Disembodiment: The phenomenology of the body in medical examinations*

KATHARINE YOUNG

> 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.*
>
> (Natanson 1970: 12)

Body symbols and the symbolic body

I am inserted into the world bodily and my experience of the world comes to me through my body. As the phenomenologist 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 does my body take in information about the world, but it is also an aspect of the world, an object in it. Here is the source of the temptation to take my body's objectivity as its primary condition and to suppose its subjectivity to be secreted invisibly inside — what might be called the physical object hypothesis of persons. 'All the signs of mundane 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). But my body's corporeality, its objectivity, has a more profound significance. It is as an object that my body takes on symbolic properties. Anthropologists Isenberg and Owen write:

> The individual's body is presented to him, taught to him by society, usually in the manifestation 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 workings of that complex system called the body,

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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)

My body appropriates, wears, 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 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 ones. So powerful is my sense of my body that body symbols come to be used to characterize other aspects of culture. As 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, Douglas (1973) argues, cultural symbols become lodged in the 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)

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Hence, as this interplay between philosophers and anthropologists suggests, a phenomenology of the body also recovers the folklore that is invested in it. Symbolic properties of the body can be seen in body symbols and in the symbolic body, in the way in which the body is inscribed on culture and the way in which culture is inscribed on the body.

> 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)

In this inquiry, the symbolic properties of the body are investigated in situations in which bodily intimacies are routinely undertaken: medical examinations.[1]

Frames and boundaries

Because the body is invested with symbolic properties, its parts are treated differentially[2] (see Morris 1969, 1977, 1985). What Goffman calls evidential boundaries are interposed between others and their visual, auditory, tactile, and olfactory apprehension of certain parts of the body.[3]

> Whenever an individual participates in an activity, he will be situated in regard to it.... He will find barriers to his perception, a sort of *evidential boundary*. Everything beyond this boundary will be concealed from him. (Goffman 1974: 215; see also 1959: 151–165, on communication barriers or boundaries; 1976: 127, 140, on participation shields)

Concealments of the body itself behind evidential boundaries are at issue here. These boundaries can take the form of bodily clothing; scents and descenters; 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 closer 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. (The sense of protection afforded

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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.) 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 inquiry.

For the purposes of the examination, the body is reframed to exclude some of 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.[4] 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 (Schutz 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,[5] and physicians' bodies become the lodgement of a detection apparatus. The management of frames during medical examinations is, therefore, the other concern of this inquiry.

A medical examination could be taken to operate under a social contract[6] which would read as follows: 'for medical purposes, I grant license to this physician to examine my body'. Under this interpretation, reframing of the body as object could be understood as performatives (Searle 1969), linguistic or metalinguistic messages which enact what they express and take 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 which renders it, for the nonce, an object instead of a self. On closer inspection, however, it becomes apparent that realm-shift is an intermittent, periodic, or partial phase, layer, or aspect of the medical examination. The incompleteness of the transformation can be seen from 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 its 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.

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Spatio-temporal ontologies

Realm-shift in medicine is grounded in the distribution of realms in space and their sequencing in time. In the University Hospital[7] of a large Eastern city, the 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 to 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.[8]

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 its margins' (1966: 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

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stringency of the system; for them the tempo of the transfer is simply accelerated.

Within the realm of medicine, spaces are further differentiated.[9] 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. However, because of the nesting of networks within networks of spaces within the hospital, 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 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.[10] 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.[11]

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.[12] It extends not only to objects attached to the body, but also to objects possessed by the person and to the envelope of

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space that contains them (Sommer 1969: viii; Hall 1969: 113–128, 1977: 25–38; Goffman 1979: 28–60). Constraining the self to its bodily integument is a move in 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 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, appears to take on the realm status 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.) 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.[13] 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 their lack of supporting undergarments. Men patients may be said to sustain a deeper parity with men physicians, but not one which is symmetrically displayed. The entanglement of professional with gender roles here is evidenced by woman 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

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and interactions between different genders are regarded as sexually charged.

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 enclaves (Schutz 1973: 256, footnote) of another ontological status within the realm of the ordinary. 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 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 1966: 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 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

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arranged, movements contained and directed, voices 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.

Case studies

In the Department of General Medicine, persons 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 whose entrance they guard. Having given their names to an intermediary, persons then wait to be reinvoked as patients. In this practice, physicians collect the name of their next patient from the chart which is delivered to a rack outside their door by the nurse or from the receptionist or her list, 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. Dr. Mathew Silverberg 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. Dr. Adam Kleinfeld 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 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 profes-

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sional 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 used to call 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 Dr. Michael Malinowski, 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 examination 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 both 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', 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. Or with a patient he knows, Dr. Kleinfeld says, 'Hi Dave' and waves him in. 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.

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She says 'Hi'. Then he precedes her to his office, goes in and stops 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, 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 physician'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 tucking it into his desk, leaning forward, and looking at his charts. Dr. Silverberg 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 his 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 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, spacing, and bodily orientation (see Sommer 1969: 12–38; Hall 1969: 1–146; Goffman 1974: 215, 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 requires side-to-side orientation with a low degree of eye contact. Both constellations of arrangements maintain 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 says to Dr. Silverberg:

	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.

Attempts by the patient to attend to the physician as a social person can get short shrift. Dr. Kleinfeld escorts Mrs. Hardy, a slim, well-dressed

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black woman of sixty-two, to his examining room, goes over to his desk and says:

	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, inflect Dr. Silverberg's office toward humanity. Framed medical degrees would inflect it toward professionalism.

Conceptual frames

Realm-shift is materialized in the architecture of these spaces because, as 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:

	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. Dr. Silverberg says to Mrs. Johnson:

	How are you.
Mrs. J:	Fine. ((and then jokes about saying so when she is not, thereby noticing and effecting the appropriate shift of realms))

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

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 persons' inclination to use a socially correct response instead of a medically informative one, resulting in a failure to shift realms.

To hedge against failure to shift realms, 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 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:

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 inquiry altogether and to 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 patients. 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. Because of the overlap, Dr. Silverberg 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

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does not respond, so Dr. Silverberg, abandoning greetings, says 'Have a chair' and indicates the same one. 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 another chair in the corner behind the desk and says, 'Let me sit down here (so I can hear you)', at which point Dr. Silverberg, catching on to his deafness, pulls the chair over next to him 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', realizes he has not got the right one, and excuses himself to go out for it.

Difficulties of this initial scene turn out to be grounded in the fact that the patient is rather deaf. Stage directions by the nurse and by 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, 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 his or her 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; 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. 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 his or her body.

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

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Dr. K: I thought you were having a cold.
Mrs. H: Yeah a cold and then 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....

Not only does she refer to her cold as 'the cold', but she even refers to her back as 'the back', as if she were outside them. This kind of objective self-referencing also informs her gestures. In describing pain in her back and her 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 outsider.

Occasionally it is difficult for the physician to induce a person to shift his attention to his 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.

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

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

Finally Dr. Silverberg turns to Alex and says:

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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:

	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.

However, Dr. Malinowski appears to have got the import of this line of inquiry, because Dr. Silverberg then starts to say,

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

and tells 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 the history-taking, acts are inserted into interstices in talk. For instance, Dr. Silverberg asks Dr. Malinowski, '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 sitting right 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

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that if a person is to change clothes, he or she can retire behind it 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 formal 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 is instead described from the physician's perspective as a table. As physician and patient move into intimate space, there is an enormous reduction of eye contact and face-to-face orientation along with the deployment of other evidential boundaries. A heightening of the 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:

> 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

> 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:

	Take the shoes and stockings off?
Dr. K:	Uh
	Do you have panty hose on?=

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Mrs. H:	Yeah.
Dr. K:	Yeah then take them =
Mrs. H:	all off.

After a moment, Dr. Kleinfeld says

	How're you doing all right?
Mrs. H:	Umhm.
Dr. K:	Come on 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 has to tell 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 his or her 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 the door, escorts his patient down the hall, opens the door, and gestures Dr. Malinowski in, saying:

Right in here.
Just fine.

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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 which 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, hands, 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 which 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, examines 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.

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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 or diseases ('The kidney in 101' or 'How's the coronary') are concealed from persons: they show too little attention to bodies as selves. However, physicians must also be concerned not to show too much attention to bodies as selves. Some parts of the body are incorrigibly symbolic, especially the sexual parts. Since 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 bottom 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 insure 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:

Dr. K: 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 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 bottom.

Dr. S: I'll be very gentle.
Dr. C: You will be gentle?

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Dr. S: Absolutely.

The doctor puts on his gloves and says:

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.

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 which might be called an etiquette of touch.

Appendix: Transcription Conventions

Line-ends — Pauses
(From Tedlock 1978)
= — Absence of obligatory end-pause

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/ — One turn 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
(Adapted by Malcah Yeager from Schenkein 1978.)
Initials preceding : — Abbreviation of speaker
English spelling — English speaking

Notes

* A version of this paper was given at the 1984 American Folklore Society Meetings in San Diego, California.

1. The pursuit of philosophical puzzles in medicine has a long tradition by practitioners within medicine, among the more interesting of whom are Richard Selzer and Oliver Sacks, and (most phenomenologically) Paul Schilder. Among approaches in the philosophical vein to medicine from without are those of Erving Goffman, David Sudnow, Charles Bosk, and Yael Zerubavel, and again most phenomenologically, John Berger.
2. 'Of course, different parts of the body are accorded different concern — indeed this differential concern tells us in part how the body will be divided up into segments conceptually' (Goffman 1979: 38).
3. The body itself constitutes an evidential boundary. States which 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 1975: 216).
4. This view is at odds with 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 Goffman (1979: 69); by Wollheim in terms of expression and correspondence theories, and iconicity and arbitrariness (1968: 26–29, 104–107); by Bateson in terms of primary and secondary process, mood-signs and signals, and digital and analogic communication (1972: 135, 178, 372–374); and by Needham in terms of inner states and external expressions (1981: 53–71).
5. Just here is the uncovering of the mystery of the body-as-self and the body-as-object. Merleau-Ponty writes: 'One must believe that there was someone over there. But where? Not in that overstrained voice, not in that face lined like any well-worn object. Certainly not *behind* that setup: I know quite well that back there is only "darkness crammed with organs"' (1973: 133–134).

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6. Social contract theory originates with Locke (1959: 159).
7. Material for this analysis is taken from transcriptions of tape recordings and notes on observations of medical examinations which I obtained during my research on the conduct of medical examinations in 1984. All observations are actual and all transcriptions are verbatim, but the names of patients and physicians, as well as the name of the hospital, have been fictionalized to protect confidentiality.
8. For an argument for rituals as transformative, see Turner (1980: 161).
9. The innermost region of the hospital — that is, the one to which access is most severely restricted — is the operating room, whose rituals are discussed elsewhere.
10. My husband, who is a physician and uses his own name, is occasionally, in the nature of things, addressed as 'Mr. Young'. He corrects it to 'Dr.' since, as he once remarked, 'It's not the "Young" I object to, it's the "Mr."'.
11. 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).
12. Objects are not supposed to have extensions into social or conceptual space, though exceptions have been claimed, for instance by Armstrong for esthetic objects (1971).
13. Apparently both the fabric and the form of these coats modulates with the status of the practitioners so that discriminations between 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 titles embroidered on the edge of the upper left-hand pocket; their receptionists wear short-sleeved white nylon tunics; their patients wear white paper gowns. Thus, along with realm-shift, a hierarchization of statuses is effected.

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Katharine Young (b. 1943) is in her research primarily interested in esthetics, phenomenology, folklore, narrative analysis, nonverbal communication, body symbols, and the self. Among her publications are 'Ontological puzzles about narrative' (1984), 'The notion of context' (1985), and *Taleworlds and Storyrealms: The Phenomenology of Narrative* (1986).

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