodology to Methods used in my Work

Overall research design

The empirical research activity for the study took place over a five year period from 1998 until 2003. At the beginning of this chapter, I summarised the study in Table 2 and Figure 4 outlining the aims of each of the phases and the key research activities undertaken during each phase. In total, I undertook 44 interviews during phases one to three and these are set out in Table 8.

Phase	**No. of interviews included in data set**
1	24
2	10
3	10
Total	44

Table 8: Summary of numbers of interviews

Table 9 summarises information about the four phases. Essentially, phase one was intended to be exploratory with phases two and three becoming more focused around the research questions and issues; phase four attempted to complement the previous phases by exploring how particular issues were represented or played out within curriculum texts. During each of the interview phases I concentrated on asking students about the activities they were undertaking at that particular time rather than activities from the past, such as previous year. In effect, this meant that the data generated about students' encounters with dead and dissected bodies came from years one and two of phase one as it is during their first two years that students work in the Dissecting Room (DR). Data generated about students' encounters with the conscious and unconscious body and about negotiating access to the body were derived from phase one students in their third year, phase 2 students in their fifth year and phase 3 students in their third year.

In this section I outline what I did in each phase and provide a rationale for the decisions I made and the activities that I undertook.

Phase	**Purpose**	**Key research activities**	**Year of BM**	**Timescale**
1	Exploratory phase: • Discussion around relevant aspects of the curriculum • Exploration of expectations and anxieties • Developing set of issues and themes • Exploration of major themes	Longitudinal study In-depth interviews and analysis N = 8 x 3 = 24	1st to 3rd year	Sept 1998 to August 2001
2	Focused phase • Exploration of major themes • Developing links between themes and theory	In-depth interviews and analysis N = 10	5th year	Sept 2002 to December 2002
3	Focused phase • Exploration of major themes • Developing links between themes and theory	In-depth interviews and analysis N = 10	3rd year	Jan 2003 to Feb 2003
4	Documentary analysis • Identification of questions • Developing links between themes and theory	Documentary analysis	Key texts: 1st to 5th year	March 2003 to Sept 2003

Table 9: Detail of research design across the four phases

Phase 1: Sampling and interviews

I chose to begin an exploration of the broad subject area of the objectification of the body in the medical curriculum by conducting a longitudinal study, starting in the first year, and finishing in year three of the five year Bachelor of Medicine (BM5) course at Southampton; this formed phase 1 of the study. One way to gain an understanding of how students worked with the body was to start by conducting fairly open in-depth individual interviews once a year with a group of medical students. The intention was that this would enable me to talk to them about different aspects of the curriculum as they were experiencing them; for example working with dissected bodies during the first two years and working with patients' bodies during their third year.[4]

I set out to explore a number of issues and aspects of the curriculum with a small group of medical students from the 1998/9 cohort. I wanted to find out about and explore students' views and their experiences across the range of different admission categories of medical student. Essentially, the School admitted three categories of students: school leavers, mature/graduates and overseas.[5] Table 10 gives details of the number of students in each category for the phase 1 cohort which was made up of 85 women (51.5%) and 80 men (48.5).

Category of student	Science A levels	Science degree	Non-science A levels	Total
School leaver	108		24	132
Mature/graduate	2	18	5*	20
Overseas	12	1	0	13
Total				**165**

* *these 5 all had science degrees so are subsumed within the 18 of this category*

Table 10: 1998/9 cohort information

Medical students at Southampton on the whole tend to have undertaken science-based A levels but a few do have arts-based A levels and I wanted to include this category in my sample. Graduates also tend to have science-based degrees and I was unable to include any students with an arts-based degree as there was none in the 1998/9 intake. In addition, I was keen to ensure that I represented both male and female students in my sample.

I chose a purposeful sampling strategy (Patton, 1990) in which I tried to include students from each of the different categories in order to elicit a range of experiences and viewpoints. I selected students from each category randomly, running through the

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[4] Whilst medical schools in general have been attempting to overcome the divide between pre-clinical (years 1-2) and clinical (years 3-5) parts of the medical curriculum by introducing earlier clinical experience, the 3rd year of the Southampton BM5 still marks the real beginning of students' exposure to clinical medicine.

[5] 'School' from now means the School of Medicine at Southampton.

list picking out, for example a male graduate from one page and a female from another, selecting 14 students in total: 7 male and 7 female across the range of categories.
I then sent a letter to all 14 asking them if they would be willing to participate in the longitudinal study; I had hoped for a sample of 8 students. (See Appendix A for set of invite letters.) I received responses from 11 students, all of whom responded positively. I interviewed 10 of these of whom 7 were female and 3 were male.[6] Table 11 gives details of the sample that participated in the first year of phase one.

Category of student	Science A levels	Science degree	Non-science A levels
School leaver	FM		FF
Mature		FM	FM
Overseas	F	F	

F=female, M =male

Table 11: Categories and number of students who participated in the first round of interviews in phase one

The following year, when students were in their second year, I invited the group of ten to participate in a second interview. Two students did not respond and I assumed they did not wish to take part again after I had followed them up a couple of times with no success. This left me with 8 students who all participated in this and the following third year of the phase. Table 12 gives details of my sample for the longitudinal study.

Category of student	Science A levels	Science degree	Non-science A levels
School leaver	M		F F
Mature		F M	F M
Overseas		F	

Table 12: Phase one sample

I wanted to represent the different administrative categories in my sample in order to ensure I elicited views from across these broad categories within the cohort and identifying the students within these categories was straightforward. I did not attempt to represent a range of other categories such as socio-economic status, ethnicity, religion etc., as to make any meaningful judgements about such differences would

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[6] One student responded too late for me to include him in my sample.

require a much larger sample size, and, in addition, such categorisations would have carried inherent problems of definition (Mason, 1996). I had not set out to compare experiences between different groups of students in my analysis; rather to identify and explore the issues that arise for the cohort of medical students.

The interviews I conducted were semi-structured in nature. I used an interview framework for the interviews to act as a guide for me to steer the conversation. However, I did not stick rigidly to my framework as I felt this would be inappropriate given that there could be no standardised answers to my questions. I also allowed the participants to go off on tangents and explore some areas in more depth than others if they seemed comfortable with this. As I moved from year to year, I was able to explore issues in a more focused way around the developing themes. (See Appendix B for set of interview frameworks.)

As each interview progressed, I attempted to follow-up and clarify aspects of students' stories if I was not clear what they meant, if I needed further explanation, or if they appeared to contradict themselves (Kvale, 1996). I also allowed enough time for a short de-briefing after the interview was finished and the tape was turned off. Sometimes students followed up particular aspects in this time or we went back to a question they may have had about the curriculum. At this point I was able to acknowledge the students' contribution to my work and highlight, and sometimes discuss further, particularly interesting points.

All the interviews were transcribed and then I carried out a cross-sectional analysis of the data which I discuss later in this chapter.

Phases 2 & 3: Sampling and interviews

Phase 2 involved interviewing a group of fifth year students and phase 3, a group of third year students. I considered that 10 interviews for each of these phases would be sufficient to provide me with data to allow me to explore, in a more focused way, the emerging themes from phase one. During phase one, I had been concerned that 5 out of the 8 students taking part had been graduates and the subsequent lack of input from school leavers to the data. I, therefore, chose to focus on interviewing school leavers who make up the majority of the cohort, in order to address this imbalance. As with phase 1, the underpinning rational for my sample strategy was to ensure I represented a range of views from across the administrative categories of medical students rather than identify different categories of students.

It is generally difficult to involve fifth year students in activities unrelated to their education: they are dispersed on placements in District General Hospitals around the Wessex region, which rotate throughout the year and students are very busy with different priorities, not least the finals examination as the year progresses. Moreover, during this year they follow an apprenticeship model of education which means that they are integrated into the 'firm' or team they are working with and therefore have a responsibility and commitment to them that is not evident in other years of the curriculum.

A group of fifth year students is, however, always located at Southampton General Hospital and in other more local hospitals, such as Portsmouth and Winchester and I chose to invite a sample of these local students to participate in phase two. The sampling strategy for this group of students was a mixture between purposeful and convenience (Patton, 1990) as I targeted school leavers (male and female; science and non-science A levels) and targeted locally based students who would more likely to be able to participate. The advantage of this latter approach was that it was easier to arrange interviews at very short notice and it was also possible to conduct the interviews out of the students' working hours, as they were resident in Southampton or nearby. The cohort of fifth year students was, in fact, the 1998/9 cohort that I had used for phase one and so had followed the same curriculum. I needed to invite two sets of students from different rotations in order to achieve a sample of 10 students who agreed to participate. Table 13 shows the categories of the sample of fifth year students participating in phase two of the research.

Category of student (5th yr)	**Science A levels**	**Non-science A levels**
School leaver	F F F F M M M M	F M

Table 13: Phase two sample

Students in the third year (2000/01 intake) were, at the time, mostly located locally and so are more accessible and as a consequence organising a sample for phase 3 was somewhat easier. In this case, I randomly selected 19 school leavers (male and female; science and non-science) and invited them to participate (every 10th or 11th student in the cohort list). Fourteen students responded positively, out of whom I interviewed the first 10 that I could arrange interviews with. The positive response rate amongst this group could, in some way, be accounted for by the fact that I was this cohort's pastoral tutor for their first two years at medical school and I was, therefore, well known by the students.[7] Table 14 gives details of the categories of students that I interviewed for phase three.

Category of student (3rd yr)	**Science A levels**	**Non-science A levels**
School leaver	F F F F M M	F F F M

Table 14: Phase three sample

I undertook the interviews for phases two and three using the same approach as for phase one and again used a cross sectional analysis. (See Appendices A for set of invite letters and Appendix B for set of interview frameworks.)

Ethical issues

When I first wrote to students in phase 1 of my research, inviting them to participate, I was very vague about what my research was about and just said that it would "involve discussing different parts of the first term." I think that this was justifiable given that, at that stage, I was unsure about what the focus of my research would be. In my correspondence inviting them to interviews in the second and third years, I was more explicit about my work being about different students' approaches to the physical body. After each interview, during phase one, I asked the students if they would be happy in principle to be interviewed the next year and in all my correspondence I tried to ensure that participants would feel they had the option not to contact me again if they did not wish to participate. I did this much more formally in the first year with a reply slip

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[7] The pastoral tutors' role is to oversee the pastoral care and progression of a cohort of students

attached to the letter. At the end of the phase one, I gave each of the students a £20 book token with a thank you card.

For phases two and three, I was specific about the purpose of the interviews being about discussing working with the physical body. At the beginning of each of these interviews, I briefly outlined the themes arising from my work to-date and the sorts of issues that I wanted to discuss with them. In addition, I outlined what I thought confidentiality meant in relation to my study: that I would be the only person who could tie their names to the identifiers and that I would not use any quotes that I thought would reveal their identity.

I informed participants that I would like to tape record the interview and then asked their permission before the start of all my interviews. I explained that the recording would only be heard by me and a secretary/or another person who would transcribe the tapes. I always gave participants the option not to be recorded; however, all the participants gave their permission on each occasion. If students discussed particular issues after the tape had been turned off, I did not use this as part of my data; although inevitably, it provided me with contextual information often. The tapes were stored in a secure place.

My work did not require ethical approval from the NHS Research Ethics Committee (REC) as, at the time, it did not meet any of the seven criteria outlined in the REC's remit. (See Appendix C for a list of these criteria.)

Transcriptions and quotes

All the interviews conducted during phases 1-3 were tape recorded and then transcribed 'word for word'. However, I acknowledge the partially constructed nature of the transcript: different transcribers are likely to write the text in different ways (Kvale, 1996). I used three people to transcribe the tapes: two were secretaries in the department in which I work and the third was someone outside the school whom I paid. I operated a fairly simple format for the transcriptions: I did not adopt a formal transcribing convention that would be necessary if I were using a discourse or conversation analysis. Essentially I just used the symbols that were useful to enable me to read the text and these are outlined in Figure 7.

One of the key issues relating to the transcripts is that the interview was conducted orally, yet the transcript is written and therefore the data generated from the interview appears in a different form or language from its original context. Essentially as the researcher, I was interpreting the text produced from the interview in my analysis rather than analysing the interview itself (ibid.). One way to stay in touch with the actual interview is to transcribe interviews oneself and so, during each phase, I transcribed one or two of them, (see for example Seale, 1998).

......	overlapping or interrupted conversation
(...)	edited/removed sections of text
??	unable to decipher what was being said.
[ ]	author addition for clarity
(laugh)	for laugher
(pause)	for a long pause

Figure 7: Transcription symbols

I have used quotes from the interview throughout chapters 3, 4, 5 and Kvale (1996: 267) outlines some general guidelines for using interview quotes:

- Any quotes should relate to the general text.
- They should be contextualised; i.e., where appropriate they should include the question or the response.
- They should be interpreted within the general text.
- There should be a reasonable balance between any quotes and the general text.
- Quotes should be short.
- Use the 'best' quote/s to illustrate the point.
- They should be constructed in written format unless using some form of linguistic analysis.
- The quotes should include simple systems to show where the text has been edited and I have used (…).

I concur with all the above guidelines and have attempted to incorporate these where appropriate. I chose quotes that illustrated the key themes that I was addressing – supporting a point or giving an alternative view – and drawn from the range of participants in my study. I agree with the practice of 'tidying' up quotes, to a certain extent, as the purpose of the quotes within my text is to illustrate the point rather than emphasise particular features of spoken grammar. However, I have applied this using a 'light touch' in order to retain the student's voice. One difficulty that I encountered as I wrote up was that sometimes if the quote was short it appeared misleading in that it only told a partial story and did not reveal the complexity of the point. I found that I needed to balance the length of the quote with the need to illustrate the fuller picture and so some quotes may appear 'long' rather than 'short'.

Interview data analysis and theory building

In phase 1 of my research, I set out to conduct a longitudinal study, following a group of students through their first three years of the medical curriculum. I originally intended to carry out a cross-sectional analysis of the data and that is what I did after the first year's interviews. This was done in order to explore the range of issues that might be relevant to a rather general and vague aim of wanting to explore how the curriculum influences students' objectification of the body. In order to begin to analyse the transcriptions, I attempted to sort the data under headings of various themes. I began by describing the content of participants' responses, what Mason (1996) terms reading the data 'literally', assigning codes as I went along. As I moved through the transcripts, I began to concentrate on particular sections that seemed more relevant to my general focus – primarily around students' work in the dissecting room (DR). By the time I had worked through all of the transcripts, I had identified a series of very preliminary categories or thematic headings which related to how students were experiencing and constructing the body. It seemed apparent that there were a number of tensions for students, for example between objectifying the body in order to cope with the activity in the DR and being respectful when certain specimens reminded them that they once belonged to a person.

By the time I had completed the second year's analysis, I began to consider the appropriateness of constructing descriptive case studies illustrating different student's experiences of the different bodies they were encountering. However, as Yin (1994) points out it is very difficult to write anonymous case studies as the very act of writing a case study means that I would need to include little pieces of information about participants that would be likely to reveal individual identities. As I promised anonymity, I felt I was unable to proceed with this sort of analysis.

As I progressed through the last two years of interviews and analysis for phase 1, I began to form a structure around which to organise my themes. I identified the types of body that students encountered; for example the dissected body, the conscious patient's body. By this point I was looking for themes which linked up to how students experienced the body, for example through sensory reactions; where they expressed viewpoints which appeared to objectify the body; and where objectification appeared to be avoided.

During the third year of phase one and during phases two and three, I attempted to draw on some of Layder's (1998) suggestions that form his adaptive theory approach, identifying different types of codes and whether they were related to agency or structure and whether they linked into wider theoretical literature. Table 15 gives examples of the concepts I developed relating to students' encounters with the conscious body (Chapter 4).

Key bridging concepts	Core codes/categories	Wider conceptual frameworks
Using the patients' bodies	• Educational use of body • Lack of reciprocity	• Appropriation of the body • A-symmetrical relationships • Disciplining the body
Being useful	• Rationalising activity • Reflecting on patients' needs • Mediating use of body	• Reciprocity and symmetrical relationships • Student agency
Connecting with the body	• Mediating use of body • Reflecting on patients' needs • Difficult encounters • Older patients as teachers	• Student agency • Everyday body • Communicative body • Symmetrical relationships • Contingency
Inspecting the body	• Rationalising inspection • Lacking control over process • Lacking responsibility for process • Reproducing inspection through assessments • Older patients as compliant	• Disciplining the body • Power relationships (Student/doctor; student/patient; doctor/patient) • Ageism
Challenging the use of the body	• Accepting role and lack of responsibility • Micro-resistance	• Power and resistance • Reproducing normalised practices

Table 15: Examples of concepts from research

Appendix D contains transcription excerpts with some associated codes and concepts showing examples of how I interpreted the data.

Phase 4: Analysis of key documents

The key purpose of documentary analysis was to explore how the body was represented within key curriculum documents and how this might affect students' encounters/interactions with different bodies. I chose a pragmatic approach to this phase of my research adopting an interpretive version of textual analysis that attempted to look at different levels of representation relating to the key themes arising from my work, in a bid to illustrate and support (or counter) my developing understanding of the interview data (see for example Atkinson & Coffey 1997; Mason, 2002). As well as looking at and attempting to analyse what is included in the texts I chose, I also looked for what appeared to be missing. Where appropriate, I have included examples in chapters 3 to 5 of my thesis.

I chose a small sample of key documents relating to anatomy and clinical examination which were used by the students who participated in the research. Table 16 outlines the documents and the rationale for their inclusion alongside some contextual information. After I had undertaken the analysis, of the interview data, I identified key questions to ask of the documents or parts of documents and which chapter of my thesis they related to, and these are contained in Table 17. Appendix E contains some excerpts from the documents with associated levels of interpretation and as mentioned above, I will return to discuss this again at the end of my thesis.

Document	Rationale for use in research	Author/s	Internal/ external & purpose
Foundation Term (Term 1, year1): Gross Anatomy Handbook 2001/2	First handbook for anatomy that students are issued with for the BM programme and the handbooks form the basis for their work in the DR.	CLAS[8]	Internal Students handbook and learning tool for the term's anatomy
Policy on the rights of patients in medical education	School policy document for use by students and teachers	Adapted from Doyal, (2001)	Externally generated but adopted for use by the School
Year 3 Student Handbook 2002/3	This handbook provides information for students for year 3 of their curriculum and contains information about history taking and clinical examination. Students interviewed for phase 3 of the research would have been expected to refer to this handbook	Year 3 co-ordinator	Internal Outline of curriculum and associated activities in year 3. Includes some key information about activities
Year 5 Student Handbook and Learning Portfolio 2002/3	Provides information about year 5 of the curriculum and students interviewed during phase 2 would have been expected to refer to this handbook	Year 5 co-ordinator	Internal Outline of curriculum and associated activities in year 5. Includes some key information about activities
Introduction to Clinical Examination	A School recommended text for physical Examination	Munro, & Ford (1993)	External publication
Clinical Examination	A School recommended text for physical examinations	Epstein et al (2003)	External publication

Table 16: Documentary analysis: documents used and their purpose with rationale for their use

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[8] CLAS: Centre for Learning Anatomical Sciences, School of Medicine

Chapter	Documents analysed	Key question areas
3	• Foundation term gross anatomy handbook (pages 1-22) • Year 3 Student Handbook sections: introduction & surgery • Year 5 Student Handbook sections: introduction & surgery	• How is the body represented: as medical or everyday body? • What are the indications that the body is or was once an everyday body? • Are there any indications that how the body is viewed by students might vary over time/encounter? • What references are there and what might be their underlying meaning, to how students' might be expected to interact with the bodies or parts of bodies that they encounter?
4	• Year 3 & Year 5 Student Handbook sections: Revision of Introduction to History Taking and Examination (Appendix 2) & Medicine Block: General Medicine • Munro and Ford: Chapter 1: General Principles of History Taking and Physical Examination (p.1-9) & Chapter 2: The Cardiovascular System (p.13-28) • Epstein et al: Chapter 2: General examination (p.18-53)	• How is the body represented: as a medical or everyday body? • What are the indications that the body is an everyday body? Is the body's contingent status represented? • Are there any indications that how the body is viewed by students might vary over time/encounter? • What references are there and what might be their underlying meaning, to how students' might be expected to interact with the bodies that they encounter? • Is there any acknowledgement of the difficulties that students might encounter?
5	• Policy on the Rights of Patients in Medical Education • Year 3 & 5 Student Handbooks sections: Introduction to Students in Clinical Areas; Revision of Introduction to History Taking and Examination (Appendix 2); & Surgery attachment	• How is the body represented: as a medical or everyday body? • What aspects of the negotiating access process are outlined for students and what might this indicate? • Does the patient's role in the negotiating access process appear to be represented as a passive or an active one?

Table 17: Questions asked in the data analysis of key texts

Methodological Issues Revisited: Reflections on the Quality of my Work

Finally, I want to turn to the consideration of the quality and limitations of my work. To summarise, the criteria I want to cover when making such judgements are outlined in Table 18 below.

General criteria	Areas to cover
Reliability	• Appropriate use of methods and analysis to answer my research questions • Inclusion of examples of how I went from the data through the analysis to my findings • Explanation of the different methods and how they complemented each other
Validity	• Exploration of my research questions in relation to my findings • Understanding of the context in which the research is carried out • Explanation and critical approach to use of methods, analysis and findings • Exploration of my relationship with the participants
Wider claims	• Justification and limitations for wider claims

Table 18: Criteria for judging the quality of my work

Methods and analysis

In the first part of this chapter, I discussed the different methods that I used to explore my research questions and also their limitations and advantages in general terms. I found interviews a particularly useful method for discussing students' experiences with them and, despite the sensitive nature of some of the areas that we covered, they were mostly very open and willing to discuss difficult issues. I was very keen to draw on the students' voice for my research but this focus, inevitably, meant that I excluded other voices: in particular, those of patients and teachers. A recurring anxiety during the write up of the 'research account' was that, as I had not spoken to patients, I would in fact be compounding the very problem that I was writing about: reducing patients to a passive, object body. This is not something that I have resolved and, given more time, I would have liked to have included some patient interviews in the research design.

Moreover, I believe that whilst observations of student-patient encounters would have been interesting to undertake in addition to the interviews, I suspect my presence would have influenced students' behaviour, as I mentioned earlier, which might also have been accentuated by my role within the School.

I found the documentary analysis phase of the research problematic and unsatisfactory, possibly because I chose to use it to support/explore the points coming out of the primary part of my research. It seemed somewhat of an appendix sometimes, although I do think that it was a useful exercise to show how texts can represent the status of the body and, perhaps, the importance of documents in this respect. I also found that, having worked on the analysis of interview and developed some of my concepts, I could look at the documents in a different light and from a different perspective. Given more time, again, I would have liked to have taken an historical perspective and analysed how curriculum documents and external publications have changed (or not) over time; for example, the patients' rights policy is a recent addition to School documentation. Looking at more external texts and comparing them would have also been another useful addition but, to do this comprehensibly, would have been a whole thesis in itself.

The sampling strategy for the interviews was chosen to enable me to represent the views of a range of students but I also acknowledge that if I had been able to identify differences between students in my analysis, this would have added a further dimension and depth to my work.

I have outlined how I analysed the data generated from my interviews and I found Layder's 'adaptive theory' approach a useful one to help me to think about the level of my concepts: macro or micro. On a couple of occasions – during phases one and two – one of my supervisors independently analysed transcripts and we discussed the developing concepts together afterwards. I did not use this approach as any sort of guarantee of reliability, as discussed above; rather as another way to critically engage with the data and get a second opinion on the appropriateness of my concepts in the context of my work. I have included excerpts of raw data from interviews and documents and how I have interpreted this at various levels, in order to keep the stages of my analyses as transparent as possible.

My role as a researcher

In the preface, I outlined my role in the School of Medicine at Southampton. During the interview phases of the work, I was clearly 'in control' as the interviewer/researcher and this was associated with a power dimension located within our respective roles as student and lecturer. The interviews were set up to explore students' experiences and not to discuss my role, and whilst I sometimes answered questions or discussed issues that students asked me about aspects of the curriculum, on other occasions I deferred these until after the interview had finished and I had turned off the tape recorder.

During the first year of phase one, I was a tutor and course co-ordinator and was aware that that this was likely to affect our interactions, perhaps making students reticent about discussing certain things with me and/or giving me answers they thought I wanted to hear.[9] After the first year, I was no longer involved in any of this groups' teaching and I felt they were more relaxed on the whole in my presence and I was able to build up a rapport with them over the three-year period. I was the pastoral tutor for the students in phase three so this group all knew me in a different capacity; phase two students were from the same cohort as phase one. Whilst I attempted to create an informal atmosphere in terms of my approach and style, most of the interviews took place in my office or other available offices on different sites, which may have emphasised the student/lecturer divide. From one perspective, I occupy a position of authority in the medical school; however, from another, I lack authority both amongst my colleagues and the student population: many of whom occupy a higher social class category than me. Moreover, being located within a social science discipline also affords me a lower status in a medical school hierarchy. One advantage of my role within the School as an 'outsider', albeit one working on the inside of medical school, is that it may have led participants to tell me things that they would not have told anyone else.

I was cognisant that much of what was discussed at interview could be seen as sensitive and sometimes intimate, and in all of my interviews I adopted a policy of not pursuing anything that appeared to make participants feel really uncomfortable. I tried to be aware of the participants' reactions to the conversations: if they appeared worried or

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[9] I was joint course co-ordinator for a course that linked sociology and psychology to primary care early patient visits

anxious, I would give them some space to be silent or I would move the conversation on.

There were also times where I felt worried, uncomfortable or angry with some of the things that participants were talking to me about especially when they mentioned activities or situations that seemed inappropriate to me, or when they seemed to have undergone an experience that was upsetting for them. I tried not to express my responses in front of students but, inevitably, I did sometimes reveal how I felt about things through my response or perhaps through the way I phrased another question. I also acknowledged that some things must have been difficult for them. Students sometimes asked me about aspects of our discussions after the tape recorder had been turned off and, to facilitate this de-briefing, I always allowed additional time.

Some of the activities that participants revealed in interviews constitute, in my mind, unethical practice and this raised a number of issues for me, especially because I have included some of these situations in my work here. I am currently Lecturer in Medical Education in the School where I undertook the research, and whilst part of my role is to provide support and advice on curriculum developments, what I say usually takes place within the School – it is not public. This is a particularly sensitive issue, given the current heightened climate about unethical practice in medicine. Alongside these points, I am also cognisant of the fact that working within a school of medicine for sometime may mean that my critical voice may be compromised.

My position in the School during the time I undertook the research enabled me access to students and the practicalities associated with this. Moreover, my experience of working within the School has given me the privilege of being able to gain a greater understanding of the context in which students find themselves, invaluable in terms of relating to students during the interview and analysing the data generated. My role as a researcher, however, is distinct from my current curriculum management role[10] and this difference is important in terms of the impact of my findings: recommendations from the research may not be able to be implemented for, for example, political or resource reasons. However, my role as a curriculum manager does enable me to have some

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[10] BM4 programme Deputy Director

influence over curriculum developments and has given me an understanding of how I might attempt to apply recommendations particularly in my sphere of influence. I shall return to this point again in the final section: Reflections on Practice in chapter 6.

Findings

Chapters 3, 4 and 5 are 'findings' chapters; however, I have chosen to write up these in a way that includes discussion about the findings and relevant literature because I find an artificial separation between findings and discussion chapters problematic. I have also attempted to outline some background context information in these chapters – mostly at the beginning – in order to underpin the discussion of findings that follows. I have used my 'discussion' chapter to give an overview of the findings in relation to my research questions and I then attempt to move beyond this to some broader issues raised by the work.

I do think my work has limitations as I have outlined above in terms of the methods I chose to use. Moreover, medical curricula are not static and change over time so any reading of my work needs to take this into account as I undertook the research over a six year period. However, whilst the research was located at Southampton, I think the issues I raise do have wider resonance because there are similarities across medical schools in terms of their medical curricula and the culture in which they operate; and, I believe, my discussion about encounters with bodies is relevant to all medical schools. Furthermore, they all sit within the same healthcare and governmental structures.

In these following chapters, 3 to 5, then, I set out and discuss the findings from the study, drawing on both data generated from interviews and documents.

Chapter 3

Encounters with the Dead and Unconscious Body

As I have previously outlined, knowledge about the body in medicine was founded on an understanding of the dead and objectified human body. The object body can also be seen as being scientific, open to observation and scrutiny. This chapter discusses students' work with the dead body within the disciplines of anatomy and pathology and with the unconscious body in surgery.[1] I have linked these two body states together in this chapter as they share the common feature of being non-sentient. Students do not have any social interaction with dead or unconscious bodies when they encounter them in the curriculum. One difference to bear in mind, however, is that the body in the DR is one that has only a purpose for students.

I want to show, in this chapter, how the body is rendered an object in these two contexts and how this impacts on students as they negotiate their way through a set of contradictions and tensions. I also explore where the dead or unconscious body gains symbolic meaning or is interrupted by the everyday body: in effect, then, I explore the links between the object and subject body.

Encounters with the Dead and Dissected Body

Context

The disciplines of anatomy and pathology can be seen as the foundations of the biomedical model of medicine. Both reduce the body to a collection of parts which can be observed and measured in order to define the 'normal' functioning of a body (anatomy) and the 'abnormal' (pathology). Traditionally, all medical students would undertake whole body dissection in their anatomy classes, which takes place in the Dissecting Room (DR): at the start of medical school, groups of students are allocated a body that they themselves dissect over the course of their studies. This dissection has

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[1] The unconscious body might also relate to the patient in a coma or similar state, but for focus I concentrated on the unconscious body in the operating theatre.

been identified as one of the 'rites of passage' into the medical profession, dating back to the eighteenth century (Sinclair 1997: 171).

Good and Good (1993) note that, through the discipline of anatomy, medical education begins with students entering into the human body and that this exploration of the interior of the body is, in fact, a very intimate act. Given that this intimacy is combined with the sense that coping with the DR is a fundamental part of their education, it is, perhaps, not surprising that such activity can cause high levels of anxiety in students; for example, Lief and Fox (1963) identified students' use of humour as one way to relieve such stress and anxiety. Some more recent studies have examined students' attitudes to the DR and the dissection of human bodies that they undertake, (see for example: Abu-Hijleh et al, 1997; Charlton et al, 1994; Horne et al, 1990; Nnodim, 1996). These all involved the use of questionnaires to identify students' reactions to the DR, including levels of apprehension and certain physical responses, such as loss of appetite. Charlton et al and Abu-Hijleh et al reported that women had stronger reactions to the activity of the DR than men. In addition, some looked at the coping mechanisms that students employ. For example, Charlton et al (1994: 290) found that "Students rapidly develop a coping mechanism which enables them to view cadaver dissection as an occupation quite divorced from living human beings" and that any concern for those who have died decreases over time. They conclude: "Educators should be aware of the dramatic change of attitudes among students and the process of professionalization which might influence the caring of future patients" (ibid.). There is, therefore, an underlying assumption in such studies that how students work and interact with dead bodies in the DR impacts on, or reflects in some way, their encounters with live patients (see also Horne et al 1990).

The dead body in the DR can also be seen to represent the live patient's body. When Sinclair (1997) observed a group of students in a DR undertaking whole body dissection, he noted that students discussed what name they should give to the body: "She's an old woman.... Mabel? Winifred" which he acknowledges is "a time honoured but unofficial act of groups of dissecting students" (ibid.: 177). This act can be interpreted in a number of ways: Hafferty (1991) points out that it can be seen either as an attempt to personalise a de-personalised body or as a way of avoiding thinking about the actual person whose body it is, particularly if the name chosen is impersonal, sarcastic or attempting to be funny. (See, for example Lief & Fox's (1963) reference to students naming cadavers Hitler or Mussolini.) Interestingly, however, half of the students in Hafferty's study (1991) did not assign names to their cadavers as they found the very act of doing this inappropriate or dehumanising once they were faced with their body to dissect; and students who did give their bodies a name gradually stopped using it over time.

According to Sinclair (1997:180): "Dissection confers Status on students. The body is therefore seen as a reciprocal element in the relationship involved in the disposition of Status, that of patient". Essentially, then, the body in the DR can be seen as a means by which students come to understand their superior position in the hierarchy between the doctor's and the patient's body in the medical encounter. The act of naming a cadaver can also be interpreted as a statement of ownership – the body becomes a possession (ibid., 1997).

From another perspective, Weeks et al (1995) propose that the 'student-donor' (as opposed to a student-cadaver) relationship is a good model for the doctor-patient relationship. They argue that anatomy and human morphology courses can be seen as the first opportunity for students to appreciate the patient as a 'whole person' – the donor representing the student's first patient (see, also Bertman & Marks 1985). Rodning (1989: 277) sees dissection as essential for the improvement of patient care and the development of medical science: "I would argue that it should be perceived as an expression of an interdependence among all sentient beings, and as such should be promoted as the *zeitgeist* of all interpersonal relationships within contemporary society." I think this viewpoint is worrying, in particular the reference to the relationship between a student and dead body being a 'good' model for the doctor-patient relationship, as it appears to reinforce and perpetuate the notion of the patient as being passive and dead.[2]

The contradiction between respecting the body through an understanding of its origins and needing to objectify the body in order to deal with the activity of the DR is

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[2] Another way at looking at this is that such a argument acts as a rationalisation for the existence of the activity of dissection within the medical curriculum particularly within a climate which is questioning the medical profession and which is focused on the importance of the doctor-patient relationship.

problematic and complex and reflects the tension between the everyday body and the medical body that I outlined in chapter one. This is further complicated by the possibility that different students begin their studies with different conceptions of the nature of the body in the DR. Hafferty (1991: 63) identified two different student views of the cadaver in the DR: one that reflected "a biological-specimen perspective" and the other seeing the body as a "formerly living being". The latter group of students were focused on the need to respect the body while the former group were worried that the body would appear "too human" which would affect their ability to engage objectively in the activity: indicating that the objectification of the body acts like a defence mechanism and coping strategy.

The shortage of dead bodies available for medical students to dissect during the second half of the twentieth century led some medical schools to pre-dissect the bodies (Nnodim, 1990), which can then be re-cycled, and this is the case at Southampton. Interestingly, the new Peninsula Medical School have developed their anatomy curriculum without the use of cadavers and, to-date, they are the only UK medical school to have done so. Their rationale behind this move was that doctors' actual work largely involves working with live patients and interpreting imaging technology and because of this learning anatomy might best be facilitated in the context of clinical care, rather than with dead bodies. They have substituted cadavers with plastic models and imaging data and introduced activities which require students to work with each; for example: living anatomy (identifying anatomical structures below the surface of others' bodies), projecting images of the internal body onto their own bodies, and body painting (McLachlan et al, 2004)[3].

Students at Southampton study prosections or specimens and their relationship is not with one cadaver that they themselves dissect; rather it is with pre-dissected body parts that could come from a variety of bodies.[4] They do not take part in any dissection and so the activity they are engaged with is rather different. Links with an individual person's body would seem, therefore, to be more tenuous; however, the students that

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[3] Additional information from John McLachlan's presentation at Southampton in December 2004.

[4] The terms specimen and pro-section are interchangeable: I refer to specimens as do some students, whilst others use the term pro-section.

participated in my study did reveal some similar tensions to those identified in the previous studies I have referred to.

Students at Southampton begin to learn both anatomy and pathology from the start of their medical course, week one in fact. Anatomy classes take place in the DR and students are encouraged to be self-directed with the help of handbooks which guide their learning. They move around the pre-dissected specimens in the DR identifying parts and the connections between them. The DR sessions are complemented by tutorials with anatomy teachers and anatomy teaching takes place over the first two years. They currently have no formal DR sessions after the first two years and learning about anatomy is incorporated into the clinical teaching.

Traditionally, pathology teaching was in a laboratory using preserved specimens and slides. However, during the first two years at Southampton, pathology is now delivered using computer software and tutorials and, as a result, this aspect of the curriculum forms only a marginal part of my research. Students do encounter the recently dead body through lunchtime PM (post mortem) demonstrations that take place every day and which can be attended on a voluntary basis. Typically, a pathologist would select a specimen from a recent case to discuss in the session and so again students would encounter part of a body but only at a physical distance, as the sessions are conducted in a lecture format; thus students do not actually work with the recently dead body during their medical education at Southampton. However, some students reported being invited, by their pathology tutor, to attend an actual PM that might involve a whole body.

The following sections cover the issues surrounding participants' encounters with the dead, dissected body.

The body as object

When working with specimens in the DR, students rarely encounter a whole body. It is therefore, difficult to imagine any students giving a name and identity to the specimens. In effect, students are presented with specimen body parts that relate to the area that they are studying; this is mostly around the different body systems. For example: a trunk for the cardiovascular system; a head, or slices, for the nervous system.

I asked some of the participants whether they would like to know more about the people that donated their bodies. A couple of students were interested to know some information: why they had died, how old they were, and what kind of people would give up their body for dissection. One student told me that she was 'silently curious':

> *I'm quite silently curious you know about (...)why these people want to do it and what kind of people they are, and I know they said that you know a lot of people that do it are very poor and they do it to pay for their funerals.(1/3 – 1st year)*[5]

What she says resonates with the history of anatomy. She was curious about general information that would relate to all donors and what would motivate them to donate their bodies. I am unsure why she could not be openly curious; perhaps this is not something that students feel can be openly talked about, reiterating Fox's (1988) point that lack of talk about emotional issues helps to reinforce distance or detachment. Students in Hafferty's study (1991) were also curious about where the body they were dissecting came from but in this case some bodies were unclaimed rather then donated and students were uncomfortable about working with bodies that had not been donated: effectively showing interest in the origin of a body that they are using for their education. The student above reflects on the possibility that the donation may not be straightforward and may be done out of necessity rather than altruism and I think this acknowledges her privilege. Whilst she is not seeking information that would enable her to personalise the body parts, she is thinking about the relationship between her and the body parts. As Lief and Fox (1963) pointed out, however, there is a difficult balancing act to play: humanising a dead body (or, in this case, parts) may be helpful only to a certain extent as at a certain point it would raise anxiety levels which would prohibit students undertaking the activity.

In contrast, there was also a strong negative reaction about the idea of knowing more about the bodies from which the specimens came from. One student said knowing more about the body would make her feel disrespectful about what she was doing to the specimens:

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[5] (1/3): 1 indicates the phase number from which the data emanates. 3 indicates my student ID number and year is the year of the curriculum that the student was in when I interviewed them

> *So I'd just be standing there and people would be prodding and I'm not really noticing and I think that if I knew about them having given up their bodies to our research and I'm not really paying attention, I don't know, it's funny, I'd just, I'd feel bad really. (1/7 – 1st year)*

She went on to explain this need for de-personalising and de-humanising the body parts:

> *I see it as an exercise, as something clinical, not at all emotional. There's no emotion there when I'm in there. I just see it as a thing, a non-living thing, but if I found out, I just don't think I could, I couldn't cope with it really. If I knew anything about who they were, even their name, I don't think I could. (1/7- 1st year)*

Keeping a distance from any sense of the personal, therefore, enables her to deal with the activity in the DR, particularly undertaking anything that would be seen as disrespectful to a living person and therefore distressing to her; for example, the practice of 'prodding' the specimen or not paying attention. Her sense that the exercise is something 'clinical' is interesting, given different meanings of the word. 'Clinical medicine' usually refers to working with patients (mostly from the third year, hence the 'clinical years' of the curriculum); but its other meaning, and most likely the one referred to here is, "scientifically detached; strictly objective: a clinical attitude to life" (Collins, 2000: 302).

Other participants also referred to seeing the specimens as de-humanised objects:

> *I don't know what they call them* [specimens], *it's just like bits of meat on a slab. (1/2 - 1st year)*

When I asked this person how he connected up the different parts of the body in his mind, he told me that he understood how the *"buckets of bits go together." (1/2 - 1st year)* Less stark, but along the same lines, another student said they viewed the body in this context as 'like a model' as opposed to being related to a human:

> *I do feel I dissociate from it and it's just a model, it's like that whether it's like a whole body or whether it's like a bit (...). The inside bits are like totally different, that's the model, that's like a model." (1/5 – 1st year).*

She acknowledged that this disassociating oneself from any sense that the specimens once formed part of person might be viewed as rather strange, especially to people outside the profession, and she reported a recent conversation she had had:

> *The thing I think like very strange is how you do dissociate from it. And I was talking about it with some friends the other night because I had a friend from home come down who was talking to a couple of us medical students and saying, you know, how could you do that it's totally disgusting, you know that's a person. And I don't know what it is but you don't, you don't think about that, I don't think. (1/5 – 1st year)*

Working with body parts from different bodies and rarely encountering a whole body means that it is not really surprising that students objectify the body parts and there is an implicit requirement to adopt this approach. Furthermore, the parts have been preserved and the colour and texture of the body parts bear little relationship to a live body.

However, this process of objectification of the body parts was not always easily achieved by students, indicating – as in Hafferty's (1991) study – that students may begin their studies with differing perceptions of the body. For one participant, the origin of the specimens and its relationship to a person meant that this objectification was problematic. She explained how she had had to 'toughen up' and say to herself *"this is a person, or was a person but now it's, there's nothing there, it's just a body" (1/3 – 1st year),* but she acknowledged that she found it difficult to "get in there" like some students and indicated that this struggle prevented her carrying out certain activities in the DR:

> *I can't go in there* [the DR] *and get people's arms and really tug them about and people do (...) but I can't. (1/3 - 1st year)*

She talks about getting people's arms and tugging them so despite a quite rational belief that she is being presented with parts of a dead preserved body, 'just' a body, she still finds it difficult not to remember that it belonged to a person; in effect the everyday body interrupts the medical body. The following year this student reported some change in her approach: *"All in all I think I am more inclined to look at them as kind of pro-sections now" (1/3 – 2nd year).* She indicated a certain sense of achievement about being able to overcome her difficulties and no longer humanised the specimens. She did, however, acknowledge that the activity still presented her with difficulties:

> *I'm more willing to be hands-on, um it varies from term to term and what kinds of things you are looking at. I've shuddered a few times this term, I have to say. Well I mean it's not altogether a pleasant experience to be up there because the smells are like, and especially when you are dealing with ?? it does make you feel a little bit sick. And it's when you put your hand in and you pull your hand out and you've just got gunk all over your hand and it makes me cringe for a minute. (...) I'm not so scared to touch anymore. In fact in one of the DR classes we had to locate the spleen and I called over and I said can you show me the spleen and she said right give me your hand and literally I think half my arm disappeared into this specimen and I was a little taken aback. (1/3 – 2nd year)*

Similarly, another participant appeared to find the whole activity pretty distasteful when I first spoke to her. When I asked her if she ever picked up the specimens, she replied: *"you have to sometimes" (1/8 – 1st year);* and when I asked her about looking inside them, she answered: *"yeah I'm not a great one for doing that but some people do"*. Little had changed for this student in her second year: she remained rather matter of fact and distant about her experiences and continued to display little enthusiasm for the task. However, she thought that she needed to distance herself from the specimens, even though this was difficult for her:

> *It is never really pleasant but I suppose the more like an actual person they look, the worse it is (...) I can't claim to be someone who goes in there religiously and really enjoys it (...)I try to mentally dissociate from it. (1/8 – 2nd year)*

These students began by adopting a fairly 'hands-off' approach to their work in the DR; others (both male and female) were quite the opposite and were very much 'hands-on' in their approach and seemingly had no problem 'getting in there':

> *The sections that they have are physical, you can actually get in and you can touch them, you can peel the muscles back and have a look. (1/2 – 1st year)*

> *Totally hands-on (...) and in fact people like said to me 'oh well you know why are you touching it?' I think I didn't have a problem with it cos I have done it before so it wasn't so horrible. (1/5 – 1st year)*

> *I tend to go a lot on the texture of things. I prod a lot. (1/7 – 1st year)*

For these last three students it is almost as if the body that they encounter and touch is different from the body the previous students encountered: they appear to have the ability to view the body parts as part of a medical body without the everyday body interrupting their activity. The result of this is that they are able to view certain activities like picking the specimens up and physically doing things with them as unproblematic.

Reminders that the parts have a living human origin

Maintaining a view of the specimens as objects is somewhat more challenging with certain specimens. As has been pointed out elsewhere (see for example Penny, 1985; Lief & Fox, 1963; Hafferty, 1991; Sinclair 1997), some body parts are more problematic for students than others. Participants confirmed that those that most resembled 'human' body parts and attributes were the most disturbing. These included the head, hands, feet, nails, teeth, freckles and hairs on the skin as these are parts that are related to personal identity or represent notions of humanity which link with our ability to think and feel, what Hafferty (1991: 90) termed, "anxiety provoking 'human referent'". One student (1/7), told me that when she saw teeth in the head of an elderly body and realised that they were false, she at first laughed. She then felt sorry that no one had bothered to take these out; the teeth gave the head human qualities that had reminded her of her granddad, illustrating again how the everyday body can impact on the medical body. Similar observations included:

> *I just tried to focus on individual areas of the body (...). I didn't like to look at the faces. (1/3 – 1st year)*
>
> *I don't know whether I just distanced myself (...) but the fact that this hand looked so life-like, I kept thinking it really did come from a human (...) it just turned my tummy a bit. (1/7 – 1st year)*
>
> *(...) it was quite a funny experience in the neuro term because then you were presented with just heads and that's quite, you know funny, because heads are very personal things because that's for your identity. (1/3 – 2nd year)*

However, one student reported having no problems dealing with the specimens that resembled human body parts. If anything, he said that he found they motivated him to learn as they revealed a specific connection to what he was trying to learn about:

> *I don't think so no, well yeah whatever I get presented with I don't really have much trouble thinking about what it is and what it isn't (...).If it's a finger, I look at it and say, yeah, this looks like a finger (...).if you can relate with it more cos it looks more human then you want to study it a bit more because it makes sense a lot more. (1/6 – 1st year)*

This student seems to have the ability to maintain an objective eye on the body parts and despite its human-like qualities he engages with a medical body. Of course, as I outlined earlier, 'scientising' and objectifying the body parts can also be seen as a defence mechanism (see, also Lief & Fox, 1963; Hafferty, 1991).

Term five of the medical curriculum (during 1999/2000) covered the human reproductive system and students were presented with male and female whole bodies in the DR, which was not a usual occurrence. I asked the following participant whether they had been expected to touch the bodies and when she replied that they had, I asked if this was more difficult. She replied:

> *Yes it actually was and I actually thought about that because I mean we have had you know reasonably whole bodies before for things and we have had to sort of you know, we've still had to sort of put on the gloves and touch them and things like that and I've never had any problems with things like that before. I don't know, it did make me think. I thought, why am I, why do I not like this as much, why is this a problem for me? But I think mainly I didn't feel it was adding, it wasn't of any educational purpose for me. I didn't feel I was gaining anything by having those there, so actually I thought they were really superfluous. I mean that, you'll have to talk to other people. (1/9 – 2nd year)*

For this student, then, being presented with a whole body raised issues for her that she herself had attempted to identify. In effect, the appearance of a whole body seemed unnecessary and was thus seen as gratuitous rather than being of educational use. I asked this student if there was something less acceptable about these bodies in the DR and she responded:

> *Not so much not so acceptable, I don't know if acceptable is the right word, I mean I suppose it is that because if I'm saying it is superfluous, then yeah it almost is. I can't think of another way of putting it, but I am sure that it is not, that it is not acceptable, I just think it is maybe going a little bit, you know we don't, we don't really need to do it. (1/9 – 2nd year)*

Perhaps the encounter with a whole body reminded her of the living person and that this was an unnecessary contribution to her education. One might also speculate that seeing no educational value in the whole body specimens may be a way for her to rationalise her dislike and discomfort about working with them. However, the dislike of what might be seen as gratuitous specimens showed a respect for where the body had come from; in effect, a specimen needs to be of use to her in order to justify its use in that context.

Another student reported similar thoughts but at the same time hinted that the difficulty might be related to intimacy. He also hints at the gratuitous nature of these specimens:

> *Um the classes have been quite intimate, that's the problem, um there was, yeah, there was some whole body ones and it seemed quite pointless actually cos there was a whole body section and it wasn't really dissected at all and it just referred to male and female genitalia and you can sort of get an idea of what they are like already. (laughs) (1/1 – 2nd year)*

I asked this student whether there was something more personal about these specimens. His response is not terribly direct and he never referred to any sexual connection explicitly: *"I think so, yeah I think so. There's, it's just I don't find it as nice. I don't find it as easy to go in there and just handle them as it were, just go in there (1/1 – 2nd year)*. Perhaps not surprisingly, he adopted the strategy of missing these DR classes:

> *Well, it's yeah it's meant to be like any other system and I was speaking to (...) about this earlier in the term and I say I'm quite, I think this is the reason that I haven't been in there that much this term because I don't particularly like the dissections. (1/1 – 2nd year)*

One student described the content of the DR in these sessions as being *"more involved than usual at the moment cos it's like all the reproductive stuff so it's all genitals." (1/5 – 2nd year)* Another student did explicitly refer to the sexual nature of the specimens in the DR during term 5: *"Well, I know a lot of people are nervous of sexual subjects and also there are people with religious taboos around the opposite sex." (1/2 – 2nd year)*

In effect there is a 'double whammy' for students: both encountering a whole body which may be more difficult to objectify and having to think about and touch genitals, making an explicit link with the sexual act. The appearance of a sexual body, which has explicit links with the everyday body which is alive and engages in intimate social activity, is problematic for the process of objectification. For some students this means avoiding such encounters. However, others reintroduced the link between the body in the DR and the patient's body and saw emotional reactions as something to get used to or suppress in order to be able to adopt a professional approach to the practice of medicine and their future engagement with patients, reiterating the notion of the patient's body as a medical body and the role of the activity in the DR as preparation for this:

> *You know I'm not, I'm not a callous person, but I'm also not a squeamish person and I feel that you have to have certain professional ways of looking at things. (1/9 – 2nd year)*
>
> *(...) to be a functional doctor they have got to get over that sort of thing." (1/2- 2nd year)*

The balancing act between seeing the whole body as an objectified medical body and recognising its link to the everyday social body which needs to be treated with respect is indeed complex and students' struggle with this tension is well summed up by one female mature student:

> *Well obviously the people in the DR, they are, they were also people and they also died (...) but you still treat them with respect but what I'm saying is that maybe from the point of view of maybe shock you know the effect the physical or emotional effect it has on you as a person. Seeing someone who has died and it's the whole body and you know they are there and then it's not a person who is basically now, you know, scientific material. I know that sounds terrible and it sounds very cold but basically it's been preserved. You, you stop, you do stop thinking of it as a person, you go in and it's very difficult to think of them being perfect people cos you are seeing bits. (1/9 – 2nd year)*

Linking with the imperfect patient's body

I wanted to explore how the body and its parts that the students encountered in the DR may reflect the body of a patient. Lief and Fox (1963:19) noted how students used words that might also refer to practices with patients; for example: "cutting into, exploring the human body, death and things dying". One student in my research (1/2) who had experience of dissecting animals told me that he was used to putting a 'professional' distance between himself and what he was dealing with; however, he also recognised that this distance would not be appropriate when interacting with patients: only so much distance is professional. Another felt that touching the specimens was the same as touching patients, (which she had had experience of), thus reinforcing the notion the even if the body is pre-dissected it may still reflect the body of a patient in some way for some students: *"picking things up and you know, so it's the same as it was like with patients." (1/5 – 1st year)*

There is a tension here: students may need to de-humanise or objectify the body parts in order to work with them but at the same time might acknowledge the connection between the body parts and the body of living patient. Furthermore, if this latter connection is not made it would be difficult for students to understand why the dissections are used to help them to understand structures within the human body.

The dissections were seen as looking/seeming like the 'real thing' in three dimensions as opposed to pictures/diagrams in books that were seen by some to bear no resemblance to what structures in the body really looked like. Juxtaposed with the view that the specimens gave students a 'real-life' view of the body parts, was the notion that diagrams gave a 'perfect' view of the body. One student told me that the specimens were not as anatomically perfect as in the books that gave you the ideal:

> *The trouble is it's not always clear what's on a dissection and I know that the books are (...). It's not always perfect, it's not always as anatomically perfect as it is in the book but I think you have to recognise what it would be in an ideal world before you go and see that it's not actually, because otherwise it just confuses you. So I don't think I would try to look at an arm to try and fit them together. I think I'd have to look at a book. (1/3 – 1st year)*

Similarly, another said that the diagrams set things out in an orderly fashion like a 'normal' person, whereas with specimens, things were not always found in the 'right' place:

> *When you are looking at it in the diagram it seems quite simple cos it's all laid out in orderly fashion and you know like this is a normal person. Whereas when you are actually in the DR they (...) give you a body and like you then have to look for other things, you know everything's not quite in the right place (...) when it comes to an exam or something, you know, you are used to it and that's what I am trying to do – become more familiar with what it looks like in real-life. (1/6 – 1st year)*

Here 'real-life' specimens appear to be abnormal rather than normal and this is further complicated by the fact that anatomy as a discipline aims at helping students to understand the 'normal'. However, the specimens represent a chaotic, unordered world. One student indicated that he preferred using books or the computer: *"especially as there's not any kind of blood and stuff like that making identification more difficult." (1/1 – 1st year)* Normal is characterised by what can be idealised in a diagram rather than in actual dead human body parts facilitating learning.

Not engaging with the prosections may mean that certain students become disadvantaged in the DR; they may, for example, be unable to see/feel certain parts that they need to identify in order to understand the structure of the body, and may, as outlined by one student above, visit the DR rather less frequently than others. In effect, such students must conform to the requirement that they distance themselves and objectify the body parts in the DR or risk missing out on certain aspects of their education.[6] For students to undertake the activity in the DR, they need to identify the body parts as belonging to the medical body and suppress any interventions from the everyday body and, even though students at Southampton are not dissecting in their anatomy classes, the body parts still reflect aspects of a patient's body. The assertion by Good & Good (1993: 97) in essence appears to hold for the participants in my research:

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[6] I am assuming here that learning anatomy using actual body parts provides something in addition to what students can learn from CAL software or from books but I think this assumption needs questioning.

> Our point here is not that anatomy is a 'dehumanising' experience, substituting technology for humanity, but simply it is one significant contribution to the construction of a person as an object of the medical gaze, an object identified as a case, a cadaver, or a patient.

Moreover, if the less than 'perfect' body parts in the DR are associated with the patient body, might this mean that, as no person will ever be able to present with this perfect body, all patients may be associated with a flawed body?

Working with the recently dead body

Students are encouraged to attend the post-mortem demonstrations that take place at lunchtimes and are delivered for teaching purposes by the pathology staff. Each day an 'interesting case' is chosen to be presented and then appropriate body part/s are used to illustrate the pathology.[7] My understanding is that these are rarely whole body presentations. All the participants from phase one of my research had, however, attended at least one of the post-mortem demonstrations[8].

The main differences between these demonstrations and working in the DR appear to be as follows:

- Students are part of an audience whereas in the DR they are expected to work on their own or in groups to a large extent. Students don't pick up the specimens.
- The specimens are explicitly linked to a recent clinical case and therefore to an individual.
- The specimens are different in respect of their texture, colour (blood) and their smell because they have not been preserved.

Participants indicated that the post mortem demonstrations served the purpose of helping them to identify what was 'abnormal', as opposed to 'normal' with the DR specimens, and helped them to link their knowledge base with clinical problems in order that they might begin to solve them.

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[7] 'Interesting cases' mean unusual cases or specially useful for learning (see, for example Becker et al, 1961)

[8] I did not speak to participants in phases two and three about pathology demonstrations as their focus in years 3 and 5 of the curriculum was clearly on working with patients.

In general, the participants tended to find these motivating in terms of linking to the clinical aspects of their training and, given what we understand about the need to contextualise knowledge, it is not really surprising that the students confirm this in relation to their learning:

> *You kind of remember stuff more easily when you have actually seen them or when somebody has discussed a case with you. (1/4 – 2nd year)*

> *There's the kind of like clinical relevance as well, which is after all what we are all interested in. It's nice, it's good to have gone though both because then you can compare the ones that are normal to the abnormal ones. (1/5 – 2nd year)*

The post-mortem demonstrations give students the opportunity to link body parts with an actual story of what has happened to someone and why their organs have ended up in the demonstration. For example:

> *When I go into the post-mortem demonstrations I'm not so interested in the specimens (...) it's more of the way they present and the story. (1/3 – 2nd year)*

The body parts are linked to a 'case' but the flip side of these demonstrations is the explicit connection to the everyday body: to 'real' life and to a person with a story and by implication, to being a doctor:

> *The woman was 27, she'd gone in to have a baby and she became breathless and three days later she died. She'd had pulmonary deficiency, basically she'd had a ?? defect as a child which had been on her records from 0-7 but they didn't sort of pick up on it in the night. I think they were aware of it, but they didn't, so I'm not saying it was negligence or anything like that but it just gave us an insight into how, and the things that can happen and the things you have got to look out for. So it, it's looking at a whole different side of medicine really. (1/9 – 2nd year)*

> *They have got a history, they have got a story behind them and I tend to think of relatives more with regard to that. I don't really think of relatives up in the DR (...) but this you know these people are arranging a funeral for this, these organs really (...) these people hadn't wanted to die. (1/3 – 2nd year)*

I wondered how students dealt with this connection, and whether this connection with the everyday body intruded on their encounter with medicalised body parts. The following student illustrates that the body in this context is not just an objectified medical body but is at the same time an everyday body which makes her think about the activity she is engaged with: *"I just always think that I'd never want anyone I knew to have a post mortem." (1/3 – 2nd year)*

She struggled with the difference between her relationships with bodies that have been donated for the DR and therefore it was known that students would be using them for their education and the parts of bodies that ended up in post mortem demonstrations. This raised issues of consent for her and made her think about how the person who the organs belonged to might feel or have felt about the use of their body for this purpose: she recognises the issue of consent here and makes it explicit:[9]

> *But for whatever reason the people in the DR have willingly donated their bodies whereas the post mortem specimens you know they just haven't, they haven't you know of course they haven't given their consent to, you know, to have their organs used for post mortems demonstrations. (1/3 – 2nd year)*

Interestingly a student who struggled with the DR found it easier to objectify the body parts in the post mortem demonstrations:

> *In the post mortem demonstrations it's very much more dissociated so you don't find yourself thinking that this was actually once a person even though you are happily listening to the story of how they were wandering down the street, collapsed with a heart attack, were bought into the hospital and this is the pathology that we found. (1/8 – 2nd year)*

This may of course be because she is physically removed from the specimens in the demonstration and does not have to touch them. It may also be because the demonstration is conducted in a way that is de-personalised. This and the fact that the demonstrations are voluntary may account for the fact that, on the whole, participants that I spoke to reported few difficulties with the post mortem demonstrations. However, as was apparent in relation to certain other activities, it can be 'other students' who have problems. The following student observed an actual post mortem:

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[9] I shall pick up on this point again in chapter 5

> *I watched with another girl that went with me and a guy, and the girl had to leave and so in the end there were only two of us which was really brilliant (...). Yeah she felt sick. I don't know it was fine, it didn't bother me. I think it was a bit, you know because these people have like just died and they don't look like the dead bodies that you have in the DR, they look you know much more like real people, um but no that's fine, it's really, really interesting, I really enjoyed it. (1/5 – 2nd year)*

Encounters with the Unconscious Body

Context

The surgical attachments in the medical curriculum at Southampton occur in both the third and the fifth year. In theatre, students reported observing the surgical team and their activities: holding implements, and sometimes examining patients. Outside theatre they are advised to follow a patient through clerking into the operating theatre and out again so that they have a sense of who is in theatre and why. In this sense, students are encouraged to make links between the physical body in theatre and the patient and they reported various benefits from doing this as opposed to going into the theatre 'cold':

- It increased their interest and motivation and therefore improved their ability to learn something from the encounter:

  Probably it increases my interest in what is actually going on and yes I suppose if I just walked into theatre and seen, I don't know, that I had not met the person before, I would just watch it and be off. (2/10 – 5th year)

- It enabled them to feel part of the surgical team if they could answer questions about the patient when asked:

  One thing, sometimes the consultant will ask questions you can answer which is always quite nice and very useful and probably the anaesthetist wanted to know whether she has got any vascular problems or whether she has ever had, I don't know, any previous operations or anything like that. (2/8 – 5th year)

- It made them aware of the patient and the problems they were experiencing:

  I suppose you have slightly less interest in what's going on with them if you've never seen them before and personally for me the part of medicine that I really enjoy is the interaction with the patient and the talking and the medicine bit (...). (2/4 – 5th year)

The body as object in theatre

The transformation of the everyday body to the medical body is one example of what Young calls 'realm shift' in medicine: "Crossing over from the realm of the ordinary into the realm of medicine entails a change of ontological condition" (Young, 1997: 13). The body in theatre can be seen as the epitome of the medical body: passive and objectified; the difference between this body and that of the dead and dissected being that the body in theatre is alive. As Young (ibid.: 89) states: "Unconsciousness appears to complete the transformation of the body from subject to object", and students reiterated this:

> *I find it quite strange because they go from being a kind of normal, walking, talking, chatty person and the next time you see them they are flat out on an operating table. (2/2 – 5th year)*

> *It's almost like they turn from being a human (laughs) into just, I was going to say a slab of meat, but that sounds really bad (...) and I suppose I generally just see them as no longer a person. (2/1 – 5th year)*

A number of the participants told me that in theatre the body is completely covered up except for the part being operated on; what is revealed in theatre is only a part of the body and in this way the body is divided up in the same way as in the DR. The focus on the body part rather than the whole body enables the everyday body to be subjugated to the medical body and students referred to this loss of personhood or self:

> *They get wheeled off into theatre and they're all covered up and then what I actually saw was a colonic cancer being removed so obviously it was only the abdomen that was exposed (...). So in a way I looked at it as a body rather than a person simply because I mean I was only looking at the abdomen (...) Every so often the anaesthetist would check that you know all the tubes were OK and I thought, oh yeah, it is this fellow in there as well, so you do tend to forget slightly simply because it's all covered up. (1/6 –3rd year)*

> *I think it was very easy to forget in my first few times in the theatre to forget that underneath the green ??, and the exposed and very small area that you are operating on, is a patient rather than just an unspecific mass with an operable section. (2/9 – 5th year)*

The practices and routines that support the work in the theatre might also serve to place the body in its object position:

> *Everything's following a protocol so you can see the logic behind everything. I can stand there and think, right, this is going to happen next because that's how it's written down but at the same time it also makes it very clinical, almost makes it detached from the fact that what you are actually doing is operating on a person. (2/1 – 5th year)*[10]

The objectification of the patient's unconscious body in theatre may be necessary in order for the act of surgery to take place. Young (1997) points out that if the body were not objectified in theatre then the very act of surgery would be inhumane; the shift from subject to object enables the removal of the self which is necessary for both the patient and the doctor:

> This dislocation of the self from the body is crucial to the humane practice of surgery. It ensures that surgeons do not commit trespasses against persons but perform operations on objects (ibid.: 97).

One student illustrated the problem for them of seeing the patient's face (as with the human referents in the DR) in theatre:

> *S:* *I remember I was in theatre and someone was sort of awake* [presumably local anaesthetic] *and they were having something done to their face and they are actually a person. I always faint. I really do have to think of them as not actually a person*
>
> *A:* *So you actually fainted?*
>
> *S:* *Yes, I do quite regularly. Like whenever it is dermatology or something is being removed from the face and bleeding from the face and sometimes I just faint (laugh). (2/7 – 5th year)*

Connecting with the unconscious body

So, like in the DR where students need to construct an objectified medical body in order to undertake curricula activities, so in theatre the medical body status is necessary for patients, doctors and students. However, this may have some negative consequences for how the patient's body is treated in theatre. For example, one student reported that in her experience the body was not treated with respect in theatre:

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[10] Clinical, here again, appears to mean objectified

> *S:* *I've been to the theatre (...) but that's always very surprising about just how the poor anaesthetised body is treated by all the doctors and staff.*
>
> *A:* *How is it treated?*
>
> *S:* *Quite badly, not like you know physically but just it's more like disrespectfully and you know the, just the comments (...) like if it's someone that's quite overweight then they'll all make a comment about it (...) it's purely like the chat that goes on in the theatre. (1/5 – 3rd year)*

This student was concerned that patients might wake up and remember what had been said and worried about how they would feel about what had been said. I think that the transformation to the medical body is incomplete for this student and this illustrates again a connection with the everyday body. Another student made a similar connection in relation to the patient being covered up:

> *I find that funny because you know you'd feel claustrophobic if you had something over your face and obviously they're unconscious and they've got ventilators or whatever but it always seems a bit cruel to me I think when they cover their faces up but um you don't, it's not a person on the table really because they've just, they're not recognisable as a person. (3/3 – 3rd year)*

Moreover, some students were very aware of how vulnerable a patient was in theatre:

> *They're just completely vulnerable to you and the people around you. (2/2 – 5th year)*
>
> *Seeing patients, it makes you feel really vulnerable about having to go into theatre* [as a patient] *because you are just covered up by a sheet and people are digging around in you. You are vulnerable. (2/7 – 5th year)*

This last student explained that this acknowledgement was connected with how they felt when they themselves had undergone an operation so they could put themselves in the patient's position.

Drawing on Documents

I put the dead and unconscious body together in this chapter because of the essentially objective and passive status accorded to the body in both these states. Curriculum documents appeared to reinforce this view although more explicitly in relation to the body in anatomy than perhaps to the unconscious body, which I will now discuss.

Body representations in anatomy

The gross anatomy handbooks, that CLAS produce, act as both workbooks and textbooks for students' learning in anatomy and are organised around organs and systems of the human body which are supported by specimens in the DR.[11] Students are given the first of such handbooks in their foundation term and this, therefore, also acts as an introduction for students to their work in the DR.

In the introduction to the handbook there is a clear message that the purpose of the anatomy sessions is for students to gain anatomical knowledge:

> One of the general aims of the anatomy sessions in the Foundation Term is to allow all students to attain a similar basic knowledge to cope with the anatomy contained in the systems courses of subsequent terms (CLAS, 2001: 1).

At this point, therefore, there is no mention of patients' bodies, perhaps because anatomy is characterised as the study of the 'normal' rather than 'abnormal' body. The body is clearly represented as a medical body: an object of inquiry from which students can gain knowledge and facts about anatomy; for example: "One approach to human anatomy is to realise that the human body is composed of cells and extracellular matrix which together form tissues" (ibid.: 6).

Whilst there were references to the "human body" and the "body as a whole", body parts were referred to as "specimens" and there was little other indication of where the body might have originated from; for example, students are asked to "examine these specimens of the human head" (ibid.:7) but there is no acknowledgement in the text that

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[11] Centre for Learning Anatomical Sciences

this might be a problematic encounter for students because of the ‘human referent’. What is stated is very matter of fact and ‘scientific’ in its approach. Students are asked to ‘examine’, ‘identify’, ‘write a definition’, or ‘list’ in terms of the activities they are asked to carry out. Whilst in the introduction students are encouraged to “examine your own body and if possible that of other students” (ibid.:1), indicating a link to the everyday body, this recommendation was not referred to again in the rest of the text. There are (outline) drawings of whole bodies with faces sketched in and one of a female body wearing a swimming costume, but these are very much outline drawings of the body in the ‘anatomical position’ (ibid.:11-12).[12]

The only indication I could find that the specimens being referred to might once have formed part of a living person was in the introduction – in a ‘do and do not’ section. Students are asked to “cover specimens when you have finished” and not to “take photographs” (ibid.: 2). However, this is stated without any explanation as to why these instructions may be necessary. Both might be seen as needed as acts of respect; on the other hand covering the specimens is also practically necessary to prevent them from drying out. On reflection, I think there is a lost opportunity here in terms of acknowledging the previous status of the bodies/body parts.

There was no reference to how the students might respond to the specimens, what encounters might be difficult or what students might do if they did experience difficulties. Whilst I had expected the handbook to represent the body in the way that it did, I was surprised by the lack of any information about the specimens themselves: where they came from, how people donate their bodies, why they might do this. In effect the specimens are almost perfectly represented as objects within the text, with no prior life or history. How students should interact with the specimens is implied rather than explicitly stated: their interaction is with objects.

Body representations in theatre

How the unconscious body was represented in curriculum texts was rather more difficult to determine, not least because I did not find many references or allusions to the body in theatre. The year 3 and year 5 student handbooks for 2002/3 (School of

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[12] I can only assume that the addition of the swimming costume represents an act of modesty.

Medicine (SoM), 2002a & 2002b) contain the same introductory section called "Instructions to students in clinical areas" which sets out 'rules' of behaviour relating to such aspects as communication, examination, health records, and practical procedures; however, this contained no reference to patients in theatre, only aspects of communication with patients and their families.

The year 3 handbook has a section specifically related to surgery but this again focused on the conscious patient's body for example, with reference to taking a history and examining a patient. This is not surprising in one respect as one of the main aims of the third year is to help students develop these skills and assessments of students' learning are focused on these; however, the unconscious body is conspicuous in its absence and its invisibility. The section does make reference to gaining experience of "theatre work" but there is no further explanation about this.

In the surgery section in the year 5 handbook there was also a lack of reference to the unconscious body. There is more detail in this handbook about the clinical skills and abilities that the students must develop during the surgery attachment, including a list of technical and practical procedures, but these are abstract and listed; for example 'suturing and removal of stitches', 'digital rectal examination', 'recovery position for the unconscious patient' (SoM, 2002b: 59-60). In the aims of the surgical attachment, where patients are mentioned specifically, they are represented as passive entities and the object of students' observations and experience:

> To *see* patients with the conditions usually encountered in surgical wards and clinics in hospital
>
> To have some experience of the operating theatre, and to *watch* commonly-performed operations. (ibid.: 53) [My emphasis]

Both handbooks emphasise the importance of informed consent for surgical procedures and I will return to discuss this in chapter 5. Again there is no reference to how students might interact with the unconscious patient body; but, in addition, there is no acknowledgement that there is any difference between the conscious and the unconscious patient body. One interpretation of this is that the unconscious body is afforded the same status as the conscious body in the texts (perhaps as a medical body);

however, as my discussion above showed, the unconscious body is treated differently in theatre and one consequence of not acknowledging this difference is that almost no status is accorded to the unconscious body: in effect, its invisibility is its objectification.

Summary: Encounters with a Medical Body

In this chapter, I have explored students' work with the dead and recently dead body in the DR and in pathology demonstrations and with the unconscious body in theatre. I would argue that, in these contexts, the body is primarily rendered an object and this is reinforced by the fact that that the body is in a state where there can be no social interaction between it and the students. Students described ways in which they viewed the body as a medical body and indeed the necessity of so doing in order to carry out the activities required of them as part of their medical education. Furthermore, documents confirmed this view of the body as object. Despite this and the non-sentient nature of these bodies, the everyday body still makes something of its presence felt in each of the contexts, and in similar ways, revealing another view of the body and provoking reactions from students. For example: through the bodily reminders that the body parts have a living human origin; students' thoughts about whether someone would have consented for their body parts to be used for teaching in a pathology demonstration; and observations and resulting anxieties about the way that the body in theatre is treated.

Students are faced with the following dilemma: if they do not objectify the body in these contexts then the activities are more difficult to undertake precisely because you would not behave in these ways outside a medical curriculum; however, to objectify the body can also be seen as disrespectful. The curriculum appears to demand that they engage in the activities I have outlined but does not explicitly seem to acknowledge this dilemma.

Whilst it can be argued that the medical body may be pre-requisite for certain activities to take place, it also carries certain consequences, illustrated by students' accounts of how the patient's body can be treated in theatre. Although I do not agree with direct comparisons between the student-donor relationship in the DR and the student-patient or doctor-patient relationship in clinical medicine, I believe that this incomplete 'realm shift' serves as a useful and essential reminder of the body beneath the 'covers'.

Chapter 4

Encounters with the Conscious Body

This chapter is concerned with medical students' work with the conscious patient's body. What I am concerned with here is substantively different from the previous chapter in that students are engaged in a social interaction with patients and their bodies. However, as with the previous chapter I will first provide some context to what I discuss in the second part of chapter, which arises from my interpretations of the interview data across the first three phases of the research. I end the chapter with some supporting comments from the analysis of key texts.

Context

The participants in phases one and two had very little physical contact with patients during their first two years of the medical curriculum. Students participating in phase three (3rd years) had experienced a new course in the curriculum, Medicine in Practice (MiP) which involved learning about history taking and physical examination with patients; however, even for these students actual physical contact with patients' bodies had remained fairly minimal. This physical contact means that students must touch patients' bodies and, whilst the aim might be to undertake this activity in a matter of fact manner, touching the skin is at once both a physical and a social act. As Synnott (1993:169) explains, as a social act, touching expresses a range of emotions and relationships, including power relationships and hierarchies: "The general rule is that superiors touch inferiors more than inferiors touch superiors". Students must learn to touch and engage with patients' bodies as part of the process of 'clerking'; ie taking a history and undertaking a physical examination. This term 'clerking' has historical foundations: medical students were known as 'clerks' who carried out the essentially administrative tasks of gathering information for the senior doctors (see, for example Newman, 1957).

The ultimate aim of learning these two clinical techniques is to lead students to the goal of making a diagnosis and, following this, constructing (or negotiating) a management plan for dealing with a patient's condition. The aim is to uncover clinical signs that will reveal what the possible diagnoses might be; a sign is what the doctor uncovers and the symptoms are what the patients outline. The focus for the third year student is on developing these clinical skills through gaining experience of, and practising with, patients. In the fifth year, however, the focus shifts to diagnosis and management.

According to Sackett et al (1991: 3), diagnosis is the "crucial process that labels patients and classifies illnesses, that identifies (and sometimes seals!) their likely fates or prognoses, and that propels us toward specific treatments in the confidence (often unfounded) that they will do more good than harm." The language here is biomedical (the authors are clinical epidemiologists): patients are labelled and classified. They identify four diagnostic strategies:

- *Pattern recognition.* Within this strategy, a doctor instantly recognises a known (or learned) pattern of disease. Visual signs are often detected in this way; for example when a patient presents with psoriasis, doctors may be able to diagnose the complaint by just looking at the affected skin.

- *Multiple branching.* Using this strategy, an observation or a response leads the doctor down a particular route or pathway. The process essentially entails the person following a pre-established algorithm. This also enables people other than doctors to carry out the diagnostic process if they have access to or know the different pathways.

- *Exhaustion.* This strategy involves undertaking what is termed a 'full' or 'complete' history and examination, which means collecting rather copious amounts of data and then sifting the information to find the diagnosis. As Sackett et al (ibid.) remark, medical students and some clinicians believe that this is the 'right' way of undertaking the diagnostic process but most clinicians do not use it.

- *Hypothetico-deductive.* It is this method that most clinicians adopt and it involves identifying, from clues, a number of different possible diagnoses (differential diagnosis). Taking the history, performing the examination and ordering tests are all undertaken in order to reduce the number of possible diagnoses. Barrows et al (1982) found that clinicians simultaneously generate hypotheses (usually three at a time) and conduct the parts of the history taking and examination which will enable them to narrow the field down to one working hypothesis, which the clinical signs and the patient's symptoms support.

Students in their third year are asked to practise history taking and examination techniques by using the exhaustive strategy although it is accepted that for any one patient students may not (or should not, in the case of vaginal or rectal examinations) cover all components of both (SoM: Revision of Introduction to History Taking and Physical Examination, 2002/3). The history taking part entails: undertaking a history of the presenting complaint (what the patient is 'complaining of'); a history of the present illness; questions about any pain; past medical history; a systematic inquiry which involves questions which cover the different biological systems and which aim to help students screen out or include other important information concerning a patient's symptoms; and finally a social history to uncover aspects like the impact of the illness or issues which may affect management and a family history of the symptoms or related conditions. The examination involves a general assessment (mental state, physical observations) and then examinations of the six biological systems: cardiovascular, respiratory, gastrointestinal, genito-urinary, nervous, and locomotor. The examinations involve the particular skills of: inspection (sight), palpation (sight and touch), percussion (sight, touch and hearing), and auscultation (sight and touch and hearing using a stethoscope) (Sinclair, 1997).

Students in their third year reported that taking a full history and examination took up to an hour, so it is not a 'quick' process and the examination can be physically demanding for patients. Neufeld et al (1981) found that students do in fact adopt the hypothetico-deductive method and indeed students did report focusing on particular systems for history and examination depending on their relevance to the possible condition.

Students are asked to clerk patients and present information to clinicians, sometimes informally, sometimes more formally as 'case presentations', as well as practise clerking as many patients as possible on the wards on their own. Students may also be asked to clerk patients 'on-take', which effectively means clerking new patient arrivals through casualty, and in these circumstances students are asked to report their findings to the consultant or senior doctor responsible for the patient. Bedside teaching or ward teaching may involve returning to a patient that the student has clerked; following clinicians on their ward round or teaching round; students demonstrating examination techniques or undertaking particular tasks such as listening to a heart murmur, feeling a swollen kidney and reporting/discussing their findings.

Essentially, students engage in the activity of examining a patient's body within the medical curriculum because it is part of the curriculum: this might be as part of an assessment; when they are part of a teaching situation; when they are told to do something; or it may de driven by the need to practise examination techniques in order to pass their assessments and ultimately to be able to practise as a doctor.

Atkinson (1997) in his work on students' clinical experience identifies how students differentiate between 'hot' and 'cold' medicine:

> On the one hand, hot medicine is seen as exposing the students to real medicine: histories are being taken for the first time and are crucial to the patient's treatment; the illness must be managed and diagnosis attempted. There is a sense of the dramatic, the unpredictable, and the rough and tumble of acute hospital medicine. Cold medicine, on the other hand, is characterised as contrived, involving carefully managed encounters that lack the same sense of immediacy and unpredictability (p.146-7).

Being 'on-take' can be seen as hot medicine whereas clerking a patient who has already been diagnosed, and whose presenting complaint may be essentially 'lost' in the patient's memory because of subsequent events in hospital, would be seen as cold medicine. This distinction is helpful in understanding students' attitudes and approaches to activities undertaken in different contexts.

I found an underlying contradiction in students' engagements with conscious patients' bodies, similar to the dilemma outlined in the previous chapter, but amplified because there is now a social interaction: essentially they are stuck between a rock and a hard place. They need the experience and practice of examining patients and yet at the same time need to engage with the patient and their body in a respectful (non-mechanical) way and it is this tension (or conflict) that they must negotiate their way through; essentially they are often engaging in a fairly 'unreal' situation which lacks the purpose that the doctor/patient interaction is founded on. As I outlined earlier, medical students have been characterised as becoming detached or, indeed, dehumanised as they progress through the medical curriculum, but I think that this underplays the complexity of the students' activities and engagements with the patient's body and their role in mediating activities. However, students' ability to undertake the latter is also limited by their place in the medical hierarchy and the status that is accorded patients' bodies in medicine. In this chapter, I attempt to focus on the student's voice to portray and explore their perception of their engagement with conscious patients' bodies and how they perceive and grapple with this tension, which is well articulated by the following student:

> *(...) examining is a kind of mechanical thing. But I mean you know you can't do that with people because they have got things to do in their day and they have got things to think about (...) and yet you do need to do that because that's part of your training. So that's pretty much the conflict that you have got. (3/5 – 3rd year)*

Using the Patient's Body/Being Useful

Students have to undertake an activity that would have a very different purpose if they were in the role of doctor. A doctor would examine a patient to confirm their developing differential diagnosis or to check something in a patient's body once their condition has already been diagnosed; the act is carried out ostensibly to benefit the patient and the focus is presumably on their body and condition. Conversely, for students, the act of examination is primarily carried out for the benefit of their education and is motivated by their need to learn to become doctors rather than for the treatment or care of patients. It is important to remember that students do not 'have' any patients, as all patients would be the responsibility of a doctor.

Students were well aware that many of the activities that they carried out, or were part of, were actually for their educational benefit and were of little, or sometimes of no benefit to patients themselves; essentially by allowing them to practise taking a history and examine them, patients were helping them with their learning and their assessments. For example:

> *A:* *Why were you doing that?* [clerking a woman on the ward]
>
> *S:* *The simple purpose for that is for me to learn really and to get clear what her presenting signs were (...). It is just literally for my learning experience. (2/8- 5th year)*

> *A:* *Why would you decide to go and clerk someone in the 5th year?*
>
> *S:* *Oh, it's all about, well for me it's all about being focused, I think for a lot of people, for the exams because at the end of each attachment we have our assessments or exams which are taking a history and examining a patient and then presenting it to two consultants and so during the attachment you want to get as much practice as possible taking histories and doing an examination and then presenting it to someone. (2/1 – 5th year)*

Some students acknowledged that their activities might be invasive or intrusive to patients, which made them feel awkward about asking if they could take a history or examine them, especially in their third year when they needed to practise a lot on the wards and lacked the confidence to 'cold call' patients: *"But I do get a bit kind of: Oooh, I have to go and find a patient, but I don't want to be annoying." (3/2 – 3rd year)*

Students are thus faced with the notion that they are 'using' the patient and their body for their own gain: "*You feel a bit rude, you know, because you, if you don't feel it is necessary for them, for their benefit, then it is totally using them" (3/4 – 3rd year).*

The effort involved for patients in the process of a full clerking should not be underestimated: as I have already mentioned, participants told me that to do this 'properly' took up to one hour. In order to feel comfortable with the task and not a 'pain in the neck', I think students need to feel that they are being of some benefit to patients. Being faced with social interactions with people, which are only of benefit to them, is, perhaps, an almost impossible burden to bear. Such an interaction would act counter to a symmetrical rule of conduct in which each party involved has reciprocal expectations and obligations (Goffman, 1969). I think this is a clue to why most of the students that I spoke to, whilst acknowledging the use of the body, attempted (and sometimes struggled) to find ways to justify their activities with patients as being of some benefit to people other than themselves; that is, being useful.

Taking a history was often seen as being less problematic because the interaction involved could be seen as having a chat with someone: some patients might like talking, need to talk, feel scared, bored or lonely. Essentially, students could see the activity of history taking as having the side effect of being 'a friend' to patients, thus giving something back during the interaction:

> *It very much depends on what sort of person they are, because some of the patients just like talking to you, especially if you are in general surgery. (3/2 – 3rd year)*
>
> *But I felt in psychiatry, when I did, I didn't do any examinations in psychiatry really, I just did history taking and I did actually feel very useful there because the people I talked to genuinely just wanted to tell their story and I would sit for ages and I seemed to have a lot of spare time and I was able to just sort of sit there and listen to them. And I didn't think that I had to encourage or ask probing questions – they wanted to talk and they did (...) and there was this lovely lady I clerked the other day who I have been back to a few times because she kept saying 'I am so bored, come back and see me'. So in her case I feel as though I am benefiting her in some way. (3/3 – 3rd year)*

Students in their fifth year had more experience and were more confident about their knowledge and there was a suggestion that an additional benefit for patients was that they could answer patients' questions and not just do the clerking and then report to the doctor:

> *I mean for the patient it can quite valuable if you are confident in interpreting then that can be really valuable to the patient because they can ask you questions that other doctors might not have time to answer. You would be able to go through it with them (...). In fact I have started asking people more and more of the questions they may have. They are not necessarily complicated questions when you are on call and you can give answers. (2/6 – 5th year)*

Being part of the 'team'

Finding ways to justify examining patients other than for their own educational use was more difficult, however. One possible way of being useful was to feel that they were contributing to the work of the medical team (and thus to patients' care) and many students highlighted this, both in the third and fifth years. The following student outlines how they were able to pick up things that doctors might miss, although they still struggled with the notion that they are not doing anything for the patient:

> *If they do want to see me* [the patient] *you know I respect that they're giving up their time, they're doing me a favour, you know not the other way round. I'm not really doing anything for them. That said if you feel that in some way you can do, there are some opportunities that gentleman had a throat infection (...) and they* [the doctors] *hadn't picked up on that. (1/9 – 3rd year)*

Actually being able to feel part of the team may be more possible when students are 'on-take' as they are often seeing a patient for the first time and then reporting the results of their clerking to the doctor in charge; the activity is more akin to that carried out by a doctor and essentially gives students a role, and there might even be the possibility, as the above student notes, that the patient benefits in some way as well.

Feeling part of the medical team is perhaps somewhat easier for fifth year students as they are individually attached to a firm[1]; however, both third and fifth year students indicated that being 'on-take' meant there was some mutual benefit: that they could feel part of and perhaps contribute to the team, learn something useful and feel that they themselves were being useful in some way:

> *I feel a lot better about seeing a patient on take because you just feel like what you're doing is beneficial to them as well as yourself. (2/2 – 5th year)*

> *Well now that I am getting close to graduation, if I am clerking patients on take it is as part of the team rather than as a tacked on medical student. So it will either be me or the house officer who goes and sees a patient (...)so from the patient's point of view I am, would have been, part of the team and should have been reviewed and seen by someone senior. From my point of view there is a useful contribution to the team and for my own education. (2/9 – 5th year)*

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[1] A 'firm' just means the small team of health professionals who work closely together.

That patients might actually see somebody more quickly if students were on-take was seen as a definite benefit for patients and so being involved with 'hot medicine' was not just a case of students wanting to be involved in the more exciting aspects of medicine:

> *They probably get seen a lot quicker, because you don't see them, the really important ones, you usually see the ones that have come in with something not so critical. And so they probably would not have been seen for a couple of hours because they are not going to collapse on you or anything. So you get to go and see them, you can present them and then they are probably seen more quickly. (2/7 – 5th year)*
>
> *I do feel useful at that point because generally there is so much going on and everyone is so busy and yes the registrar does have to take time out to listen to your history but it means that they don't have to go through it all themselves. (...) and the patient that I was asking as well felt appreciative especially if they had been waiting for sort of four or five hours and then they had actually got someone who looks like they are doing something. And I had one, the first time I was on-take actually, a patient who had been in for about five hours and straight after I had clerked her – it had nothing to do with me – but she said 'thank you so much for getting me up there'. And it wasn't anything to do with me (...) So I did feel that I was in a position to help, that I had not been useless as far as she was concerned. (3/3 – 3rd year)*

Using the justification that students are of some benefit to patients because they are seen more quickly is not unproblematic, particularly if students are firmly identifying themselves as students, as they may reflect on what it might be like for patients who have waited a number of hours only then to be seen by a medical student. The following student articulates this difficulty especially if she puts herself in the patient's position: her involvement may also be a possible irritation or frustration for them.

> *I mean when you do it in clinic, you end up with your own room and a desk and you are the only one in there with a patient (...). But if you say to them I am going to do this, I think they are relieved that they have got someone to speak to, so they feel the wheels are in motion to them getting seen. So you say I'm going to do this and then the doctor will be in to see you. But I do find that, I personally do find it difficult, that initial saying I am a medical student because I think they are going to go 'What, I have sat there for four hours waiting for a doctor and I have got a medical student'. (3/5 –3rd year)*

Ward teaching

When students are involved with teaching on the wards the patient's body is used, by definition, for students' educational purposes and there is little doubt that it is the patient's physical body that is of use to students; the social interaction that takes place through history taking is disregarded. This was also uncomfortable for some students:

> *And I do sometimes feel that the patient does sort of end up just fading into the background and they are unimportant because no-one is actually going to really find out what is wrong with them to help them. They are just doing it to find out what is wrong with them so we can learn. In those situations they do become more like a useful instrument. (3/3 - 3rd year)*

> *We sometimes have teaching sessions and it's like: Oh here you go this person's got a heart murmur and then ten of us listen to the murmur. I don't really approve of that to be perfectly honest but that probably is one of the few ways of learning about murmurs you know (...). People do it in different ways, some tutors explain to the patient what's going on and what's going to happen next and some will just say this person's got a murmur and you know drag you all in and it's too many people and it's I think it's impersonal, and the patients often lie back and take it you know and don't really have an awful lot of say in it. (1/9 - 3rd year)*

Despite this last participant saying that she doesn't approve of the practice and acknowledging that the patient has little choice in the situation, she can still see that the practice and activities employed are useful for her education as she needs to learn about heart murmurs. In effect the patient is no longer a 'patient' in the sense that they are part of doctor/patient relationship founded on patients' needs; rather their bodies become primarily an educational tool.

However, students continued to look for justifications, other than for just their education, for the use of the patient's body in such circumstances. Some identified ways that such encounters also might be of benefit to patients, for example: by feeling that they were contributing to students' medical education; being entertained; or having the attention of a group of students and a consultant:

> *Some patients seem quite proud actually that they're being so helpful to young medical students and I find that's the best situation (...) because you feel less guilty about it. (2/2 - 5th year)*

> *I think sometimes patients might feel a bit more like meat or whatever, but quite often they are OK and if they've got something that's quite interesting they want everyone to have a listen and stuff and in my experience the patients have seemed quite comfortable with that because they feel, I think they feel kind of quite comfortable because the consultant or the registrar is there so you know someone is there who knows what they are doing more. (1/5 - 3rd year)*

Another student expanded on this by explaining that such situations may benefit the patients because they are actually getting more time with their doctor and therefore more information from them; in effect the very fact of their presence facilitates this:

> *Some doctors can be great and it can be like a really good teaching session for us, but at the same time it can be a really good experience for the patient because they are getting a bit more time with their doctor and the doctor will often, (...) a really caring doctor will spend a bit more time with the patient and chat to them a bit and explain things a bit more clearly to them. (2/1 - 5th year)*

I think this latter reason may be stretching a point: if students were not there, the patients may get additional time anyway with their doctor especially if they are 'caring'. Whilst I am sure that some patients do not mind, I would also argue that students need to believe that patients don't mind about what happens in order to continue to engage in certain activities. It is not surprising that students may need to rationalise this activity similarly to the way that they needed to rationalise their clerking. These examples illustrate students' need to find ways to justify what they do and the fact that these reasons need to be over and above their own individual educational needs. What also appeared to be the case was that the more intrusive the activity, the more need there was to justify it in this way.

Connecting with/Inspecting the Body

Practising the activities of history taking and examination could be seen as another way that students learn 'detached concern' (Lief and Fox, 1963): balancing objectivity and empathy in their relationships with patients. As Atkinson points out, students expect their attitudes to 'harden' but also that they and their teachers should be able "to establish sympathetic relationships with their patients" (Atkinson, 1997:74).

The students who participated in my study illustrated the tensions that existed between what I now call connecting with and inspecting the body. Sometimes one would take precedence over the other, or sometimes one would act as a brake on the other. For example, connecting with a patient and their body seemed to mediate the effect on both a patient and the student, of the distancing process involved with the inspection or, in effect, to personalise an objectified body.

The act of examination is essentially an inspection of a patient's body: students are looking for signs that back up the patient's symptoms and that will eventually enable them to make a diagnosis:

> *And once you have got to the end of your history, your examination is focused on trying to elicit any signs that you think the child might have to help you form a definite diagnosis. (2/1 - 5th year)*

In general terms, students acknowledged how difficult it must be to be a patient in hospital. When I asked students about their experiences of being in hospital and what they thought it would be like to be a patient in hospital, the most common descriptions of what it was/might be like were overwhelmingly negative, acknowledging patients' vulnerable, often humiliating position. The following student describes how they felt humiliated and exposed after undergoing minor surgery:

> *I just remember it being sort of all embarrassing (...) sat in a gown that was all backless and when they came round to do the pre-assessment, just standing there, totally exposed to whoever it was that was doing it. And after the procedure waking up and feeling totally disorientated with everything, in completely the wrong place (...) and then still being in this exposed condition and everything and the surgeon who had done it did not come back round. (3/3 –3rd year)*

Participants also acknowledged what it must be like for patients during ward teaching but again might try to rationalise this as something that some patients might not mind:

> *I wouldn't like to be a patient with eight medical students round me but I don't know I think they try and choose patients who don't mind as much. I don't know. (3/4 – 3rd year)*

Controlling the process

The tension between connecting with and inspecting patients' bodies revealed itself in different ways depending on the different purposes of encounters. Unless directed by a clinician, students must find patients to clerk in both their third and fifth years in order to practise their history taking and examinations skills. Most third year students reported asking the nurses who might be a suitable/appropriate person and then approaching the person to ask for their consent to the process. Many were worried that very sick patients, or patients who had previously given time to other students, would find the process too exhausting, and the latter appeared to be a particular problem for third year students who were essentially competing for patients to practise on. Students identified a number of ways in which they could make the encounter more comfortable for patients; for example ensuring the curtains were drawn which at least created an illusion of privacy; encouraging patients to undress and dress themselves where possible; postponing the examination if patients looked tired or were in pain.[2]

In this context, establishing a relationship with a patient was identified as being very important, particularly to enable students to move from the history taking to the examination component of the clerking. The history component essentially appeared to help students to build up a rapport that then allowed them access to the patient's body in the examination; without a relationship or connection, the examination, or inspection, would be more invasive:

> *I like to do the history first because it gets you sort of in with the patient and they are comfortable with you. (...) I find it is good to do before you examine them, because if you just went in to examine them, I think this is quite invasive. (3/5 - 3rd year)*

> *I think you kind of get to know them and maybe they get to trust you whilst you are chatting to them (...) they are much friendlier and much more open at the end of the history taking, usually anyway. (...) They have kind of got to know you; they have kind of tested the water first. (3/4 - 3rd year)*

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[2] The curtain forms what Goffman refers to an 'evidential boundary' which identifies and covers up parts of the body that have symbolic significance. As Young (1997) observes the curtain serves as a replacement for clothing in the medical examination.

Participants described how they would use their intuition or 'feelings' to judge whether a patient really minded participating in the clerking process or whether they had had enough at various points in the encounter. (I think this is problematic and I shall explore this is the next chapter.) Students reported abandoning or shortening the process if they felt it was getting too much for the patient, again sometimes linking this to the lack of perceived benefit to the patient:

> *It was because he had abdominal pain and so I just, I ended up not palpating properly and did actually just listen to his stomach and went on asking questions and things. Because I did feel that I was - they weren't gaining anything from me being there - I was not going to go away and help them at all. So I just did not think it appropriate to keep going. (3/3 – 3rd year)*

Another interesting consequence of students' awareness of the patients' experience of the encounter was the adoption of a different method of clerking: instead of carrying out a full history and examination, they might adopt a shorter version more akin to the hypothetico-deductive model outlined above or just concentrate on the most relevant system. The result of this was that they were then actually able to focus in on what was related to an individual patient's condition.

> *This lady was sitting in a chair, wasn't wildly comfortable, and so I had to, I wanted to make it as quick as possible. So it's a kind of foreshortened examination (...). You are supposed to look for peripheral pulses as well; these are things that medical students miss out lots of. You're supposed to, you know, feel for all the pulses. (1/9 - 3rd year)*

One student explained that they did not want to undertake the full clerking process because it took too long and so picked one system to work on which might be related to the patient's condition:

> *I would worry that I would keep people for a long time, because you are not a doctor, you don't feel you have got the right to do that, even thought most of the patients would be fine with that. So what I do is I tend to pick a system to do and then I will go through it in the order that we've been taught to do. (3/5 – 3rd year)*

The importance of maintaining a relationship throughout the clerking process was emphasised by some students; for example, through talking to patients during the examination and explaining what they are trying to do and why. This again might be somewhat easier for fifth year students:

> *It depends how experienced you are because certain types of examination I have become quite experienced at and I have become quite comfortable in communicating thoughts of findings with patients. (2/6 - 5th year)*

The ability to balance connecting with a patient and inspecting their body might well depend on a number of factors such as confidence and maturity. Fifth year students who are attached to teams on an individual basis may be at an advantage because they get to see the patients within their particular team more often:

> *S:* *Yeah, I felt like I got to know the patients quite well so it was even less, you know, I have been more comfortable with you know doing the examinations.*
>
> *A:* *When you were in the third year is that not the case so much? (...) You don't know them in the same way?*
>
> *S:* *No, I think there is so many more other stuff to learn in the third year (...) and it kind of hampers you, if you want to get to know the patients and stuff like that. (2/6 – 5th year)*

Being around more to get to know patients in the fifth year may also mean that if they want to ask a patient if they can clerk them on the wards, then they are not cold-calling: some sort of familiarity already exists.

What does appear to be the case is that when students are clerking patients on a ward on their own they have a certain amount of autonomy in terms of how they might approach and progress through the clerking process; in effect how they might balance the acts of connecting with, and inspecting, a patient's body. However, this autonomy can not be independent of the patients with whom they interact and I will discuss this in more detail in the following chapter.

Lacking control of the process

The relative autonomy to mediate curriculum requirements or the demands of clinical teachers contrasts heavily with other situations in which students are less able to make choices or act on their own judgement in relation to what they are undertaking. For example, if students were clerking to present to a clinician, to be assessed or if they are joining the clinician on a ward round or for ward teaching, they are less able to make choices about how the encounter should proceed.

Some teaching situations on the ward involve students clerking a patient and then returning to the patient's bedside with the consultant. In such situations, the focus for the teaching encounter may be on the examination, but the student will have had some time alone with the patient to get to know one another. Encounters during ward teaching, when students have not spent time alone with patients, might be particularly problematic, as the practice and culture associated with such encounters can so easily objectify the patient's body. The following participant illustrates how the patient is then more easily turned into someone with something abnormal, and despite saying it is not a 'freak show', she goes on to describe something resembling this; with the emphasis firmly on the act of inspecting the patient's body:

> *And usually in that setting somebody has brought you round to see this patient and you do feel a little bit uncomfortable that they're sort of presented as this. It's not a freak show but it's they look at this person you know they've got something really abnormal with them, let's all come and have a touch and yeah that doesn't feel as comfortable doing that. (1/3 - 3rd year)*

Another was explicit about the use of patients in bedside teaching having a de-humanising effect:

> *I think you lose, you lose sight of that especially when in teaching you walk round and this is the patient with appendicitis and this is the patient with Crohns. But that patient is also the person that you might see shopping in Tescos with her children, you know it's a different thing. (1/3 - 3rd year)*

Losing sight of the self in the patient's body is one consequence of such situations which is exacerbated by the fact that there is little time for students to build any sort of relationship with patients as they are in a group (especially in the third year) with a limited amount of time to acknowledge the existence of the everyday body. One fifth year student explained that during ward teaching the focus was firmly on the patient's disease, not on making any sort of connection with a patient. She had previously told me that she often used the history taking component to talk about personal things like cats as part of forming a relationship. That she was not able to do this within ward teaching situations she saw as being part of the culture of medicine that did not value, or see as professional, such informal interactions:

> A: *So is asking about a person's cat and having that encounter, would you say that that was seen as not part of the professional approach?*
>
> S: *Yeah, I would say that that was seen as not part of the professional approach, not to do in front of consultants. (2/4 – 5th year)*

The fact that many students indicated the importance of forming a relationship during the history taking before they examined a patient contrasts with the lack of connection in such encounters. Knowing the patient prior to the encounter may make such encounters easier for students although, as one student pointed out, there are different ways of 'knowing' a patient: knowing the 'case' which is very different from what is involved in interacting with a patient:

> *It feels more awkward I guess. I would not be as settled as I would be if I had talked to the patient for quite a long time. I think it is probably the trust element rather than knowing the case a bit better. (2/10 – 5th year)*

However, students did find some ways to connect with patients in such situations; for example by quickly introducing themselves[3]:

> S: *I think it is awful if there are 4 or 5 of you. It is not so bad if there is just one of you. But if there is a queue of people waiting to hear then I would rather leave them (...), it feels like it is a group of people just waiting to hear a murmur not hear a man or this patient who is ill. It does not happen as much as it used to but it still does happen.*
>
> A: *How do you cope with that?*
>
> S: *Well I feel uncomfortable but I try to sort of introduce myself to the patient and just talk him through it because a lot of people just go up and listen and then walk off without saying hello or*

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[3] Such advice is given to students as part of their communication skills teaching.

> *whatever. It sounds like being really big headed but I try to be different. I try to introduce myself and make them feel a bit more comfortable as if I was talking to them. (2/5 - 5th year)*

Having to examine someone in front of other students and a doctor or consultant was seen by some students as being very stressful, as it would be for some patients as well. Increased confidence was again seen as a one way of overcoming this, just as if a patient had been examined in front of students a number of times they might also get used to it. Being a third year student or a newly admitted patient could be seen as a disadvantage in ward teaching situations.

One perceived advantage of ward teaching identified by one third year student was that the students and patients would feel more comfortable with the examination in the presence of a consultant. I can envisage that a student might think this, particularly if they were feeling that they had little right in their role as students to examine a patient:

> *And* [the consultant] *will say 'I would like you to examine Mrs X's stomach' or whatever. (...) And I would feel more comfortable with that because they are there and I think the patient is always happy to do it because the consultant's there, because they usually pick patients that they have got on well with. (3/5 – 3rd year)*

Students' lack of control over what happens in such ward teaching encounters is also linked to responsibility for students' work with patients. When students are on their own clerking, the person with overall responsibility is not present and therefore students must take some level of responsibility for their interaction. During ward teaching the doctor or consultant is present and, therefore, students may well feel able to locate most of the responsibility for their interactions with them. Relieving or picking up on patients' stress levels may be seen as the doctor's rather than the student's responsibility in such encounters. I will pick this point up again in the following chapter.

Examining the examination

I was interested to know whether there was any difference between students' examinations when they were being assessed. Third year students that I spoke to had little experience of being formally assessed examining a patient's body. However, fifth year students were all very focused on this aspect of their education because of its contribution to their finals. The notion that students must undertake the activities 'perfectly' in order to appear competent or gain the highest grade was interesting and I was curious about what students' perceptions of this were.

Students explained that the clerking they undertook for assessments was indeed different in that they had a specific task to carry out that they needed to undertake in a particular way within a particular timescale.[4] One student likened the assessment to a driving test:

> *A medical exam is a little like a driving test. The examiners are watching to see that you have looked for everything and noticed all the possible complications and thought very carefully about what is going on. And much like when you are in a driving test, you look in the mirror, but you don't make it very obvious you have looked in the mirror, so in a long case I clerk rather more slowly. I would ask every single question I could think of rather than a directed set of questions (...). I would do a complete examination rather than a directed one. (...) It does not capture any more useful information than the history you would take on the ward but it does make it very clear that you could clerk other patients with other conditions.*[5] *(2/9 - 5th year)*

Other students also described clerking in the assessment as being less focused on an individual patient's condition and more focused on getting the clerking 'right' in order to pass:

> *I try not to miss anything out. I think that in assessments you are very focused on what you need to tell the examiners in order for you to look good and for you to pass, so usually you just try to collect every bit of information that you think is useful and you are constantly thinking have I got it all (...) and you're constantly thinking, I need to get on with this. (2/2 - 5th year)*

What these students are describing is a very asymmetrical interaction: the purpose of the encounter for students is to pass and for the assessors to ascertain whether students are competent to clerk, essentially to assess their clinical skills. Where the relationship with the patient fits in with the notion of competence is important and students explained that they were not able to undertake actions that helped them form some sort

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[4] Such assessment are marked with the use of a checklist of areas/activities that the students must cover.

[5] This student also explained that he undertook a similar approach when clerking for a case presentation.

of relationship with the patient. There may be a number of reasons for this. First, they themselves might be too nervous:

> *S: You don't, because in the exams I have done I have not been at ease enough to try and chat with them or explain anything*
>
> *A: Presumably you are quite nervous as well doing them. It is quite a nerve-racking thing to do because you are being observed doing something?*
>
> *S: Yeah, you do find it a bit upsetting, yeah, pretty much so. (2/6 - 5th year)*

Students also described how they might need to cut patients off from chatting during an assessment which might appear 'rude' and some students told me that they adopted the policy of explaining this to patients at the beginning[6]:

> *I suppose you become a bit more curt with them, a bit more abrupt. Just because in an assessment situation as well you are limited in time and you are given a set time and you have to stick with it so at the beginning of the assessment, we were always told to say well, you realise this is my assessment and that I have got a limited amount of time with you and I'm sorry beforehand if I rush you along a bit or if I stop in mid flow but I need to get through a set list of things so that I assess what's wrong with you. (2/1 - 5th year)*

Whilst patients are likely to know that students are being assessed and have volunteered to take part in the activity, their part appeared very passive; in effect their body again becomes an education tool and the focus is on an inspection of their body. The need for fifth year students to practise for their assessments may result in the tipping of the balance towards inspecting the body with less focus on the fact that the encounter is a two-way relationship between the patient and the student:

> *S: The closer I get to an assessment, the more thorough I become*
>
> *A: Right, 'thorough' meaning?*
>
> *S: The more I'll make sure that I do everything that needs to be done*

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[6] Students told me they were advised to do this in their communication skills teaching

> *A:* *Needs to be done for whom? Needs to be done for you or the assessment or the patient or all three? (...)*
>
> *S:* *No assessment and me, definitely not the patient. I don't think anything we do is worthwhile for the patient, as a student. (2/1 - 5th yr)*

The irony is that the 'perfect' clerking may be one where students have made little real connection with a patient; in effect the very act of assessment militates against this. This could be interpreted as being an unfortunate consequence of the need to assess students in a comprehensive and ultimately perhaps 'unrealistic' way to ensure that they are competent, and any assessment would be problematic. Alternatively, the assessment could be viewed as a mechanism of social control ensuring that students conform to a certain behaviour required to objectify the patient's body in medicine.

Difficult encounters

Most third year participants in my study were fairly open about finding the process of examination in whatever context a difficult activity in itself, especially in the third year. History taking may be seen as less problematic since it can be viewed essentially as a directed conversation, *"you are just talking to them rather than touching them" (1/4 – 3rd year).* Students sometimes referred to 'other students' who managed to get through the third year with the minimal amount of examining patients and one third year student told me that they had concentrated on taking histories though all their attachments, despite the fact that third year objectives closely relate to both activities, and she indicated ways that she found to avoid the examinations:

> *Basically I think the whole point of all my attachments so far has been to concentrate on taking histories rather than physical examination. (...) I try to make sure I do one every week (...). I've taken a lot of histories where the phone rings a couple of times and you have to wait outside. I mean it all forms part of the education really but if that happens at the end of me taking a history it's very convenient for me because I just go away. (1/4 - 3rd year)*

The difficult encounters that students described to me were interesting in that they often appeared to reveal a connection between students' feelings and experience and the patients' experience; essentially some form of emotional response to the encounter revealed more explicitly the sense that the interaction was a two-way event and that patients had an impact on students.

Inevitably examining more intimate parts of the body was problematic, especially for the first time and this was unsurprising given the symbolic and sexual nature of genitals, breast and the anus. Patients with cancer or in pain were also examples given of difficult examinations.

Young people or people of the same age as the students seemed a particularly difficult group of people to examine. One reason cited for this by students was that teenagers or young people were more aware of their bodies and thus more prone to embarrassment:

> *I think probably with a younger person, I think it makes the examination more difficult, I don't know how to explain this one. I think maybe if you've got a teenager or something, you know they are probably just coming to terms with their own body so if you are asking to examine them they'll probably feel embarrassed about it. (1/6 –3rd year)*

People of the same age were difficult precisely because I think students were able to identify with them and make some form of connection which made it much more difficult for them to objectify their bodies:

> *I don't know maybe it's because you've got more in common or something (...) When I was on-take last Thursday, there was a girl, a University student that had taken an overdose and I found it really difficult just because it could have been, she could have been one of my friends. (1/5 –3rd year)*

The following student talks about how such situations can be confusing in terms of their role: having things in common with a patient may lead to the relationship being less distanced and friendlier than it would otherwise be and, as they describe, could personalise the encounter:

> *I think it is (...) a lot easier to connect to talking about things like you would with someone you met at the pub and they may see you as their age and their peer. I think that probably makes it more difficult (...). When you have somebody young you can't ask about their job or their kids or what have you so you do ask about things you have common*

> *ground in. And often they will say: 'oh my friend's a medical student' and then it is sort of personalised. (2/8 - 5th year)*

Examining patients of the opposite gender was an issue cited by some students as it revealed the sexual nature of the body.[7]

> *'There is quite a big difference actually especially girls who are sort of young girls. I clerked a girl who was a year younger than me last week (...) she had pneumonia so obviously I had to do a respiratory and chest examination and I didn't really uncover her. I just sort of felt for her heart down there and heart sounds and went up the back to listen to the chest. But it can, I find it quite, I mean I get slightly flushed.' (1/1- 3rd year/male)*

Another student was more explicit about being sexually attracted to some patients:

> *I'm a great suspector of my own motives which means that if there is a patient that I'm attracted to, I find it much more difficult to examine them. I'll be much more tentative about my examination and I think that's just something that will come with time. (1/2 – 3rd year/male)*

Another category of examinations that were difficult were those where the student was being watched either by relatives or parents of children:

> *When there are other people around that aren't happy, like relatives or parents with children, that can get a bit more difficult. Again it's not that people say anything to you, you just get an impression that they're not happy with you being there doing what you're doing which just makes me a bit more uncomfortable. (2/2 – 5th year)*

In effect, having someone else present whilst you are examining a patient is difficult because the student is being observed, making them self conscious about their actions, but that person can also act as a check on their actions; in effect act as an advocate for a patient.

The examinations that students found difficult all demanded a way of relating to patients that did not allow students to just 'go through the motions'; for example, intimate examinations or examining someone in pain had the effect of making students

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[7] I imagine this might also be an issue for some students for the same gender but no students mentioned this to me.

question whether they should be undertaking the examination. What appears to be the case is that students described situations in which patients' feelings and their bodies came into the foreground; it is almost as if they were unable to keep patients, and how they felt towards them, in the background because they identified with them in some way or that the physical nature of the examination made them self-conscious. I would argue that, here again, the everyday body interrupts the medical body in a way that makes students feel uncomfortable. The students' own identities and feelings were revealed in such situations: for example their sexuality or their empathy. Hiding behind their script and the role they take on as medical students is more difficult as the patient's body can no longer be seen as an object. The examples revealed a strong connection with the patient and their everyday body and this may, indeed, serve to mediate the act of inspection.

Older patients

I was intrigued by the notion that examinations of young people were more problematic. Students emphasised how much easier it was to examine older people: *"And the chap was elderly and you know I don't know why again but it was easier. I think it would have been more difficult with a person of my own age." (3/2 - 3rd year)*

Students did give me a number of reasons to explain why this might be the case; for example, they were more experienced with the routine of hospital and had been examined lots of times before and were less self conscious about their bodies:

> *They are more mature, you know and they are happier with their bodies and not so worried about what they look like in front of a student or whatever. (3/2- 3rd year)*

> *Because they are older and used to being examined and they will almost jump on the bed as soon as you finish the history which is one thing that makes it quite nice about it. (...) A lot of older people have been in and out of hospital and are quite used to being examined and it's not a problem for them. They don't feel embarrassed about it or anything like that. (3/5 - 3rd year)*

It is likely that older people have had more experience of hospital because of their large numbers in hospital but there is an assumption that because they are older they are more experienced, when in fact, on an individual basis, some young people in hospital may have had more experience.

Worryingly, one male student indicated that he would be less likely to get a chaperone for older women patients, as they were not likely to make any complaints, presumably because they are more passive and compliant. The student seems to be assuming that an older woman is no longer a sexual person:

> *It is just like I feel I should have a chaperone (...) but I think sometimes with younger women probably more so than elder women because, it sounds awful but they are less likely to say anything, that you have done anything. I think it is more important. I have examined a 17-year old girl before and I did get a chaperone for that. It is inconsistent and probably bad practice but I just felt that I needed it really because I am not much older myself. (2/5 - 5th year)*

The 'sexless' nature of older people was also prevalent in some of my discussions about breast examinations; for example, it was necessary to keep a young woman's breast covered during an examination because they were more self-conscious:

> *Young women are a bit more sensitive about their bodies; you just have to be aware of that. That it's not appropriate to uncover them and examine their chest and that sort of thing, it would be more appropriate to make sure that they're wearing a bra or a top or something so you could then examine them through that. (2/4 - 5th year)*

I asked this student why older people were not considered to be so sensitive and she replied: *"It's not the ideology not to see women of an older age to be sensitive, I just haven't found them"*. However, there is an assumption that, as a student, you can tell what another person is thinking. Furthermore, if it is possible to examine a woman's chest when it is covered, why is this not the usual practice for all women?

It may be that students were more comfortable with older people's bodies because they did not challenge their identity in the same way as those described as 'difficult encounters'. It is these difficult encounters that also challenge the notion of the patient's body as passive and older people's bodies were often reported as such. This sometimes revealed a pervasive ageism, mirroring practices in the wider social context.

Older people were also described in very affectionate terms as being like a grandparent and being willing to talk, be examined and generally seem helpful to a student on the wards. One student described how they found it easier to build a rapport with older people, and how they took on a parental role:

> *I have found it easier with people who are older. I don't know if that's just, it's not through anything that has necessarily happened but I do feel that they seem to accept me a lot more. I do feel that there is a little less, I don't know if it is embarrassment, just that they seem to be happy about chatting away and telling me what is going on (...) it makes it easier to get a rapport. I do think sometimes it is almost a sort of, they take on a parental role in some ways. Because you come in and say 'I'm a student and I am just learning about what is going on with you and everything' and they actually (...) quite like to educate you and they are going to tell you everything they know about especially the health condition that they have had for a while and they know a lot about it.*
> *(3/3 - 3rd year)*

What is interesting to me here is that there is a description of patients being an important part of a students' learning and in an explicit way the older person is likened to a teacher rather than being a passive recipient: they are not just using the patient's medical body but are learning from the everyday body of a patient. Building a rapport was seen as an important aspect of the interaction and it may, of course, be easier for this third year student precisely because they were able to be in student role rather than doctor role.

Challenging the Use of the Body

Students receive conflicting messages about how they should undertake practices and are critical about them at times in private. The activity of examination is one of the key aspects of the clinical encounter and is an accepted practice within medicine. As I discussed earlier, when students have more control over this activity, for example whilst gaining experience and practising their techniques independently on the wards, they can more readily use their own judgement as to whether, for example, they actually examine a patient, how long they might spend undertaking the process and what they might cover, in order to mediate their use of the body. Such subtle, yet active, ways of challenging the activity of clerking on the wards carry little risk in that they are unlikely to be noticed by those in authority.

However, in more closely supervised activities, such as ward teaching, these approaches might be seen as a direct challenge to authority if students have been asked to do otherwise. Students' position in the medical hierarchy puts them at a disadvantage in terms of their ability to challenge practices openly and in their early years they may also lack confidence: *"maybe I would pipe up and say something; but in the third year I would feel too scared to do it." (2/10 – 5th year)* Challenging authority directly is a high risk strategy especially as consultants are also responsible for students passing or failing their assessments and sometimes for their future career prospects.

I was interested to know whether and how students did challenge these normalised practices, particularly in these situations where students had less control over their activities, and how these related to the use of the patient's body in their education. Students did report subtle ways through which they challenged the use of the patient's body in these contexts. (I will discuss issues relating to negotiating access in the following chapter.)

Students gave me examples of very subtle ways in which they challenged the status quo and often these related to their acknowledgement of how a patient might be feeling. In one instance, a student explained how she had surreptitiously tried to mediate a situation in which, during a ward teaching session, a woman's breasts were on display. Her efforts were somewhat thwarted but at least she had attempted to challenge the way that a patient's body was being unnecessarily exposed by the consultant, even if she was unable to challenge the consultant directly:

> *There was this woman; you know her top, the registrar whipped off her top so that we could all like listen to her heart. And really there was no need to totally expose both her breasts while we were listening to her heart and it was quite easy just to pull her pyjama top over and slip the stethoscope over and I don't know, and I actually did that and I kind of put it back and I noticed that after I had finished listening he had opened it up again. (1/5 - 3rd year)*

Another student illustrated how they said things to patients to reassure them about the discussion they were having in front of them and managed to do this in front of consultants:

> *Some consultants are really good at it* [bedside teaching] *but others I think they are a bit sort of – they talk about stuff, not stuff that is wrong with a patient but as a differential about a routine cancer or something that is obviously scary for the patient and they don't explain to the patient that they have got that. You know if you are a patient and you don't really know what is wrong with you and the consultant comes in and starts talking about cancer to his medical student, things like that I always feel really bad about. And I always say to them 'Don't worry we are not talking about you particularly, we are just talking about it in general' (2/7 - 5th year)*

Whilst this student felt confident to interject and indirectly challenge what was happening, they felt unable to challenge consultants' actions directly:

> *S:* *I had a lady the other day that I had to do and examine and they were doing the testing for neck stiffness, and it was obviously painful for her and he had all of us have a go again: 'You are not doing it right, do it again' and this poor lady who was in obvious pain and I felt bad for her and I did not know her at all and we had just come in.*
>
> *A:* *Did you try to say that in any way? (...)*
>
> *S:* *You just try and sort of say: 'thank you very much, I really appreciate it' I mean you can't really say anything. I am scared and I wouldn't ever have the guts to say to a consultant, 'I think enough people have done it now' (2/7 - 5th year)*

One student described her actions as: *"you try to apologise without apologising* [in this instance for a consultant's attitude] *because you can't be seen to do that (2/2 – 5th year)* and explained that you can do this by just smiling at a patient – presumably with a knowing smile – or alternatively by not staying very long if she was asked to clerk someone that she felt was not very willing or when she felt they were wasting the patient's time. Another described how she could make something up to say in these circumstances: like the patient was asleep or didn't want to talk so they couldn't clerk them.

A slightly more risky strategy described by one student was in a situation where they were examining a patient and the student was asked to comment on the diagnosis but she felt this was not appropriate:

> S: *Because if you said cancer then you know obviously it is going to be distressing for the patient. There have been a couple I can think of where he pressurised me to say: 'I think it is cancer' but I have not felt comfortable doing it.*
>
> A: *What have you done?*
>
> S; *I have usually said 'that is all I can think of' even if I have known the answer (2/8 – 5th year)*

Although some students illustrated how they could find ways to actively challenge existing practices in such exchanges, challenging in more direct ways was more problematic. In conversation about ward teaching sessions where a doctor might ask someone to "pop your top off" without introducing themselves, I asked the student what they could do. They responded that there was really nothing that could be done in such circumstances:

> *You just have to accept, so you understand that it is not how I would do things. It is not really how it should be done and it annoys me occasionally, but I can't do anything about it. And it would not do any good for anyone if I complained about it. And it's not, it's not dreadful things, it's not how it ought to be done but it's not terrible. So it's not difficult per se, it is just not how I think would be perfect. (2/9 - 5th year)*

This resignation is depressing yet understandable, given his lack of power, but it is also 'quietism': students' lack of responsibility in such circumstances has another consequence, in that they do not see it is their responsibility to do anything about such practices.

Drawing on Documents

I was interested in how the issues I have discussed so far in this chapter were represented – or not represented – in curriculum documents and recommended publications. The School produces a document, Revision of Introduction to History Taking and Physical Examination, which is contained in the student handbooks for both years 3 and 5 (School of Medicine 2002a & 2002b). My assumption was that it would contain guidelines regarding key aspects of these two processes that the School wished to emphasise for students. The document began with a brief introduction outlining that the purpose of history taking and examination, "is normally to find out the cause of a patient's symptoms, but may be for other reasons, for example to assess someone's fitness for an anaesthetic, or life insurance" and moves on to some questions for students to think about to help them test developing hypotheses. The implication is that the School does not necessarily expect students to take 'full' histories and examination. This is emphasised again in the examination section. The second and third sections, on the 'Introduction to the Patient' and 'Physical Examination and Chaperones', contain various statements about what students should do when they first introduce themselves to a patient and the rules for chaperones. I shall return to discuss these in the following chapter. However, some of these statements pertain to a necessary relationship between students and patients; for example:

> Your patient will be able to help you more if you have made a good relationship with them.
>
> Always explain what you are doing as you go along as this will help the patient to help you.
>
> They are doing you a favour, but most people recognise that they benefit indirectly from the training they receive – so take pride in your job!

There is also a call for students to remain sensitive to patient's needs during the process:

> Remain sensitive to the patient's comfort, both physically and psychologically. Don't delay food. Make sure a patient's cup of tea/coffee is brought in and not left to get cold. It may sometimes be appropriate to cut short an interview because a patient is distressed, and to seek help from a staff member.

And indeed students did indicate in some of their discussions with me that they acted on or thought about these things. There is an explicit acknowledgement that patients are helping students but the relationship is not represented so much as interactive but, rather, as necessary in order to get patients to help students. There is nothing about how patients might help students, over and above allowing their body to be used for students' education and, as such, the expected patients' role in the encounter is represented as a passive one. In the history taking section there is long list of areas for students to cover – both generic and system related – and similarly, in the examination section, there is a list of areas identified as being "especially important". There are references to the need to explain to patients what they are doing, again for the purpose of gaining help from patients in some way.

Advice about aspects of the students' relationship with patients during history taking and examination, and the need to be sensitive to patients' feelings, is included as well as advice about cutting the process short if a patient is distressed and then seeking help from a staff member. Patients' everyday body is represented to a certain extent. However, there is no acknowledgement, anywhere in this document, about how students might be feeling and what sorts of encounters/activities might be difficult for them or what they might do if they themselves were distressed. In this way students are represented as disembodied agents in the process.

There is a similar lack of attention to students' feelings in the section on the General Medicine attachment which outlines its aims and learning outcomes. Whilst it does contain the statement, "At first you will feel awkward asking patients who are ill [to clerk], and who often have seen numerous doctors before they see you" (ibid.: 39), there is no other mention of difficulties students might encounter. This lack of attention to students' feelings may be because of the assumption that students must overcome any anxieties or emotions attached to their encounters with patients; but it seems strange to me that, even if this is the case, there is no reference to what they should, or can, do in such circumstances.

In the two recommended publications that I analysed, Munro & Ford (1993) open their introduction with history taking, the first stage of which is "a brief introduction to establish effective rapport", the second, where "the doctor listens carefully to the patient's story" and the third which is "an interrogation by the doctor to classify the history and to obtain information about the presenting symptoms, previous health, family history and the social setting" (ibid.: 2-3). It goes on to acknowledge that students may find history taking difficult and emphasises that students must be "caring and compassionate yet have to remember that they are not directly responsible for patients' medical care". It goes on to say:

> (…) patients may confide in students and tell them of their health or personal anxieties. The student has to learn to listen to such comments without embarrassment, but should then obtain the patient's consent to discuss these with a member of the medical staff as they may be of special importance to the patient's continuing management. The student can learn much about the complex interaction between patient and doctor by attempting to

> analyse unusual feelings aroused by patients and discussing problems of this type with a tutor.

In this way then, the text seems to imply that the difficulties during history taking are not necessarily something to 'get over' and acknowledges the complexities of the relationship.

In the examination section, however, there is less explicit reference to 'difficult encounters' for students. General principles are listed and these include ensuring privacy, warmth etc. for patients comfort, taking care with painful areas, and avoiding exhausting the patient. Another states, "Apprehensive female patients require special consideration by a young male student", indicating that patients, rather than students, may find such encounters difficult. Gender issues, with an underlying heterosexual bias, are indicated for patients rather than other factors such as age. What is lacking in this short section is any mention about the difficulties students might have when interacting with patients' physical bodies.

The following chapters each concentrate on the examination of a particular system. I looked at chapter 2, the cardio-vascular system, which goes into detail about how students should examine this system of a patient's body. The language in this chapter used verbs such as inspect, locate, auscultate and assess, along with sentences in the passive voice: "Measurement of the blood pressure should also be undertaken in the erect position in patients in whom postural hypotension requires to be excluded (...)" (ibid.: 15) as is standard practice in scientific literature. The agency of neither patients nor students is apparent in such language. Apart from an occasional reference to ensuring the patient is relaxed or comfortable, there is no other representation of the patient's everyday body or the difficulties students may experience with certain encounters, even though an examination of the chest may sometimes be problematic for both students and patients. The instructions are to examine or inspect the medical body; references to the everyday body are limited to the history sections of the text.

In Epstein et al (2003: 18), this separation between the history taking and examination parts of the encounter is deemed as "artificial" because "examination commences as the patient walks into the consulting room or as you sit down at the bedside to take a history". It then goes on:

> It this first encounter, even before you initiate the history, decide whether the patient looks well or not and whether there is any striking abnormality. You will also gain an immediate impression of dress, grooming and personal hygiene. As the patient approaches you in the consulting or examination room, observe the posture, gait and character of the stride (ibid.:18).

Such instructions reveal one of the ways that the body is transformed into a medical body. Students are instructed to inspect the body even before they have started: does this include before they have negotiated access with patients for the inspection to take place? I would argue that there is an inherent assumption here that patients' bodies are open to inspection whether they have agreed to this or not and I will return to this in the following chapter.

However there is recognition of the intimacy of the physical examination. Students are told to shake hands when they first encounter a patient, which will "reassure a patient and serve as a gentle and symbolic introduction to the more intimate physical contact of the examination that follows the history" (ibid.:19): indeed, students explained that holding and examining the hand at the beginning of any examination also serves the same purpose. The detailed instructions in this text make more reference to the everyday body in the form of instructions which include some reference to the patient; for example: "explain to the patient" or "ask the patient to (…)". There is also an introductory section which asks students to imagine what they would feel like if they were "laid out naked on the examination couch or bed (…) confronted by a near stranger who is about to inspect, percuss and auscultate your body, a daunting thought" (ibid.: 19). The tension between the connecting with the everyday body and inspecting the medical body is revealed here: students must start inspecting almost before they are introduced to a patient and thus begin the transformation to medical body, but must keep in mind respect and sensitivity towards the patient and their everyday body. However, there is, again, no reference to any difficult encounters and what might be done in such instances.

Summary: Encounters with the Body as Medical/Everyday

This chapter explored the way that students work with the conscious patient's body on the wards in a hospital setting. In this social interaction between students and patients, the students encounter a number of tensions which can be seen to represent a balancing act between responding to the patient's body as a medical body and at the same time as an everyday body. Certain activities and practices may encourage the view of the patient's body as a medical body: for example, activities over which students have less control, such as ward teaching with groups of students; or where they have little chance to form any connection with patients, such as in formal assessments. Difficult encounters appear to be difficult because they represent times when the everyday body interrupts the medical body, and this appears to happen when students can empathise or connect with patients in some way. Making such connections with patients and their bodies may also encourage students to challenge existing practices or act as advocates for patients, albeit in small and subtle ways. Students' explanations of such challenges related to activities where the body was treated in a way that indicated its status as being a medical body (for example, discussing diagnoses over a patient's head), and therefore, not requiring the respect which might be accorded to the status of the everyday body.

Chapter 5

Negotiating Access to Work with the Body

In the last chapter, I explored students' encounters with patients' bodies and attempted to identify some of the factors which might influence the ontological status of a patient's body within different situations and contexts. All such encounters between students and patients need some form of starting point. This chapter is concerned with how students negotiate access to work with patients' bodies and I attempt to explore the very start of their encounters. This is important precisely because it is the beginning and effectively sets the agenda for the student/patient encounter.[1] As we have seen throughout, the medical body is viewed in a quite different way from the everyday body that we encounter and interact with outside medicine. Before a person in hospital is ever encountered by students they have already begun the transformation from person to patient through their encounters with the rituals associated with the hospital and with medicine. Mishler (1984) showed how the practice of history taking serves to privilege the 'voice of medicine' over the 'voice of the lifeworld' and Young (1997) identifies the medical examination as another ritual which contributes to realm shift: from the realm of the ordinary to the realm of medicine; from people to patients; from an everyday body to a medical body:

> Patients, who are outsiders, must undergo a transformation in order to become participants in the realm of medicine. The routines associated with conducting medical examinations can be regarded from this perspective as rituals for effecting this transformation (...) Persons are not turned into patients; rather, they undergo a series of transformations in the course of which they become patients. (p.13-14)

In effect, I am interested in students' role in this transformation and how current practices around negotiating access contribute to, and implicate students in, the medicalisation of patients' bodies.

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[1] When I discussed this with a colleague, Lesley Millard, she referred to the importance of 'making good beginnings' which was exactly what I was trying to articulate in another way.

I discussed earlier the need for students to see their encounters with bodies – either in the DR or with patients' bodies – as being useful in some way, either for their education, for the patient, or for the medical team. The purpose of the encounter is therefore, an important factor in how students view the activity. Atkinson's (1997) 'hot' encounters are essentially ones in which students think that they contribute in some way to the care of a patient and 'cold' encounters are those in which interaction serves principally as part of the student's learning experience. Of course these two purposes are not mutually exclusive; however, the primary purpose of an encounter needs to be borne in mind when attempting to interpret students' explanations of their 'beginnings' with patients. As part of this beginning, students need to negotiate access to the patient's body, for whichever of these two purposes (or it needs to be negotiated for them). However, negotiating access with a patient for the use of their body to contribute to a student's learning is somewhat different from negotiating access to a patient's body to undertake activities related to their care. This is complex, as I will illustrate, because it reveals the blurred boundaries between the role of the student as student and as doctor; and the role of the patient's body as an educational resource or as being in receipt of care.[2]

In using the term 'negotiating access' I mean to encompass introductions, the establishment of some sort of relationship and the seeking of permission for any activities which a student may wish to undertake with a patient. With regards to the latter, exactly what patients are being asked to consent to when they are approached by students, and how this process is carried out , also needs to be explored. Is the process of negotiating access one of the rituals or routines which serves to transform the person into a patient? Do the practices that students undertake enable the patient freely to render their body an object for the purposes of examination or are the circumstances such that students may already have begun to view the patient's body as devoid of self and rendered an object?

In chapter 1, I discussed the recent focus on informed consent in relation to the use of the body after death, but there has also been recent attention to patients' consent to

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[2] This blurring takes place less problematically at postgraduate level once medical students have completed their training and are registered to practise with the GMC: whilst they continue to learn they are also qualified doctors who have responsibility for the care of their patients.

'intimate' examinations by students (these tend to refer to rectal, genital and female breast examinations). For example, Coldicott et al (2003) outline the results from a recent survey in which they found that intimate examinations carried out by students in the earlier years of their education were less likely to have been done with written or oral consent from patients than those which occurred later on in the undergraduate education. They also highlight a similar tension to the one I have been referring to: "student doctors face special difficulty in trying to balance their learning needs with these ethical duties" (2003: 97). Whilst procedures relating to intimate examinations and informed consent may throw up concerns in the current climate, I wish to explore the broader process of negotiating access and apply this more widely than just to 'intimate' examinations, in this chapter.

Context

The responsibility for negotiating access to examine patients is not straightforward and depends on the nature of the encounter – whether it is student- or teacher-initiated – and I think students receive mixed messages about this. However, what appears to be the case is that, when students are looking for patients to clerk on the ward, they are often essentially the first person to ask the patient if they can clerk them. When they are involved in ward teaching, in theatre or on-take, the responsibility for this is more apparently with the doctor or consultant whose patient they are examining and, as we saw in chapter 3, students may have less opportunity to negotiate access directly in these circumstances.

The School introduced its *Policy on the Rights of Patients in Medical Education* in October 2001 (during the period of my research) following an article in the BMJ by Doyal (2001) that outlined the policy.[3] It was hoped that this would "help protect students from being asked to behave unethically" (2001:685), recognising that students were sometimes being put in a position where they were asked to engage in inappropriate activities. It was further designed to provide a back up to the rhetoric of patients as partners in their care and to remind clinical teachers of their ethical

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[3] NB all quotes from phases 2 and 3 were reported in 2003, 2 years after the introduction of the policy. 3rd year quotes from phase 1 were reported in the year prior to its introduction. The policy was slightly redrafted in early 2004.

responsibilities towards patients who contribute to students' education. I shall explore the policy in more depth in the documentary analysis section later in this chapter.

Beginning: I'm a medical student. Is it OK if I ....?

In this first section, I shall address how students went about negotiating access for their encounters with patients' bodies. In the section following, I shall look at some of the issues that arise when students are not responsible, or do not assume responsibility, for directly negotiating access with patients.

Clerking a patient

The transformation that the everyday body must undergo to become a body that can be transgressed during an examination can also be seen as a reframing of the body and can be achieved through a variety of rituals and practices, two of which are "greetings" and "forms of address" (Young, 1997: 11). How students go about this, therefore, needs careful scrutiny, as this forms the foundations for the next part of the process, which is asking for consent to carry out the clerking process.

The hospital is a teaching hospital and, as such, there is a general acknowledgement that the students need to practise their clinical skills; however, I do not believe that students have the right to practise on any individual patient. As I have previously mentioned, if students wish to clerk a patient on a ward they may ask a nurse or a doctor who might be appropriate to approach. They may also be asked to clerk someone by a doctor and then report back, and this appears to be the usual situation when they are on-take.

Once a student has approached a patient, the common practice seems to be to introduce themselves, ask if they can take a history and then examine them:[4]

> *You sort of introduce yourself, take their history and (...) ask if you can examine them. (2/3 - 5th year)*

Students tended to report this process in a fairly matter of fact way, most likely because it had become such a routine exercise.

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[4] Students reported covering this in their communication skills training.

The participants on the whole said that they introduced themselves as a 'medical student' and there appeared to be an assumption that the term 'medical student' is somehow self-explanatory. I questioned the following student about this:

> *A:* *Do you introduce yourself as a third year medical student?*
>
> *S:* *Yes, or just a medical student*
>
> *A:* *And do you think patients do understand what that means?*
>
> *S:* *I think people have a lot of different understandings of what it means. I mean I think maybe people think, I have never discussed it with them or anyone actually but I think maybe some of them think you're, you see I'm not even sure what I think the role of the medical student is. (laughs) I think a lot of them think they should let me take a history of them and examine them because you're part of the hospital staff. So I mean it's a strange role as a medical student because you are not, you are in limbo between being part of the staff and being in the education side (3/5 - 3rd year)*

This student outlines how the term is problematic, not only because patients may not understand what the term means but also because the student is himself unclear about his role. I think part of the confusion relates to the different functions that students might carry out: are they part of the hospital staff and therefore involved in some way in the patient's care or are they there just to learn from patients? This goes back to the tension for students between using the patient's body and being useful. Being useful equates with being a doctor and using the body equates with being a student. Students may be anxious about the activities they carry out precisely because they are students and not doctors; and this is not uncommon as Lief & Fox (1963:32) illustrated in their study in a common question asked by students: "Should I tell them I'm a doctor or a student?" However, if a student feels unsure about their role and the purpose of their actions, then it will be even more difficult for patients to understand these issues.

One fifth year student was very open about avoiding the term 'medical student' when introducing himself, precisely because, for him, the phrase meant lacking experience and he wanted to appear more useful to a patient than a less experienced medical student:

> S: *I tend to introduce myself as a student doctor, because it has a little more kudos with patients than a medical student, to differentiate a medical student from a first or second year who is on the wards visiting*
>
> A: *What happens? What is the difference in terms of patients' reactions?*
>
> S: *In most patients there is not really a difference. In some patients they think that a medical student knows absolutely nothing and are of no help to them and a student doctor is someone who is potentially useful, who is more senior and has a bit more knowledge and is part of the team rather than just an add on.*
>
> A: *Right and does that make you feel better saying that?*
>
> S: *It does not make you feel better in itself but it does mean that people don't then tell you to go away*
>
> A: *Alright, I see. So patients are likely to say 'yes'?*
>
> S: *Mmm. (2/9 - 5th year)*

This term 'student doctor' may, of course, be no more explanatory to the patient than 'medical student' but this student's perception is that it serves to assert his seniority as a fifth year student in order to appear more useful to the patient. In an attempt to present himself as someone who might potentially be of more use to a patient, as he has necessary medical knowledge and is integrated into the team, the student also appears to be using a title to encourage the patient to agree to being examined. Negotiating the balance between using a patient's body for students' own ends and being useful, then, may also be played out in the process of negotiating access and is well illustrated by this student. What he did not describe was how he attempted to establish relationships based on mutual trust, explain to patients what his role actually was, and the purpose of the encounter: was it to have some sort of educational experience, to contribute to the patient's care or a mixture of both?

Whilst a different term may encourage patients to view this student as someone providing useful help (like a doctor) rather than simply making use of the patient's time and body, it has the effect of reducing the patient to a passive body needed by the student for their own ends. The approach is adopted to try to improve compliance; in effect using a form of coercion to ensure that patients agree to the clerking process. As

Waitzkin (1991:20) notes, social control in medicine is a "subtle process, based in the structure and margins of discourse" and I think this is an example of how a simple activity such as how you introduce yourself can contribute to this process.[5]

The above two approaches: just using the term 'medical student' or changing the term to 'student doctor' were in contrast to methods adopted by a few students who reported that they went into much more detail about their role and what this entailed; for example, the following student reveals a concern for patients' understanding about their role and how much knowledge they may have, as well as the need to explain what they are there for:

> *It is pretty similar with everyone you see. It does vary a little. Actually I usually go, the least I would say, was that I was a fifth year medical student and that I was going to spend another six months in specialties in this part of my education in preparation for being a doctor and how long I am going to spend there and the kind of things that I am doing. Maybe some other steps as well, because some people (...) they might be worried that I have come to see them for a specific reason and I want them to know that basically I would go and see everyone and I had not selected them out. (2/6 - 5th year)*

After introducing themselves, students asked in various ways for consent to clerk the patient. The words that they used differed between students, but tended to be a variation on the theme of: "Is it OK?":

> *And then I went over, I said who I was, a third year medical student, and would it be OK if I clerked him. (3/2 - 3rd year)*
>
> *Introduce myself, say hello and say who I am and ask if it would be OK if I talk to you quickly about your family and your history and maybe do an examination (3/4 - 3rd year)*

There are two points that I want to make in relation to what I might call the "Is it OK?" approach: first that the question format assumes a positive answer; and secondly that there often appeared to be an underlying assumption that patients would know what 'taking a history' and being 'examined' would entail.

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[5] Incidentally, the *Policy on the rights of patients in medical education* (School of Medicine, 2001 & 2004) explicitly states that students should introduce themselves as either 'medical students' or 'student doctors'.

In respect of my first point – on the whole, but with exceptions – students felt that patients were generally happy to have their history taken and be examined by them and this may go some way to explain the approach:

> *I generally tend to say virtually all the time: 'I just need to examine you now if that is OK with you'. I always ask if it is alright. Em, generally it is. I have not really been with people who have said no or anything like that. (2/5 – 5th year)*

Of course students do need to believe that patients are 'OK' with the activity on the whole, in order to carry out their role. More experienced students appeared more likely to discuss what they were doing as they moved through the examination, but a key point to make here is that asking questions in a way that assumes a positive answer is again a subtle form of coercion, as it is more difficult to refuse something if the question is framed in such a way. Nelson and Hofmann refer to this when exploring the way that doctors ask patients for consent to certain procedures:

> The mere framing of information can unduly influence the way a patient responds to the content. More often than not, such framing is intended to elicit a reply corresponding to what the physician has decided is the proper course of action" (Kushner & Thomasma, 2001:19).

A few students did report asking again for permission to undertake an examination once they had completed the history taking, showing some engagement with how the patient might be feeling about the change from a less to a more invasive procedure:

> *But most people will let you talk to them and generally are open to it. But I think doing an examination is slightly different. I mean some of them might not mind you speaking to them but would not want you to examine them. (2/5 - 5th year)*
>
> *You try to be as polite as possible about it. Usually at the beginning you make it clear to a patient, well with the adult patients, that you've come and you'd like to take a history from them and you'd like to do an examination. And usually they probably don't even hear the examination bit so once you've finished the history again you'd say, I'd generally say thank you for your time and would it be possible if I could examine you now and see if I can find any of the signs that were there when you first came in. (2/1 - 5th year)*

Turning to my second point about the assumptions about what 'history taking' and 'examination' might mean to a patient, this is important as providing sufficient information is a necessary part the process of seeking consent. As I outlined previously, 'full' clerking might take up to an hour and most doctors would not take this much time for the process, and I therefore think that patients who have never been clerked by a student before would not necessarily know what it entailed or why exactly they were being asked to participate, except perhaps for a broad idea of their contribution to students' education.

A number of students mentioned describing what they were doing or were about to do during the clerking process and the following student did highlight the need to be more explicit about what an examination might mean before they started, but the implication is that she did so only when she was concentrating on a particular area:

> *I generally just say: do you mind if I (...)? Usually if you know what it is, like a cardiovascular examination, I would say: do you mind if I have a look at you and listen to your chest, and things or whatever and those people generally say you know: I don't mind, of course not. But obviously if they didn't want to I wouldn't if they said no, if they didn't want to. But I would just generally say: is it OK if I just have a look at you, really. (3/3 - 3rd year)*

The consequences of the lack of explicitness, about what students are asking patients to consent to, was emphasised by one student who outlined how he had needed to ask for permission from a patient to undertake a vaginal examination when they were in theatre later. What he illustrates is the difficulty he had in asking for consent to an invasive procedure, perhaps because he was embarrassed:

> *S:* *I was also being asked to do a vaginal examination on the patients and even though I had asked the patients beforehand if it was OK for me to do an examination, I'm never quite sure how clear it is to the patient what they think I mean.*
>
> *A:* *Oh right, so you ask them if you can do an examination and you're maybe not specific about what sort of examination you're going to do?*
>
> *S:* *Yeah. So it's for me, I don't know. I think for any student it's difficult, especially in those circumstances, it's a difficult subject to broach, you're kind of skirting around the issue a bit, or I was. And then you go in there and they're under general*

> *anaesthetic and I just kind of think well, they are not going to know anyway. But it's, I think it certainly not a good way to think about it. And so you're examining them and thinking is this ethical, is this appropriate that I should be doing this? (2/1 - 5th year)*

What is disturbing here is that the student is aware of the consequences of his vagueness when seeking consent for the invasive procedure – that it is unethical – but that he can rationalise this to a certain extent by emphasising that they were under anaesthetic anyway. Coldicott et al (2003: 101) note that these sort of comments "show that some students continue to put the need to practise techniques above the need to practise ethically"; however, I think it is more complex than this, as students operate within the context of existing medical practices and hierarchies and as I have shown in chapter 3, the body under anaesthetic in theatre is reduced to a passive object – clinical material – with no agency. This example shows how the body, prior to surgery, is already being transformed.

The following student explained how he felt that he needed to adopt a different approach for more 'invasive procedures':

> *Let's say if it was a rectal examination, I don't feel I would have the same approach. I would not say "Right now I have taken your history, is it OK if I do an examination which is going to include a rectal examination? (...) The things I consider would be invasive would be any examination of any genitalia, female breast examination (...) and then probably yeah, the cardiovascular examination in the female person can be quite invasive. (2/6 - 5th year)*

I think this student is struggling slightly towards the end of the extract in terms of what might be considered to be invasive. What is interesting is that the more invasive procedures throw up the inadequacy of a brief "Is it OK" approach. The sorts of examination that might be considered the most invasive appear to bring attention to how students negotiate access and the potential impact of the examination on the patient in a similar way to that which I indicated in my previous chapter in relation to difficult examinations. I think that all examinations are potentially invasive: they intrude on a person's personal space and involve touch, and the way in which students negotiate access should be seen as a vital part of their interactions with patients. If students are less than explicit about their role, their proposed actions and the purpose of the encounter, then the beginning of a relationship with a patient is founded on invalid consent and contributes to the reduced status of a patient and their body in the encounter (or in future encounters as in the example outlined above). Taking a history is very different from examining a patient and, because of this difference, I think the conflation of the two into the 'clerking process', and thus into the consent process, is problematic and needs re-thinking.

Students ensuring that they are explicit about who they are and what is intended are important in relation to each patient and their bodies, but it has wider applicability in that students are practising how they will negotiate access when they are qualified doctors. In effect, giving minimal information to patients and employing subtle forms of coercion could be seen as part of the professional socialisation process. However, I am also concerned that, even if students negotiate access with valid consent, the patient body remains something to be done to; the patient's agency appears to be restricted to their ability, as an autonomous person, to consent to be examined – rather than being manifested an active participant in the activity itself.

Negotiating access to the unconscious body

As my work progressed, and I became more interested in the status accorded to a patient's unconscious body, I grew concerned about how and whether students negotiated their access to attend a patient's surgery in theatre. Students might observe a patient in theatre or sometimes students examine them in some way or assist in a very minor capacity. I wondered how, and whether, students would ask for permission from patients to participate in either of these activities, at the same time as they clerked patients before they went in for their surgery: a practice which I outlined in chapter 3.

Some students, in responding to my questions about being present in theatre, said that they ask the "Is it OK?" question if they are clerking:

> *The ones that I clerked I said 'I might come into theatre, would that be OK?' and they all said 'Yeah, I'm not going to know, don't worry'.*
> *(3/2 - 3rd year)*

Others reported that they really just assumed that it would be no problem attending theatre and were unsure whether there were any procedures about this:

> *I wouldn't ask them. I would probably just say: 'oh well I will probably see you in theatre' and just assume that's OK. (2/10 – 5th year)*

When I went on to question this student, he told me that this assumption was usual practice:

> *A:* *Is that OK?*
>
> *S:* *I don't know. That's an interesting question (pause). I guess in an ideal world you would ask everyone in theatre: 'Do you mind if I take part in the operation?' but...*
>
> *A:* *...Is it an accepted practice in a teaching hospital?*
>
> *S:* *It's one of the unspoken sort of rules, I guess. (2/10 – 5th year)*

This lack of being involved in negotiating access to a patient's body in theatre, whether through observation or touch, may be further evidence of the unconscious body as first and foremost medical. When the student was talking to the patient beforehand he may not have seen any necessity to negotiate access to the body as object in theatre – as I highlighted above.

However, students are also asked by their consultants to attend certain operations, perhaps because there may be an 'interesting case' or because such activity is part of their everyday education/experience on the attachment. In such circumstances, it is difficult for students to refuse, as they will risk being seen as uninterested or lacking in motivation and, in addition, give up the opportunity of gaining experience. In these situations, students may not have already met the patient. One student told me that they did not think that patients always knew that students were present in the theatre. Of course, it may be that the consultant or another member of the team does always gain consent for individual students to be present, but if this is the case, it seems strange that students would not be aware of it:

> *S:* *When you just go into theatre and you see 5 or 6 people, none of them have been asked whether (...) and I was on the lower deck and I think a lot of people wouldn't have been comfortable with students being there when that sort of thing was happening.*
>
> *A:* *And so how does that make you feel?*

> S: *It makes you feel a bit uncomfortable but it is just, I will just get used to it in the end. I mean I don't feel bad because the patients are anaesthetised, but erm because they don't know.*
> *(3/5 - 3rd year)*

Whilst the student expresses some discomfort about patients not knowing they are there, they also think they will get used to the situation, implying that it might be common practice and another practice that they need to get used to. The fact that the patient is unconscious and so unaware of the student's presence seems to ameliorate the situation slightly and I think this again illustrates how the unconscious body is afforded less status than the conscious body. The patient does not know what is going on, and their body is passive and objectified.

The same student describes how they were also involved with assisting in operations even if in a very minor way and describes a situation where a patient is under local anaesthetic. They start describing what another student did but end up owning the situation. This, alongside the explanation that they were not doing anything 'important', again appears to act as a justification for the patient's lack of consent to student involvement:

> *So they can't see and we were all standing sort of at the end there and one of my colleagues - another medical student - insisted on holding a clamp or something for that operation. But the patient was actually conscious but they wouldn't have been able to see that it was a medical student and they weren't asked at all. So I have assisted in an operation with a patient. I mean you don't do anything important; you just pull the skin back a bit. (3/5 - 3rd year)*

Another participant reported undertaking a rectal examination on a person in theatre for a prostate problem. They were asked to do this by the surgeon in charge. The student grappled with the problem of whether the patient had fully consented to this: they knew they had consented to the operation, but felt it was unlikely that they had consented to the student carrying out the examination:

> *I'm not sure they were asked if that could be done (...) But he got me to you know he just basically gave us the gloves and we knew that was, and I kind of you know it hadn't, up until that point there'd been various reasons why we'd avoided doing one and I knew we were going to have to do one at some point. It doesn't bother me at all. I have to say again*

> *just being terribly politically correct it doesn't bother me if a person hasn't been asked but I think that's just one of those things that I mean it just, I mean they sign a consent form, you know it's appalling really. (3/9 - 3rd year)*

This student tried to find a way to rationalise this and, again, revealed a tension between the needs of her education and respecting the patient; not to take up the opportunity can be viewed as a missed opportunity to learn something new:

> *You see it sounds terrible really but I didn't really, I mean I was aware of the fact that I don't think the person probably had been asked. I mean he probably would have been asked, I mean it's probably quite normal for the surgeon to do it so obviously somebody is going to be doing it whether or not they would know that the students would do it. But we have to learn somehow and it, you know it's probably easier to learn on an anaesthetised patient and less traumatic for any patient than when you finally have to do it on somebody who's you know awake and having to feel it. And I've also done, I've catheterised a gentleman as well, again when he was anaesthetised with the senior reg. The senior reg. said you know do you want to do this and I said yeah. (3/9 - 3rd year)*

Whilst assisting in procedures is different from observing activities in theatre, I think that negotiating access to both needs attention. The following extract serves as an illustration and is a story told to me by one third-year student who, with other students, was called to an emergency surgery situation by the consultant because it was an 'interesting case'. In fact, the patient died and this would be a memorable and distressing experience for anyone, especially given the rather dramatic and prolonged circumstances. What struck the student was that they watched someone die that they did not 'know from Adam' and what she describes is that this, alongside the realisation that he had a family waiting for news, served to connect them emotionally with the situation; it was no longer possible to de-personalise the encounter or the person in theatre; the everyday body was very present. Putting herself in the daughter's position led the student to the conclusion that they should not be present, as she "wouldn't want a load of students there". I think it appears disrespectful to her, although she does not explicitly say this. I suspect that no one would have asked the family if they minded students observing in this situation. What stands out for me is this student's genuine human response to the situation:

S: *There were a couple where we were called in when I was on vascular; the consultant just called down to the ward and said 'if there are any students, tell them to come to theatre, we have got a ruptured aneurysm'. And we didn't know anything about the case at all. We walked up to theatre expecting to see some brilliant surgery to fix this guy's aortic aneurysm and he actually died on the table and I was totally unprepared for it. I didn't, I had never met the guy, you know I didn't know him from Adam and I was really upset, really, really upset. It was the first person I had ever seen die and I didn't feel like I should have been there. We couldn't really see what was going on and it was going on for hours and hours with this guy just bleeding and they could not put him back together. And you know he obviously didn't know that you were there, but he was rushed in from the ambulance.*

A: *And how did that, what did that make you feel like? (...)*

S: *I felt that I wanted to get out as quickly as possible because I didn't feel I should be there. (...) We were reading his notes to try and get a gist of what was going on and it said at the bottom his family, his wife and children are here and they have been informed that the risk you know that there is 90% chance that he is going to die on the table basically. I remember thinking, if I was that you know if I was that daughter, I don't think I would want a load of students just standing there. Yeah, I was really upset about it. (3/2 - 3rd year)*

Patients' ability to say no

A further third year student also told me that certain procedures were invasive and that, because patients may not be in a position to refuse, it was up to students to take responsibility for negotiating access, giving adequate information.

> *The problem is that patients will accept the examination almost blindly and I think the onus that is put on us to explain what we are doing as we go along and why we are doing it is a good one. You know there are only a limited number of excuses for a rectal or vaginal exam.*
> (3/2 – 3rd year)

The notion that "patients will accept the examination almost blindly" is an interesting one as there is an assumption that patients are freely able to refuse to participate, when they are asked, and I found that different students had different views about how possible it was for patients to refuse consent to be examined by a student.

The following student was unusual in that they reported that quite a few people had, in fact, refused their requests to examine them and indicated that there was a need for students to be proactive in the exchange and offer patients the possibility of saying no. She also, interestingly, made reference to how the patient might feel intimidated by a group of students and what they might think were the consequences of saying no:

> *S:* *I think you need to tell a patient that they can say no if they want to. They just need to know that. And maybe don't go round in big groups and things. I wouldn't like it if I was lying in bed and there were five or six medical students around me.*
>
> *A:* *Do you think it is easy for patients to say no?*
>
> *S:* *I think, I think some might do (laughs) Probably not though, because once someone has come up to you, you don't really feel you can say no, and I am sure that a lot of patients think: if I say no, will the doctor treat me differently? (3/4 - 3rd year)*

Another student again mentioned the problem of the blurring of the role boundaries: patients wouldn't say no to doctors and so if they were not quite sure what the term 'medical student' means, they would not feel able to say no to students:

> *I think that if people really didn't want to be examined or approached then they would say no. But I think some of it comes out of this thing of the medical students' role in that they are not always sure whether they can say no to you as medical students. And people feel obliged not to say no to doctors as well. (3/5 - 3rd year)*

Some students thought about the problem when I questioned them about it and the following student acknowledged that patients may feel under an obligation:

> *I am not sure whether people feel under pressure or not, yeah, I guess it is quite difficult to say no, especially if they are kind of lying there and they have nothing else to do. I guess they do feel kind of obliged to do it. Yeah, mmm, probably. (3/2 - 3rd year)*

Some students were reflective about how difficult it was for patients to say no (even though the general consensus seemed to be that most patients do not mind) and were upfront about patient's right to refuse their requests to clerk or examine them. However, attempts to rationalise their activities also lead to contradictory statements or circular arguments:

> *I don't think it's, I never do feel that I am imposing on a patient because they definitely are asked before they see us so they can say no. And I have never seen anyone who I thought felt uncomfortable with the situation or anything. (...) I do think there are times when it is just assumed that it is a teaching facility and all patients should accept that but I don't think they should. I think everybody should have the right to say 'Oh no, I don't want a student'. (3/3 - 3rd year)*

The following student also illustrates the problem of the circular argument: there is an underlying assumption that patients will not refuse, as they have never refused their requests; yet at the same time the student acknowledges that it is difficult for patients to say no:

> *I usually ask if it is OK. But to be honest it is quite, I mean it is difficult. I try and kind of remember to say if it is OK, but if they are not happy it is usually very difficult to refuse in that kind of situation. I usually do ask if it is OK if I do this. But I guess it is probably more for my benefit in that I know that I have asked it because no-one has ever said to me 'no I don't want you to do that'. (2/6 - 5th year)*

This student illustrates how complex the process is for them: on the one hand they know that it is hard for patients to say no and on the other none have ever said no. What is revealing here is that they acknowledge that the act of asking if it is OK to examine a patient is more for the students' benefit than the patients'. For me this illustrates how the focus is not on negotiating access with each individual patient and seeing this as the important beginning to a two-way interaction between themselves and a patient; and further illustrates the shifting ground of the status of the patient body from everyday to medical.

As I mentioned in the last chapter, some of the participants in my study explained to me that, as they began to take a history, they were also judging whether patients were happy with this or not. Sometimes they picked up that the patients were uncomfortable or didn't really want the students to examine them and therefore stopped or foreshortened the process. This, I think, is a good example of the complexity of the relationship and shows how students do attempt to connect with patients' everyday body, as the following two examples show:

> S: *But I mean I am only going on what I feel coming from the patient, which most of the time tends to be that they are, that they*

> *feel comfortable with this. And I don't think I have examined or taken a history off anybody who has been uncomfortable with it.*
>
> A: *So are you trying to judge that all the time? Is that possible?*
>
> S: *Yeah, I do yeah.*
>
> A: *Judge whether they feel OK and ....*
>
> S: *...I mean some, I have not examined people when I finish the history. I judge that I would feel uncomfortable examining this patient because they don't seem totally comfortable with me. So then I would not want to do that. (...) People who I don't feel relaxed after you have spoken to them for a long time and can be anxious and things. Or (...) is just a practical thing is just people who seem like they want to get away to go and do something else. (3/5 - 3rd year)*

> *And there are occasions, when with certain patients, I'll think I'm not so happy about doing the examination on this patient cause you can sense in the history that they might be a bit nervous or anxious and you just think well, there is no point really because you are going to have to obviously undress them to a certain extent and you can sense that they are not going to be happy with that so you sometimes, I just leave it. (2/1 - 5th year)*

What struck me in such conversations with students was that they were not only trying to pick up how patients might be feeling but were also expressing to me that they felt uncomfortable when they realised that patients were unhappy, which in some way seemed to acknowledge the two-way nature of the interaction. However, whilst I think this connection with patients and their bodies reveals a sensitivity and respect for patient's feelings, there is an inherent, rather paradoxical, problem. In effect, students are compensating for some patients' lack of ability and power in the encounter to actually refuse consent at the beginning of the encounter. Despite their connection with patients, they still operate some level of control, during the encounter, for how it progresses; it is therefore clearly not an equal 2-way encounter or symmetrical relationship (Goffman, 1969) in this respect.

Taking Responsibility

What generally appeared to be the case was that students' attention or focus was on practising the history and examination or feeling a useful participant in a patient's care, rather than on the process of negotiating access. Students did not report inappropriately clerking people who were not competent to make an informed decision. However, one third year student did refer to an incident that they had experienced and I think this starkly illustrates the consequences of any lack of attention to the opening of the encounter. They had asked a nurse which patients might be useful for them to clerk and the following exchange explains what followed:

> *S:* *And I get there and they are very confused and the particular patient I am thinking of I couldn't actually get a history out of her. And it was afterwards I went to speak to the SHO who was taking care of her and he said: 'I don't know why you even bothered, she has quite severe dementia'. But the nurse hadn't, either hadn't known because it wasn't her patient (...).*
>
> *A:* *So did you give up, in terms of did you go from the history to the examination?*
>
> *S:* *I did yes, although I just did a general examination because from the history I couldn't really tell what was going on. And in fact it was not until I went away and asked the SHO that I found out what was happening. (3/3 - 3rd year p.3)*

What I think occurred here is that, because the nurse has suggested a patient to clerk, the student almost took this as proxy consent from the patient. Although the student obviously knew that something was not quite right, as they were unable to 'get a history', they still carried on with the examination and only found out that the patient suffered from dementia after the encounter when they spoke to the SHO. Apart from illustrating how the process of negotiating access can be subjugated to the history taking and examination, this encounter also indicates that the student did not necessarily feel responsible for their interaction and therefore for negotiating access with the patient as they had been informed by the nurse that the patient would be suitable to clerk.

Hafferty (1991:9) notes the importance of the concept of "what it means to be responsible" in the professional socialisation of doctors. This focus on 'responsibility' in professional socialisation has also been raised in the other contexts. Earlier work by Kleinman and Fine (1979:280) highlighted this notion of 'responsibility' as a particular concern for moral organisations. In education this would refer to those that expected to change/better students in some way as opposed to just teach them technical skills as part of "the emerging perspective of the humanistic professional".[6] Becker et al (1961: 223) named 'experience' and 'responsibility' as two 'perspectives' or ideas/actions which medical students draw on as part of the medical student culture "which tells them what direction they should put forth their effort" and it is these perspectives that their teachers also wish to inculcate to students. In the previous chapter, I illustrated how students struggle with the need to acquire experience of examination, through effectively using the patient's body for their educational needs, whilst at the same time needing to find some purpose or use for their actions so that they did not feel they were using patients' bodies for their own ends. Becker's work was concerned with the doctor's responsibility in relation to their patients:

> (...) basically the term refers to the archetypal feature of medical practice: the physician who holds his patient's fate in his hands and on whom the patient's life or death may depend. Medical responsibility is responsibility for the patient's well-being, and the exercise of medical responsibility is seen as the basic and key action of the practising physician. The physician is most a physician when he exercises this responsibility (Becker et al, 1961: 224).

Essentially, Becker and his colleagues were interested in actions that could result in adverse care or errors of judgement for patients and how students drew on their understandings about responsibility to interpret these and their consequences. Sinclair, drawing on Becker's work (and extending it to include reference to Bourdieu's concepts of dispositions and habitus), also proposed 'Responsibility' as one of his dispositions: psychological structures which structure or guide people's actions or thoughts. 'Responsibility' for the patient's care in the clinical years of students' medical education is located with the patient's doctor, as students do not actually 'have' any patients. For Sinclair, a student may only take on "real Responsibility" when they are involved in hot medicine, for example when they are on-take; but otherwise operate "hypothetical Responsibility" as they gain experience on the wards (Sinclair, 1997: 199).

Neither Becker nor Sinclair was concerned with the concept of responsibility in relation to negotiating access and, to a certain extent, this may be a product of the dates of their

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[6] This research drew on two contexts: students in a seminary and little leaguers to highlight ways in which moral organisations use rhetoric to control recruits (such as caring, sharing, and teamwork) and emphasise their responsibility to take on these values or participate in certain activities.

work. Whilst students may only be hypothetically responsible for the care of patients with whom they interact in much of what they undertake before they qualify (a doctor would always take overall responsibility), I think that students must be, to a certain extent, responsible for their individual interactions with patients. The *Policy on the Rights of Patients in Medical Education* (School of Medicine, 2004) clearly places students as well as their consultants as being responsible for their actions; but it is focused on the process of obtaining consent. In this section I want to explore this in relation to negotiating access to examine a patient. I am interested in the boundaries of this responsibility: where students were able to take responsibility and when and why responsibility was located elsewhere, in order to explore how this changing location of responsibility might impact on the objectification of the patient's body.

I have discussed how teaching on the wards removed students from the process of engaging in any meaningful manner with patients that they were examining and placed students firmly on the side of inspecting a patient's medical body. What happens to patients in these situations is essentially out of students' control and I found a similar pattern in relation to how access to a patient's body is negotiated in such circumstances. The following student outlines the difference between being on their own (and in control) and when they are working directly with doctors:

> *S:* *It's when you are with the patient and you are on your own, you have got to make them comfortable and make them feel fine with doing that and get consent and things. But when you have got the consultant there you feel you can almost do what you want in terms of the examination. That's fine because the consultant's got the consent and he is there.*
>
> *A:* *And so you are not actually responsible for the patient's care in any way (...) and you are not responsible for the consent issues?*
>
> *S:* *No. (3/5 - 3rd year)*

In a teaching encounter on the ward, the student describes how they are excused from taking responsibility for the patient's comfort or for their consent for any actions that might take place. This student also goes on to say how they can "almost do what you want" because the consultant is taking responsibility for their actions. The patient is again seen as the passive recipient of whatever might be decided for them and not as an active participant in the process; how they might feel or what they might want to happen in the situation is not something the student needs to be concerned about as they are not responsible within this sort of encounter. Responsibility for the patient's comfort and consent is firmly placed with the consultant.

Another student described how consent for examinations might be obtained, in this sort of context, in two distinct ways: students may or may not be present but the "Is it OK" approach is again evident:

> *Where they* [the doctor] *have said to us you wait outside so the patient doesn't see us and then the doctor will go up and say 'I have got a couple of third year students with me who would like to come and chat with you or would like to come and look at you and things like that and examine you. Is that OK?' (...) Sometimes, I have seen that you know where people are being asked in front of* [me], *yeah. I have experienced that more recently with the clinics. (...) sometimes in clinic if they have a new patient they will say to me to clerk them first and then they will come back and ask me about them and the patient is asked with me in the room. And that is a very difficult situation. (3/3 - 3rd year)*

The point I am attempting to make here is that in certain activities such as teaching on wards or in theatre, the responsibility for negotiating access for students to examine patients is placed with the doctor, but the same issues apply: in the above situations there is an assumption that patients will respond affirmatively and a subtle coercion is apparent; in the second situation patients are likely to have even more difficulties with saying no if they wanted to because the student is already present.

Once the responsibility for negotiating access to examine a patient is seen to lie not with the student/s examining but with the consultant, there are inherent dangers for students (and patients); in effect students are removed from taking responsibility for their direct relationship with the patient's body. The potential consequences of these sorts of situations are again thrown into sharp relief when students are asked to undertake activities which they find difficult; in effect, a critical incident highlights a problem with a practice which might otherwise just be seen as normal, and so challenges the taken-for-granted assumptions. In particular, the issue is highlighted when the responsibility for gaining consent is out of students' control; for example:

> *I remember in the third year. I don't remember it very well but doing an internal examination on a lady under anaesthetic and I think the*

> *situation was something like they just wanted to tell me that I should practise how to do an internal examination and this is what you do and showed me what to do. I guess I kind of did it without thinking at the time. I don't know how much better an experience it would be if you do get people's consent that you do it. Because I find it difficult in a way because you are kind of thrown in to do a lot of stuff that you are not quite sure about I guess. (2/6 - 5th year)*[7]

> *And I was in a room by myself and he was* [patient with schizophrenia] *describing all these things to me. I went back to the consultant and presented the case and he said OK off we go and he just didn't prepare me at all. He went back into the room and said: 'Right we are going to examine you now'* [testicular examination] *and I was kind of not happy about it and didn't want to do it. I just didn't and the consultant examined him first and then he said: 'Right, now the student is going to' and he did not kind of address me at all. He, I think he, he definitely said: 'Is it OK if the student examines you as well?' and the chap said that was fine and I did so. Well it was OK but I was really nervous and I did it. You know to be fair I think in retrospect I was thrown in at the deep end and it probably, maybe was a good thing as I wouldn't necessarily ask to be shown how to examine someone (...). At the time I was not that happy about it. (3/2 - 3rd year)*

The medical hierarchy is very apparent in this context and, in effect, the patient sits at the bottom, the doctor at the top with the student stuck, often uncomfortably, in the middle: should they act as advocates for the patients and refuse to undertake an activity which they feel is inappropriate but risk the consequences of this from the doctor; or should they just put their head down and get on with what they have been instructed to do, gain the necessary experience and not risk any fallout? In effect, the patient may be reliant on the student's decision in such circumstances.

However, as we have already seen, students find it extremely difficult to challenge practices that they think are inappropriate or the people that are carrying these out. Some students did report ways that they found to challenge practices as their confidence grew; for example, the following student outlines their response to not being introduced as a 'medical student':

> *There have been a few instances where I have been introduced as 'my colleague' or 'young doctor' or that sort of thing and I feel very nervous*

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[7] This student is describing an incident which took place before the introduction of the patients rights policy and did go on to say that during her fifth year she had seen a change *"they sat us down and said this is a process and you must consent people before doing this before the operation"*

> *in those situations (...) because it happened in the first and second year as well and I didn't say anything because I didn't feel that I had the confidence, or I was scared of the consultant or whoever it was. Whereas now, I would just make sure I would say 'Hi, I'm X and I am a third year medical student'. And you just make sure that even if they don't know what a third year student does or is, I have made the effort to say that I am not a doctor, I am a student.* *(3/5 - 3rd year)*

The student is well aware of the limits of their challenge – patients may still not know what a medical student means – but feels that at least they can do something and takes responsibility for this; it is another example of subtle resistance. I asked this student if they would feel able to challenge the person that introduced them incorrectly by, for example, directly pointing out to them that they would prefer to be introduced in a different way. They responded that this was more difficult, especially if you had no relationship with the doctor: *"if you are only meeting them once, only connect with them once, or for whatever reason. I don't know how they would react or whatever. I do feel a bit intimidated to say, tell them what to do or how to introduce me".*

Another fifth-year student described how they still tried to establish some sort of relationship with a patient even when it was the consultant who had previously negotiated access:

> *He would ask me to have a go,* [examine the patient] *then I would have done, but I would have felt more uncomfortable because I had not introduced myself to the patient before. But I still would do certain things like introduce myself and ask her if she was in pain and ask her if it is OK if I do try to do that.* *(2/8 - 5th year)*

Interestingly, Atkinson (1997) writes about how he negotiated access for his research observations on the ward and there are interesting parallels with what I have been attempting to explore in this chapter. Whilst he had wanted to be introduced to patients by the doctors, in the event this was not something that was made explicit; he was subsumed into the group and might have been taken by patients to be another clinician or a medical student. He writes:

> To that extent, then, although I was an open observer with regard to the doctors and students, I was a disguised observer with regard to the patients. From my point of view this was less a deliberate research strategy, but more an exigency forced on me by the situation I was in.

> Control of teaching situations lay unequivocally with the teaching consultants, registrars or house officers. To that extent, both the negotiation of permission to teach, and disclosure of my identity, were the prerogative of the clinicians themselves. For me to attempt to enter into separate negotiations, and to achieve an open identity for myself when the clinicians remained silent, would have been to question the position of the doctors. It could have endangered the entire enterprise (ibid.: 52).

For students, the enterprise is their education and indeed their future careers.

Drawing on documents

For the documentary analysis part of this chapter, I wanted to explore the School's *Policy on the Rights of Patients in Medical Education* (School of Medicine, 2004), the connections between this and the written instructions students receive in their handbooks and the practice of negotiating access that they described to me.

Patients' rights

The patients' rights policy was introduced in the School in 2001 and the document, that sets it out, was updated in 2004. I analysed the most recent version and I have included this in Appendix E. The first point that I want to make about this is that it was developed by Doyal to "help protect students from being asked to behave unethically" (2001: 685) and, therefore, its audience was intended for clinical teachers and students rather than patients, despite purporting to set out their rights. There are no instructions, that I could find, that indicate that the policy should be shared with patients themselves or how this might be done.

The document begins with the statement: "Patients have a moral right to exercise control over the circumstances in which they are physically touched and in which personal and clinical information about them is communicated to others", implying that patients should be active participants in the student-patient encounter. There are, then, a series of statements that I think are identifiable as ways to ensure this is the case. However, apart from a following sentence, "The patient should be involved as a partner in the educational activity", the patient appears to be represented as someone to which things are done. So, for example there is no explanation as to what form this partnership might take, or what a patient's role in this partnership might be. The fact that the document is not addressed to patients may compound the sense that the patient's role, in any active way, is underplayed.

The document contains statements, the purpose of which is to ensure that patients receive enough information to give informed consent, but these too are sometimes vague; so, for example students must not be described to patients by clinical teachers as "'young doctors', 'my colleagues' or 'assistants'", but may be described as "'medical students' or 'student doctors'" which, as I have outlined earlier, may not be self explanatory for patients, especially in regard to the sometimes blurred boundaries between students' educational needs and patient care. Furthermore, there is an instruction that "patients should be reminded of the purpose of any activity in which they participate with students", but this does not acknowledge that the purpose may not always be straightforward to students, or give any information about the amount of detail that patients might need, over and above 'take a history and examine you', in order to make a informed choice as to whether they want to participate or not.

Students are informed that patients "should understand that their participation is entirely voluntary and resistance should be respected with reassurance that unwillingness to participate will not compromise their care"; however the tenor of this instruction is that patients need only be reminded if they are unwilling, rather than this being a general point to cover in all encounters. There are clear instructions that state that physical examinations should not be carried out on patients under anaesthetic, without their written consent, but as I have outlined this does not always take happen (see also Coldicott, 2003 whose study took place in Bristol). There are no instructions about students being present in theatre, with or without patient consent, and this is not surprising given the response that I had from students when I asked them about this.

My sense about this document is that it is a 'wish list', which, whilst its statements are laudable, does not acknowledge the structural difficulties for students: students are responsible for obtaining valid consent from patients but the instruction about this groups them with clinical teachers: "Clinical teachers and students must obtain explicit verbal consent from patients before students take their case histories or physically examine them" and, as I have shown, students are sometimes in a position where they cannot take responsibility or openly question their clinical teachers. By grouping students and clinical teachers together the statement avoids the question of whether students should, indeed, be held responsible for the process in any, or in which, of their encounters.

Similarly, the phrase, "Clinical teachers and students should never perform physical examinations that are potentially embarrassing for primary educational purposes without the patients' verbal consent, both for the physical examination itself and for the number of students present", does not help students who find themselves in a ward teaching situation where they feel there are inappropriate numbers of students present: should they be expected to ask the patient how many students they want present if the clinical teacher does not?

The document ends with saying that clinical teachers are responsible for following the guidelines and states that, "Encouragement of students to ignore these guidelines is unacceptable and if students feel unduly pressurised they should report the incident to the Clinical Sub-Dean or the appropriate Associate Clinical Sub-Dean. However, as we have seen, it might not be so much that students are 'encouraged' to ignore the guidelines; rather that certain practices are normalised. Moreover, telling students to report incidents does not mean that they are actually able to do this, particularly if there is a culture which really does not, in practice, encourage this because of the possible, or perceived possible, consequences for students. Statements of rights, for whatever purpose, does not mean it is necessarily so.

Students' instructions

The policy document is included in the year 3 and 5 student handbooks (School of Medicine, 2002a and 2002b). One issue is that, as it contains statements about the rights of patients, it is not explicitly a set of instructions for students and, as I have just outlined, the wording does not always make it clear who is responsible for what. Both the handbooks have the same section at the beginning called "Instructions to students in clinical areas", which includes paragraphs on, communication, examination, health records, and practical procedures. The first of these contains the following statement:

> Whilst you are encouraged to talk to patients and relatives, you should not offer information on diagnoses which is not already known to the

> patient and their family. Ask permission to talk to them and to relatives and always obtain the patient's verbal consent before you take a history from him/her (SoM. 2002a: 9)

The second paragraph, on examination, follows this with:

> Always obtain the patient's verbal consent to examine him/her. Ensure a chaperone is present when appropriate (see Appendix 2). Invasive procedures (i.e P.V. or P.R.) should not be performed unless requested by a qualified member of the medical team and either supervised by them, or by a nurse if the latter has been authorised by them to do so, and the patient has consented (ibid.: 9)

What might constitute consent is not detailed here and also it is again unclear what students should do in ward teaching situations: should they always seek consent as well as the teachers? There is no cross referencing to the patients' rights document under this heading, which is included in the next section. I suspect this is because the patients' rights document is a recent addition to the handbooks, but the effect of this is to present different instructions to students in different places. Appendix 2, of both handbooks, contains the "Revision of introduction to history taking and physical examination" section which I looked at in the last chapter" and, under the heading, "introduction to the patient" it says, "You should not assess any patient without the verbal consent of a member of the responsible medical team" (ibid.: Appendix 2), which is slightly contradictory to the information in the introduction to the handbook, which implies that students can take a history and do an examination, once the patient gives consent. It may, of course, be referring to assessing patients as part of clinical care rather than as solely for educational purposes, but, if so, this is not made clear. The Appendix does contain a little more detail on the consent process with patients, but still remains vague:

> Introduce yourself by name as a medical student
> Say that you would like to talk/to examine the patient, if it would be convenient, as part of your training.
> You should give an indication of how long you hope to spend with the patient (ibid.: Appendix 2).

Whilst introductions and negotiating access is covered as part of students' communication skills training, I still think that the written instructions could be clearer, and, as with the section above, there is no cross reference in this Appendix to the patients' rights document. A consistent approach would also help to emphasise, for students, what is important. Furthermore, the instructions imply a passive patient, as apart from the need to give consent, there is little other sense that the relationship is an interactive one.

In the surgery attachment section of both handbooks, there is no mention of what students should do in terms of seeking consent from patients to be present in theatre.

Summary: Negotiating Access with the Everyday or Medical Body?

The focus for this chapter has been on how students negotiate access to work with patients' bodies, encompassing both the establishing of a relationship with patients and seeking consent for any activities that might ensue. I have attempted to show the importance of 'good beginnings' and some of the potential consequences of a lack of focus on negotiating access through highlighting some of students' more critical incidents, especially those where they have either given responsibility away or where they had never been given responsibility. Negotiating access with a patient to carry out an examination is fraught with difficulties for students, not least because of their position within the medical hierarchy, but this process is a vital one in terms of their current and future relationships with patients and their bodies.

During the initial contacts, patients and students form the foundation for their relationship with each other. If this is not based on a mutual respect for one another, then the rest of the interaction, which would include seeking valid consent for any forthcoming activities, is likely to follow in the same vein. When students are clerking on a ward they have more responsibility for negotiating access and they are, I believe, more likely to be able to view the patient's body as active rather than passive. However, the routine nature of clerking patients on wards may also have the effect of normalising existing and taken-for-granted practices. Furthermore, if students do not have the responsibility for negotiating access, there are a number of consequences. My concern here is that, in order to negotiate access with patients for the use of their bodies in the educational process, students must be able to view the ontological status of the body as that of the everyday body and take some level of responsibility for all their interactions. If the patient's body is already accorded the status of the medical body (or is in the process of transformation) prior to any negotiating taking place, I would argue that it is much less likely that appropriate negotiation will take place. This is because essentially this initial interaction would take place with the body as becoming, or as an object. In effect, part of the negotiation needs to be about people consenting to be a patient for students in the encounter. Polices and procedures, whilst containing useful statements, are unlikely to be able to fully compensate in such circumstances.

How access is negotiated, then, reflects the status of the patient's body: a lack of concern about establishing the relationship reveals a patient body seen as passive and objectified. A discourse that refers to informed consent or negotiating access with a 'patient' also disguises and subjugates the individual self: students negotiate access with patients rather than people.

Chapter 6

Discussion & Conclusions

The Ontological Status of the Body

The following is an extract from Pat Barker's book *The Eye in the Door* (1993), the second in her Regeneration trilogy about the First World War:

> He [Rivers] watched Head's expression as he looked at Lucas's shaved scalp, and realized it differed hardly at all from his expression that morning as he'd bent over the cadaver. For the moment, Lucas had become simply a technical problem. Then Lucas looked up from his task, and instantly Head's face flashed open in his transforming smile. A murmur of encouragement, and Lucas returned to his drawing. Head's face, looking at the ridged purple scar on the shaved head, again became remote, withdrawn. His empathy, his strong sense of humanity he shared with his patients, was again suspended. A necessary suspension, without which the practice of medical research, and indeed of medicine itself, would hardly be possible, but none the less identifiably the same suspension the soldier must achieve in order to kill. (….) Head's dissociation was healthy because the researcher and the physician each had instant access to the experience of the other, and both had access to Head's experience in all other areas of his life. (p.146)

Rivers, a psychiatrist, is observing Head, the researcher and physician. One way to approach looking at Head's encounter with Lucas, his patient, is that Head switches between showing concern for his patient and detachment, which, as I have discussed earlier, has been seen to be one of the professional socialisation goals of the medical curriculum (Lief & Fox, 1963; Fox, 1988). Another way of looking at this is through an examination of the ontological status of Lucas' body: Head can view his patient's body as both medical and everyday and can switch between the two with ease.

In my introduction I outlined two recent events – Alder Hey and the Marchioness disaster – in which the medical professionals involved acted in a way which shocked both those people close to events and the wider public as they learnt of them. If we perceive the medical professionals involved in these two events as having accorded, to the dead bodies, attributes associated with the medical body, then their actions become more understandable. If the families involved still assigned attributes of the everyday body to the dead bodies of their relatives, we can understand why they reacted in the way that they did. In effect the two 'sides' were speaking from different standpoints and so found it difficult to understand each other's feelings and actions; in effect they were speaking a different language.

Exploring the ontological status of the body is, I think, a useful approach precisely because it allows us to look at actions at an individual as well as at an institutional level. One shortcoming of an approach which concentrates on the developing attitude of a medical student in preparation for the doctor role is that it has a tendency to underplay the complexity of the interaction between the student and the bodies they encounter. Further, the changing status of the body in the encounter may be removed from the analysis. Hafferty (1991) commented, that for students in his study, it was difficult to classify their attitude as one of 'detached concern' and I concur when he notes that "Fox's implication that detached concern represents some reasonably well-defined and stable state does not adequately capture the dynamics that exist between these two conflicting orientations" (1991: 205); that is, between detachment and concern.

This thesis has addressed both agency and structure in relation to understanding students' encounters with bodies. The agency/structure dualism which sits parallel to people as both subject and object is not one I would want to attempt to resolve here. Rather, as Smart (1982: 140) asserts, I would see these dualisms as "constituent and necessary features of the epistemological configuration within which the human sciences are located" – people's actions are located within, and influenced by, the social, cultural and historical context. I have attempted to show that how the body is viewed both at a micro level (the level of the student) and macro level (the culture of medicine) is an important part of our understanding of encounters between students and bodies, alive or dead. This is complex, as the status of the body is not static and may differ for different people.

In chapter 3, I illustrated the similarities between the ontological status of the dead body and the unconscious body that medical students encounter; both bodies are quintessentially medical – passive and objectified. The lack of any social interaction with these types of body means that it is difficult for students to view them in any other way; when students encounter these bodies they have already been rendered as objects. However, even in these circumstances, the everyday body is invoked during encounters with symbolic parts.

Students in my study reported how the body in the operating theatre bore a resemblance to the body in the DR in the way that it was covered up, revealing only the part that was to be operated on; in this way, then, the body is presented in parts like the dissected specimens. Similarly, they are laid out on a table and strict routines and rules guide activities in both the operating theatre and the DR. Although the transformation to the medical body is sometimes incomplete, I would argue that both types of body are primarily the object of observation, or the 'medical gaze'.

However, in doing so, I am not saying that this is necessarily 'wrong'. Hafferty (1991) noted that students approached bodies in the DR with one of two perspectives: "biological-specimen perspective" or a "formerly living being" and, whilst I did not categorise students' responses in this way, there were students in my study who struggled with the specimens more than others. There was a general sense that it was necessary to objectify the body parts in order to be able to undertake what would otherwise be considered a strange and abnormal practice of touching and manipulating dead, preserved human specimens. Moreover, Young (1997), asserts that the objectification of the body in the operating theatre is a necessary part of the process of enabling surgery to occur: it needs to be performed on objects and not on people and the need for this is as great for patients as it is for surgeons. If I render my body an object then I may feel less violated by the doctor's or surgeon's actions.

In chapter 4, I explored the ontological status of the conscious bodies that students encountered. This, I believe, is likely to be more fluid precisely because of the additional dimension of social interaction. The patient's body in such encounters, however, remains an object of enquiry for students, a means by which they will learn their 'trade' or as a learning resource. As this chapter and the following illustrated, the body is often still viewed as passive rather than active in this learning process. Whilst the patient's body can still be seen as essentially medical within the context of the medical curriculum, students struggled with the need to find some purpose and identify some aspect of reciprocity in their encounters and they explained ways in which they attempted to connect with patients. When so doing, I would suggest, they are attempting to 'find' the everyday body in their encounters. The ontological status of the conscious patient body does shift, then, between the medical and the everyday for students but the body remains one which carries the tag of 'patient', rather than person.

Students explained how in certain encounters, like clerking on wards, they were able to make judgements about how appropriate certain activities might be with particular patients, arising from the fact that they were able to form some kind of relationship with them, usually through the history taking process. At other times, for example in ward teaching situations, or being called to an 'interesting case' in theatre, they had no direct responsibility for what happened in the encounter, and had little opportunity to form any sort of relationship with the patient. The consequence is that they become complicit in a teaching hospital culture which allows groups of students to observe the patient's body without being able to engage in any meaningful way with patients, or engage in a dialogue about the consequences of this. Some students expressed discomfort with these circumstances, and others found comfort in their lack of responsibility at these times. These group encounters persist as normalised practice in hospital medicine but, I suggest, they are problematic in that they place both patients and students in a passive role. Although some students do find subtle ways to challenge the status quo, even in such instances, students – perhaps because of their lack of responsibility – are, nevertheless, compliant.

My work shows how the everyday body continually interrupts the medical body. In the DR the 'human referents' (Hafferty 1991) reminded students of what they were observing and its origins. Such encounters, just like the difficult encounters that I identified in chapter 4, had the capacity to evoke an emotional response from students – a feeling of discomfort or empathy – and to make a connection between themselves and the experience of the patient or dead body. These 'difficult encounters' were often seen as problematic for students; however, such encounters do enable the everyday body to present itself and may have the impact of mediating a view of the patient's body as essentially medical. Some bodies, however, may be less likely to fall into this sort of category, as I have argued in the case of older bodies: students may find it more difficult to connect with older people both because they have less in common with them, and so find it more difficult to empathise with them and because of the structural problem of ageism in Western society (see, for example, Biggs, 2002). In this way the presence of the everyday body is influenced at the level of agency and structure.

A recurring point that arises from literature on medical students is the problematic nature of the student role in medicine. Unlike most other degree courses, there are blurred boundaries between their role and the doctor role precisely because they are learning to become doctors and, also, because they experience the work environment whilst they are students in what remains, to a certain extent, an apprenticeship model of education.[1] As Sinclair (1997) observed, one of the main preoccupations for students is to gain experience. In effect, then, all experiences can be seen as useful. When students are standing around a patient's bed with six other students they may be able to empathise with how patients might feel, but, on the other hand, there may be the off chance that they might learn something from observing how the doctor examines a patient or get some feedback on their own examination skills. A key tension for medical students, then, can be between their need to gain educational experience and respect for a patient's space or dignity (or indeed respecting a dead body). This tension may be underpinned by notions of the medical and everyday body in that the drive to gain experience may serve to reinforce the status of the medical body. Similarly, this may be compounded if viewing the body as medical is equated with being professional, or indeed, as a necessary pre-requisite for certain activities to take place. As I have shown, managing this tension is at times more overtly within students' control than at others. In any case there may be no resolution to this dilemma.

The rendering of the body, whether it be conscious, unconscious or dead, to the status of the medical body within the medical curriculum has a number of implications for the way that the body is treated and for what practices are seen as acceptable or unacceptable. For students, particularly where they feel uncomfortable, most often when the everyday body is invoked, it is problematic if they are unable to challenge or question what they are asked to do or what they see others do. This reinforces the

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[1] Although this is changing to more structured clinical medical education at both undergraduate and postgraduate levels with stated curricula. The introduction of Foundation levels 1 and 2 at postgraduate level is further evidence of this (DoH, 2003).

notion that one student's view of the body may not be congruent with that of others present in encounters.

The Use of the Body in the Medical Curriculum

I have shown how the different constructs of the medical and the everyday body can be useful in exploring the ontological status of the bodies that students interact with and the inherent tensions that exist for students as this status changes over time and context; however, I now want to turn to look at a key aspect arising from the research, namely the use/s of the body in the medical curriculum.

A clear observation from my work is that, within the medical curriculum, the body acts as an important resource for students' learning, whether it is dead, dissected, conscious or unconscious; in effect then, in whatever state, it is an 'educating' body and students use this body to learn medicine: it is thus a means to an end. As Shooner, (1997:535) a clinical doctor notes:

> During training, many of us have experienced the moral uneasiness that accompanies the process of learning clinical procedures by using real patients, often without obtaining their explicit and truly informed consent. Although such procedures are usually adequately supervised and unlikely to cause any physical harm, students are sometimes left with the uncomfortable feeling that somehow the relationship between physician and patient has been impoverished and violated. In the process of learning important skills that will benefit students and potentially benefit the patients they will eventually care for, the essential element of trust has been jeopardized.

Her 'answer' is to ensure that students seek informed consent from patients, but this may be complicated by how the body is viewed as I have highlighted in chapter 5. The point here is that the students' relationship with patients is different from that between doctor and patient, because they primarily use the patient's body for learning rather than as part of patient care. I would, therefore, argue that this use of the educating body may compound the objectification of a patient's body.

Medicine has a long history of using the body as a means to an end as, for example, Richardson (2000) has explored. Becker et al's early work (1961) also showed how this use of the body was extended within the medical curriculum: patient's bodies become 'interesting cases' if they are associated with having 'real diseases' and useful for students' learning and we can, therefore, see the body within the curriculum as a commodity. Other examples abound: clearly, the fashion industry uses the body to display the latest creations. However, the educating body in the medical curriculum can be viewed as either passive and medical or as active and everyday and perhaps, the more it is seen as, or is enabled to be everyday, the less likely it is to be able to be objectified and commodified.

Williams and Bendelow (1998) note two types of body use: 'bodily order', regulating bodies at institutional level; and 'bodily control' implying individual action to take back control from institutional power. Foucault's disciplinary power can be seen as part of 'bodily order' and, in relation to medicine, this power is exercised through normalised medical practices which serve to regulate and control individual bodies. Foucault's concept of resistance, however, is located at the micro-level of the individual who challenges normalising power.

In chapter 1, I outlined Turner's and Frank's attempts to provide a model for understanding the connection between the body and society and how the body is used. Turner based his approach on a Hobbesian model of social order which is focused on the regulation of bodies at the level of society. He was concerned with the tasks and functions of the body at this level (bodily order). My work has looked at how the medical curriculum represents the institution of medicine and regulates both patients' bodies and students' bodies in their encounters with patients' bodies.

Frank adopts a bottom-up model taking social action or agency as his starting point (bodily control) and is concerned with body use in action; my concerns are with students' use of the body. Frank's model of body use in action identifies four body actions – control, desire, self-relatedness and other relatedness – and, I have adopted this model to inform my work. The ontological status of the body in the medical curriculum is likely to determine the attributes which inform the style of body use – mirroring body, disciplined body, communicative body and dominating body – and which arise from questions that the body asks itself about its actions and interactions (see chapter 1) relating, in my context to students' actions with patients' bodies.

So when, for example, students described their encounters with bodies they could approach this act in different ways:

1. They may have, or see, little or no relationship between themselves and the body they encounter (monadic relationship to others) and have a need or desire to actively learn from the use of the body through an activity. Examples of this can be seen in students' explanations of their clerking activity and when they are looking for 'interesting cases' or people who they can practise on; engaging in the ward teaching sessions; in the use of bodies in the DR; and the use of patients' bodies for assessments. Students' actions have a tendency to become predictable because they are based on carrying out a technique on an objectified body, but they have self-awareness about the necessity of their actions in order to fulfil their educational needs. I think the style of body use in this context is one of consumption (mirroring) of the medical body.

2. Closely related to this is where students do not see or understand the purpose of their encounters, or do not see the encounter as a productive experience which contributes to their learning and lacks any sense of their relationship with others; examples of this might be when they are clerking a patient who is not 'interesting' or when they undertake activities which they do not see as useful for their education like some 'cold' observations of surgery. This style of body use may be seen as disciplining the medical body.

3. When students are aware of what they are doing and see the need, in relation to their education, to connect with the body which they encounter and understand its contingent nature, they can be seen to be connecting with the everyday body and some students that I spoke to did indicate actions and approaches to their actions which showed a desire for this style of body use. This parallels Frank's ideal type of body use which, effectively, is unobtainable: the communicative body, and in certain respects connecting with the everyday body, may only be possible to a certain extent, given the culture in which students find themselves and students' lack of ability to directly challenge taken-for-granted practices.

4. The last quadrant in Franks' model, if applied to my work, would be where students do not see or understand the purpose of their encounters and do not see the encounter as a productive experience which contributes to their learning, yet they connect in some (possibly negative) way with the body and understand its contingent nature. Such a style could be called dominating the everyday body. Examples of these sorts of encounters might be encounters with patients which students are asked to undertake but which they feel uncomfortable about, yet still undertake, like intimate examination in theatre without valid consent from patients.

I think that different types of student encounters with patients could reflect any of these styles of use, but that some situations encourage one or another. For example, a ward teaching session organised in a particularly sensitive way could encourage a communicative style of use. However, I would suggest that, when ward teaching takes place with groups of students who have had little communication with patients prior to practising examination techniques, it is likely that it would encourage a more consuming style of use.

Frank's model is not intended to be static: students might move between these styles or they may all be interconnected within one encounter. What it does do is illustrate in another way the central tension for students between using a body for their own educational purposes and still retaining some element of respect for the bodies they encounter: the tension between desire and self-relatedness and between control and other-relatedness. I was aware that, as I was undertaking my analysis, I looked for examples of Frank's idealised state of the 'communicative body' where students' interactions with live bodies were more symmetrical. My conceptual categories of using the patient's body/being useful and connecting with/inspecting the body reflect this attention. The fact that the patient's body is being used for students' own ends was acknowledged by some but students either expressed discomfort about this or searched for some way to counter it with a reciprocal action; for example, by being useful to the team and ultimately, therefore, to the patient's care; being able to chat to a patient who may feel lonely; or the long term benefit to society. In effect, students looked for some meaning to their encounters other than the mere use of another person's body for their own ends: their mode of use was not purely one of consumption. This is perhaps unsurprising if one considers reciprocity as being an essential component of social action. As O'Neill (2004: 75) states:

> At the heart of every social system there lies the *reciprocal* gift – the exchange that binds people together for the sake of everything and anything else that they may undertake

What is interesting, here, is that the medical curriculum – and the use of the patient's body as the object of students' education – was sometimes mediated by students themselves. Students, on the whole, found discomfort in encounters with patients' bodies where they were not able to form any sort of relationship, and, furthermore, could sometimes see how such types of encounters could reinforce the objectification of patients' bodies. Whilst the curriculum might serve to encourage students to view bodies as a means to an end, the students themselves found ways of rationalising their actions as being in some way reciprocal.[2]

In addition, the presence of the everyday body, whether it is through human referents in the DR or through difficult encounters with conscious patients' bodies, can aid this process. The human referents in the DR whilst being problematic for students serve to remind them that the body was once alive and had an identity and is not present in the DR through chance – someone donated their body for the students' use. The presence of the everyday body in difficult encounters serves to remind students of the person beyond the patient label, and the relationship between themselves and the body in question.

I would argue, therefore, that the more objectified the patient's body and the more it is viewed in terms of the medical body, the less likely it is that any two-way communication or, as Frank terms it, 'other-relatedness' can occur. This was well illustrated in some of the accounts that students gave about their experiences of ward teaching and the artificial activity of assessments; and the status and use of the unconscious body or the soon to be unconscious body can be seen as the epitome of this. Interestingly, when students felt the whole body specimens were unnecessary for their learning and, in effect, were gratuitous, they also expressed discomfort.

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[2] This could be interpreted in terms of deontological and consequentialist ethical positions.

As I highlighted in previous chapters, students also found different ways to express forms of resistance to the status quo albeit in very subtle ways; however, the direct challenging of taken-for-granted practices was not something that was revealed by the students that I spoke to. In effect, then, students' bodies are being regulated by institutional power – the medical curriculum and the culture in which it operates (Turner, 1996).

I have identified the body in the curriculum as the 'educating' body and in doing so I have purposefully used a word that implied action rather then passivity. Even if the dead body in the curriculum cannot be seen to be active, the act of donation of the body for students' use meant that at some time an individual made an active choice. If we could see the patient and their body as an active participant within the medical curriculum, this might help to encourage students to see the status of the body as fluid and to arrest or interrupt transformations to a medical body – and, therefore, enable them to adopt a connection with the everyday body. Hafferty (1991) wrote about the emotional socialisation of medical students and illustrated how this operated in favour of suppressing their emotions. An active educating body could, therefore, serve to counter some of this suppression.

One way to foster this would be to encourage patients to take on more active roles in educational encounters with students and, in fact, this is something that is increasingly being seen as important and beneficial. For example, Hendry et al (1999) found that teaching of musculoskeletal examination skills by trained patients was as effective as the teaching of this skill by consultant rheumatologists. Wykurtz & Kelly (2002) found similar positive benefits in other examples of patients as teachers. However, Stacey & Spencer (1999) add a cautionary note in that such approaches can also become exploitative.

Another approach is to replace the use of patients, where possible, with simulated models or 'simulated patients' in the form of actors or trained lay people. This approach is advocated by Ziv et al (2003:783) both as a way to improve safety for patients and to overcome the "unreflective use of patients – especially sedated or dying patients – as training tools for clinicians". Whilst I agree these are useful and essential for the teaching of certain invasive procedures, they are limited both in the 'unreal' nature of the encounter, whether it be a 'simulated patient' or with a model, and, in the latter case, the by-definition object status of the body or part of body.[3]

However, the problem, as we have seen, is that the medical curriculum rests within the professional culture of medicine. Within Frank's three dimensions of the body: discourses, institutions and corporeality, discourses and institutions would be seen to enable the notion of the communicating body in which there is reciprocity and mutual recognition. However, if certain normalising practices exist to encourage the transformation of the everyday body to the medical body, and therefore discourage 'other-relatedness', is it likely that recommending that they be replaced will have the desired result? Will they not just be replaced by others with the same function?

Using the Body and the Consumer Society

Students' use of the body in medical education is different from that of doctors', whose actions are underpinned by the purpose of healing, treatment or management of the patient's condition.[4] Doctors' actions do not inherently imply use of the patient's body for their own needs. I now want to explore this use of the body by students in the broader context of the consumer society and, in particular, of higher education and health care.

The notion of a shift to a 'consumer society' in western cultures has been seen to have its roots in the 1960s and 1970s but the underpinning principles behind a consumerist approach effectively depends on where one sits politically; for example, a left wing or liberal approach might be to question authority, ensure civil rights and enable everyone to have access to, and participate in, institutions such as higher education and medicine; whilst a right wing motivation would be to encourage a free market to flourish through the commodification of goods and services (Lupton, 1997; Meerabeau, 1998). In a consumer society, patients and students are consumers of health care and education respectively; however, the way in which this consumerist approach is enabled depends on the driving force of the government or institution. Involving patients more actively

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[3] The safety of patients is particularly an issue at postgraduate level when doctors undertake procedures on patients that they have never practised before. See, for example Jed Mercurio's article: *We all kill a few patients as we learn* (2004).

[4] Although as Ziv et al (ibid.) confirm this use can be extended to clinical training at post-graduate level.

in students' education could be seen as a way to empower patients and acknowledge the importance of their everyday body in an institution which historically has medicalised their bodies or, alternatively, could be seen as rhetoric to cover up the dismantling of a welfare state in favour of private medical care.

Encouraging patients to take on the role of teacher could be seen as part of a wider drive towards a consumerist approach to health care which draws on a rhetoric of patient partnership in their own health care and in planning and delivering the health service, and patient choice. During the last fifteen years, there has been a plethora of reports and policies which have driven this agenda in the NHS: for example, *Working for Patients* (DoH, 1989), *The Patient's Charter* (DoH, 1992, 1995), *The NHS Plan* (DoH, 2000), *The Expert Patient* (DoH, 2001) *Patient & Public Involvement in Health (*DoH, 2004). Almond (2001) summarises the mechanisms underpinning this drive as including satisfaction surveys, the articulation of rights, more choice of General Practitioner, and complaints procedures.

Given a political climate in which successive governments tend towards the centre, one needs to adopt a cautious and sceptical approach to the underpinning rationale behind such moves and, therefore, the intended and resulting outcomes. As Pollock (2004) reveals, many of the re-organisations and policy announcements surrounding health care over the last 20 years can be interpreted as the 'creeping privatisation' of the NHS. Annandale (1996) when interviewing nurses and midwives found them concerned and anxious about an emphasis on patients' rights, rather than on relationships between doctors and their patients, which had seen an increase in complaints and litigations. Lupton (1997) cautions against a notion of consumerism which assumes lay people are rational actors in the medical encounter, acting reflexively: critical of expertise and striving for self improvement. Her research showed how such an approach underplays the complexity of the doctor-patient relationship in which the patient may be passive or active and "the changeable nature of the desires, emotions and needs" (p.373) within the encounter (see, also Meerabeau, 1998, who highlights the lack of attention to emotional issues in such approaches).

The introduction of the patients' rights policy, which I explored in chapter 5, is one example of how this has impacted on medical education. A consumerist approach, however, is evident not only in health care but also in higher education: the imminent introduction of a Student Entitlement Framework at Southampton (a students' rights policy by another name) and local and national student (consumer) satisfaction surveys are examples of mechanisms in this context. Moreover, the embedding of student tuition fees in higher education is likely to compound the view that students are consumers, as they see themselves as directly buying their education.

Whilst the rationale behind these moves may be to challenge the hegemony of medicine and the higher education sector, there are inherent dangers in the context of medical education. Adopting a discourse of individual rights may appear emancipatory in intent but may have undesirable consequences. For example, in relation to the use of the patient's body in the medical curriculum, whose rights take precedence when there are competing rights? Students may feel they are entitled to access patients' bodies because they need them to learn medicine (and have paid for this privilege) but patients may assert their right to refuse to consent to students accessing their bodies for educational purposes, leading to student complaints about their rights not being upheld.[5] Rights may be seen in the context of partnership or they can be seen in the context of the individual rights taking precedence over any notion of the social good. As Mason et al (2002: 8) assert: "the language of rights may also become unduly assertive and combative and may hinder, rather than promote, moral consensus". Individual rights need to sit within the context of the needs of the wider society; thus the use of the body is a necessary practice and, in this respect, represents a partnership between the different parties involved. Attempting to develop an ethics of the use of the body, rather than relying on rights policies and procedures, may be a more productive way forward.

As Lupton writes: "Dependency is a central feature of the illness experience and the medical encounter serves to work against the full taking up of a consumer approach" (Lupton, 1997:379). In a similar way, encouraging a culture in which the switching between the medical and everyday body in students' encounters is welcome, the use of the body is acknowledged and its possible consequences discussed, may militate against

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[5] Ironically, the quality monitoring of higher education, another mechanism which can be seen as part of a consumer society, acts as a brake on the statements of rights for students as only statements which can prove to be happening when the monitoring process takes place will be included.

the style of body use being seen as one of consumption. Students are dependent on patients for their education and patients are dependent on the education of doctors for their future health care.

Concluding Points

I have shown how an integral part of students' medical education is their use of the body which can be seen as moving between the status of a medical and everyday body: between a passive and an active educating body. Students must cope with the tension between using and respecting the bodies they encounter. I think there are ways to encourage patients to be, and to be seen as, less passive in their encounters with students; for example:

- Restricting the number of students who attend bedside teaching sessions.
- Acknowledging the dilemmas involved in assessing students' clinical skills and discussing these with students and patients.
- Using expert patients to teach students clinical skills rather than just outlining their experiences of illness.
- Finding innovative ways of teaching anatomy and examination that can be utilised alongside the use of the dead body and the patient's body.
- Normalising difficult encounters as part of medical practice/being professional and changing the way that curriculum documents are written to reflect this.
- Ensuring that students are held responsible for negotiating access to patients' bodies, whether on the wards or in theatre, and that students provide enough information about their role and the purpose of their actions to enable patients to make an informed decision.

Frank's (1991) call for a developing ethics of the use of body which tolerates the complexity and diversity of people's lives (contingency) and challenges the consumption of the body (appropriation) is pertinent to the position in which students find themselves. An open and on-going discussion with students about the tensions they experience, the difficulties they encounter and how their actions may impact on patients is vital. Furthermore, as an essential component of this, students' own contingent bodies also need to be acknowledged.

Reflections on Practice

My work as Lecturer in Medical Education in the School of Medicine at Southampton and as Deputy Director of the new graduate entry programme (BM4) at Southampton is directly related to the subject of this research and the issues raised made me consider my own practice, both during the research process and since completion. My curriculum management role gives me an opportunity to negotiate and implement curricula activities but more importantly to discuss underpinning values and principles in educational roles. The medical hierarchy and the power of normalised practices do, of course, limit what can be achieved, most certainly in the short term.

In the BM4 programme, we have designed the curriculum to reflect an underpinning principle that students should be encouraged to ask questions in relation to both what they are learning about and what they are doing. To facilitate such an approach, however, teaching staff need to be approachable and be willing and patient to engage with students. One very small policy we adopted from the beginning was to encourage students to address the core programme team by their first names. In addition, we only use first and second names on the timetable as opposed to using titles and surnames. Whilst a small gesture, I think it is symbolic in terms of breaking down hierarchies, much needed if students are to feel able to challenge and question what they are doing and ultimately effect change. However, as students progress through the curriculum, they will undoubtedly encounter resistance to this approach and particularly outside the core team's sphere of influence.

We have also recently introduced peer examination into the clinical components of the first year of the programme, initiated by students who felt it would be useful to do some initial practice on each other rather than using patients unnecessarily for this. The clinical teacher demonstrates the examination on one student and then students work in pairs practising on each other. There are other ways to help students gain and practise examination skills without using patients' bodies which we can usefully also consider; for example at the Peninsula Medical School they employ people who are normally life models in an art school to demonstrate on and for students to experience practising examining on a diverse range of body types/ages. These people are also a teaching resource for students giving them feedback on the encounter and, therefore, having an active role in a two-way encounter.[6]

I have also facilitated a session with students exploring some of the issues raised in this work, in particular: the difficulties inherent in their role in terms of using bodies for their own ends; the need to clarify the purpose of the various activities they undertake with patients in order they give more information to patients about what they are doing when they negotiate access to patient's bodies; and exploring the boundaries of their responsibility.

I hope I will continue to find ways of bringing the insights from this work into my own practice and the environment in which I work.

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[6] Southampton has built up a bank of people who can act as patients in skill practice and examinations but currently are primarily used for history taking purposes.

Appendix A

Set of invite letters

Phase 1, year 1: Invite letter

Dear (Student Name)

I am currently carrying out some research for my PhD which is investigating how different students view and respond to different parts of the curriculum. I am hoping that my work will help to inform the development of the course.

This term I would like to interview a small number of first year medics which will hopefully include school leavers, mature and overseas students. You have been randomly selected from your cohort and I am writing to ask you if you would be willing to participate in an interview with me that would involve discussing different parts of the foundation term. I envisage that this would take approximately ¾ hour. I would like to tape record the interview if this would be acceptable. This work may be followed up with further rounds of interviews.

I would be interested to hear your views. What you say in the interview would be confidential and completely separate from your record. Please do not feel under any obligation but if you are willing to take part, either contact me by email: ajf3, pop into my office (room 2097) or complete the slip below so that we can arrange a time and place that would be convenient for you.

Many thanks.

Yours sincerely

Angela Fenwick
Lecturer in Medical Education

✂---

Name..

*I would/ would not be willing to participate in an interview

I can be contacted to arrange an interview time on *email/telephone number...............

Please return to Angela Fenwick, c/o the School of Medicine Office

* delete as appropriate

Phase 1, year 2: invite letter

Dear (student name),

My PhD

You very kindly agreed to be interviewed by me last year for my PhD which is investigating different students' approaches to the physical body. You may remember that I said at the end of the interview that I might want to speak to you again during this current academic year and you indicated that you would be happy for me contact you again. I am now very interested to hear how your views/thoughts have changed or developed over the last year and I would really appreciate it if you could spare me another ¾ hour of your time sometime over the next month. I would again like to tape-record our discussion.

Please do not, however, feel under any obligation in take part again. If you would be willing to participate in another interview you can contact me by email: ajf3 or pop in to my office (room 2097) to arrange a time and place that would suit you.

Many thanks.

Yours sincerely

Angela Fenwick
Lecturer in Medical Education

Phase 1, year 3: invite email

I used email to communicate with the students during the third phase as I felt a slightly less formal approach was appropriate. The following is the text used:

Dear (student name), I hope this finds you well and that you are enjoying your third year. If you are happy to participate, I would like to carry out the third and final interview for my PhD with you sometime in the next few weeks. The focus for this interview is how different students approach patients. If you would be happy to do this again, can you let me know some dates and times that would be convenient for you. I'd be happy to come to you if this would help. If you would prefer not to be involved again, please don't feel under any obligation. Best wishes, Angela

Phase 2: invite letter

Dear Name,

Research for my PhD

I am currently undertaking a PhD which is investigating different students' approaches to the physical body. I am interested in how the medical curriculum supports, for example, the physical examination of patients and how students experience their education which relates to the body. Identifying what the difficulties and tensions are for students is of key interest to my work. I am hoping that my research will help to inform the development of the course.

To-date I have interviewed students in their first, second and third years. In this next phase of my research, I would like to interview a group of fifth year students. I have randomly selected your name and I am writing to ask if you would be willing to participate in an interview with me. I envisage that the interview would take approximately 1 hour and it would not require you to do any preparation. I would like to tape record the interviews if this would be acceptable. The transcripts of the interviews would be confidential, in that individual interviewees would not be identifiable to anyone other than me.

I would be very interested to hear your views. Please do not feel under any obligation, but if you are willing to take part, you could contact me by email: ajf3@soton.ac.uk or complete the slip below so that we could arrange a time and place that would be convenient for you.

Many thanks,
Yours sincerely

Angela Fenwick
Lecturer in Medical Education

✂……………………………………………………………………………………………

PhD research

Name……………………………………………………………………………………
…

* I would/would not be willing to participate in the research

I can be contacted on email or telephone number ……………………………………

Please return to Angela Fenwick c/o the School Office, SGH or BWD
* delete as appropriate

Phase 3: invite letter

Dear Name,

Research for my PhD

I am currently undertaking a PhD which is investigating different students' approaches to the physical body. I am interested in how the medical curriculum supports, for example, the physical examination of patients and how students experience their education which relates to such activities. Identifying what the difficulties and tensions are for students is of key interest to my work. I am hoping that my research will help to inform the development of the course.

To-date I have interviewed students across the different years of the curriculum. In this next phase of my research, I would like to interview a group of third year students. I have randomly selected your name and I am writing to ask if you would be willing to participate in an interview with me. I envisage that the interview would take up to 1 hour and it would not require you to do any preparation. I would like to tape record the interviews if this would be acceptable. The transcripts of the interviews would be confidential, in that individual interviewees would not be identifiable to anyone other than me.

I would be very interested to hear your views. Please do not feel under any obligation, but if you are willing to take part, you could contact me by email: ajf3@soton.ac.uk or complete the attached slip so that we could arrange a time and place that would be convenient for you.

Many thanks,

Yours sincerely

Angela Fenwick
Lecturer in Medical Education

✂……………………………………………………………………………………

Research for PhD

Name……………………………………………………………………………

* I would/would not be willing to participate in the research

I can be contacted on email or telephone number…………………………………

Please return to Angela Fenwick c/o the School Office, SGH or BWD

* delete as appropriate

Appendix B

Characteristics of students participating in research

Table showing characteristics of students participating in interview phases 1-3

	St. ID	Female	Male	School leaver	Grad/ mature	Non-science A levels
Phase 1	1		x		x	x
	2		x		x	
	3	x		x		x
	4	x			x	
	5	x			x	x
	6		x	x		
	7	x		x		x
	8	x			x	
Phase 2	1		x	x		x
	2	x		x		x
	3	x		x		
	4	x		x		
	5		x	x		
	6		x	x		
	7	x		x		
	8	x		x		
	9		x	x		
	10		x	x		
Phase 3	1	x		x		
	2	x		x		
	3	x		x		x
	4	x		x		
	5		x	x		x
	6		x	x		
	7		x	x		
	8	x		x		x
	9	x		x		
	10	x		x		x

Appendix C

Set of interview frameworks

Phase 1, year 1: interview framework

Intro – what I'm doing and why
Permission for taping. What will happen to the tape, confidentiality issues.

1. What were your expectations about EPC before you started the course?

2. Did you have any anxieties about approaching the people you met during the 2 EPC visits? What preparation did you have for this? Did you need more/different? Do you feel any differently now?

3. What were you supposed to learn for the POM course? What did you learn? Why? For your essay how did you go about linking the experiences of the people you met with issues covered in the literature? Did you find this difficult? What difficulties did you encounter?

4. What relevance does the POM course have for the practice of medicine? (experience of meeting 'patients' early on in course and linking people's experiences of their illness to the literature)

5. What were your expectations about working in a dissecting room before you started the course? Had you expected whole body dissection?

6. Did you have any anxieties about approaching a dissected body? What preparation did you have for the working in the DR? Did you need more/different? Do you feel any differently now?

7. How did you use your time in the DR? What were you supposed to learn and why? How did you link what appears in the anatomy textbooks, the anatomy handbook and the computer images with the pro-sections. What difficulties did you encounter?

8. What relevance does the work you are doing in the DR have to the practice of medicine?

9. Can you see any link between what you do in the DR and the POM course? (eg social, psychological and physical factors all contributing to persons experience of their illness)

January 1999

Phase 1, year 2: interview framework

Introduction

PURPOSE etc in ANATOMY

1. We talked about Anatomy and you outlined what you thought the purpose of your DR sessions were (say for individual student)

   What do you see as the purpose of your DR sessions one year later? Do you still think the same? Are you trying to get different things out of them? Have the sessions changed for you in any way? Pick up on particular issues from last year.

POSTMORTEMS

1. Have you been to watch many post mortem demonstrations? What do you think the purpose of these are? Can you remember your first time? What was it like? How does it make you feel? Do you have any particular response to these?

2. What are you trying to get out of them?

C&F EXAMINATION

3. Have you touched a patient yet? How did this feel? What concerns do you have? What did you do in surface anatomy? Did this prepare you for touching a patient? Would anything?

4. What do you see as the main differences in the way you feel etc and what you are trying to do between approaching the parts of body in the DR and the live body?

5. What relationship do you see between history taking and examination? (history taking includes social history etc, examination is physical). What is your major priority when taking a history and examining a patient?

6. How do you incorporate the social and psychological factors into the process of making a diagnosis? (Need to try and ascertain what they see as the role of sociological and psychological knowledge in the practice of medicine?). In terms of your training so far what would you say has been the most important knowledge you have gained which helps you to make a diagnosis?

7. This is a huge question which I would want to explore further perhaps at another time if you were willing but just to open up the topic....How have you learnt to identify what is 'normal' and what is 'abnormal' when you approach a patient.

March 2000

Phase 1, year 3: interview framework

Introduction

Thanks for agreeing to be interviewed again. 3rd and final time.
Tape recording – confidentiality and what this means.

I am looking at how different students approach the body in its different forms. We have talked about EPC, DR PM and today I would like to talk about physical encounters with patients.

1. **Experiences**

   What attachments and in what order?

   Choose a recent encounter with a person you have taken a history and examined – not Mental Health. Can you describe the encounter to me outlining what you wanted to do and what you did and why?

   Pick up questions - for example:

   Not much about the patients?
   What were you thinking at the time?
   Did anything feel strange?
   How did it feel?
   What was your role?
   What did you want to know? What were the most valuable bits of information?
   What knowledge were you drawing on?

2. **Choose another one? Why did you choose this?**

3. **Have you found any encounters more difficult than others?**

   Why?
   Has anything changed over time?
   How have you dealt with this?
   Anaesthetised body – physical encounters? Tell me about what you were doing?

4. **Clinical skills area**

   Have you used it? What have you used and for what? How has this been?
   How do they help you deal with a patient?

5. **Representations**

   In books – do you ever think about male/female/different ethnic groups and their representations?
   Does it matter?

6. Alder Hey

To finish, ask about issues raised

PM without permission?
Bits of body being kept for research without informed consent?
Paternalistic viewpoint of doctors?

Thank you

Really grateful for sticking with me.
Feedback issues, identification etc. Coming back for clarification etc.
Card and voucher

March 2001

Phases 2 & 3: interview framework

Introduction

PhD is an exploration of how students work with the physical body within the medical curriculum and I'm especially interested in some of the tensions that exist that are often hidden or not talked about. I have interviewed 1, 2, 3 and 5th yrs.

This interview may last up to an hour and I would like to talk to you about your experiences of encounters with patients' bodies during your current year in particular. If we have time I would like to touch on early years but only if we have time. It will then be transcribed and then analysed by me into themes. No-one else will know that this is you and if I think there is any likelihood of identification I would not use a quote or I would contact you. Would you be happy with this? If you are worried about it just let me know.

If you feel uncomfortable about any of the questions, just let me know.

1. Current context

- What attachments have you done to-date?
- Is there any general pattern to your days?
- Clerking?

2. Description of a recent encounter

Choose a recent encounter with a patient that you have taken a history and examined (not mental health). Describe the situation in general terms and then what you did and why.

Pick up questions

- Why did you choose this encounter?
- What were you trying to do? Purpose of encounter? What was your role? Education/patient needs
- How did you engage with the patient during the examination?
- Did anything feel strange to you?
- Why?
- What did you want to know and why?
- What were the most valuable bits of information and why?
- What were you thinking/feeling at the time? Can you remember?
- What did you do after? Why?
- Consent issues

Does your relationship with the patient change from the history to the examination?

Do you feel differently when taking the history as opposed to the examination?

Do you remove yourself in any way? Why?

Has the way that you examine patients changed at all over time?

Is it any different with adults/children?

What is the role of the patient's account of their illness in an examination?

Where is the patient's voice in this encounter? (And in the case presentation) Has this changed over time?

4. Difficult physical encounters

Do you find or have you found any (other) physical encounters difficult and why?

Has this changed over time?

How have you dealt with this?

Do you ever have any worries ever about what you are doing, could be aspects that make you feel uncomfortable or particular ethical concerns? Or perhaps seemed inappropriate?

What would you do in such circumstances?

Who can you talk to about these sorts of things?

5. Encounters with anaesthetised patients

What encounters have you recently had with anaesthetised patients? Why?

What is your role generally? How does this feel?

6. Assessments and other educational demands

Is it different if there is an assessment involved? For eg a long case?

Was your relationship with the patient different?

What about when you do case presentations?

Do you ever think you have been asked to do anything that involved a physical encounter that seemed inappropriate for the patient as part of your training?

What can you do in such circumstances?

7. Teaching

What form does this take? Issues re ward rounds? What happens re physical encounters?

Is this any different from when you are being more self-directed?

8. When you were/are a patient

When was the last time you were a patient being examined?

What did it feel like for you?

Do you think about any of this when you are examining patients?

If time

9. Anatomy and pathology

What did you think of working in the DR?

What was the purpose of what you were doing?

Do you remember having any difficulties?

Postmortem demonstrations or PMs. Do you have any particular response to these?

Thank you very much. Tape. OK for you etc….
Summary of key points from my work?

Appendix D

Criteria for NHS Research Ethics Committee

Criteria for NHS Research Ethics Committee

The following is an extract from the Remit of an NHS Research Ethics Committee 1998/9:

3.1 Ethical advice from the appropriate NHS REC is required for any research proposal involving:

   a. patients and users of the NHS. This includes all potential research participants recruited by virtue of the patient or user's past or present treatment by, or use of, the NHS. It includes NHS patients treated under contracts with private sector institutions

   b. individuals identified as potential research participants because of their status as relatives or carers of parents and users of the NHS, as defined above

   c. access to data, organs or other bodily material of past and present NHS patients

   d. fetal material and IVF involving NHS patients

   e. the recently dead in NHS premises

   f. the use of, or potential access to, NHS premises or facilities

   g. NHS staff – recruited as research participants by virtue of their professional role

3.2 If requested to do so, an NHS REC may also provide an opinion on the ethics of similar research studies not involving the categories listed above in section 3.1, carried out for example by private sector companies, the Medical Research Council (or other public sector organisations), charities or universities

Appendix E

Transcription Excerpt

Excerpt from Phase 2/Interview 1

The following is an extract from a transcript which illustrates the development of my thinking in relating to the analysis. I have listed relevant parts of my text from the orgininal

- *Writing on the left- hand side relates to initial thoughts any provisional coding*
- *Writing on the right- hand side relates to developing core codes*
- *Words/phrases in capitals relate to possible wider concepts and bridging concepts*

A: So when you're say, like clerking, why would you decide to go and clerk someone in the 5th year?

Purpose = focus on exams

Medical Talk

S: Ooh, it's all about, well, [for me it's all about being focused, I think for a lot of people, for the exams because at the end of each attachment we have our um assessments or exams which are taking a history and examining a patient and then presenting it to 2 consultants and so during the attachment you want to get as much practice as possible taking histories and doing an examination and then presenting it to someone.] Particularly on medicine I found that, that, that just helped me so much, [like going to clerk patients especially patients that had only just come in by A & E because they are fresh, they haven't been seen by any other doctors and you get a really good history and if they 've got signs on their examination, you get really good signs of them as well.]

Use of body for own needs

MEDICAL BODY

TENSION: Sts' use/ PATIENTS' NEEDS

A: And really good signs means?

S: Oh sorry, signs being um…

A: ….No, but what are really good signs?

Medical Talk

S: Really good signs? Well, er, let me think, [respiratory wise may be it could be something like they have got noises in their chests, like crackles or crepitations and they might have a mass in their abdomen and, what else? Just anything that is physical on them that you can demonstrate in your examination.]

INSPECTION

Used body from own needs

? Everyday body backup

A: So is it something abnormal?

S: Yes, usually abnormal.

A: OK, OK. So sort of a way into this to see, for me to understand, you know, what's going on is if you could describe….pick somebody, I don't know, it could be a child if you wanted, and that would be interesting or it could be an adult and I don't mind which attachment it's from, but pick somebody that stands out for you that you clerked and if you could describe to me what you did..

S: The process?

A: Yeah, and why, that would be really helpful and, but before you start, tell me why you've chosen the person that you choose. Have a think for a second.

S: Um. (long silence). I think I'll have to go for one of the paediatric ones. There was one medicine one I was thinking of but that's a bit, I've forgotten a few things, but I have seen one quite interesting kid who has got some good ?? but it's fairly a simple one that goes through everything quite nicely.

A: OK. So

S: Generally, we either see 2 patients, um we either see patients in three circumstances: either in outpatients clinic, or on the ward or they come in via an assessment unit or they've come in via A & E. And so this patient was on the ward which means that for this particular patient they'd come in the night before via A & E as an emergency and it means that, that the parent and child had already been seen by a doctor and everything so I was probably number 2 or number 3 to see them, but the first medical student. Um so I'll just go through the whole process. [I, we ask the nurses, the nursing staff first, it's always important to ask the nursing staff first, that we can talk to the patient, um that they are fit and well enough to have someone chatting to them and then once they have okayed it, I've, we usually go up to the patient. I went up to the mother obviously and said is it OK if I come and chat to you and examine little Joe Bloggs.] And then they're usually fine with it and then you just kind of like try to get them at ease and just ask them open questions like, um, how is little Joe today? or how are things going? and just get a general assessment of how things are. And then you obviously have to get more focused in the history towards what's wrong with the child, why they are in hospital and what's brought them in and um if there's anything relevant in the medical history, anything that they are taking drug wise, anything in their family history and then try and get a social overview of the patient and then kind of in all that you're slowly going through filters in your mind of all the things it could possibly be. Like the child I had it was acute presentation of um, had a fever and had a fit so like automatically in my mind or most doctors minds, I presume, they'd be thinking down the side of that this is a convulsion and so it could be whole list of things that flip up in your mind. But at the same time, you, you automatically exclude a whole other list of things that it isn't going to be anymore. And so as you go down the list of questions that you ask you're kind of like ticking of, so to say, mentally in your mind, important things to try and find out.

not
medicine

SEEKING CONSENT
- nurses' role
- mother
IS IT OK?

not expecting
-ve
answer

History
Taking

List

And the, once you've got to the end of your history, your examination is focused on trying to elicit any signs that you think the child might have that help you to um form a definite diagnosis. So all the time you are working of the differential diagnosis and you're trying to home it down to one or two or three things and...And with this child that, I mean, from the history it became clear that, that he had a previous infection, a cough, or a cold, um, hadn't really recovered fully from that, had got quite high temperatures with that and then had this one off convulsion or seizure which is quite common for children to get that fibrile convulsions but you just worry that it could be the first presentation of something like epilepsy. [And obviously parents are going to worry about things like brain tumours and stuff, and

Purpose of
exam

cancer and I mean, it's a very common condition but it's not common for non-medical people so you obviously have to balance the two things so, so with the, when you come to the examination you're really focusing mainly on neurological things so, the nerve, the nervous system and kind of trying to find out if there are any, if there is any damage there or anything which is quite difficult in a child because they are not always very co-operative.

Sensitivity to pt needs

EVERYDAY BODY
Awareness of others feelings/needs

ACTIVE PATIENT - EVERYDAY BODY

A: No?

S: Especially not when you are a medical student. (laughs)

A: Do they know the difference?

What do they think of med Sts

S: I, I don't know, since we don't have to wear white coats there it is less easy to tell the difference but I think just coz they can, I think children are just as quick as adults to pick up that you look younger, you act less confident in what you're doing, um, and you're also less assertive about things so I'm not about to force a child to do something because I feel in myself, I feel I'm only a medical student, you know, this isn't important to a child's welfare, it's not important to their health, it's not important to anything that is going to happen to them in the, in this day so if they don't want to go through with something, I'm not going to do it.

St role is diff

Used body for an educational needs
NOT BEING USEFUL

A: Because this is really for you?

S: Yeah, just for me. It's for my learning purpose.

EDUCATIONAL USE OF BODY

A: And so, just to sort of get this, this is different in that you take the history off the parent....

S: ...Of the parent, yes

A: And then you would examine the child...

S: ...The child, yeah

A: So how does that work? How do you move from focusing on the parent to focusing on the child and examining the child? What do you do? How do you negotiate that movement from one to the other?

S: It's quite easy if they are babies, so if, probably under 18 months before they have started, like got up and walking around, because um generally while you are talking to the parents you can be playing with the baby a bit and kind of, you know, obviously the mother is going to be sat next to the cot coz she is concerned about the child and so you'll be sat on the other side and you can just quite easily, just like with this child, I was just sat on one side, and I could just quite easily pick up some of the toys and just rattle in front of the child and just, at the same time as asking questions and listening, you're just getting a general overview of what the baby is like but also try and form a little bit of a, a relationship with the child so that you know, you, it's not like you're in a closed room then you'd kind of arrive and start pulling them apart and stuff so..(laughs)

Building rel

Awareness of others' feelings

Building rel

? Presence of parents
ADVOCATE FOR PT

What does this mean?

A: ..mumm. mumm

S: ....But as they get older if they're speaking age and understanding things, maybe 4 or 5 or older than that obviously, you involve them a lot more in the history. One child last week that I spoke to she was 12 and I took most of the history from her even, mum and dad were sat either side but I spoke mainly to her because it was her that I'd be examining not the parents and at 12 she understands. If she sat there and I'm talking to mum she understands perfectly well what I'm saying to mum and she can answer the questions because most of them are things like, you know, how old, what was the problem and a child can answer that so you try and balance it between the 2 and try and focus on both of them.

A: Mumm. And if it was an adult you'd go from the history to the examination. What do you do to bridge the gap between taking the history and then doing and examination that involves touching a patient? Do you have some sort of.....

S: (sighs)

A: You can't sort of stop talking and then...

S: You can't, no (laughs) and then jump on them (laughs)

A: What do you do?

moving between exam + hx needing to ask again

S: You try to be as polite as possible about it. [I mean, usually at the beginning you make clear to a patient, well with the adult patients, you make clear to them that you've come and you'd like to take a history from them, and you'd like to do an examination.] And usually, they probably don't even hear the examination bit so then once you've finished the history again you say , I generally say thank you for your time and would it be possible if I could now examine you and see if I can find any of the signs that were there when you first came in.

ST IN CONTROL
MEDICAL TERMS
FOR CONSENT ?

A: Mumm

S: Or sometimes it's a good idea, [coz histories can sometimes take quite a long time especially with some patients that have got a chronic illness, um like cancer or something that you know that's been long term and so you can spend upwards of 30 minutes talking to them and so then it's important to give them a break coz you know they don't, well I, well I think if I was a patient I wouldn't want someone jumping on me straight away after they've been talking me for about 30 minutes. So I generally say, you know, um, thanks for your time for the history, would it be possible to come back later to examine you?]

Awareness of others' feelings

Strategy for pts who are tired

A: And then how does that work coz then you're coming back sort of cold? So what would you do then? So if you went of and came back....

S ...And then came back later..I'd just, just generally just come back again and just say, you know, if, ask them if it's an appropriate time to examine them. You know, Is it OK if I come and examine you now? And then. It's usually, it can be quite tricky sometimes because if you've got a child you have to have the parent present, if you've got a female patient you generally

Chaperones? Clarity

have to have someone, especially as a male medical student, you have to have someone else present like either another medical student or you have to go and find a nurse. Or what, generally, like, I think most of us try to do in our fifth year is we try and get another doctor to come and watch us so then they can watch us do the examination and they can say well yes, you are doing this right, you are doing this right, you are doing this wrong and try and help you a bit with the examination.

A: And does it feel different for you, in terms of the way that you are actually feeling in yourself, does it feel different when you are taking the history to when you are examining? Or does it feel much the same but you're doing something different?

touch
taboos

S: Um, it used to feel different. It used to, back in the third year I'd be quite nervous about it going from the history into the examination coz, like, you know, you have all the taboos about the examinations and stuff and um it's quite new to you when you are in the third year because you've only really just started doing them, especially only just started doing them on your own without supervision. And, but since the fifth year, the start of this year, I've, I've found that it feels like it's almost a job to me it's like, you know, you take the history and then you do the examination. And there are occasions when, with certain patients, I'll think I'm not so happy about doing the examination on this patient coz you can sense in the history that they might be a bit nervous or anxious and you just think well there is no point really because you're gonna have to obviously undress them to a certain extent and you can sense that they are not gonna be happy with that so you, sometimes, I just leave it. But most kind of patients are generally quite good about it and I just think, oh I dunno, I suppose in the history I'm concentrating on thinking about it, finding out about the patient and finding out what's wrong with them and then in the examination I'm more probably focusing on their body and trying to work out, well you know, are there any signs, so is there anything that I can pick up from their body that there is something wrong with them.

USING INTUITION — awareness of others' needs

Graduate — MEDICAL BODY (transformed by inspection)

(...) section not included

A: Mumm. OK. OK. And, I mean do you, I mean it may be different from what happened in the third year, but say currently in the fifth year, um do you find any encounters difficult? More difficult that the norm, if you like?

ass^n
obstruct^n

S: I generally find it more difficult if, um, there's someone else there with me who's observing me. If it's just like a nurse or something, I'm not that bothered or if it's a relative, the husband's there or the wife's there or mum or dad or whatever, then it doesn't bother me. But I generally find situations where there is someone watching me from the point of view that they're assessing what I'm doing, I find that nerve wracking. And I also find it sometimes nervous if, if the patient obviously has something, such as cancer, and um, I mean usually if they've got cancer they know they've got cancer and so they're fairly OK with their, um, diagnosis and um, otherwise someone wouldn't let me see them. But sometimes if you're in A & E and you're one of the first people to see them and you've gone through it all and ou're doing the examination you think, well, you know, this person could have cancer and sometimes for me that's a bit nerve

Difficult encounter

Difficult encounter

Awareness of what it might be like for pt to see a Sr in A+E

Ethics of use of BODY (Lamends)

Use - not OK in certain circs

wracking coz I'm thinking, you know, um, (laughs) should I be doing this? I think, you know, I think doctors should be here, and in one case I did stop an examination of a patient who had like, I think it was ended up that she did have a um tumour in her head so she did have a brain tumour and she had some classic signs and I just thought it's not appropriate for me to be doing this and I just, I don't know how I got out of it really, I, not that I wanted to get out of it, but I just felt that someone more senior should be seeing her. So I just, I think I just excused myself and I went and got someone else to come and see her in that situation.

St in control.

A: So was it inappropriate because you couldn't carry on or inappropriate because of what you were doing, or..what was inappropriate?

Ohas-Lee Atkinson

Sensitivity

S: I dunno, I suppose other people would have just carried out and finished it but I just felt inappropriate because I just thought, I'm a medical student, I'm the first person to see this patient , um, they have obviously got a serious diagnosis here, I mean it might not have been cancer, it could've been any number of things but it, it was certainly something serious and, I, I'd obviously done the history and that what I'd been asked to do and then if I, they'd also said, you know, if you got a chance to then do the examination as well and through the history I'd kind of gathered, you know, there was obviously something wrong and I thought, you know, it'd be OK to do the examination and I started on the examination and when I realised that they were obviously, some, there were some obvious things coming out of the examination that I felt well hang on a minute, you know, this is.

EVERDAY CONNECTION
Some form of resistance

Maintaining control + stopping

A: Mumm, Is that because of your role as well, you're a student not a doctor?

different role of dr

S: Yeah, definitely I think obviously if I was a doctor then I would have carried on and I would have finished it and I would have gone off and, you know, presented it to someone more senior but I felt just as a student then, I mean I think the main thing on my mind was this patient if, you know, they have got something seriously wrong they gonna end up seeing a whole line of doctors now and the last thing they want is to end up having me finish this examination and then, no matter what happens, someone else is gonna have to do it again because as a student you're not, what you pick up is not always taken as, as said, you know it's, it's not, they don't always trust what you found so to say.

educational use

awareness of pts' feelings

drs ≠ sts

A: Mumm, Mumm, that's reasonable?

S: Yeah, fair enough, yeah.

(...) rest of interview

Appendix F

Documentary Analysis Excerpt

Excerpt from Documentary Analysis for Chapter 5

Policy on the Rights of Patients in Medical Education

Care must be taken to obtain the consent of patients for participation in educational activities. Patients have a moral and legal right to exercise control over the circumstances in which they are physically touched and in which personal and clinical information about them is communicated to others. Therefore:

active patient - control/but central role?

- Education should not be demeaning for the patient or student. The patient should be involved as a partner in the educational activity.

NB

active - everyday - meaning?

- Clinical teachers must ensure that patients understand that medical students are not qualified doctors and that cooperation in educational activities is entirely voluntary. Students must always be described as "medical students" or "student doctors" and not, for example, as "young doctors", "my colleagues" or "assistants".

link to chapter re vagueness. Instructions say "medical student" only

- Clinical teachers and students must obtain explicit verbal consent from patients before students take their case histories or physically examine them. Patients should be reminded of the purpose of any activity in which they participate with the students. They should understand that their participation is entirely voluntary and resistance should be respected with reassurance that unwillingness to participate will not compromise their care.

? st responsible to get consent. WHEN? st/teacher??

Only if refuse. No acknowledgement of pt vulnerability

- Clinical teachers and students should never perform physical examinations or present cases that are potentially embarrassing for primarily educational purposes without the patients' verbal consent, both for the physical examination itself and for the number of students present. The student should ask the patient if they would like a chaperone present for any physical examination and a chaperone should be present for any intimate examination.

What should students do?

- Students should never perform any physical examination on patients under general anaesthetic for primarily educational purposes without the patients' prior written consent, which should be placed in the notes. Patients who are otherwise unconscious or incompetent for other reasons must only be involved in physical examination or practical procedures with the explicit agreement of their responsible clinician and after appropriate consent (with children) of someone with parental responsibility or (with adults) after consideration with relatives/carers.

Does happen. Link to Coldicott research

? presence in theatre

- Clinical teachers should obtain the explicit verbal consent of patients for students to participate in their treatment (suturing, taking blood, delivering babies etc.). Where the procedure is normally written in the notes, the fact that such consent has been obtained should be recorded. Procedures that do not require supervision should only be undertaken if there is recorded evidence of competence.

- In accordance with the principles of the General Medical Council, students must respect the confidentiality of all information communicated by patients in the course of their treatment or

Rights for whom?

participation in educational activity. Without prior authorisation, no written information about patients by which they might be identified should be removed from the place of treatment. Patients should understand that students may be obliged to inform a responsible clinician about information which is so related.

- Clinical teachers are responsible for ensuring that the preceding guidelines are followed. If students are asked by anyone to do the contrary, they must politely refuse, making specific reference to these guidelines. Encouragement of students to ignore these guidelines is unacceptable and if students feel unduly pressurised they should report the incident to the Clinical Sub-Dean or the appropriate Associate Clinical Sub-Dean.

No acknowledgement of hierarchy

Adapted from "Closing the gap between professional teaching and practice" Len Doyal BMJ 2001; 322: 685-686 (24th March 2001)

About st/teachers—, Why call it patients' rights??

(School of Medicine, 2004 Revised version)

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