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PRESENCE IN THE FLESH

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THE BODY IN MEDICINE

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as-object, and both of these are aspects of the experience of being a body. I am aware of my body, by turns, as self and as object. Medicine takes up or puts forward my body-as-object without necessarily, always, or altogether, and sometimes not at all, dispossessing me of my embodied self.

The bearing of narrativity on constructions of the body becomes pivotal in the Coda. "To write the body," as ethnographers, is likewise a narrative gesture. Conventions of perspective and voice fabricate the bodies of others and the universes of discourse they inhabit. These conventions are anchored in the bodies of ethnographers as percipients. Hence our cultural hierarchy of modalities of perception informs our social scientific epistemology. Realistic writing constructs the bodies of others as objects, separates their universes of discourse from ours and so estranges the ethnographer from the Other. This discursive move toward objectivity reiterates medicine's inclination to regard its subjects as objects. Unconventional writings, by contrast, fret the continence of the body, the closure of the universe, and the detachment of the perceiver. They reinscribe the body into discourses of subjectivity. The Coda invents different narratives in order to conjure up different embodiments.

These investigations of the phenomenology of the body in medicine proceed from the conscious body to the split consciousness of the gendered body through the unconscious body to the dead body. In each of these transformations, bodylore brings out the post-Cartesian metaphysics by virtue of which medicine produces the body. The material but insensible medical body is excoriated to expose its metaphysical sinews, attached, just beyond the site of incision, not to the bone but to the imagination. Medicine issues from a folk epistemology of the body. Despite the transformations of the body by medicine, signs of presence press through the flesh.

ONE

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DISEMBODIMENT

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INTERNAL MEDICINE

The immediacy of my experience of corporeality should be understood as an indication of the interior perspective I occupy with respect to 'my body'. I am neither 'in' my body nor 'attached to' it; it does not belong to me nor go along with me. *I am my body.*

—Maurice Natanson, The Journeying Self

I am inserted into the world bodily and my experience of the world comes to me through my body. The phenomenologist Maurice Natanson writes, "my body is the unique instrument through which I experience my insertion in the world" (1970, 17). My body is the locus of my percipience, the vantage point from which I perceive the situation in which I find myself. "The perspective from which and through which that situation presents itself is the insertion of the individual at some place in the social fabric" (Natanson 1970, 60). Not only do I apprehend the world corporeally but my body is also an aspect of the world, an object in it. "Visible and mobile," writes Maurice Merleau-Ponty, "my body is a thing among things; it is caught in the fabric of the world, and its cohesion is that of a thing. But because it moves itself and sees, it holds things in a circle around itself. Things are an annex or prolongation of itself; they are incrusted into its flesh, they are part of its full definition; the world is made of the same stuff as the body" (1964, 163). Here is the source of the temptation to take my body's objectivity as its paradigmatic condition and to suppose its subjectivity to be secreted invisibly inside. This might be called the physical object hypothesis of persons. "All the signs of mun-

dane reality lend implicit support to the assumption that the model of the physical object in the quantified space of nature is a paradigm for the being of man in the world" (Natanson 1970, 2). The difficulty with the physical object hypothesis is not the materiality of the body but the resistance of its materiality to a putatively immaterial self. This dispossesses me from my corporeal self, as if I were different from my body.

If I am not dispossessed from my body, neither am I subsumed by it. The way I experience my body, the way I speak of it and think about it, is rooted not so much in its sensible apprehensions as in my symbolic perceptions. I learn my body even as I learn bodily. The anthropologists Shelden Isenberg and Dennis Owen write:

> The individual's body is presented to him, taught to him by society, usually in the manifestations of parents, and then by peers, perhaps also by schools. Our attitudes about our bodies arise from society's image of itself. So if we can learn how a person understands the working of that complex system called the body, its organization, its spatial arrangement, and its priorities of needs, then we can guess much about the total pattern of self-understanding of the society, such as its perception of its own workings, its organization, its power structure, and its cosmology. The human body, then, is a universal symbol system: every society attempts in some way to socialize its members, to educate its bodies. (1977, 3)

This is not a matter of imposing education on the resistant flesh. A natural fact, a physiological given, a material substrate is not somehow prior to the idea of the body. That notion is grounded in understandings which, Barbara Duden argues, "implicitly presuppose something like a nonhistorical (biological) matter of the body, which is then molded by time and class, on which 'culture is imprinted' or which is 'culturally shaped.' The matter itself always remains a given" (1991, 6). The naturalization of the body is a consequence of a history, Duden points out, in the course of which "the body and its environment have been consigned to opposing realms: on one side are the body, nature, and biology, stable and unchanging phenomena; on the other side are the social environment and history, realms of life subject to constant change. With the drawing of this boundary the body was expelled from history, and the problem of how it has been perceived fell outside the sphere of social history" (1991, vi). But the body

bears its historicity materially. It is only perceptible as it is conceived. My body, as it were, inhabits its own subjectivity. It is imprinted from the start with traces of my being in the world, of my language, my culture, my experience, how my body is handled and the interpretation I put on that handling, so that, as Merleau-Ponty writes, "whenever I try to understand myself the whole fabric of the perceptible world comes too, and with it come the others who are caught in it" (1964, 15). Natanson expands this: "The world I inhabit is from the outset an intersubjective one. The language I possess was taught to me by others: the manners I have I did not invent; whatever abilities, techniques, or talents I can claim were nourished by a social inheritance; even my dreams are rooted in a world I never created and can never completely possess" (1962, 103).

The intelligibility of the world is constituted corporeally. The body is the source as well as the site of symbolic understandings. Maxine Sheets-Johnstone writes:

> Meanings are not free-floating entities; meanings are incarnated, anchored in living bodies. It is clear why corporeal representation is a fundamental biological matrix. It is a primary mode of symbolization and communication. Where meanings are *represented,* animate bodies represent them corporeally. In their form and behavior animate bodies are potential semantic templates. This is why a psychology, aesthetics, archaeology, and linguistics of symbolizing behaviors is possible—why pears and mountains can represent female breasts and umbrellas and tree trunks can represent penes. (1990, 121)

The body symbols that inform culture are already replete with mentality as well as corporeality. Victor Turner describes this:

> The cosmos may in some cases be regarded as a vast human body; in other belief systems, visible parts of the body may be taken to portray invisible faculties such as reason, passion, wisdom and so on; in others again, the different parts of the social order are arrayed in terms of a human anatomical paradigm. (1970, 107)

By the same token, Mary Douglas argues, incorporeal as well as corporeal properties are already inherent in the symbolic body.

> The physical body is a microcosm of society . . . At the same time, the physical body, by the purity rule, is polarized conceptually against the

social body. Its requirements are not only subordinated, they are contrasted with social requirements. The distance between the two bodies is the range of pressure and classification in the society. A complex social system devises for itself ways of behaving that suggest that human intercourse is disembodied compared with that of animal creation. It uses different degrees of disembodiment to express the social hierarchy. The more refinement, the less smacking of the lips when eating, the less mastication, the less the sound of breathing and walking, the more carefully modulated the laughter, the more controlled the signs of anger, the clearer comes the priestly-aristocratic image. (1973, 101)

Hence, as this interplay between philosophers and anthropologists suggests, a phenomenology of the body also recovers the folklore that is invested in it. Properties can be seen in body symbols or in the symbolic body, in the way cultural inscriptions become visible in the body and in the way corporeal inscriptions become visible in culture. Such inscriptions body forth properties held to be present in the flesh.

> The social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange of meaning between the two kinds of bodily experience so that each reinforces the categories of the other. As a result of this interaction, the body itself is a highly restricted medium of expression. (Douglas 1973, 93)

This inquiry opens with an investigation of the symbolic properties of the body in a situation in which bodily intimacies are routinely undertaken: medical examinations.

FRAMES AND BOUNDARIES

Because the body is invested with symbolic properties, its parts are treated differentially. "Indeed," writes Erving Goffman, "this differential concern tells us in part how the body will be divided up into segments conceptually" (1979, 38). What Goffman calls "evidential boundaries" are interposed between others and their visual, auditory, tactile, and olfactory apprehension of the body or its parts (1974, 215; see also 1959, 151–165,

on communication barriers or boundaries; 1976, 127, 140, on participation shields). The body itself constitutes an evidential boundary. States that are supposed to be internal to the individual "make their appearance through intended and unintended bodily expression, especially through his face and words. His epidermis can thus be seen as a screen, allowing some evidence of inner state to pass through, but also some concealment . . . In addition to functioning as a screen to what is presumably inside him, his body also functions as a barrier which prevents those on one side of him from seeing what is directly on the other side or those in back of him from seeing his facial expression" (Goffman 1974, 216).

Concealments of the body itself behind evidential boundaries are at issue here. These boundaries can take the form of bodily clothing; scents and de-scenters; voice levels and direction; gaze direction, concentration, and focus; position, posture, gesture, and movement; arrangements of furniture, spacing, and architecture. Such boundaries at once locate and conceal those parts of the body that are symbolically charged. Over the course of a medical examination, certain of these boundaries are peeled away to permit a close inspection of parts of the body. At the same time, other boundaries are introduced. Thus persons to be examined are put into a closed room so that its walls substitute as evidential boundaries for the clothes they take off, the difference being that the physician is inside the boundaries along with the person.[1] A complex choreography involving the disposition, shift, removal, and replacement of boundaries is undertaken by physicians in concert with their patients. The management of evidential boundaries during medical examinations is one of the concerns of this chapter.

For the purposes of the examination, the body is reframed to exclude some if its symbolic properties, especially sexual ones. Symbols, then, are not inherent in the body or its parts; rather, they are interpretations attributed to it by persons in situations.[2] Framing is accomplished by greetings, forms of address, language about the body, deference and dominance behavior, costuming, role play, the management of verbal and nonverbal delicacy, ritual, and metacommunication. These frames create and sustain alternate realms of experience, to adopt Alfred Schutz's terms (1973, 252–253), the realm of the ordinary in which I am a social person and the realm of medicine in which I am a body, and orchestrates the passage between realms. From being a locus of self, patients' bodies are transformed into

objects of scrutiny, organs in a sack of flesh. Physicians' bodies, their personhood narrowed though not expunged, become instruments of detection, lodgments of a perceptual apparatus. The management of frames during medical examinations is, therefore, the other concern of this chapter.

Following John Locke ([1690]1959), a medical examination could be taken to operate under a social contract which would read: "for medical purposes, I grant license to this physician to examine my body." Under this interpretation, reframing the body as an object could be understood as the act John Searle describes as a performative (1969), a linguistic or metalinguistic message that enacts what it expresses and takes the reading, "I hereby render this/my body an object." The contract would be supposed to hold across the interaction, performing a transformation on the body that renders it, for the nonce, an object instead of a self. In practice, however, it becomes apparent that realm-shift is not a prior contract but an intermittent, periodic, or partial phase, layer, or aspect of the medical examination. The incompleteness of the transformation can be seen from the one side as the uncontainability or flooding of the patient's social person through the reframing, and from the other as the physician's invocation of or attestation to the presence of a self in the body. An appreciation of the contractual expectations of medical examinations does not in itself transform persons into patients; it merely makes them alert to the cues for their own transformation. A good deal of fiddling with the body's ontological constitution is required before the shift from one realm to the other is complete. Indeed, it may be that it is this ontological unsettledness that tinges the realm of medicine with its characteristic air of unease.

SPATIO-TEMPORAL ONTOLOGIES

Realm-shift in medicine is grounded in the distribution of realms in space and their sequencing in time. The University Hospital itself appears to seal the realm of medicine off from the outside world. But within the building, the differentiation between the realm of medicine and the realm of the ordinary is in some measure reinvoked. A network of public spaces and connecting pathways interlaces the network of professional spaces and connecting pathways, with points of intersection and areas of transition between systems. Crossing over from the realm of the ordinary into the

realm of medicine entails a change of ontological condition. Physicians are regarded as initiates of the realm of medicine, and pass freely across the border. Other members of the realm of medicine can be required to display tokens of their status. Nurses pass across without question by virtue of their uniforms. Other employees of the hospital (cooks, cleaners, maintenance people, mail personnel) who are not native practitioners may wear badges that mark them as insiders. 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.[3]

The maintenance of physical boundaries between spaces supports the maintenance of conceptual boundaries between realms, for, as Douglas writes, "Any structure of ideas is vulnerable at it margins" (1970, 145). To maintain discretion between realms despite the trafficking across their borders, crossover points are narrowed, partially obstructed, concealed, or sealed. Where the integument between realms is thin, discretion may be maintained by locked doors to which staff people have keys. Where the pathway between realms is open, it may be narrowed to a corridor or partially obstructed by desks. At these points, guardians of the realm may be posted in the form of receptionists, secretaries, security guards, and the like, who monitor the ontological propriety of those passing through. This monitoring must be done with considerable caution. It is not proper, for instance, to challenge a physician—they are understood to be inextricably enfolded in their roles—so that anyone who makes the crossover with appropriate style is likely to be passed without question. For insiders, passage into the realm of medicine is eased by the existence of separate paths and entrances either obscurely placed or locked. For outsiders, passage between realms is slowed, obstructed, deflected, or sequentialized partly in order to provide interstices in which to accomplish transformations. Emergencies do not constitute breaches of the stringency of the system; for them, the tempo of the transfer is simply accelerated.

Within the realm of medicine, spaces are further differentiated. At University Hospital, practitioners of a given specialty are clustered together in separate suites in which the distinction between the realm of the ordinary and the realm of medicine is reinvoked. Internists, for instance, practice in the Department of General Medicine, consisting of a waiting room with

reception desks set up beside the opening into the corridor that leads to physicians' examining rooms and offices, and further along to supply rooms, secretarial cubicles, the chairperson's office, and a conference room for medical staff. These deeper regions are never penetrated by persons in their role as patients. Persons as patients shift between the waiting room and the offices and examining rooms. Because of the nesting of networks within networks of spaces within the hospital, however, there is no single boundary between the realm of the ordinary and the realm of medicine. Instead, there is a modulation of ontological properties from outer to inner spaces. Commensurately, a person's movement through these spaces is sequentially ordered so that there is also no single moment of transition between realms. Persons are not turned into patients; rather, they undergo a series of transformations in the course of which they become patients.

REALM-SHIFT

Both physicians and persons initially carry their identities across the border into the other realm. Indeed, physicians retain the accoutrements of their medical role pervasively in the realm of the ordinary. It becomes a social presentation, attended by an analogue of the status it holds in the hierarchy of medicine. Physicians' sense of self is deeply invested in their professional role. Unlike individuals with more lightly held roles—professors, for instance—whose titles can be quite easily detached, physicians' roles are not lightly discarded, and their titles tend to remain attached in ordinary life.[4] This retention can be gracefully regarded or, conversely, uncomfortably perceived as a kind of aristocracy. By contrast, except in the case of the gravely or frequently ill, the patient role is quite transient.[5]

As persons become patients, they relinquish their social personae. They divest themselves of some of their social properties with their clothes. Taking off layers of clothing circumscribes the self by limiting its extensions into social space. The boundary of the self is not ordinarily coterminous with the skin. It extends not only to objects attached to the body but also to objects possessed by the person and to the envelope of space that contains them (Sommer 1969, viii; Hall 1969, 113–128, 177, 25–38; Goffman 1979, 28–60). Constraining the self to its bodily integument is a move toward rendering the body an object.

Occasionally, for certain kinds of examinations, patients are permitted partial retentions, in the form, for instance, of all their clothes (provided that their shirts can be rolled up at the sleeves or opened at the front), or of all their clothes from the waist down, or of some of their underwear, or perhaps just their socks. Conventional underwear, not being socially presentable, shifts from the realm of the ordinary to the realm of medicine fairly easily. Socks are quite another matter. It may be that feet never quite enter into the region of medicine unless it is they that are being examined. Interestingly, many patients whose feet are not being examined nevertheless take off their socks, apparently in the interest of completing the transformation from one realm status to the other. These remnants of their social appearances give patients a hold on themselves during the examination, but in so doing they create an anomaly within the realm of medicine by maintaining there some aspects of a presentation of another ontological status. Such partial transformations appear to be tolerable when the examination is not regarded as very extensive or intimate. Complete changes which appear to be functionally designed to allow complete access to the body are phenomenologically designed to allow the complete transformation of the body from self to object.

Physicians achieve a commensurate narrowing of self by the addition of a layer of clothing: a knee-length white coat.[6] The archeology of these artifacts is suggestive here: the layering of an outermost and predominant role over a complete social person as opposed to the reduction of a complete social person to a diminished role. In women who are patients, the circumscription of self is arrived at by both these means, the removal of layers of clothing and the addition of a white gown. Both physicians' and patients' garments reduce sexual signaling and other social communications by concealing the contours of the body. Thus at the beginning of the physical examination, women achieve a superficial parity with their physicians, but one that is easily undermined by the flimsiness of the gown and its lack of supporting undergarments. Men patients may be said to sustain a deeper parity with men physicians, but not one that is symmetrically displayed. The entanglement of professional with gender roles here is evidenced by women physicians who are exercised about the question of whether or not they should have men patients put on gowns for examinations. At issue is whether to interpret the examinations under the medical paradigm, in which the physician is regarded as gender neutral but the

patients are supposed to display differential modesty, or under a gender paradigm, in which interactions within the same gender are regarded as neutral and interactions between different genders are regarded as sexually charged. Most women physicians in the hospital I studied provide women patients gowns and not men in an attempt to establish their gender neutrality.

Physicians make their initial appearance already in costume for their role, whereas patients change costume in the course of the performance. Persons who are physicians, then, present themselves in what is initially a social situation in the restricted role they expect to sustain throughout the interaction, thus constituting themselves what Alfred Schutz calls "enclaves" of another ontological status within the realm of the ordinary (Schutz 1973, 256n). Persons who become patients work a transformation on their own bodies from self to object and back to self again, thus shifting realms during the examination. As they move into the realm of medicine, the balance is reversed and persons become enclaves of the ordinary in the realm of medicine. Because enclaves of one realm thus extend into the other, the transformation is never complete.

The existence of multiple realm statuses in a single context creates ambiguity: alternative interpretations of a given event or object are always possible. This ambiguity can be used strategically to manage the examination, but it also gives rise to an uneasiness about how to move, especially by, and with respect to, the transmuting self (see Goffman 1974, 548, 560–575). For this reason, there is some impulse to achieve ontological congruity with the realm of medicine by turning the person into a patient. The rhythms of the examination seem to be designed to arrive at this unambiguous condition by the physical examination. Hence, at the center of the medical examination, the body of the patient is most nearly congruous with the realm of medicine, whereas at the periphery, it is most nearly congruous with the realm of the ordinary. The physician's presentation of self, in Goffman's phrase (1959), as a hold or transfix and the person's presentation of self as a variation or transform display the asymmetry between the modalities in which each of them moves through the examination. Multiple statuses are apparently easier to handle than changing statuses. Being in both realms provides a better grounding for interaction than being in neither. The interstitiality of transitional states eludes ontological placement (see Douglas 1970, 137–153; Leach 1971, 132–136; Van Gennep 1960, 1–14). It is to protect these interstices that changing clothes, which shifts the body from self to object, characteristically occurs behind evidential boundaries. The problem is not a sexual one but an ontological one.

The process of transformation might be said to begin on being born into a society with its particular conventions about the symbolic properties of the body. It is abstracted in the social contract, implicitly invoked in making the appointment, and put into operation on entering the hospital. Once there, persons feel obliged to observe some of the conventions of the realm of medicine: clothes are carefully chosen and arranged with an eye to the proprieties of the situation, cleanness perhaps being of more moment than formality, movements are contained and directed, voices are subdued. But it is in the waiting room that persons await realm-shift, and await, too, the cues that tell them when to shift realms. A person's social self is not held in abeyance, but put on the alert for these cues to its own transformation. This inquiry cuts in on the unfolding of such cues from the point in space or moment in time when the person first sees the physician face-to-face.

THE REALM STATUS OF THE BODY IN INTERNAL MEDICINE

In the Department of General Medicine, people come into the waiting room and give their names to one of three receptionists whose desks are arranged so that they form an extension of the corridor into the inner rooms and guard its entrance. Having given their names to an intermediary, persons then wait to be reinvoked as patients. In this practice, physicians collect the names of their next patient from the chart that is delivered to a rack outside their door by the nurse or from the receptionist or her list and come out into the waiting area and call the name out, scanning the waiting room for responses. They appear already accoutred for their role in white coats, but this appearance can be inflected with propriety or panache. Matthew Silverberg, M.D., wears his crisp coat over a well-cut three-piece brown tweed suit with a blue shirt and tie, and brown oxfords. The coat, which he wears open at the front, fits well across the shoulders and loosely over the body, effectively concealing its contours. It holds his stethoscope in the lower right front pocket and his pens in the

upper left. He is a slender man with a narrow head, close-cropped hair, and glasses, and his face, appearing above the layers of coat, jacket, and shirt collars, has a withdrawn, fastidious air. Adam Kleinfeld, M.D., is a tall bearded man with glasses, a mild voice, and a slight stoop. His dark greyish hair is curly, longish, and undisciplined at the ends. He wears a grey jacket and trousers with a soft old sweater-vest and loafers. His stethoscope is hung around his neck, his coat is rumpled, and the short belt across the back of it has come unbuttoned. These modulations of the conventions of the realm of medicine provide each physician a slightly different foothold in the same realm.

Opening Frames

Greetings and farewells attest to the presence of social persons. Dr. Silverberg addresses his patients by a title of courtesy (Mr., Mrs., Miss) and a surname, and introduces himself by his surname and his professional title, which can have in this culture the aspect of a title of rank, thus inserting into the sociality of greetings a hierarchy of statuses. Dr. Kleinfeld addresses his patients by titles of courtesy and last names, by first names, or even by nicknames, but does not introduce himself. The hierarchical distinction between titled and untitled persons is to some extent preserved in the distinction between naming and what Goffman has called no-naming. In response to this informal naming system, his patients often call him "Doc." Each physician is thus solicitous of his patient's social person but dominant over it.

These moves for differentiating doctor from patient can be confounded by the presence of a patient who is also professionally titled. As he leans across his desk to shake hands with Michael Malinowski, Ph.D., a seventy-eight-year-old professor of Jewish history and literature, Dr. Silverberg uses the "sir" solution to show deference yet reserve title: "Hello, sir, how are you?" Shaking hands inflects touch as initially social and symmetrical, but requires Dr. Silverberg to transform the meaning of touch during the physical examinations to achieve the proper asymmetry and objectivity. Dr. Kleinfeld abstains from handshaking and so reserves touch for his professional attentions to the patient's body, but in so doing he keeps his social distance. What Dr. Silverberg creates is a realm of formality and social proximity, whereas what Dr. Kleinfeld creates is a realm of flexibility and

social distance. By inserting dominance relations into social forms, both clusters of greeting behaviors operate to lodge control over the shift from the realm of the ordinary to the realm of medicine in the physician.

Spatio-Temporal Frames

Realm-shift is accomplished in part by moving from the waiting room to an office or examining room. Dr. Kleinfeld collects his next patient's chart from the rack outside his room, comes out into the waiting room and says, "Mrs. Peary?" On hearing her name, Mrs. Peary stands up, unfolding her body to view, and then moves into the physician's greeting space so that their apprehensions of each other are limited to the upper body and focused on the face. As she approaches him, Dr. Kleinfeld says, "Will you come in, please." He turns and precedes her down the hall to his room. He enters and crosses over to his desk, nodding at the chair beside it as he passes. She follows him in and sits down. With a patient he knows well, Dr. Kleinfeld says, "Hi, Dave," and waves him in. In contrast Dr. Silverberg comes out into the waiting room and says, "Mrs. Cenci, please." As she approaches, he leans toward her and says, "Dr. Silverberg is who I am," and shakes hands. She says, "Hi." He precedes her to his office, goes in ahead of her, pauses near a chair and says, "Have a chair, if you would," waits for her to sit, then says, "Thank you," goes around to the other side of his desk, and sits down. Or, with a patient he knows well, Dr. Silverberg says, "Mr. Rachelson, Hi." They shake hands in the waiting room and then Dr. Silverberg precedes him down the hall to his office.

These inner rooms are arranged at once to lay the patient open to the physicians's regard and to protect him or her from it. Dr. Kleinfeld sits in a chair facing his desk, which is flush against the wall. His patient sits in a chair set side-on to the desk, facing out into the room. Thus the desk does not interpose an evidential boundary between their bodies, and their bodily orientation and gaze direction are turned away from each other. Dr. Kleinfeld modulates this basic arrangement by flicking his swivel chair out and away from the desk, leaning back, and looking at his patient, or pulling the chair into his desk, leaning forward, and looking at the patient's chart. Dr. Silverberg, however, sits behind his desk, which faces out into the room. The patient's chair is drawn up sideways along the front so that the desk is interposed between the physician's lower body and his patient's,

but he faces the patient across it and maintains eye contact. He modulates this basic arrangement by glancing down at the patient's chart on his desk, or turning aside to read a chart in his lap. In both instances, persons can turn their upper bodies to face the desk, thus achieving a side-to-face orientation with Dr. Kleinfeld or a face-to-face orientation with Dr. Silverberg. Four variables appear to work together here as a system: evidential boundaries, eye contact, personal spacing, and bodily orientation (Sommer 1969, 12–38; Hall 1969, 1–146; Goffman 1974, 215; Goffman 1979, 28–60). Concealing the lower body with an evidential boundary like the desk permits the maintenance of a face-to-face orientation with a high degree of eye contact at close proximity. Lowering evidential boundaries at about the same distance is associated with side-to-side orientation and reduced eye contact. Both constellations of arrangements maintain some evidential boundaries at close quarters.

With the shift of realms, persons become enclaves of the ordinary in the realm of medicine. The continued presence of a social person can be attested to by the physician, as when the professor, Dr. Malinowki, says to Dr. Silverberg:

Dr. M: I will be in July the— seventy-nine.
Dr. S: Seventy-nine
Dr. M: July twenty-sixth I will be
seventy-nine.
Dr. S: You'd never know it.
((For transcription devices, see the Note on Transcription.))

Attempts by the patient to attend to the physician as a social person can get short shrift. Dr. Kleinfeld escorts Mrs. Hardy to his examining room, goes over to his desk, and says:

Dr. K: You got he— Come on you sit here—
((Motions to his desk. She sits. So does he.))
You got here while I was eating my half of a sandwich.
Mrs. H: Oh just half a sandwich.
((Chuckles.))
You didn't eat a whole one huh.
Dr. K: Now where were we.
((He turns to the patient's chart on his desk.))

Though within the realm of medicine, these rooms are not ontologically pure. Photographs of his children, for instance, incline Dr. Silverberg's office toward humanity. Framed medical degrees would inflect it toward professionalism.

Conceptual Frames

Realm status is materialized in the architecture of these spaces because, as Gregory Bateson argues, "human beings operate more easily in a universe in which some of their psychological characteristics are externalized" (1972, 188). Realm-shift is, in fact, only incidentally spatial; it is essentially conceptual and can be modulated by the interactions of persons over time as well as by the movements of the body in space. The remark, "How are you?" can serve as a pivot between realms. In the realm of the ordinary, this turn of phrase occurs as a greeting formula to which the proper response is, "Fine." In the realm of medicine, it has the status of an inquiry about the patient's health, to which "fine" is not the proper response. Patients are instead supposed to respond with accounts of their medical condition. Dr. Kleinfeld says to Mrs. Frye:

Dr. K: So how are you.
Mrs. F: Same old thing mostly sick.

Since in the realm of medicine, the response to "How are you?" is not properly "Fine," producing this response can cause a slight hitch in the shift of realms. Dr. Silverberg says to Mrs. Johnson:

Dr. S: How are you.
Mrs. J: Fine.
((Mrs. Johnson then makes a joke about saying she is fine when she is not, noticing and thereby effecting the appropriate shift of realms.))

This hitch can also be handled by the physician, as when Dr. Kleinfeld says to Rose Shawn:

Dr. K: Hi.
How're you doing.

Mrs. S: I
[[[ ]
Dr. K: I guess I'm supposed to tell you.
Mrs. S: Right.

The catch with this form of inquiry is people's inclination to use a socially correct response instead of a medically informative one, resulting in a failure to shift realms.

To hedge against this failure, these physicians use three strategies. One is a transformation of the inquiry so as to make it less formulaic. Thus Dr. Kleinfeld tries, "How're you doing?" or "Hi, how've you been today?" The difficulty with this solution is that these phrases are easily taken as the greeting formulae they are intended to transform. A second strategy is to raise the specificity of the inquiry. When he turns to her chart, Dr. Kleinfeld says to Mrs. Hardy:

Dr. K: Now where were we.
Mrs. H: Well that was (not much)
((alluding to the sandwich)).
Dr. K: I thought you were having a cold.

A third strategy is to eliminate the ambiguous inquiry altogether and move directly into the medical realm. Dr. Silverberg says to Mrs. Cenci, after she sits down, "Now you're forty-three." The physician's orchestration of realm-shift can be confounded by persons who do not take on the role of patient. Dr. Silverberg had been examining Dr. Malinowski's wife, who is now resting on a litter in the waiting room. On taking his leave of her, Dr. Silverberg signals her husband, who is waiting there with their son, Alex, to come down the hall into his office. On the way, the nurse takes Dr. Malinowski aside to weigh him, and Dr. Silverberg goes into his office. When Dr. Malinowski comes in with Alex and the nurse, Dr. Silverberg goes round behind his desk where he stands and leans across to shake hands with his patient, saying "Hello, sir, how are you?" At the same time, his nurse says to him, "One ninety-nine," referring to the patient's weight, and goes out. Dr. Malinowski does not respond to Dr. Silverberg's proffered hand. Because it is clear to Dr. Silverberg that he and his nurse have spoken at the same time so that Dr. Malinowski might not have heard him, he attempts another greeting,

"Happy to meet you." At the same time, Alex says to his father, "Why don't you sit here," and gestures to the chair across the desk from the doctor. Dr. Malinowski still does not respond, so Dr. Silverberg, abandoning greetings, says, "Have a chair" and indicates the same one Alex has. The professor, looking around the office, says, "Where should I sit on?" Dr. Silverberg quickly puts in "Dr. Silverberg is who I am" at the same time that Alex is insisting, "Here—sit here." Dr. Malinowski, responding to neither of them, sees a chair behind the desk near Dr. Silverberg's and says, "Let me sit down here (so I can hear you)," at which point Dr. Silverberg, realizing Dr. Malinowski is quite hard of hearing, pulls the chair over next to his and says, "You want to sit here? All right." The professor gets settled saying, "(I sit) here," and Dr. Silverberg says, "Fine. Now this is your ( ) chart," turns to look at it, realizes it is the wrong chart and excuses himself to go out and get the right one.

The difficulties of this initial scene turn out to be grounded in the fact the patient is rather deaf. Parenthetical remarks and stage directions by the nurse and Alex are phrased as back-channel effects (Goffman 1981, 28), but occur simultaneously with the initial greeting sequence with Dr. Silverberg so that Dr. Malinowski cannot make out what the doctor says. For his part, the professor is casting about trying to work out an arrangement whereby he will be able to sit nearer the doctor in order to hear him. His failure to respond appropriately to either greetings or directions creates an initial misimpression that he is disoriented. When Dr. Silverberg returns with the correct chart, he proceeds to move into the realm of medicine with inquiries about Dr. Malinowski's health. Dr. Malinowski, sitting right next to him, responds crisply.

The Dislodgment of the Self from the Body

The realm of medicine is further differentiated into two lesser realms called by physicians the history-taking and the physical examination. The history-taking begins the dislodgment of the self from the body by turning the person's attention to her or his own body as an object. For instance, Dr. Silverberg verbally disarticulates the professor's body into parts, inquiring in turn about his height, weight, age, and health (whole body concerns); then about his eyes, throat, blood, heart, chest, finger, heart

again, breath, ankles, and back (body parts, substances and processes); then about allergies, drinking and smoking, his relatives' diseases, marriages, and children (whole body concerns again); then his stomach, head, eyes, nose, throat, bowels, urine, stomach again, muscles, bones, and joints (parts, substances and processes). This verbal disarticulation loosens the person's investment of a self in the body insofar as the self is felt to inhere in the body as a whole, not in its parts. Shifting attention to the body as an object renders the person warden of her or his body.

The person's recognition of this move toward detachment is evident in the way Mrs. Hardy refers to her body during history-taking.

Dr. K: I thought you were having a cold.
Mrs. H: Yeah a cold and the I had this uh
back.
Dr. K: It seems
some difficulty with your back today=
Mrs. H: Yeah.
Dr. K: O.K.?
And where are you with all those things?
Mrs. H: Well
the cold got a little better
. . .
And then was there—
Oh the back
kept hurting . . .

Over the course of the history-taking, not only does Mrs. Hardy come to refer to her cold as "the cold," but she even refers to her back as "the back," as if she were somehow detached from them. This kind of objective self-referencing also informs her gestures. In describing pain in her back and belly, Mrs. Hardy arches in her chair, flares her hand out behind her back at waist level, then gestures over her belly, fingers still flared, not touching her body but directing attention to it with the propriety appropriate to an outside observer.

Occasionally it is difficult for the physician to induce a person to shift attention to the body as an object. Dr. Silverberg says to Dr. Malinowski:

Dr. S: How is your health.
Dr. M: I wouldn't complain.
Basically.

No realm-shift, so Dr. Silverberg tries a rerun.

Dr. S: If Alex hadn't asked you to come
in would you have?
Dr. M: I
had in mind I
needed a check-up.

Still no medical information, so Dr. Silverberg says,

Dr. S: Is there anything that's bothering you
other than the hearing.
Dr. M: Nothing.

Finally Dr. Silverberg formulates a medical inquiry out of an observation of his own. And he addresses it to the son rather than the father.

Dr. S: He's hoarse.
What's the history of that.

Alex tries to give some account of it, but they still fail to draw Dr. Malinowski into the realm of medicine, so Dr. Silverberg says,

Dr. S: Have you ever had any problem with your heart.
Dr. M: No.
Dr. S: No heart attacks?
Dr. M: Pardon me?
Dr. S: Heart attacks?
Dr. M: No.
Dr. S: No pain in the chest?
Dr. M: No pain in the chest.

Dr. Malinowski appears to have got the import of this line of inquiry, however, because as Dr. Silverberg starts to make another observation, Dr. Malinowski announces one of his own.

Dr. S: I
noticed that=
Dr. M: I am a graduate of Auschwitz

And he goes on to tell an anecdote that leads to an account of his tuberculosis, that is, a pain in the chest.

The Body as Object

If the history-taking is still a realm of the self, though one in which the self is becoming detached from the body, the physical examination is a realm of the body, and one in which the body is rendered an object. The physical examination is organized around acts directed to the body. Talk directed to the self is inserted into interstices between acts. During history-taking, by contrast, acts are inserted into interstices in talk. For instance, as he takes Dr. Malinowski's history, Dr. Silverberg asks him, "Do your ankles ever puff up?" When Dr. Malinowski appears uncertain, Dr. Silverberg says, "Tell you in a minute," reaches over to Dr. Malinowski, who is still sitting next to him, tugs down his sock with one hand and touches his ankle with a fingertip. Enclaves or strips from one realm are thus inset or interlayered in the other.

Realm-shift can be accomplished either by reframing the same space as a different realm, or by changing spaces. Dr. Kleinfeld combines his office and examining room in one space. His desk and chairs are clustered along one wall, the examination table, sink, and stools along the other. The spaces can be divided by a curtain running along the length of the room so that if a person is to change clothes, she or he can retire behind the curtain to do so. This flexible use of boundaries reframes the same space as a different realm. Dr. Silverberg keeps two separate rooms, an office for history-taking and an examining room for the physical examination. The ontological transformations of the medical examination are thus fitted into different realms already constituted by these fixed boundaries. The term "examination table" is indicative of the realm status of these regions. What might be seen from the person's perspective as a bed on which to lie is instead described from the physicians' perspective as a table on which to inspect things. As physician and patient move into intimate space for the examination, there is an enormous reduction of eye contact and face-to-face orientation along with the deployment of other evidential boundaries. The heightening of tactile and olfactory senses is accompanied by an elision of social presence.

The transition between realms is managed by reframing the body as an object. At the conclusion of the history-taking, Dr. Kleinfeld says to Mrs. Hardy,

Dr. K: O.K.
Right I want to
uh check your blood pressure but I want you to get undressed
and put the gown on so I can feel your belly
all right and I want to check you for blood—

As he speaks, Mrs. Hardy stands up and starts to take off her jacket. He cuts himself off to say

Dr. K: If you will
undress— put the gown on with the opening in the back
and uh
just step around here.

He gets up, draws the curtain along the center of the room, and gestures her behind it with him. He takes a gown for her out of the drawer under the examination table, comes out again, and sits at his desk with his back to her and works on his notes.

In the absence of explicit instructions about the removal, retention, and replacement of evidential boundaries, persons can be puzzled about how complete their transformation is meant to be. From behind the curtain Mrs. Hardy asks,

Mrs. H: Take the shoes and stocking off?
Dr. K: Uh
Do you have panty hose on?=
Mrs. H: Yeah
Dr. K: Yeah then take them=
Mrs. H: all off.
((After a moment))
Dr. K: How're you doing all right?
Mrs. H: Umhm.

Dr. K: Come let's pull the curtain back.
Sit down over here.

She starts to emerge from behind the curtain, he draws it open, she goes back and sits on the end of the examination table.

With the change of clothes, the person's transformation into a patient could be supposed to be complete. Dr. Kleinfeld approaches Mrs. Hardy and, without comment, picks up her right forearm, tucks it under his right elbow, wraps the blood-pressure cuff around her upper arm and pumps up the device, holding her elbow with his left hand, fingers on the crook, thumb underneath. Compliant with these cues, she attempts to sustain the position into which Dr. Kleinfeld has put her body, and he says to her, "O.K., let your arm down now. Let your arm down, that's good." The physician's arrangements to change realms take the form of instructions to the person to handle her or his own body as an object. At the close of history-taking, Dr. Silverberg and Alex are still discussing Dr. Malinowski's hoarse voice.

Dr. M: I don't know why I have it maybe because I'm putting on the show.
Dr. S: I would like to examine you.
Dr. M: For this I came.
Dr. S: I will lead you into the examining room?
Dr. M: All right.
Dr. S: I would like you to
take everything off
down to your undershorts.
And have a seat on the table.
O.K.?=
Dr. M: Do you mean when— over there.
Dr. S: We're going
right next door.

Dr. Silverberg opens his office door, escorts his patient down the hall, opens the door to another room, and gestures Dr. Malinowski in:

Dr. S: Right in here.
Just fine.
Dr. M: To leave the shorts and undershirts?

Dr. S: Just the shorts.
O.K.?
Be in in a second.
Dr. M: Take off the hearing-aid?
Dr. S: Leave the hearing-aid on.
Dr. M: Leave in the ears.

Dr. Silverberg goes out, closing the door, goes back to his office and returns in three minutes, knocks three times on the door, listens for a response, opens it and enters, and observes Dr. Malinowski lying down on the examination table in his shorts, and says, "Perfect." "Perfect" is an evaluative remark that comments on the arrangement of the body as an object in space. The patient's complicity in transforming his body into an object is encapsulated in Dr. Malinowski's offer to take off his hearing-aid, that is, to reduce his own auditory apprehension to the status of an object's.

The physical examination dislodges the self from the body so the body can be handled as an object. This objectification is accomplished in part by the physical disarticulation of the body into its parts. Dr. Silverberg begins his examination of Dr. Malinowski's body with his blood pressure, moves to his head, ears, eyes, nose, mouth, throat, round to his back, then his chest and heart, down to his abdomen, genitals, legs, up to the arms, fingers, ears again, and finally the prostate and anus.

In women patients, the use of drapes during the physical examination enhances the disarticulation of the body into parts, circumscribing each part as a separate object of scrutiny. Mrs. Hardy has on her gown with the opening at the back. Dr. Kleinfeld asks her to lie down on the examination table and lays a paper drape across her lower abdomen like an apron. He then lifts her gown up from underneath the drape and holds it crumpled just under her breasts so that only her belly is exposed. He palpates her belly with his right hand, releases her gown, which slightly unfolds, and continues the abdominal examination with both hands. With male patients a different delicacy is observed. Dr. Malinowski is wearing loose white cotton trunks that button at the top. Dr. Silverberg asks him to lie down on the examination table, listens to his heart, palpates his abdomen, working from the upper aspect downward. Then he unbuttons the patient's shorts in the front, opens the edges and folds them back, exam-

ines his genitals, and folds the shorts together again, leaving them unbuttoned. This service permits the physician to examine the patient's genitals without making the patient expose himself to the physician.

The Body as Self

Despite the reframing of the body as object, its transformation is always incomplete. It is for that reason that metonymic reference by physicians to patients as parts of their bodies as diseases ("The kidney in 101" or "How's the coronary") are concealed from persons. They show too little attention to bodies as selves. Physicians must also, however, be concerned not to show too much attention to bodies as selves. Some parts of the body are incorrigibly symbolic, especially the sexual parts. Because sexual attentions to the body can also involve its disarticulation into parts, the examination of breasts, genitals, or buttocks is hedged with further evidential boundaries. Here drapes work not only to circumscribe some parts of the body but also to conceal others. Dr. Kleinfeld says to Mrs. Hardy, "O.K., I want you to roll over on your side toward the wall. You can bend your knees up to your chest." She turns away from him. He tucks her gown under her side at the back and folds the drape over her legs so that only the fold of her buttocks shows. He puts on gloves, tells her to relax and take a deep breath, leans down, resting his left hand lightly on her upper buttock, and inserts his index finger into her anus. There are, of course, other positions that can be used for rectal examinations, the classic one being the supine, legs-up-and-apart position used by gynecologists. This one, unlike that, excludes the possibility of eye contact, and (in both males and females) partially conceals the genitals. Here drapes, gloves, eye aversion, and leg position interpose evidential boundaries between the physician and his perception of the patient. The intent of these arrangements appears to be to ensure that this, the touchiest of transactions, can transpire wholly within the reframe; the patient wholly object, silent and passive; the physician wholly operator, concentrated and active. But it never does. Even here the physician attends to the presence of a self in the body. As he palpates the interior of her rectum, Dr. Kleinfeld says, "Oh, I know that's not comfortable." And Mrs. Hardy acknowledges her inherence in her body with a wince and a thin whine.

The incompleteness of the transformation of the body from subject to

object is not an imperfection but an intention. In the course of the physical examination, Dr. Silverberg says to Dr. Malinowski, "I'd like to examine your prostate and your anus," and asks him to roll over on his side and bring his knees up to his chest. The patient works his shorts down over his hips as he turns over, and Dr. Silverberg helps him tuck them down under his buttocks.

Dr. S: I will be very gentle.
Dr. M: You will be gentle?
Dr. S: Absolutely.

The doctor puts on his gloves and says,

Dr. S: Bring your knees
up here too.
Good.
O.K.
Fine.
Bring your knees up.
//
Like this. *((Lifts the professor's knees.))*
That's good.
Just breathe in and out
and relax as best you can.
This
will be uncomfortable.

He kneels, inserts his finger briefly and withdraws it.

Dr. S: Finished.
Looks fine.
Dr. M: I should have them back?
Dr. S: Yes please.
((And Dr. Malinowski pulls up his shorts.))

THE ETIQUETTE OF TOUCH

The dislodgment of the self from the body is designed to preserve the social persona from the trespasses of the examination. But the self is so deeply worked into the body that physicians must also be concerned to

preserve the dignity of the self, the social person whose lodgment happens to be the body. This dual attention to the body as incarnate and discarnate, self and object, is handled by a delicate manipulation of frames and boundaries that might be called an etiquette of touch. In response, patients can cede their bodies to the realm of medicine by abstracting themselves for the nonce. But they can also, equally delicately, compose themselves outside of their bodies, for instance, in the realm of narrative. Either gesture of disembodiment preserves the etiquette of touch.

NARRATIVE EMBODIMENTS

Persons are tender of their bodies as if their selves inhered in its organs, vessels, tissues, bones, and blood; as if they were embodied. For us, the body is the locus of the self, indistinguishable from it and expressive of it. I experience myself as embodied, incorporated, incarnated in my body. To be present in the flesh is to evidence this implication of my self in my body.

Medical examinations threaten the embodied self with untoward intimacies. The accoutrements of propriety are stripped away: I appear in nothing but my body. What follows has the structure of a transgression, an infringement, but one in which I am complicit. I disclose my body to the Other, the stranger, the physician. John Berger writes, "We give the doctor access to our bodies. Apart from the doctor, we only grant such access voluntarily to lovers—and many are frightened to do even this. Yet the doctor is a comparative stranger" (Berger and Mohr 1976, 64).[7] To deflect this threat to the embodied self, medicine constitutes itself a separate realm in which the body as lodgment of the self is transformed into the body as object of scrutiny: persons become patients.

This transformation is intended to protect the sensibilities of the social self from the trespasses of the examination. Whatever the medical business of the examination, its phenomenological business is to displace the self from the body. However, people can perceive rendering the body an object as depersonalizing, dehumanizing, or otherwise slighting to the self. This sense of dehumanization is well attested to in both popular and social scientific literature. Elliot Mishler locates dehumanization in the discourse of medicine, where he describes it as the conflict between the voice of medicine, which is understood to dominate during medical examinations,

and the voice of the lifeworld, which is suppressed in a way, he argues, that leads to an "objectification of the patient, to a stripping away of the lifeworld contexts of patient problems" (1984, 128). The disparity between the physician's intention and the patient's perception establishes the context for "gaps," "distortions," and "misunderstandings" between patients and physicians (Mishler 1984, 171).

Because of their sense of the loss of self—a well-founded sense if also a well-intentioned loss—patients can have some impulse to reconstitute a self during medical examinations. This reconstitution can be undertaken by the patient in one of two moves: either by breaking the framework of the realm of medicine by disattending, misunderstanding, or flouting its conventions—Mishler describes this as interrupting the voice of medicine with the voice of the lifeworld (1984, 63)[8]—or by maintaining the framework but inserting into the realm of medicine an enclave of another ontological status, specifically, a narrative enclave.

Rules for producing narratives on ordinary occasions require that they be set off by their frames from the discourses in which they are embedded (see Young 1986, 277–315). Narrative frames—prefaces, openings and beginnings, endings, closings and codas—create an enclosure for stories within medical discourse. The discourse within the frames is understood to be of a different ontological status from the discourse without. In particular, the storyrealm, the realm of narrative discourse, conjures up another realm of events, or taleworld, in which the events the story recounts are understood to transpire (Young 1986, 15–18). It is in this alternate reality that the patient can reappear as a person. In making such an appearance, the patient becomes, as Natanson puts it, "the self constructing for itself the shape of the world it then finds and acts in" (1970, 23). This possibility arises among what Alfred Schutz calls "multiple realities" (1973, 245–262), different realms of being, each with its own "metaphysical constants" (Schutz in Natanson 1970, 198), which individuals conjure up and enter into by turning their attention to them.

Embodying the self in a narrative enclave respects the conventions of the realm of medicine and at the same time manages the presentation of a self, but of one who is sealed inside a story. An inverse relationship develops between the uniquely constituted narrative enclosure in which a patient presents a self and the jointly constituted enclosing realm in which the patient undergoes a loss of self. Stories become enclaves of self over

the course of an occasion on which the body inhabits the realm of medicine.

Goffman argues that persons are in the way of presenting themselves, guiding controlled impressions, not necessarily to deceive, but rather to sustain a reality, an event, a self. Structurally, the self is divided into two aspects, the performer who fabricates these impressions and the character who is the impression fabricated by an ongoing performance which entails them both (Goffman 1959, 252). On ordinary occasions, then, persons do not provide information to recipients so much as present dramas to an audience (Goffman 1974, 508). It is here that the theatrical metaphor for which Goffman is famous takes hold: talk about the self is not so far removed from enactment. We do not have behaviors and descriptions of them but a modulation from embodied to disembodied performances. Storytelling is a special instance of the social construction of the self in which "what the individual presents is not himself but a story containing a protagonist who may happen also to be himself" (Goffman 1974, 541). Here the performer in the realm of medicine fabricates a self in the realm of narrative. In this instance, embodying the self in stories occurs in circumstances in which the self is being disembodied, a complication of the matter Goffman has called "multiple selfing," that is, the evolving or exuding of a second self or several selves over the course of an occasion on which the self is being presented (1974, 521n).

This narrative embodiment of the person moves against the patient's progressive disembodiment over the course of the examination. Medical examinations are divided into two parts: the history-taking and the physical examination. These internal constituents of the realm of medicine are bounded by greetings and farewells that mark the transition between the realm of the ordinary and the realm of medicine. The shift from greetings, in which the physician emerges from his professional role to speak to his patient as a social person, to history-taking, in which the physician elicits information from the patient about his body, is the first move toward dislodging the self from the body. The patient's social person is set aside to attend to his physical body.

In the course of his medical examination, Michael Malinowski, the professor of Jewish literature and history, tells three stories in which he appears as a character. The links and splits between the realm of medicine and the realm of narrative illuminate the nature of narrative, the nature of medicine, and the nature of the self. After Dr. Silverberg shakes hands with the professor and his son in the waiting room, he escorts them to his office, and there begins to take the patient's history. The shift from the waiting room to the office reifies the transition between realms. The history-taking reorients the person's attitude toward his body in two respects: it invites him to regard his body from outside instead of from inside, and it invites him to see it in parts instead of as a whole. Dr. Silverberg's inquiries direct the patient to attend to his body as an object with its own vicissitudes, which he recounts with the detachment of an outsider. In so doing, Dr. Malinowski suffers a slight estrangement from his own body. In making these enquiries, Dr. Silverberg asks about the parts of the body separately, disarticulating it into segments. So Dr. Malinowski's body undergoes a fragmentation. Since the self is felt to inhere in the body as a whole and from the inside, these shifts of perspective tend to separate the self from the body. It is against the thrust of this ongoing estrangement and fragmentation that the professor sets his first story, which might be thought of as the story of the liberation. Dr. Silverberg has shifted from general inquiries about the whole body—height, weight, age, health—to specific inquiries about the eyes, the throat, and the blood. He then continues.

Story 1: The Liberation

Dr. S: Have you ever had any problem with your heart.
Dr. M: No.
Dr. S: No heart attacks?
Dr. M: Pardon me?
Dr. S: Heart attacks?
Dr. M: No.
Dr. S: No pain in the chest?
Dr. M: No pain in the chest.
Dr. S: I
noticed that=
Dr. M: I am a graduate from Auschwitz.
Dr. S: I know— I heard already=
Dr. M: Yeah.
I went there when— I tell Dr. Young about this

and
after Auschwitz
I went through a lot of— I lost this

Dr. S: Umhm.

Dr. M: top finger there
and
I was in a—
after the liberation we were under supervision of
American doctors.

Dr. S: Yeah?

Dr. M: American doctors.

Dr. S: Right.

Dr. M: And it uh
I was sick of course after two years in Auschwitz I was quite uh
uh exhausted.
And later I went through
medical examination
in the American Consul
in Munich

Dr. S: Yeah?

Dr. M: and I came to the United States.

Dr. S: Right?

Dr. M: In nineteen hundred forty-seven.
Nineteen forty-six—
about nineteen forty-seven.
One day—
I lived on Fairfield Avenue
I started to spit
blood.

Dr. S: Right?

Dr. M: Yeah?
And I called the doctor
and he found that something here *((gestures to his chest))*

Dr. S: Tuberculosis?

Dr. M: Somethin— yeah.
And I was in the Deborah
Sanitorium for a year.

Dr. S: In nineteen forty-seven.

Dr. M: I would say forty-seven and about
month of forty-eight.

. . .

Dr. S: Back
to your heart.

This story conjures up a taleworld, the realm of Auschwitz, which is juxtaposed to the ongoing history-taking. The preface, "I am a graduate from Auschwitz," opens onto the other realm. Prefaces are a conventional way of eliciting permission to take an extended turn at talk in order to tell a story (H. Sacks 1992, II, 40). In response to what he perceives as a digression from the realm of medicine, Dr. Silverberg says, "I know—I heard already." Having heard a story is grounds for refusing permission to tell it again (Goffman 1974, 508). Dr. Malinowski persists in spite of this refusal, thus overriding one of the devices available to physicians for controlling the course of an examination, namely, a relevancy rule: that the discourse stay within the realm of medicine. To insert the realm of narrative into the realm of medicine, the professor initially breaks its frame. But in so doing, he substitutes another relevancy rule: topical continuity. Like the history-taking, the taleworld focuses on a part of the body, the chest. It is this part of the body that the professor uses to produce topical continuity between the history-taking and the story. However, it is not the chest but the heart on which the physician is focusing. When he returns talk to the realm of medicine with the remark, "Back to your heart," he is at the same time protesting the irrelevance of this excursion. As is apparent here, the rule for topical continuity, the selection of a next discourse event which shares at least one element with a previous discourse event, permits trivial connections between discourses and, by extension, between realms. But there is a deeper continuity here. Both the realm of Auschwitz and the realm of medicine address the body.

Mishler notes that the struggle between voices for control is associated with disruption of the flow of discourse (1984, 91). He writes that to see departures from the medical paradigm as interruptions is to privilege the physician's perspective (1984, 97). "I am proposing an interpretation of the medical interview as a situation of conflict between two ways of constructing meaning. Moreover, I am also proposing that the physician's

effort to impose a technocratic consciousness, to dominate the voice of the lifeworld by the voice of medicine, seriously impairs and distorts essential requirements for mutual dialogue and human interaction. To the extent that clinical practice is realized through this type of discourse, the possibility of more humane treatment in medicine is severely limited" (1984, 127). This is so despite the fact that the objectification of the body can be intended to protect the sensibilities of the person. On the other hand, to see the dominance of the medical paradigm as an imposition is to privilege the patient's perspective. My concern here is the rhythm of interplay between perspectives, discourses, or realms.

In the realm of medicine, the dismantling of the body continues with Dr. Silverberg's inquiries about the heart, breath, ankles, and back; he recurs to whole body concerns with inquiries about allergies, habits, and relatives; then he goes on to segment the body into the skin, head, eyes again, nose, throat again, excretory organs, stomach again, muscles, bones, and joints. Into this discourse, the professor inserts his second story, the story of the torture. This story is also about a part of the body, the finger, and so again maintains a parallel with the realm in which it is embedded, although not the strict tie of topical continuity. Having created an enclosure in medical discourse for the Auschwitz stories earlier on, Dr. Malinowski now feels entitled to extend or elaborate that taleworld (Young 1986, 80–99). This story is tied, not to the discourse that preceded it, but to the previous story in which he mentions his finger. As if in acknowledgment of the establishment of this enclosure, Dr. Malinowski's preface, "I was not sick except this finger," elicits an invitation from Dr. Silverberg to tell the story: "What happened to that finger." The taleworld is becoming a realm of its own.

Story 2: The Torture

Dr. M: No.
I don't know.
I tell you—I told you Dr. *((to me))* I don't
during the twenty-three months in Auschwitz
Dr. S: Yeah?
Dr. M: I was not sick except this finger.
Dr. S: What happened to that finger.

Dr. M: I wa—
I tell Dr. Young
I was sitting
((coughs)) you have something to drink
Dr. S: Yeah.
I have for you.
Dr. M: Yeah.
I was sitting at the press—
the machine
I don't know how to say in English
—a machine or
[[[ ]
Dr. S: I understand.
Dr. M: Anyway I had to put in this was
iron
and I had to put in— in here with the right hand to put this
which made a hole or whatever it did.
Dr. S: Made a hole in your finger.
Dr. M: No.
Made a hole here *((in the piece of iron))*.
My finger got it.
And behind me was an SS man.
The SS was walking.
And he stood behind me
and at one moment he pushed me.
Just— this was a— a— a—
daily sport.
And instead to put the iron in I put my finger in.
/
But otherwise I wasn't sick.

The shift from taking the history to giving the physical examination involves moving to another space, the examining room, which is an even more narrowly medical realm. Dr. Silverberg then takes his patient to the examining room down the hall and leaves him to take off his clothes. Clothes are the insignia of the social self. Their removal separates the body from its social accoutrements. This reduction of the social self

along with the enhancement of the medical realm completes the dislodgment of the self. What remains is the dispirited, unpersoned, or dehumanized body.

During the physical examination, the body is handled as an object. When Dr. Silverberg returns, he picks the patient's right hand up off his chest, holds it in his right hand, and feels the pulse with his left fingertips. Here is the inversion of the initial handshake which enacted a symmetry between social selves; the physician touches the patient's hand as if it were inanimate. The examination is the rendering in a physical medium of the estrangement of the self and the fragmentation of the body. The person's internal perspective on his own body is subsumed under the physician's external perspective and the whole is disarticulated into parts. Of course, there is still talk: questions, comments, instructions; but now such remarks are inserted into interstices between the acts, the investigations, the physical manipulations that structure the examination. Henceforth, for the course of the physical examination, the patient's body is touched, lifted, probed, turned, bent, tapped, disarranged, and recomposed by the physician. It is here that the absence of the self from the body can be intended as a protection: the social self is thereby preserved from the trespasses of the examination. These are committed only on an object.

After completing the physical examination, including the genital examination, Dr. Silverberg has Dr. Malinowski sit up and looks again at his arms and hands. On the patient's forearm, the faint tattoo of his concentration camp number is visible. At this point, Dr. Silverberg asks the patient to touch his nose with the tips of his fingers and as he does so the patient alludes to a bump on his skull: "I have to tell you how I got that." And the physician responds, "How." Despite this invitation, Dr. Malinowski appears uncertain about the propriety of inserting a story into this most objectified realm.

Story 3: The Capture

Dr. M: I have to tell you how I got that *((the bump))*.
Dr. S: How.
Dr. M: Should I talk here?
Dr. S: You=
Dr. M: Can I talk here?

Dr. S: Sure.
Dr. M: You already know *((to me))*.
When I (s— try) to go to the border
between Poland and Germany
Dr. S: Yeah?
Dr. M: I wanted to escape
to the border over Switzerland=
Dr. S: Umhm.
Dr. M: as a Gentile.
Dr. S: Yeah?
Dr. M: When they caught me
they wanted investigation
/
Dr. S: That it?
Dr. M: (At)
the table was (sitting) near me
and (his arm) was extending behind me
with— how the police ha— how do you call it.
A police club?
Dr. S: Nightstick.
Dr. M: Nightstick.
Dr. S: Umhm.
Dr. M: And they—
I had to count
and they hit me twenty
times over the head.
And er— he told me *zahlen*
—*zahle* means you count.
And after the war—
after the liberation shortly about two three days
American Jewish doctors came
they (examined us)
and he told me
that I have
a nerve splint here?
Dr. S: Yeah.
Dr. M: And this made me be deaf.

The physician then examines the patient's ears, and finally his prostate and rectum. So here, suspended between the genital and rectal examinations, the two procedures toward which the displacement of the self from the body are primarily oriented, is the professor's third and last story. Once again, the story is about a part of the body, the ears, which maintains a continuity with the realm of medicine. But it is also about another part of the body, the genitals. As he mentions, Dr. Malinowski has already told me this story when I talked to him in the waiting room to get his permission to observe and tape-record his examination. He told me that he and a friend had decided, boldly, to cross the border out of Poland into Germany and work their way across Germany to the Swiss border. They carried forged papers. He himself got through the border and was already on the other side when something about his friend aroused the border guard's suspicion and they called him back. To check their suspicions, the guards pulled down his pants and exposed his genitals. Jews were circumcised. This story is concealed as a subtext directed to me within a text directed to the physician. On this understanding, the positioning of the story between the genital and rectal examinations has a tighter topical continuity than is apparent on the surface.

NARRATIVE EMBODIMENTS

Stories are sealed off from the occasions on which they occur, here from the realm of medicine, as events of a different ontological status. For that reason they can be used to reinsert into medicine an alternate reality in which the patient can reappear in his own person without disrupting the ontological conditions of the realm of medicine. Stories about the realm in which Michael Malinowski appears as a character, the world of Auschwitz, might be supposed to be inherently theatrical, on the order of high tragedy. But the boundary between realms insulates medicine in some measure from the tragic passion. The apertures along the boundary through which the realms are connected are here restricted to parts of the body. In telling these stories, Dr. Malinowski is not merely playing on his hearers' emotions. He is rather reconstituting for them the ontological conditions of his world and, having done so, inserting himself into that realm as a fully embodied person. Besides creating a separate reality, telling stories during a medical examination creates a continuity between

the two realms that converts the ontological conditions of the realm of medicine precisely along the dimension of the body.

The stories are tokens of the man, talismans of the salient and defining history which has shaped him. They are not, on that account, unique to this occasion, but are invoked as touchstones of his presence (as they were, for instance, for me when we talked before the examination). They present a person whose life is wrought around an event of existential proportions. Auschwitz was a life-pivoting, world-splitting event: time is reckoned before-Auschwitz and after-Auschwitz; space is divided by it. Not only has he lost a country, a language, and a childhood, but he has also lost a life form. Before Auschwitz, he had a wife and child in Poland; the son who has brought him today is the only child of a second marriage made in the United States after the war. Dr. Malinowski mentions once that he had two sisters: one "perished"; the other died a few years ago of cancer.

The sequential order of events in a story replicates the temporal unfolding of events in the realm it represents (Labov 1972, 359–60). This replication is supposed by some social scientists to extend to the sets of stories which are strung together to make a life history. In this instance, the sequential order in which these stories are told does not replicate the temporal order in which the events they recount occurred. Dr. Malinowski tells about the liberation first, then the torture, and finally the capture. There are of course clear contextual reasons for this that have been detailed here in terms of topical continuity. But I would like to suggest a deeper reason for their array. These stories cluster around Michael Malinowski's sense of self. Auschwitz provides what I would like to call centration: life is anchored here, everything else unfolds around this. The set of stories that make up the Auschwitz experience could be told in any order. There is an implication here for the use of narrativity in the social sciences. By insisting either on the notion that temporally ordered events are presented sequentially among as well as within stories or on re-ordering stories to present them so, social scientists have misunderstood the shape of experience: a life is not always grasped as a linear pattern. Serious attention to narrativity in what John Shotter and Kenneth Gergen call "texts of identity" (1989) will not force the sense of self into the pattern of narrative but will instead deploy narrative to discover the sense of self.

In so presenting the man and reconstituting the ontological conditions

of his world, these stories attain the status of moral fables and lend the medical examination a delineation that renders the etiquette of touch an ethical condition. Not that the stories are warnings to the physician against similar transgressions. On the contrary, in the existential context of these stories, what might otherwise be seen as indignities to the body are transmuted into honors: the physician is a man whose touch preserves just those proprieties of the body that are infringed at Auschwitz.

The body in the taleworld is the analogue of the body in the realm of the medical examination, connected to it part for part, but inverted. The stories spin out existential situations in which the self is constrained to the body. In the first story, "The Liberation," the part of the body is the chest and the mode of insertion of the self in the body is sickness. In that condition, the self cannot transcend its absorption in its bodily discomforts; its sensibilities are sealed in its skin. Drew Leder suggests: "The body is thematized at times of dysfunction or problematic operation" (1990, 85).

In the second story, "The Torture," the part of the body is the finger and the mode of insertion of the self in the body is pain. The self is jolted into the body, its sensibilities concentrated in its minutest part, the tip of a finger. Elaine Scarry argues that the self as the essential center of my experience and as my embodied bridge to the world are split by torture. "The goal of the torturer is to make the one, the body, emphatically and crushingly *present,* by destroying it, and to make the other, the voice, [which embodies my extension into the world], *absent* by destroying it" (1987, 49). "Pain," Leder expatiates, "exerts a power that reverberates throughout the phenomenological field, shifting our relations both to the world and to ourselves. There is a disruption of intentional linkages and a constriction of our spatiality and temporality to their embodied center" (1990, 79). He continues, "disease, like pain, effects a disruption of intentional links and a spatiotemporal constriction" (1990, 80). And "this intentional disruption and spatiotemporal constriction correlates with a heightened thematization of the body" (1990, 81).

In the third story, "The Capture," the parts of the body are the head and the genitals, and the mode of insertion is humiliation. Here the body is emblematic of the man, literally inscribed with his identity. Its degradations are his. Injuring the body changes the circumcision from an inscription of honor into a source of torment, obliging him either to disown his body and betray his honor or to own his body and accept his

torture. The medical examination, by contrast, can be understood to release the self from the body.

The phenomenological cast of the taleworld in which the self is implicated in the body is set against the phenomenological cast of the realm of the medical examination in which the self is extricated from the body. The medical history of the tuberculosis, the severed fingertip, the deafness, which could be detached from their etiology is instead enfolded in the personal history of the concentration camp and recounted as a story. So Auschwitz is invoked not as the cause of these dissolutions of the flesh, but as the frame in terms of which we are to understand what has befallen the body and, it transpires, the frame in terms of which we are to understand what has become of the man. To see the fact that both the realm of medicine and the realm of narrative are about the body as their essential connection is a trivial rendering. The stories are transforms of the ontological problem that is central to the examinations: the fragile, stubborn, precarious, insistent insertion of a self in the body.

loudness, miniature letters to indicate whispers, and repeated letters to indicate prolongation. Here, such metacommunications as I deem relevant, including volume or laughter, gestures, bodily orientation, or spatial arrangement, are noted in double parentheses as editorial comments. Double left-hand brackets indicate two speakers speaking at once and single brackets within the text mark the extent of simultaneous speech.

Apart from these peculiarities, the transcriptions work rather like a dramatic script, speakers' initials to the left, utterances to the right, and stage directions in double parentheses. Elisions in the texts are noted with ellipses. English spelling indicates English speaking. I made no attempt to suggest vernacular speech or regional pronunciation, because to do so privileges the unmarked category which, after all, has an accent, too. Phonetic transcription, which does not privilege one speech register, labors the business of pronunciation beyond my purposes.

A summary of these devices follows. Most of them were adapted for me by the linguist Malcah Yeager from James Shenkein (1978).

TRANSCRIPTION DEVICES

Line ends	Pauses
=	Absence of obligatory end-pause
/	One-beat pause
Capital letters	Start of utterance
.	Down intonation at end of utterance
?	Up intonation at end of utterance
—	Correction phenomena
( )	Doubtful hearings
(hehe)	Laughter
(( ))	Editorial comments
[[	Simultaneous speech
[ ]	Extent of simultaneity
. . . .	Elisions

NOTES

• • •

INTRODUCTION

1. Proxemics is Edward T. Hall's term for the study of personal space (1969, 1).

1. DISEMBODIMENT: INTERNAL MEDICINE

1. The sense of protection afforded by such architectural features diminishes as their distance from the body increases: it is exceedingly difficult to feel concealed in a gymnasium and easy in a closet.

2. This view is at odds with that of the post-Darwinians, who take bodily forms and expressions to be ritualizations of physiological conditions and responses and so inherent in the body (Darwin 1969, 28–29). Subtle accounts of this controversy are provided by Erving Goffman (1979, 69); by Richard Wollheim in terms of expression and correspondence theories, and iconicity and arbitrariness (1968, 26–29, 104–107); by Gregory Bateson in terms of primary and secondary process, mood-signs and signals, and digital and analogic communication (1972, 135, 178, 372–374; and by Rodney Needhan in terms of inner states and external expressions (1981, 53–71).

3. This follows Victor Turner's argument for rituals as transformative (1980, 161).

4. My husband, a physician who used his own name, as I do mine, was, under the usual assumptions, occasionally addressed as "Mr. Young." He used to correct the title rather than the name since, as he once remarked, "It's not the 'Young' I object to, it's the 'Mr.' "

5. The notion of being sick as a role derives from Talcott Parsons. "To be sick [is] not only to be in a biological state . . . but requires exemptions from obligations, conditional legitimation, and motivation to accept therapeutic help. It [can] thus, in part, at least, be classed as a type of deviant behavior . . . socially categorized as a

kind of role" (1964, 332). The theatrical metaphor for forms of social life has been neatly explored by Goffman (1959, 240–254) and Natanson (1970, 6, 167).

6. Apparently both the fabric and the form of these coats changes with the status of the practitioners so that discriminations among doctors, nurses, receptionists, technicians, cooks, and cleaners, as well as among medical students, interns, residents, and staff physicians, and between any of these and patients, are indicated by slight modulations of costume. Roughly, the more extensive the garment, the more complete the investment of its wearer in the realm of medicine. Internists wear long-sleeved, three-quarter-length white cotton coats with their last names and title embroidered on the edge of the upper left-hand pocket; their receptionists wear short-sleeved white nylon tunics; their patients wear white paper jackets or gowns. Thus along with realm-shift, a hierarchic organization of statuses is effected.

7. Nurses participate in the access we grant physicians to our bodies. Of course, we grant limited access to our bodies to a range of practitioners from shoe salespersons, manicurists, and hairdressers to dentists, masseuses, and most intimately, nurslings. But apart from physicians and lovers, access to the anal-genital region is specific to morticians and prostitutes, which suggests something about the body taboos that attend such access.

8. Elliot Mishler points out that the conventions could be shifted by the physician as well as by the patient (1984, 128).

2. PERCEPTUAL MODALITIES: GYNECOLOGY

1. Dr. Anna Copperfield described a photograph of an ultrasound of a patient's viscera to the patient, thus making the woman's interior terrain yet another degree more alien from her experience of her body (June 4, 1987, transcript, 12–13).

2. Suggestively, Hubert Dreyfus, following Heidigger, characterizes nursing as a caring rather than curing practice in his introduction to *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness* (1994, ix).

3. The gynecologist I did the most work with happened to be male so these gestures are also gendered. From brief observations, a similar relinquishment of control by the patient attends examinations by women gynecologists but it is less apt to be materialized in these body holds and is altogether less marked.

4. Feminists sometimes dismantle the hierarchy implicit in these arrangements by eschewing the assumptions of gowns and drapes that mark difference and insisting on commensurate participation in the interchange.

5. Dr. Copperfield uses a similar formula, "Going to touch you now?" as her characteristic opening move toward a vaginal examination.

3. DECIPHERING SIGNS: SURGERY

1. I can grant priority to neither the subject nor the object. Althusser writes that the great debate in philosophy has always been between idealism and materialism. I agree. And, like Althusser, I am not an idealist; unlike Althusser, neither am I a materialist. For me, the relationship between idealism and materialism remains at issue, the issue, as Althusser points out (1971, 50), always being which takes primacy.

2. Nurses customarily wear knee-length tunics of the same cotton material. When women began to practice surgery, they, too, wore the knee-length tunic. Nowadays, most women surgeons wear tunic and trousers and some nurses do, too. Men nurses never entertained such ambiguities. Like their gender group, men, and unlike their professional group, nurses, they always wore trousers.

3. Originally, women's caps were made full, like shower caps, men's like skullcaps. The distinction between them was gender specified by putting flowers on the women's. The era during which men wore long hair and therefore required fuller caps made this custom less apt. Women, especially women who are surgeons, can now wear skullcaps provided their hair is either quite short or quite long and tied back, as can men. A further cover is provided for the still gender-specific beard.

4. Ricoeur writes, "Still another way of expressing the same enigma is that as an individual the text may be reached from different sides. Like a cube, or a volume in space, the text presents a 'relief.' Its different topics are not at the same altitude. Therefore the reconstruction of the whole has a perspectivist aspect similar to that of perception" (1971, 548–549).

4. STILL LIFE WITH CORPSE: PATHOLOGY

1. This corpse, disgorging its cornucopia of organs, is arguably an instance of what Mary Russo calls the female grotesque (1995). Not only is the medical body, in respect of its passivity and abjection, feminized, but also the female body is the root instance of the grotesque body, epitomized by Bakhtin's "senile, pregnant hags." He writes, "This is a typical and very strongly expressed grotesque. It is ambivalent. It is pregnant death, a death that gives birth. There is nothing completed, nothing calm and stable in the bodies of these old hags. They combine a senile, decaying and deformed flesh with the flesh of new life, conceived but as yet unformed. Life is shown in its two-fold contradictory process; it is the epitome of incompleteness. And such is precisely the grotesque concept of the body" (1984, 25–26). "Moreover," Bakhtin notes, "the old hags are laughing" (1984, 25). "The word itself," writes Russo, ". . . evokes the cave—the grotto-esque. Low, hidden, earthly, dark, material, immanent, visceral. As bodily metaphor, the grotesque cave