

Talking around embodiment: the views of GPs following participation in medical anthropology courses

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Objectives: To explore the ways in which general practitioners talk around the concept of “embodiment” after participating in introductory courses in medical anthropology, and to contribute to the debate about what persons and bodies mean for biomedicine.

Design: This study used a qualitative interview methodology.

Participants: Participants were general practitioners who had all completed at least one introductory course in medical anthropology.

Results: In talking around embodiment, respondents articulated several interconnected dimensions of meaning. These included a Cartesian derived perspective of personhood involving complex relationships between intertwined components of soul, body, and mind; phenomenological perspectives on experience; the social meanings of the body; the ways in which individual bodies are acted upon by regulatory social and political bodies, and an implicit articulation of embodiment as relational, fluid, and processual. A theme of integrity or wholeness was discernible as a common thread linking all these understandings.

Conclusions: Critical interpretive medical anthropology crosses social science and humanities boundaries with its explicit orientation around the paradigm of embodiment as a means of understanding lived experience, social and personal meanings of the body, and the political economy of the body. Perhaps its major contribution to postgraduate medical education is its power to encourage or facilitate reflection that is grounded in practice. This study shows that it is possible for medical practitioners to problematise the Cartesianism of biomedicine and its effects on both patients and doctors, and to conceptualise the integrative framework encapsulated in the notion of embodiment as lived medicine.

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Modern Western biomedicine encompasses multiple forms of practice in diverse settings around the world. While it is misleading to portray biomedicine in homogeneous monolithic terms and despite challenges from within medicine,^{1–3} the formal discourses of Western biomedicine are still perceived as predominantly informed by a philosophical stance of non-reflective positivist empiricism that privileges neutrality and objectivity as epistemological positions.^{4–7} This has led to the charge that biomedicine is primarily concerned with the objectified bodies of patients rather than the embodied patient as an experiencing person, as is manifest in the compartmentalisation of the person into specialty specific components—for example, psychiatry and gynaecology—and a clinical focus that is reductionist in seeking the organic specifics of disease.^{8–10} In particular, the parent discipline of biomedicine is critiqued for lacking a holistic focus on embodiment that truly accounts for non-material components of the body such as spirit, and for failing to express adequate interest in the phenomenological perspectives of patients.^{2 7 11 12} (Stewart *et al.*,³ p 94)

There are numerous accounts of the difficulties that can arise for both practitioners and patients in clinical encounters and health care because of differences in each party’s cultural and social contexts and expectations.^{1 11} Where, for example, the practitioner’s goals may be a satisfactory clinical outcome such as cure or management, the patient may seek healing which involves the restoration of a sense of connectedness, coherence, control, wholeness, or integrity.¹ (Stewart *et al.*,³ p 94) These issues are highlighted in cases where physicians become ill, an experience that can be a profound assault on their professional sense of invulnerability and power.^{13–16} Implicit within biomedicine is an exclusive distinction between doctor and patient,^{17 18} but the physician patient is neither wholly one nor the other.

This paper reports on research exploring the ways in which students who had completed introductory courses in medical anthropology within a postgraduate general practice programme gave evidence of having engaged with the foundational medical anthropological concept of embodiment. This began as an evaluation of the effectiveness of my teaching on the topic, however, I soon realised that I was gaining valuable insights into the ways that this group of general practitioners (GPs) viewed their own medical practice and its broader social and professional contexts. The intention of this paper is to contribute to the debate about what persons and bodies mean for biomedicine. While the field of general practice shares the philosophical foundations of the wider institution of biomedicine, it differs from its parent discipline in that the embodied patient is privileged within general practice discourses of patient centred medicine.² (Stewart *et al.*,³ p 94) This perspective is implicit in the stories this group of GPs tell about their experiences with patients and their professional practice. These research findings further illustrate the potential of embodiment as a paradigmatic framework for biomedicine and suggest that reflexive practice demonstrates incipient or tacit understandings that are consistent with the intentions underlying the use of embodiment in medical anthropology.

EMBODIMENT

Within medical anthropological and sociological theorising, embodiment has offered an alternative to dualistic theorising, “in which mind and belief are literally embodied and, conversely, the bodies of persons literally mindful”.¹⁹ Embodiment is defined as being specifically concerned with the lived experience of one’s own body. This lived experience refers specifically to the way that individuals negotiate their everyday lives via the utility of their bodies, and how they

mediate, interpret, and interact with their physical and social environments.^{4 20 21}

Implicit within the concept of embodiment is a sense of dynamism or constantly shifting meanings and understandings. Embodiment is experienced within particular historical, cultural, political, and societal frames, and these experiences are also shaped by gender and race.^{22–26}

A broad albeit blurred distinction can be made between theorising around embodiment that focuses primarily on bodily and embodied representation using a post-structuralist framework, and theorising that emphasises embodied experience using a phenomenological framework. The post-structuralist framework draws on the work of Foucault^{9 27 28} and examines the body in relation to the deployment of power and knowledge in social institutions.²¹ The other primary dimension of embodiment theorising in medical anthropology has a greater commitment to exploring experiential aspects of embodiment. These theorists are critical of Foucault's lack of interest in the lived embodied experiences of individuals.^{4 21 26 29 30} Medical anthropologists who take this perspective tend to draw on the phenomenology of Merleau-Ponty³¹ which examines processes of objectification through embodied perception, and Bourdieu's²⁴ notion of habitus which refers to cultural influences and patterning on the way individuals use their bodies.

METHODOLOGY

GENA 825 (*medical anthropology*) and GENA 826 (*special topic: the anthropology of medicine*) are courses recently introduced into the Diploma in General Practice postgraduate distance programme (DipGP) run from the Department of General Practice at the Dunedin School of Medicine, University of Otago. GENA 825 is an introductory course in medical anthropology, while GENA 826 is a more focused course in medical anthropology which examines the culture of biomedicine and medical anthropological discourses around biomedicine. Both of these courses deal explicitly with embodiment through course readings, seminars, and audio-conference discussion. An explicit aim of both courses is that students reflect critically upon their own practice and become aware of the ways in which biomedicine is socially constructed and also of how it socially constructs its patients and practitioners through its discourses, practices, and representations. Problematising embodiment constitutes a critical reflection upon clinical practice in general practice. Specifically, students have discussed a medical anthropological "classic" on embodiment that outlines three distinct but interconnected levels of analysis of embodiment which have proved to be a useful heuristic device for medical anthropologists analysing the articulation of embodiment, illness, culture, and society.³² The first is the individual phenomenological body understood in terms of lived experience of the body/self. The second level is that of the social body in which the body is used metaphorically and symbolically to conceptualise and represent nature, society, and culture. The third level of analysis is the political body, which refers to the ways in which the body is regulated and controlled within society. The stability of the body politic rests on its ability to regulate populations and to discipline individual bodies.³²

Ten students met the inclusion criteria, having completed either GENA 825 or both GENA 825 and GENA 826. Of these, six students were recruited to the study. All participants were experienced general practitioners currently in either part time or full time practice. Although it is difficult to assess how many respondents are necessary when conducting research using qualitative interviews, this constitutes a small sample. Ideally, sampling for interview studies would continue until

saturation point—that is until no new data emerges from interviews.^{33 34} While I am not confident that I have sampled to saturation point, although this is easier with a homogeneous population,³⁵ respondents did articulate some very similar perspectives.

Participants were asked to take part in a recorded in depth interview. Two of these interviews were conducted face to face, while the remaining four were conducted over the telephone because these participants were geographically remote from my own location. These two methods of interviewing are considered to have their own strengths and weaknesses. Telephone interviews can be useful when researching sensitive topics because respondents can feel more comfortable in talking about sensitive issues, however respondents and interviewers can become quickly fatigued during telephone interviews and telephone interviews are considered to be less effective for eliciting in depth responses. Face to face interviews, on the other hand, are considered to be better for conducting longer and in depth interviews.^{36 37} DipGP students are used to audioconferencing as the primary vehicle for live discussions in their coursework, and I have also found in previous research with GPs that there is no discernible difference between telephone and face to face interviews.^{15 38} The interviews all lasted between 60 and 90 minutes.

I used a basic interview guide consisting of open ended questions oriented around the meanings of embodiment in biomedical, general practice, and medical anthropological terms. These questions were intended to prompt respondents to think about embodiment in increasing depth, beginning with the familiar so that this provided a platform for considering the more recent and perhaps difficult concepts learned in GENA 825 and 826. I forwarded respondents a handout with the above questions in preparation for the interview. The advantage of this can be increased reflection upon the research topic or questions, particularly in cases where respondents are being asked about difficult concepts. I am unsure as to the impact that this had on the quality of the interviews in this study, although it became apparent that some respondents had prepared for the interview by reviewing course materials and thinking about examples to use in the interviews.

The analysis was conducted within an immersion crystallisation framework.³⁹ In this type of analysis, entirely consistent with constructionist and interpretivist theoretical frameworks, there is a relatively unstructured approach to the data. This can be characterised as a series of cycles where the researcher immerses herself in the text, "emerging after concerned reflection with intuitive crystallisations, until reportable interpretations are reached".³⁹ This is a highly intuitive, engaged, and fluid style of analysis, requiring the researcher to be open to uncertainty, reflection, and experience. This process was facilitated through the use of a qualitative data analysis software package, ATLAS.ti, compatible with immersion crystallisation styles of analysis because it is intuitive, holistic, and non-hierarchical.⁴⁰

Ethical approval for this project was gained from the University of Otago ethics committee.

DISCUSSION

Talking about persons

The concept of embodiment in medical anthropology is intended to provide a holistic framework for conceptualising persons in a manner that does not reduce experience into dualistic Cartesian categories of mind and body, or physical and non-physical components typical of medical, scientific, and much social science discourse. Despite exposure to these medical anthropological understandings, respondents' viewed individuals in a Cartesian derived composite fashion

where the person was differentiated into reasonably well defined categories of “self”, “body”, “mind”, and “spirit”.

I believe in the triad of mind, body and soul and I think embodiment as I look at it is the experiencing of the whole three put together...I am thinking about embodiment, maybe, in a round about fashion...Through what she [the patient] puts down to a near death experience...I don't think she actually looks at mind and body any more, she just looks at self and... she is still experiencing self but she is no longer experiencing self, body and mind as a functioning unit which is what I feel embodiment is, is when all three are being experienced.

As the above example of a patient who was being counselled after a near death experience during an operation suggests, the relationships between these constituent parts were viewed as complex and exquisitely tensioned. For some respondents the self was often viewed as the primary motivating principle, or “owner” of the body. Implicit in this perspective are rights of individualistic autonomy.

Embodiment is just the focus on the fact that it is the self that owns the body. The body is part of that self but the self is the one who should be in charge of the body and owning the body, and that so often in the body society—you know the social body and the politic body—the body is taken away from the self. So to be embodied for me means to be a self in charge of the body.

Although embodiment offers a means of conceptualising the person without recourse to compartmentalising components such as mind, body, soul, and spirit, it was interesting that so many respondents used these components in describing embodiment. This is not surprising, perhaps, given that as doctors they have all trained and worked within a cultural framework of biomedicine which, as some noted, inculcates a strong reductionist and binary Cartesian view of persons. Leder has noted the difficulty of challenging let alone overcoming the Cartesian “fractured language of the self” (Leder,⁷ p 32). The influence of Christianity is also an important influence on Western perceptions of the person.⁴¹

Murray⁴² has argued that the notion of a “Western conception of self or personhood” that is essentialist, autonomous, bounded, stable, enduring, continuous, and impermeable is itself a selective creation from among the diversity of cultural realities of the past. As an academic and popular discourse it is also contested by individuals who draw upon their own experiences, lay or folk, and alternative explanatory frameworks. What is apparent among respondents in this study is that, in describing persons within a broader discussion of embodiment, they demonstrate an integration of complex ontological and paradigmatic perspectives that are informed by their cultural, social, religious, professional, and educational backgrounds, by their personal experiences in practice, and through recognition and resolution of contradictions in their lives.

The lived body

Embedded within discussion around embodiment was a strong articulation of the phenomenological body/self, and the relationship between the embodied person and their social environment. Respondents perceived that individuals experienced themselves in a subjectively unique, if socially constructed, fashion. The following respondent also expressed a keen awareness of the problem of engaging with other persons and of understanding their subjective worlds.

I think the lived in body is a personal thing...You can't get into the person (patient), you can think you are getting in because people tell you what you want to hear but I don't think that you are actually getting in to the other place, we can't mind read there...It is your experience that is giving you the knowledge to see and they may not be seeing it at all.

Language and metaphor play an important role in both the representation and construction of the body and embodied experience.⁴³ Kirmayer argues that language at its most fundamental level is grounded in bodily experiences.⁴³ Illness and illness metaphors are described by Brodwin⁴⁴ and Scheper-Hughes²¹ as coded messages in a bottle tossed on turbulent seas by the suffering and aggrieved. Respondents talked about the importance of understanding patients' own descriptions of their symptoms. One participant recalled that she used to focus on patients' medical histories and the “facts” in her practice, and described how she learned the value of engaging with patients' own perceptions and experiences.

The whole thing was you had to get the facts. And the feelings were something that was outside the medical arena. And I think it helped me start to change the focus of my consultations onto the feelings that were going on. And of course that's the way in which you do—that contact with the body self that's being presented. People come into your practice and they present what they know is acceptable to present. They present biomedical facts. But you learn to switch out of that onto the feelings...and you start to actually contact the self behind.

Respondents also described embodiment in terms of their physical interaction and engagement with patients' bodies. Being a doctor is a tactile experience in a practical sense. Medical education begins by taking medical students into the body through the microscope, through biotechnological imaging, and through gross anatomy.⁴⁵ Lella and Pawluch⁴⁶ found that students' first encounter with a cadaver could induce powerful emotional responses. In the following excerpt one participant described her first sensual encounter with cadavers during her medical training and its impact.

I had never seen a dead person...They didn't look terribly human though...they are pickled so they are green skin with orange hair...you tried not to think about [them] being human...I remember the smell got on your hands and you couldn't get it off and I became vegetarian that year, I couldn't face meat.

Good has explored the social construction of bodies in medicine, following the changing perceptions of bodily awareness by medical students as they progress through anatomy classes and the dissection of cadavers, and suggests that this reconstruction is essential to becoming a competent doctor (Good,⁴ pp 65–87). Lella and Pawluch⁴⁶ have argued that the separation of cadaveric dissection instruction from the emotions and reflections that accompany it is consistent with attitudes in medical education that encourage emotional detachment in students and practitioners. In the example above, the preservation process masks the humanity of “pickled” cadavers, but emotional detachment can be more difficult to achieve with “fresh” cadavers. This respondent went on to describe how, during medical training and cadaveric work, the way she perceived persons changed from a holistic to a more fragmented and reductionist vision.

It really wasn't until third year that you came across your first fresh body that really looked like a human...The closer they were to your age the more real it became, the more you could identify with them and the harder it became both looking at dead people and looking at live people and you saw them much more as a whole person when you first started off and they became less and less whole as you went through your training.

Another respondent described his medical practice in terms of tactile and sensual engagement with patients' bodies. While the sense of hearing is obviously relevant in terms of listening to physical signs such as breathing and cardiac rhythm, he emphasised the patient centred art of *listening* to patients as they share their experiences.

There are definitely things that you see, there are things that you feel, I mean when you write up about whether a lump is cancerous or not, you talk about size, contour, is it stuck to stuff around it?...And smell is a big thing, the amount of times you say to a woman, have you got a discharge?, yes, does it smell?, you are actually asking her for her impression of the senses and straight away you know if it is an infective thing. And sight is obvious; you can tell a meningism* when they walk through the door, you know...Hearing is the listening part, which is 90% of all medicine, is just listening to what the patient is telling you and without sort of saying too much, hopefully we don't use taste too much...They used to, I mean if you wanted to find out if somebody was diabetic, you would taste the urine to see if it is a sugary taste.

This focusing of awareness within one's body was described by one respondent as becoming "in-bodied" or associating into one's body. She described this process as a kind of embodied knowledge, where her fingertips or ears directly learn about the patient and translate this into knowledge.

To me it [embodied] means in-bodied so when I think embodied I think of somebody whose experience is grounded in their body at that time...When I learnt medicine I noticed that there were times when you had to have all your conscious awareness in your hands, like when you were palpating an abdomen, it's no good thinking what you had for breakfast or being disembodied in your own head, you actually have to put your conscious awareness not just in your brain but right into your fingertips. And you get the feedback directly from there. And when you're listening to somebody's heart, your embodied experience is really right in your ears and you're trying to transfer that from an auditory thing into a knowledge.

If *embodiedness* is a quality of individual experiential self awareness, its converse can also manifest. Some respondents expressed a subtle distinction between being associated into their body (the mindful body), and the *embodiedness* of everyday living in the world where most of the time their body was a utility, because their consciousness was "in their head" (embodied mind).⁴⁷ This sense of dis-associatedness from one's body was described in terms of dis-embodiment.

*Meningism is a condition presenting with signs and symptoms of meningitis such as neck stiffness and sensitivity to light, although not necessarily indicating meningitis.

I probably wouldn't think about it (embodiment) at all...I guess I spend most of my day dealing with sort of practical nuts and bolts sort of things and it's on a different level of thought...You know, are my bathroom tiles going to arrive today? I've been waiting for seven months and also am I going to be able to get Mrs So and So admitted to hospital or am I going to have to argue with six registrars who all say the other one should take her.

Young⁴⁸ has discussed the way the process of taking medical histories and examinations dislodges the patient's self from their body, in other words is disembodiment. The effect of medical training, for one respondent, was ultimately disembodiment in that it distanced her awareness from her own body so much so that she failed to recognise how disabling her asthma symptoms had become. It was also disabling in that she became alienated from patients as real and whole people—perhaps another example of practising the clinical gaze.

There wasn't time to think, there wasn't time to...be compassionate, you didn't have time to get to know people, you were running to physically keep up...I knew I had asthma but I didn't realise that's what was doing it and I couldn't understand why I felt exhausted all the time...It wasn't until things came to a head that I really went to see a respiratory physician who said, "you are bloody lucky you are not dead, what the hell did you think you were doing". It was that acute, so... you didn't really think about that. But I felt numb, I did feel distanced from my body, I felt withdrawn from sort of social contacts because it just took too much energy...I think you become less human. And you didn't see yourself as human.

Illness was also described as a disembodiment experience for many patients. The same respondent talked about how desperately betrayed by their bodies chronic pain sufferers felt as they searched for relief from their symptoms and causes for their suffering.

Thinking about one guy in particular, he slipped a disc in his neck and got pain, went through the surgery, has had ongoing pain since the surgery and initially went sort of through a stage of anger and denial...and he has now suddenly after about a year post surgery, hit this time where he realises it isn't going away and he has almost hit a kind of crisis where he is demanding to know...he is almost in a kind of crisis with his body where he is wanting something still to be mechanically wrong with it or something fixable to be wrong with it and then he's got another side of him which says it is all in my mind, the pain is all in my mind and this is the alternative side coming out.

Meanings of the body

Another view expounded by respondents corresponded to a post-structuralist perspective. Post-structuralist theorists typically describe the body as a text upon which is inscribed social and political discourses. The individual body and the social body represent power relations in societies and the ways in which these are articulated, contested, resisted, and altered.^{32 49-52} One respondent, for example, explicitly situated the GP within *community bodies* and suggested that GPs experience some tension in their situation between other *bodies*—namely between the bodies of patients and the hegemonic powerful body of medicine. In the following excerpt she referred to the advice she gave her patient

regarding continuing with her HRT regimen, juxtaposing her patient's need against the pressure she felt as a GP to represent and conform to current biomedical directives for practitioners.

I think that GPs feel that they are caught really between what they experience of their patients' needs and what they experience in the terms of the needs of the body of medicine in general...I mean we're literally in the community. We're not in Harley Street, we're not in hospitals. We're literally dotted around in the community and we are much more in touch with the community bodies, and it's the community that looks to us really to interpret biomedicine to them in many ways.

Conflict between the demands of social and political bodies can centre on the phenomenological body of the GP. Gothill and Armstrong³³ argue that within discourses around the doctor/patient relationship in general practice, the doctor's body is strangely unaccounted for. Instead it constitutes a field upon which is played out the conflict between the personal and the professional. In the following excerpt one participant talked about the conflation that can occur between the person who is the doctor, and the professional persona of the doctor and his resistance to that persona.

Where does your self end and where does your self start as a doctor?...It is like a mechanic's car that never works. If you look around my house now you won't find a Panadol®...One would expect me to have the minimum things but it is a way of fighting the doctor self—trying to leave it at the back door, is to try and have nothing in the house that reminds me of being a doctor...It is a different self, it is a different embodiment almost...I probably started almost hating medicine at one stage because it was interfering too much in my life and personal time...Yea, the doctor had taken over, and I didn't enjoy it at all, because there is more to me than that...my embodiment is more than that.

Similarly, respondents considered that biomedicine dehumanised patients by failing to either recognise or engage with patients as embodied persons. One respondent suggested that the evidence based medicine (EBM) movement in current medicine discourages practitioners from really engaging with patients as individuals by emphasising their role as scientists. This is felt as both subtle and overt regulatory pressure from within the discipline of medicine to conform to normative discourses that embody the "good" doctor. Evidence based medicine encapsulates a commitment in the institution of medicine to improving patient care and outcomes. Greenhalgh³⁴ notes that EBM is passionately criticised by many general practitioners, who argue that its epidemiological focus is not necessarily relevant when dealing with individual and unique patients, each with their own personal and social histories and contexts.

I think the whole evidence based movement has a lot to answer for in that. Because I think it's been pushed in an unbalanced way. And I think it's been pushed as being the be all and end all. And I think that one thing that the evidence based movement does is to deal with populations and not individuals. So although they say, "these are guidelines only, you have to look at the individual case", this is often done in a very token way...I see it as a very strong influence of epidemiology has in medicine, the

whole of medicine is being portrayed as a science rather than an art. And it's being portrayed that in order to be scientific you must be detached. You must be epidemiologically orientated. And I think that message is coming through so strongly, that people almost feel ashamed to look at it in any other way. People feel that they are less of a doctor if they are not totally evidence based. I mean that message comes across all the time.

In contrast, embodiment in general practice was described by respondents in relational, experiential, patient centred terms.² (Stewart *et al.*,³ p 94) Patients were enmeshed within social relationships and histories while GPs embodied values of caring and compassion, and engaged with patients' own frameworks for understanding their symptoms and illnesses. Most respondents noted that general practitioners have to find ways to deal with the idiopathic chronic repetitive indefinable symptoms that specialists are unable to resolve. Some respondents saw the task of re-embodiment of patients as a central concern in general practice.

In general practice...you have an ongoing relationship with the self. You really have to live with people in the way that you don't in other specialties. So I think from the general practice point of view, embodiment is very important. I mean it is what you're there for in many ways, is to help people become embodied, to own themselves again.

Reflexivity and engagement

Understandings of embodiment incorporated existential notions of personal growth, development, and maturity for most respondents. This was linked to principles of self knowledge and reflection, and with being grounded and centred in the self, as well as with autonomy. Cassell (Cassell,¹ p 27) suggests that helping patients regain autonomy has historically been a primary function of medicine. He argues that suffering occurs when the person perceives a threat to their embodied integrity (Cassell,¹ p 33). Although respondents primarily referred to patients, they also talked about reflection and self knowledge as GPs and members of society. Stein³⁵ and McWhinney (McWhinney,² p 82) both argue that the key to truly engaging with patients is self knowledge on the part of the doctor. In the following excerpt, one respondent makes a constructivist statement in talking about the effect that society can have on individuals' perception of themselves.

If you are not embodied, you can't grow, that's the way I look at it. If you are disembodied, you need help, you know, because you cannot live life to the fullest if you are not embodied...I think that is part of growth, your self alters with experience you know, and I think society has an effect on your self all the time. Your individualistic self but your self is changing due to outside influences or internal experiences and I think that's what makes your self stronger, all the time.

Another issue raised by several respondents concerned the boundaries between patients and doctors in clinical interactions. The bodies of patients and doctors are in intimate contact during physical examinations. A common critique of biomedicine is that it reduces the totality of patients as whole persons embedded within cultural and social contexts to bodies and body parts, and that sometimes the former are invisible.¹⁻⁵ All respondents in the present study considered

that as a GP it was important to attempt to engage with other aspects of patients' lives in addition to the aspect with which they "confront you". One participant suggested that people commonly present a mask to others in their professional and social worlds. This can be problematic in the consultation when attempting to engage with the patient's world. This implies that there is an authentic self lurking beneath the social self that is presented to others, a distinction between the private and public self. This is similar to the existentialist perspective of Cassell,¹ who argues that the authenticity is defined within the moment by moment choices that individuals make about their daily lives. It is also reminiscent of the I-Thou thesis of Martin Buber⁵⁶ where relational and spiritual authenticity is only found in the true engagement of individuals.

Just when you think you have got it sussed (with a patient) you find out that the mask has been on all the time and you have been taken for a ride you know, and that's when you have to try and get behind the mask and that's where embodiment really gets interesting, is when you try and get involved in that embodiment because there are very few people that will let you share that much.

Problems could arise for both GPs and patients when patients were unable to deal with their symptoms or diagnosis/prognosis, either denying or disassociating themselves from their illness; something Cassell (Cassell,¹ p 33) describes as a fragmentation of personal integrity or one's sense of wholeness. When this happened, there was a danger that the patient would place the burden of care and responsibility upon their GP rather than opening themselves to the possibility of empowerment, personal growth, and development by working through issues involved in the illness such as lifestyle, and self help. Stewart, Brown, Weston, McWhinney, McWilliam, and Freeman (Stewart *et al.*,³ p 94) similarly note a distinction between curing the patient's body, and healing the embodied person, which involves restoring the patient's sense of connectedness, coherence, control, and wholeness or integrity.

(If) they see the (illness) as outside of them and therefore they're not caring about it. It's like, this is the problem that somebody else is going to fix and it's not my problem at all...If you're owning it (the illness) you have power over it...If they're not owning it...then there's nothing that they can do that in anyway can fix it, so therefore they're powerless, therefore they need the whole medical profession to come in and fix it from the outside. Whereas the people that are calling it "my" tumour, they may be more likely to accept the responsibility for what it...—how it got there and why it got there, but they also are, I reckon, more likely to deal with it themselves as well as look to the medical profession so they're going to be working on their lifestyle and their health and their diet and doing whatever the specialist suggests as well...And I always feel a lot happier when a patient is saying "my" tumour, than when they're saying "the" tumour.

CONCLUSION

The perspectives presented here are those of GPs who have all completed an introductory course, and in three cases, a follow on course, in medical anthropology. It is difficult to ascertain the influence of their participation in GENA 825 and 826 on respondents' views. Respondents were familiar with the common meaning of embodiment found in the

Oxford English Dictionary of giving concrete expression to an idea or concept, but the medical anthropological usage of "embodiment" was new to respondents when they began GENA 825, and I suspect it is not in wide usage within general practice. The seminal medical anthropological paper outlining the three bodies (lived, social, and politic) by Scheper-Hughes and Lock³² was clearly a key reference for most participants. Although respondents used the notion of embodiment in a variety of ways, I saw evidence that they assimilated it into their own existing explanatory frameworks. While their interpretations did not exactly match medical anthropological understandings, the implicit holism across intertwined dimensions of daily life inherent in the ways respondents talked about embodiment was certainly consistent with medical anthropological usage.^{4 21 44 57-63}

Embodiment, for respondents in this study, encapsulated several interconnected dimensions of meaning. These included: a Cartesian derived compartmentalisation of personhood involving complex relationships between distinct yet intertwined components of soul, body, and mind; the ways in which the world within and beyond the individual is perceived and experienced; an appreciation of the way that physical bodies act as social signifiers; an articulation of ways in which individual bodies are acted upon by metaregulatory social bodies as the text upon which is inscribed social discourse, and an implicit articulation of embodiment as relational, fluid, and processual.

A corresponding range of theoretical perspectives was articulated by respondents at a more implicit level. As expected, these were theoretical ideas that students encountered during their coursework for GENA 825 and 826. One of these was a phenomenological orientation that places primary emphasis on the perceiving, experiencing individual and their subjective reality.^{26 57} Another was a social constructivist perspective, which focuses on the way that individuals take up and make sense of their social environments. Proponents of this theoretical framework argue that there is no objective reality existing outside the individual; rather reality is constructed within the minds of individuals.⁶⁴ Related to this is a social constructionist perspective, which similarly denies an objective reality that is external and independent of perceivers. Here, the terms by which the world is understood are viewed as social artefacts or products of shared understandings among people.⁶⁴ Respondents also gave examples of post-structural perspectives whereby the bodies of individuals are monitored and controlled in settings such as workplaces, and correctional and educational institutions, and the bodies of populations surveilled powerful social institutions such as religion and medicine.²⁸ The other theoretical perspective articulated by respondents correlated well with Bourdieu's²⁴ notion of habitus. Here individuals are explicitly situated within specific historical and spatial contexts, participating within a collective habitus. This habitus is defined in terms of its own history, and shapes or influences the bodily practices of participating individuals. The social constructionist and phenomenological foundations of habitus are explicit. Bourdieu⁶⁵ states that habitus constructs the world by a particular way of orienting itself towards the world and focusing attention upon it.

Leder⁷ views the lived body as simultaneously embedded within and directed toward an experienced or phenomenological world, existing in relationship to other people, objects, and environments. Similarly, within respondents' understandings reported here, embodiment is inherently relational, involving relationships between persons, between persons and their environments (physical, social, and meta-physical), between the components of persons (spirits, bodies, minds, emotions), and between persons and spiritual entities such as God. While respondents differed in their

theoretical orientations and in their understandings of embodiment, there was one theme that emerged strongly across all articulations. This was a clearly identifiable notion of wholeness or integrity.

This integrity or wholeness was embodied in various ways across the relational aspects of the person. Integrity was embodied in one's relationship with deity; through relationships with other persons in wider social contexts, and institutional bodies in political contexts; through an existential orientation to life; through a state of equilibrium in the relationships between an individual and their physical, social, and meta-physical environments, or through equilibrium between the components of the person (including the impaired body or mind, or personal embodied history).

The connection between embodiment and integrity was clearly seen where respondents gave examples of disembodiment. This term was used to connote alienation, disconnectedness, lack of equilibrium, discontinuity, and fragmentation in reference to experiences and relationships of persons with their own and others' bodies, with personal history and with social contexts. For patients (as respondents described them), disembodiment could refer to their responses to illness, or to their relationships with others in their immediate social contexts, as well as to the action of powerful social institutions upon them. For GPs, disembodiment referred to similar things: to imbalance between components of persons (particularly spirituality) or between work and other areas of life; to the dehumanising effects of medical training and the prevailing hegemonic discourses of biomedicine, and to the impact on practice of compliance demands from medical surveillance and regulatory bodies. The common factor in these descriptions of disembodiment is the loss of wholeness or integrity. For respondents in this study, disembodiment carried strong connotations of loss or compromise of personal control and autonomy. This notion of disembodiment is also consistent with breached or damaged integrity as described by Cassell (Cassell,¹ p 27). The idea proposed by some respondents, of re-embodiment of patients, is similarly consistent with the repairing or healing of a patient's sense of wholeness or personal and relational integrity.

This paper has attempted to show the variety and richness of a small group of GPs' reflections on bodily or embodied experience in their medical practice following their participation in introductory courses on medical anthropology. Embodiment was taken up in medical anthropology following calls to bring the body back into a curiously disembodied social science.^{19 20 32} Similarly, in a lived medicine, there have been calls to bring both the embodied patient and doctor back into the disembodied and uninhabited bodies of biomedical practice.^{8 10 53}

Leder, following Merleau-Ponty, describes the lived body as an intertwining of perceiver and perceived and proposes a "medicine of the lived body" situated within this intertwining (Leder,⁷ p 29). Within this paradigm, taking patient histories, diagnosis, treatment, and management would not distinguish between nor separate physiological and existential dimensions of care, instead providing a "genuinely integrative framework" (Leder,⁷ p 33). Schon⁶⁶ argued that becoming self aware of their own paradigms and framing can lead practitioners to the possibility of finding alternative ways of conceptualising the reality of practice. For Baron, (Baron,⁸ p 46) if a paradigm of embodiment is to be useful in medicine, it must be grounded in the experiences of doctors and patients. Critical interpretive medical anthropology is an example of a field that crosses social science and humanities boundaries, with its explicit orientation around the paradigm of embodiment as a means of understanding lived experience, social, and personal meanings of the body, and the political economy of the body. Perhaps its major contribution

to postgraduate medical education is its power to encourage or facilitate reflection that is grounded in practice. The paradigm of embodiment, with its phenomenological focus, is also entirely consistent with patient centred medicine and has the potential to strengthen this by providing a philosophical platform for this orientation in practice. Findings reported here show it is possible for medical practitioners to problematise the Cartesianism of biomedicine and its effects on both patients and doctors, and to conceptualise the integrative framework encapsulated in the notion of embodiment as lived medicine.

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BOOK REVIEW

Let Me Listen to Your Heart: Writings by Medical Students

Edited by D Svahn, A Kozak. Bassett Healthcare, 2002, US\$15.00, pp 144. ISBN 0972478108

Let Me Listen to Your Heart is the apt title of a collection of autobiographical writings—both prose and poetry—by a group of medical students from the Mary Imogene Bassett Hospital in Cooperstown, New York State. Most of the pieces deal with the experience of young people grappling with a new, and anxious reality: the transition from preclinical to clinical experiences, from studies of cells and organs, to all the ambiguities and complexity of dealing with real patients for the first time—but without the emotional and professional protection of a medical degree. Although in style some of the pieces are rather artless and flat, and a few others

self consciously "literary", the vast majority are moving, poetic, and beautifully written. The medical student experiences they narrate would be familiar to any qualified doctor, and come over as sincere and deeply felt. Perhaps unfairly, some stand out more than others. I particularly liked: April Zhu's account of her childhood in Shanghai, and her grandfather's lung cancer, which blends together personal, family, and cultural narratives; C P Krishnamurthy's account of her own hospitalisation for an ill defined abdominal pain, and the dichotomy between medical and subjective perceptions of individual suffering; Erica Shoemaker's monologue of a confused old lady, and Michael Mondress's short piece on the poignant gap between an elderly demented man, and his old heroic self portrayed in the photographs hung above his bed. All of the others had something to contribute to our understanding of the ways that medical students experience the anxieties and excitements of clinical training, and how they try to make sense of it.

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