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Citation:

KOSKI, Kaisu (2013). As if the patient were in the classroom: Video-based enquiry into the absent body in medical education. *Journal of Applied Arts & Health*, 4 (2), 207-222. [Article]

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As-if the patient were in the classroom:

Video-based enquiry into the absent body in medical education

Kaisu Koski

Abstract

This article discusses video-based enquiry as a means to explore representations of the human body in medical education. A video piece, *Preclinical Body*, will be considered as a case study introducing different views on the body, as offered in medical education. Methodological questions are central in this article as it both maps the parameters of the video-based, performative, and narrative outcomes, and draws connections between associated approaches of visual anthropology, ethnotheatre and narrative enquiry. This article parallels a data analysis with a video editing process, and introduces a synthesis of the data and the researcher's interpretation in a new video narrative.

Keywords

Body, medical education, video-based enquiry, postdramatic performance, ethnotheatre, narrative

Introduction

This article addresses methods, processes and outcomes of video-based enquiry as it explores the human body and its representations in medical education. The research project discussed here involves a three-month field trip in the Faculty of Medicine and Dentistry at the University of Alberta, conducted in

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2011. This field trip into medical education unveiled several ways that the body appears in the narratives presented and produced by students as they are taught to imagine and act as if the patient were actually there. Stemming from this trip, there has been composed a video-based artwork entitled *Preclinical Body* (2012) that explores various aspects of the 'absent' body in medical education, such as a narrative of an imagined patient.¹ The processes of producing these hypothetical, imaginative bodies are here deconstructed in fragmented video portrayals, considering the body as a voice, and viewing objects and even blood as representations of the body.

The article first sketches the disciplinary and methodological position for video-based enquiry, and subsequently addresses its relation to performative and narrative forms of expression and enquiry. This is followed by a description of the study procedure and the types of data involved in this project. The article then moves to a deconstruction of the case study video piece (storyboard), illustrating the ways in which it portrays the absence of the patient in medical education, and reflect upon it through the concepts introduced in the beginning.

Background

The video-based enquiry explored in this article is a form of arts-based health research, which employs artistic methods for research purposes in the health sciences (Lafrenière et al. 2012). Video-based enquiry refers here to audio-visual research methods employing cinematic techniques in collecting, organizing and screening data in the context of academic research. The cinematic techniques are employed in film productions as well as video. However, compared to actual film, video allows autonomous, economical, and fast production methods, and is flexible for display platforms.

While considering video-based enquiry under the umbrella of arts-based enquiries, the term 'video-based' places the medium rightfully in a central position, rather than any disciplinary tradition. In this viewpoint, all cinematic productions are subject to the laws of narrative and visual drama (van Dijck 2005), and even a utilitarian research film without aesthetic intentions paradoxically develops the 'supernatural gift' of cinematic beauty (Bazin [1947] 2000). Artists are hence not the only professionals composing (with) images. One can, for instance, differentiate raw anthropological film footage from an anthropological film: films are constructed works making use of cinematic conventions (MacDougall 2011).

While the art practice involved in this enquiry has several parallels with ethnography and visual anthropology, its outcomes cannot be labelled as ethnographic or anthropological film: it deliberately involves elements detached from the original context, and forms collages of ideas, images, and sounds from various sources. In this respect, there is an affiliation with the idea of *surrealist ethnography*, introduced by James Clifford (1988). Clifford distinguishes several elements that surrealist ethnography embraces, for instance, the use of collage: bringing together things that inhabit different times, places, and contexts. The video piece discussed in this article, in fact, purposefully obscures data with the juxtaposition of seemingly unrelated events, a feature that anthropological film-makers wish to avoid (see MacDougall 2011). The aim is to motivate the viewer to construct meanings from the material, reminding the viewer simultaneously of the arbitrary qualities associated with any data collection.

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Methodology and theory

This research project explores narratives and performances from various sources. First, there are the audio-visual interview narratives illuminating the personal experiences of the medical students and teachers. Second, there are the written narratives offered by the medical educators, aiming to stimulate learning. Third, there are the oral performances produced in small-group situations, based on the written narratives. Additionally, this enquiry results in a new video-based narrative: instead of merely thinking *about* the stories collected from, and generated in medical education, this project chooses to think *with* them, synthesizing the stories in a video piece (see Bleakley 2005). The synthesis is preceded by thematic and visual organization of the raw data, which subsequently is set into a dialogue with the researcher's interpretations in the video editing process. In this regard Goodman (2004) sees the film editing process analogous to a data analysis: it builds and manipulates a data set and uses a (film) theory to guide the storyboard and footage selection.

Within the medium of video, this enquiry manifests in the particular qualities of on-screen performance. In this regard, the methodological approach of ethnotheatre has significant similarities with this enquiry: ethnotheatre displays the research participants' experiences and/or researcher's interpretations through artistic craft and techniques in live performance (Saldaña 2003).² Furthermore, the script of such a production consists of significant selections analysed and dramatized from interview transcripts and field notes, characters being commonly research participants played by actors (Saldaña 2003). However, this enquiry portrays only the participants and the researcher, and hence does not have played characters in the sense of dramatic theatre or film. As a matter of fact, it is influenced by performance art, in that it strives for an experience of the real and alive (see Lehmann 2006). While this might sound controversial in relation to the representational medium of video, the realness in this context appears, for instance, in the transparency in the process of creation and the inclusion of mistakes and gaps in the screen events. This is a fundamentally different way of approaching data than in ethnodrama: J. Saldaña (2003) suggests that the playwright should reduce the verbatim transcript to the 'juicy stuff' for 'dramatic effect'. In this project, however, ordinary events and the participants' mere presence in the image are considered 'juicy' as well. Casualness is, in fact, one of the features associated with postdramatic ways of performing: there is usually no longer an actor of a role, but a performer who is offering her presence onstage for contemplation (Lehmann 2006).

In video-based enquiry, the participants' narratives and the researcher's interpretation are dramatized on a storyboard, which, in turn, is translated on-screen. The arrival of a storyboard is, in actuality, similar to a grounded theory approach: the researcher-film-maker does not enter into the interviews with a particular narrative in their mind, but lets the data guide the structure and emphasis of the film narrative. Instead of arriving to a conclusion, the aim of this approach is a 'turn in conversation': next to the conventional emphasis on the research participants, the artist-researcher's intentions and the viewer's perceptions are here considered equally important (Bochner and Ellis 2003).

Study procedure: Interviews and participant observation

The bodies of the medical students and educators are at the core of this project, since they produce and/or manipulate the bodies represented in the education. As research participants, they are protected by ethics protocols, and

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hence regulated in the way that they may be represented on-screen. While the data in this enquiry has been generated and collected both by interviews and participant observation, it is especially the interview procedure that is both ethically and technically challenging. Even though many of the ethical questions involved in arts-based health research are addressed elsewhere (see e.g. Koski 2012), it seems necessary to describe the influence of the ethics protocol on the interview data briefly here.

Due to the three-month time limit for the field trip, it appeared that recording the interviews anonymously was the safest way to receive an ethics clearance in time. This meant that identifiable faces would not be

involved in any of the images. Instead of choosing to blur or otherwise obscure the participants' facial images, which, in turn, might appear as ridiculing or stigmatizing, an idea in which the 'medical hands' were central was selected, by filming subsequently the participants' hands and forearms only.

Thirteen one-hour open-ended interviews, involving seven medical students and five clinical teachers, were divided over two weeks' time. In a video-based enquiry, which employs the raw data in the outcomes of the project, the design of the interview becomes featured. In order to collect various types of data from the participants, there were not merely questions asked, but the interviewees were invited in various creative, associative and visual exercises. They were, for instance, stimulated to perform a photo improvisation with their hands, and to use drawing as an anatomy-teaching tool.³

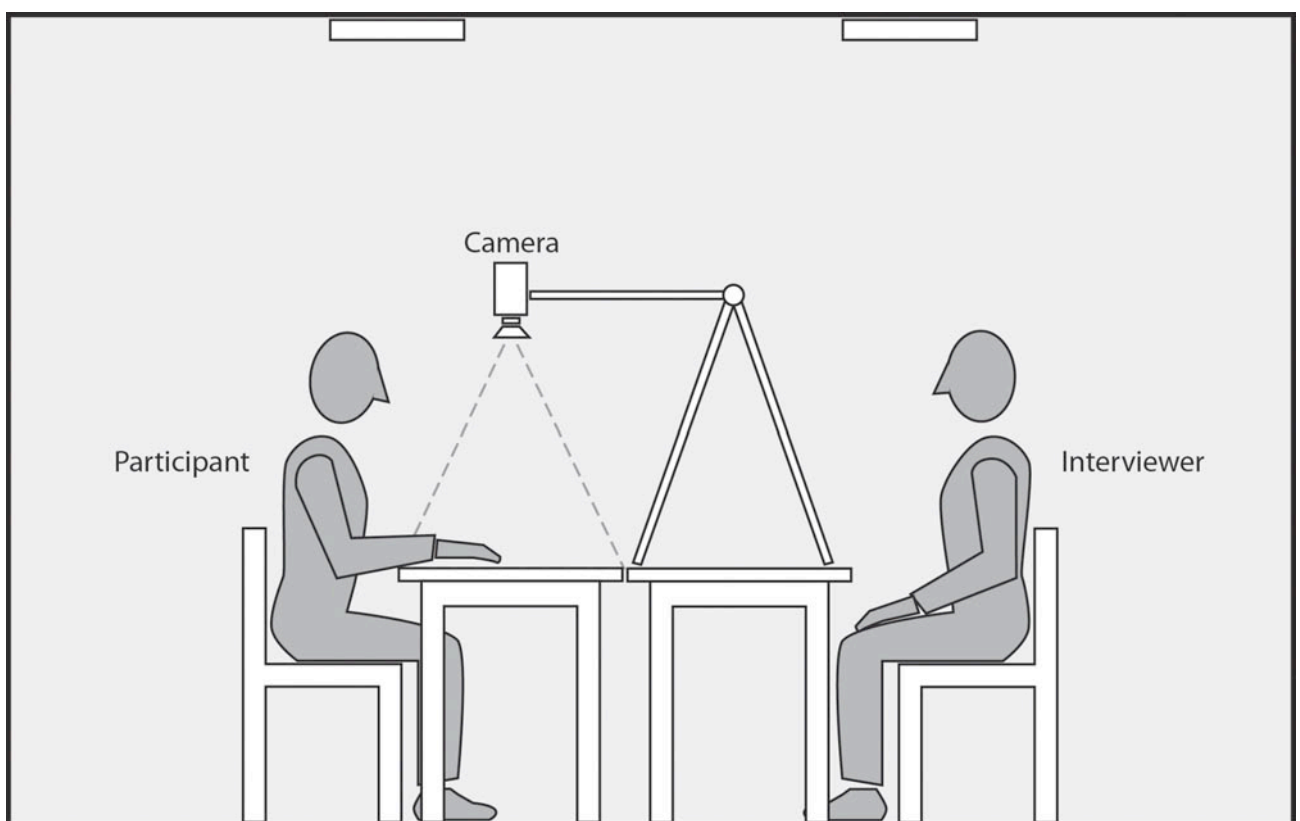


Figure 1: When recording 'in the field' instead of a studio, the lighting and acoustics, among other things, influence the camera set-up. This diagram of the interview set-up illustrates the positions of the key elements involved. I employed the TL-lights of the classroom for lighting, and carefully measured the recording set-up position to remain the same for each interview. Additionally, the room was deliberately chosen because it lacked daylight. © Kaisu Koski.

There was a wish to employ the participants as the main narrators and performers of the film. However, using voices from the actual interview recordings proved challenging: many sentences were unclear or incomplete, or there was a simultaneous noise from the hands that rendered the voices unusable. Furthermore, as one cannot see the face of the participant talking, there is no lip sync or other way

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to know who is actually talking. In the video piece the hands and the voices of each participant are kept together, and the moving pair of hands indicates which one of the participants in the image is talking at any given moment.

The camera work during the interviews is rather 'scientific': the camera is static, mounted on a tripod, without zooming or panning, and it is allowed to run for the whole interview duration until the participant has left. Because the only (camera) image is very simple, every detail within it becomes highlighted. The preference was to keep the elements in the image as authentic as possible. 'Authentic' here refers to the origin of the background, lighting, and objects from actual medical education and the interview situations. As a background for the hands, for instance, the viewer sees flip-board papers from the small group rooms in which the discovery learning sessions took place.

In addition to interviews, the data have been collected by observing various educational situations in the medical school. Medical education is conventionally divided into preclinical and clinical parts, and it does not usually confront the student with an actual patient during the first few years.⁴ Instead, due to pedagogical, ethical, and logistic restraints (de Leng et al. 2007), it brings the body of the patient in through various simulations, visualizations and narratives. The interviews, and the case study video piece, identify three main learning contexts: discovery learning, clinical skills and the anatomy lab, which all produce or imagine the patient in different ways. To begin with the discovery learning, or problem-based learning, the student is first given a problem, commonly in a small group of approximately eight students, followed by a process of working towards a resolution or understanding of the problem (Barrows and Tamblyn 1980).⁵ During these sessions, the students are being introduced to trigger scenarios of what could be, or have been, real medical situations. The discovery learning sessions observed in this study took place within three weeks, involving three different case scenarios and three different teachers' approaches. The cases introduced were text-based, employing descriptions as well as dialogue (de Leng et al. 2007).

The trigger scenarios were commonly spread over several pages, while the teacher would release one page at the time, each page revealing more and more information about the patient.⁶ One story would usually last for three sessions divided over one week. The story therefore proceeded sequentially, both in the sense of being fragmented along the week, and in occurring on multiple pages. The following paragraphs, transcribed verbatim from the field notes, point out two ways that the body of the patient is represented during the same emergency medicine scenario. First, seen from performative and narrative points of views, one of the interesting aspects of these learning situations is the continuous shift between two spatio-temporal dimensions: while the trigger story may deal with an emergency situation that happens within a few minutes in everyday life and is commonly associated with a burst of adrenaline, the story in the medical school classroom occurs as a detective story, manifests mostly verbally, and takes several days to unfold. Everybody remains calm and takes their time to discuss while 'the patient is bleeding' on the table. The excerpts below are collected anonymously from the teachers and students during the discovery learning sessions in the University of Alberta in September and October 2011.

Student 1: *We have to figure out what's wrong with the patient first.*

Student 2: *He's lost quite a bit of blood, I'd say.*

Student 3: *He is going into shock, actually.*

Student 4: *We should get a second page.*

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Teacher: *Maybe there is no page two.*

Student 5: *Is he still bleeding?*

Student 6: *We haven't gone to the OR yet, have we?*

[Two days later]

Teacher: *He was almost dead when I left the room on Wednesday. What did you do then?*

Next to the sequential character of these scenarios, and the dynamics of their manifestation in the classroom situations, there could be found multiple roles in between which the teachers and students continuously shifted. In most scenarios, the students were addressed as junior doctors, to engage them as a participant in the story. Additionally, to bring these cases vividly into the here-and-now, teachers employed various roles as well. Here the teacher's personality and teaching style have a great influence on the progression of the narrative and the roles involved. In the following paragraph, the teacher is alternating between different roles and space-time continuums, addressing the students as doctors in the scenario. As a starting point, the teacher maintains the role of a facilitator who guides the situation, but additionally portrays the patient in the case and as the patient's body as well.

Teacher: *Are there different stages of consciousness? Do a consciousness assessment.*

Teacher/Patient: [Murmurs, head hanging over the table]

Student: *So he is still conscious enough...*

Teacher: *No he's not!*

Teacher/Body: *We want more oxygen! The central nervous system says: I am not breathing!*

In addition to the field notes from the discovery learning sessions, clinical skills demonstrations are in a central position in the case study video piece. Clinical skills are core skills related to patient care, and an important initiation into the doctor's profession. In fact, the students learn to embody the doctor's role through these techniques, and are usually eager to practice them.

Participant: [...] *I remember finding the whole ritual and the whole thing he was doing very fascinating, wondering [...] What are you tapping when you're tapping over there? And when I*

started medical school it was like getting initiated into these mysteries: Oh, so that's what he was doing!

Even though there are no data recorded during actual clinical skills lessons, the participants voluntarily demonstrated several examination techniques, such as percussion, during the interviews. Percussion is a method of tapping the body surface in order to explore the underlying structures. While one needs an actual body to practice these skills effectively, it is possible to simulate them against one's own body or a table. This way the hand movements appear as choreography, which can, from artistic point of view, be viewed as rhythms, directions and intensities. Finally, the third learning context of cadaver dissection in an anatomy lab has conventionally been the main method for teaching anatomy.⁷ The cadaver is commonly unveiled one body part after another,

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and the students dissect the whole body during their first two years of study. Entering the anatomy lab confronts with the multisensory nature of the study, including the smell of formaldehyde, and gives a glimpse into the emotional challenges related to cadaver dissection.

Participant 1: *I think the thing that I was the most scared of was that what would your eyes look like, if you were dead.*

Participant 2: *I just remember being so profoundly sad that there was a dead person in front of me, that it didn't feel right what we were going to do.*

Case study: From data to the storyboard of *Preclinical Body*

Preclinical Body intertwines interview material from thirteen participants and the field notes with studio-based footage recorded afterwards.⁸ The work process began by transcribing the interviews audio-visually: the image of the hands is considered equally important as the participants' comments. In the interview transcriptions, for instance, the participants' main hand gestures have been codified by hand-made drawings, in order to trace back the visually important data such as the hand gestures simulating clinical skills. When selecting interview comments from the participants, they are thematically ordered, and set to form a dialogue with each other, often either supporting each other's opinion, or alternatively juxtaposing two or more very different viewpoints. Even though the interviews already form a foundation for the upcoming storyboard, by concentrating on the three selected learning contexts, and inviting the participants in creative exercises, most decisions are made during the editing process only. The aim was to collect both 'typical' answers, shared by several participants and thus revealing possible patterns in their thinking, as well as unusual perspectives that only one of them introduced. The video piece thus aims creating a better understanding of the personal–emotional experiences in medical education in general, as well as surprising the viewer by questioning the stereotypical images of how medical professionals are.

Next to the narratives in the data, the form of outcome is influenced by the medium of video as well. Some of the decisions made during the editing process have thus a visual motivation, such as portraying a

maximum of six participants at a time to maintain a certain size and composition. Other decisions, in turn, are based on motivations such as inclusiveness: there was a wish to portray all the participants, either as their hand images or as their voices. Most participants, in fact, appear as both. While the data are manipulated by combining several individual pairs of hands together in one image, this manipulation makes the end result strangely more 'real': it corresponds to an actual discovery learning situation as if there is a group of people sitting around the table. This is one of the examples of how cinematic techniques change the perception of the data. However, also promoting the transparency of this manipulation, pairs of hands are faded in and out, communicating the constructed nature of the situation.

Preclinical Body is divided into three main scenes: first, an introductory scene in which selected participants introduce themselves, and subsequently elaborate on the fragmented body (image) offered in the medical curriculum. The second scene combines a discovery learning trigger story and clinical skills, manifesting in hand techniques that the participants produced during the interviews. In the third scene, the participants tell about their first anatomy

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lab experiences, accompanied by a collection of objects they found personally important when connecting with the human body.

Scene 1

The piece begins by unveiling how the interview is being conducted and how the interviewer instructs the participants to sit in a particular way. Furthermore, the camera set-up and the area visible to the camera are explained, equally to the participant and the viewer. These friendly but determined directions remind one of the instructions of a health care professional when guiding a patient to position them for a physical examination.

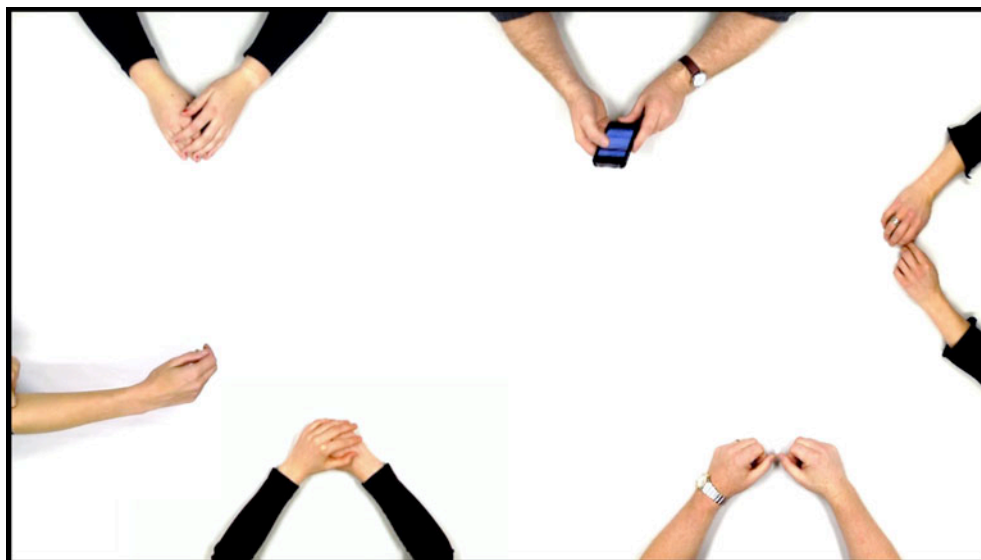


Figure 2: The first scene begins by introducing the setting and the participants. © Kaisu Koski.

Interviewer: *If you come a little bit closer to the table, actually very close to the table... that's perfect, and then if you put your hands on the table, just like normally, I can see where my focus is and stuff like that. [...] And you can pull the sleeves up little bit up so we see a little wrist.*

[Six participants arrive at the table, check their phones, sleeves, remove jewellery...]

Interviewer: *OK, that looks great. Let me start by asking: How were you attracted to medicine? Did you know as a child that you wanted to be a doctor?*

Participant 1: *Not really, you know, my initial interests were actually religion... [...]*

Participant 2: *Both of my parents were physicians, so I didn't know there were any other options...[...]*

Participant 3: *I always thought medicine was way too smart for me...[...]*

The first question goes around the table, and each of the six participants tells briefly about their path to the medical field. This gives an expectation that the piece is constructed as an interview. However, after the second question, the participants' answers take the narrative slowly into another direction without the interference of the interviewer. It gradually moves from the (beginning of the page 215) curriculum to viewing the body as a mystery, and the 'detective' work involved in being a doctor.

Participant 4: *The systems-based approach creates a wall between the systems, but I'm not entirely convinced that systems are separated like that. [...]*

Participant 5: *At some point in medical school you kind of got to understand that 'We took the body apart so that we could teach it to you, and now you've got to put it back together for yourself'. [...]*

Participant 6: *I think we think of the body like a puzzle: it presents itself in symptoms and you have to go ahead and solve what exactly the mystery is.*

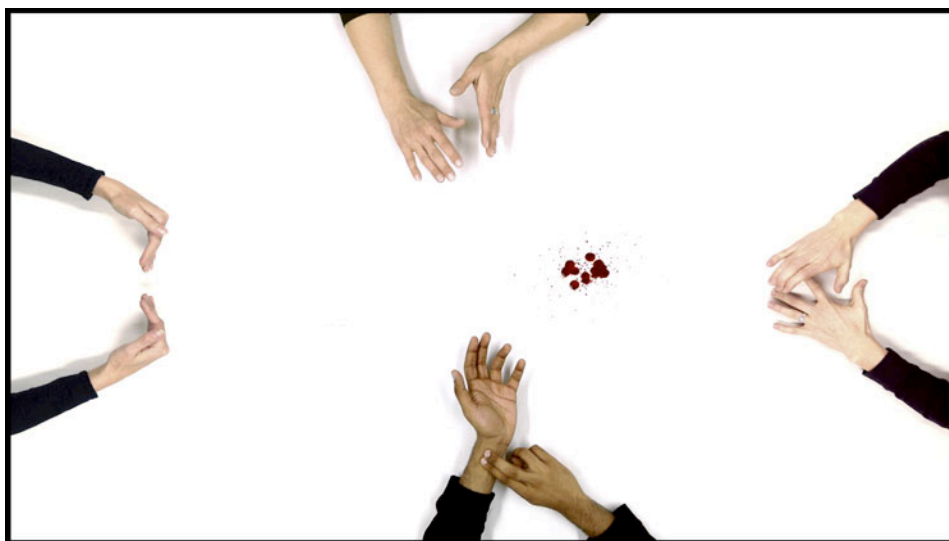


Figure 3: The second scene merges clinical skills techniques with an imagined medical scenario.

Scene 2

The second scene begins in silence, quite literally depicting something mysterious: one pair of hands after another appears, demonstrating clinical skills such as measuring pulse and various percussion techniques. A tapping soundscape develops: the body is approached here as a sound, as echoing cavities. Seen from another point of view, the choreography of the hands sketches the body contours in the absence of an actual patient, performing an absurd 'air-percussion' concert. More hands appear to demonstrate different techniques against the white background. In fact, the background becomes a large body on which these hands operate. The voice-over of the interviewer now introduces a discovery-learning scenario on which the hands seem to be working. The interviewer first asks questions as a teacher, ending with a question as the patient:

Interviewer: *We are now going to get a trauma patient who was stabbed at a house party.*

What are you going to do first?

What are you going to do second?

What are you going to do to me, doctor?

The participants remain silent: they answer with their hands by producing repetitious clinical-skill hand movements. Moreover, as many of the trigger (beginning of the page 216) scenarios indicate the patient's body (processes) in various quantified data, the students in this scene receive information about the patient in numeric form as well. The body is, in other words, represented in numbers that signify, for instance, its rhythms, volume and temperature. The film employs typography in describing the patient's status:

140 beats/min

76/56 mm/Hg

22resps/min

37.0°C

Meanwhile, in the middle of the table a blood-dripping process begins, which represents the spatial-temporal dimension of an actual emergency room (ER) as blood dripping from the examining table. There are, in fact, three parallel narratives represented: the here-and-now as the interview, the study situation in a classroom, and the illusory world of the trigger story ER. In addition to the process of blood dripping, sounds from a 'real' ER are introduced as indications of the trigger story world as well. More and more blood is dripping, and the hands pull back: the case seems to 'go wrong'. The participants are invited to enter an 'auto-pilot' mode, in which their answers to an associative exercise are played: in the interview the participants were invited to say their first association with a group of words. Some of the words, such as 'insult', have different meanings in medical vocabulary. In medicine, 'insult' refers to a bodily injury or trauma. The narrative progression of the scene is indicated by three keywords: *insult*, *blood*, and *shock*. In the film narrative, the patient first experiences an insult, subsequently starts bleeding, and eventually goes into shock. The

spontaneity and intuition of the association exercise parallels the qualities associated with an emergency situation, in which one might operate 'from the backbone'.

[ER sounds, accelerating]

Interviewer: **Insult**

Harsh

Offence

Sad

Too frequent

I had almost at the same time 'verbal insult', but then also started thinking from the lecture that it meant an insult by an invading body. It's almost as if there is one definition trying to supersede the other.

Interviewer: **Blood**

Red

Life

Beauty

Blood...

Life

...you are asking a surgeon about blood...

Warm

Flowing

...loss

Disease

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Interviewer: **Shock**

Put your finger in a light socket

Terror

Shock...

Heart rate

Misunderstanding

...shock?...

Hypovolaemic shock, you are bleeding out and you are going to shock

Fear

Death

[Flatline sound]

Participant: [...] they asked what happened to Jessica, this patient in the case. And I said she died. And a couple of students started to cry, and this was a fictitious case but they had worked

through it and they were so upset [...] and they just said they weren't ready for that outcome. So I don't have my patients die in the first little bit, because I think it really does profoundly affect you, even if it's not a real patient.

[humming *Amazing Grace*]⁹

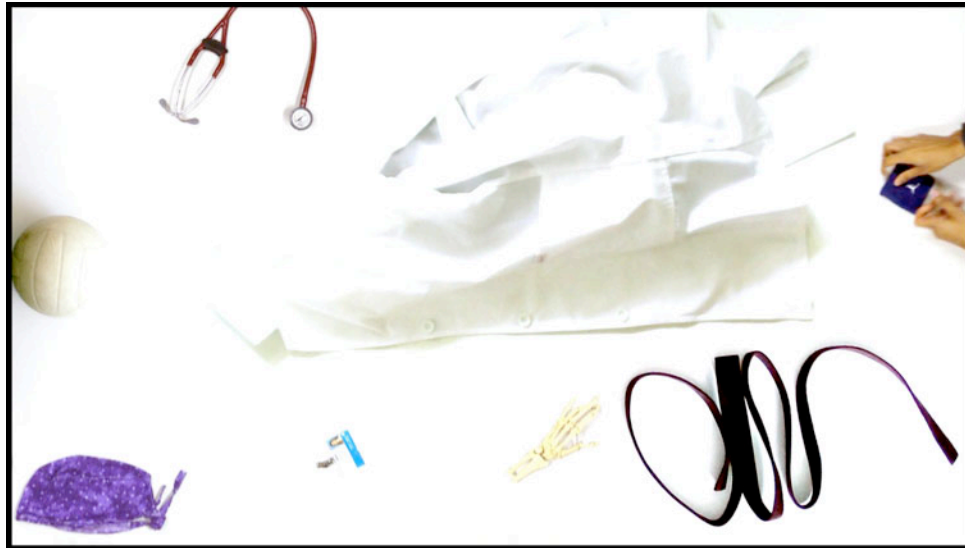


Figure 4: The last scene deconstructs the body of a medical professional by instruments and accessories related to it. © Kaisu Koski.

Scene 3

The third scene continues from the 'failed' discovery learning case, and enters the anatomy lab with the participants. While they recollect their first cadaver dissection memories, the 'dissection table' slowly becomes filled with various objects.

In the interviews, the participants were invited to bring an object that helped them to connect with the body. These objects appear in the third scene, as representations of the body fragmented into the different organ groups in medical education. Furthermore, cadaver dissection physically separates the body parts as well, in order to observe their structure properly. While it was expected that majority of participants would bring some kind of a medical instrument, several participants brought surprisingly objects completely

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unrelated to medical practice. From an ethnographic viewpoint, the objects may be categorized in various ways, namely:

- four medical instruments
- three medical costumes
- three pieces of sports equipment
- three pairs of hands (absence of objects).

However, from a film-maker's viewpoint, the objects are employed to visually metaphorically construct the 'universal' doctor's body: these are the objects that the health care professionals find important in connecting with the body, hence these objects can be seen as extensions of the doctor's body. The scene's aims, as with the previous clinical skills demonstration, draw the contours of the absent body on the examination table. Whereas the manipulating hands function as a point of reference for where the actual patient would be, the objects brought to the table mark this body by themselves.

[volleyball rolls into the image, followed by the other objects]

Participant 7: *I've never seen the human body in that context I guess; I'm not sure how I would react or deal with the idea that this used to be a person...well, this is a person, but this used to be a live person, this person had a family, this person had friends, this person mattered to other people.*

[...]

Participant 8: *Oh, my goodness, I'm looking at all these tendons and vessels and the bones of the hand, and that was this incredible moment of 'I can't believe I'm really doing this!'. This is a real person, 'this could be me'.*

Participant 3: *My personal view is that the body is really spirit and body separated, and when you're a cadaver, you're not there anymore.*

Once the body is constructed with the objects, the volleyball as its head, the coat as the torso, and the rest of the objects as separated organs, the participants begin the actual deconstruction of the body. One by one they lift the objects from the table while simultaneously explaining why these objects are meaningful for them. As the objects are taken back to everyday life again, the process is a metaphor for a dissection in the anatomy lab. Furthermore, in the so-called systems-based approach to the body there are several gaps, areas with less attention, left in the body. Students need to fill the gaps in between the fragmented body parts by finding links between them. The film employs the stories of the participants in knitting together seemingly unrelated object-organs. The scene ends with an empty table, and the interviewer's comment as a reminder of the origin of the material.

Participant 7: *I try my best to take good care of it, so that I remember him at least. Because if I never, ever see him again I have something that can remind me of him.*

[The wristband is taken away]

Participant 9: *Everything in medicine is really hands-on. I think the hand represents a lot of skill and dexterity.*

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Participant 10: *[...] and if I'm telling someone bad news, I touch their hand.*

[The hand simulator is taken away]

Participant 3: *It's really the athletics, the feel of the air going in and out of the lungs. I just feel the connection with the life, how we are formed; it's just the joy of the body I guess.*

[The volleyball rolls away]

Interviewer: *Oh, that's fantastic, thank you!*

Results and discussion

The case study video piece *Preclinical Body* arranges the research data as a multilayered narrative, simulating an actual educational situation, a medical emergency, as well as a research interview. Following a linear interview dialogue, the piece operates with abstractions and metaphors, juxtaposing seemingly unrelated images, which, in turn, require the viewer to take an active role in decoding them. The viewer is, in fact, invited to execute detective work similar to the medical students' dealing with the trigger scenarios: the viewer is given a context and 'characters', but should question the origin and meaning of the events, and travel between the illusory and actual medical realities. The film therefore does not visualize the absent body, nor does it literally tell how the medical curriculum represents the patient. Sometimes its deconstructed representations, however, render the image clearer than in 'messy' reality, as when viewing the hand choreography manipulating the absent patient. Seen from another point of view, the participants telling about meanings related to their personal objects sketch an alternative doctor's body beyond biology or technical qualifications. Even though not considered a documentary, in many ways *Preclinical Body* is authentic and realistic: it screens raw audio-visual data and reveals performative and narrative dimensions, as well as ethical dilemmas appearing in actual medical education. Employing the actual participant images and voices supports this authenticity, yet the project simultaneously provides them with anonymity.

The audio-visual interview data of this project, the participants' hands and forearms being filmed from above, has been employed in various ways in three different artworks. While these processes enable multiple approaches on the same data, sooner or later the image also runs a risk of being exhausted as an artistic-visual composition. Unlike leaning on a standard format of an academic article, each video-based enquiry seems to inherently involve the search for the (grounded) forms of outcomes, deriving from the data itself. This, on the one hand makes it difficult to apply the procedure directly to other cases. However, the procedure of collecting and disseminating visual-performative data can be executed in health humanities research in numerous ways. Furthermore, the outcomes of such processes may be employed in medical education as well. In fact, there is a need to increase the medical students' empathic skills and ability for sensitive listening: when medical students, for instance, restore professional conflicts encountered, they often formulate persons as medical problems (Bleakely 2005). A video-based enquiry has a potential to invite the medical students and educators to reflect on their emotional, spiritual and intellectual

engagements on themes such as health and illness, doctor–patient relationship, and doctors’ professional identity formation, resulting in touching yet sometimes confronting video works. Such

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works may reach the medical school communities beyond the levels academic articles do, especially regarding the audio-visually oriented students. Video-based enquiries may be employed to stimulate discussion in various learning situations, and to increase awareness of the narratives produced within medicine in general.

It is here suggested that video-based enquiry benefits when the researcher collecting and analysing the data is the same person who creates the video-based outcome: employing an external film-maker adds a risk of misinterpretations and potentially conflicting (artistic) agendas. Furthermore, while video-based data may mechanically be edited by a technician as well, editing is here seen as an essential part of the data analysis that should preferably be conducted by the researcher–film-maker. However, ‘going solo’ is not simple either. In fact, next to the artist-researcher’s, or perhaps the funders’ and participants’, wishes for the project, it may be that an artwork itself begins to ‘demand’ certain approach or additional material when its form gets clearer (Koski 2012). Subsequently, employing video both in data collection and knowledge dissemination is commonly more time (and thus money) consuming than writing an article only. Yet another challenge relates to the publishing forums for video-based enquiries: art galleries and film festivals typically reach only a limited amount of viewers. In fact, online presence of such video projects seems relevant.

Regarding the performative and narrative outcomes of video-based enquiries, it is here suggested that the professional artist(-researchers), embedded in the contemporary arts scene, may pursue their subject using different modes of composing and arranging data than researchers from social science, for instance, by employing the method of ethnotheatre. Whereas most ethnotheatre relies on the conventions of dramatic theatre, the practitioners affiliated with postdramatic theatre and performance distance themselves from these. Seen from another point of view, film has always been a secondary way of communication in anthropology and the social sciences (Ball and Smith 2001). However, the arts-based research field is continuously debating whether artistic outcomes may be the primary, or only, form of communication in an enquiry. In fact, does the video piece *Preclinical Body* stand alone as a research outcome, rendering this article unnecessary? Even though the video could be considered to be the primary way of communicating this research project, and promote hybrid forms in which artistic expression merges with the research results, in an academic context, *Preclinical Body* requires other voices to sketch the surrounding context and operate as a reflective mirror. In this regard, hopefully, texts from various sources such as verbatim field notes, interviews, the storyboard and descriptions, all shed a different, and complementary, light on the ‘empty examination table’ in the medical education that the video piece is portraying.

Acknowledgements

With thanks to all of those who participated in this arts-based enquiry, including: Kerry Atkins, Melanie Bodnar, Chantelle Bowden, Pamela Brett-MacLean, Sarah Forgie, Marie Gojmerac, Sachin Rathee, Shirlee Ren, Lynora Saxinger, Urooj Siddiqui, Trish Sigurdson, Jonathan White and Tim Winton.

Thanks to Dr Pamela Brett-MacLean and The Arts & Humanities in Health & Medicine programme in the University of Alberta for facilitating this project.

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This postdoctoral research project is financially supported by the Academy of Finland.

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Notes

¹ Although the title of this article is analogous with the 'absent body' in Leder's (1990) inspirational study in the phenomenology of the human body, 'absence' in this context refers merely to the physical absence of an actual patient and the ways the (patient's) body is introduced through the means of narratives and visualisation.

² Ethnotheatre and -drama have overlappings with so-called performance ethnography. However, performance ethnography does not necessarily manifest in a stage production (see Hamera 2011).

³ Both of these exercises resulted in arts-based outcomes for this research project. The hand-photo collage *Systems-Based Body* can be viewed at: www.kaisukoski.com/about/systems-based-body. The anatomy drawings of the participants, in turn, form the core of the interactive online artwork *Bodytrace*. The piece is available at: www.kaisukoski.com/bodytrace/.

⁴ This division derives from the so-called Flexner report, written in 1910, which set a template for how and where medical education takes place (Bleakley et al. 2010).

⁵ While problem-based learning is the more commonly used term, I employ 'discovery learning' here, since it is what the Faculty of Medicine and Dentistry at the University of Alberta calls this learning approach.

⁶ However, video cases are employed as stimuli in problem-based medical education as well (de Leng et al. 2007).

⁷ There are several new ways being innovated in anatomy teaching, methods that do not involve cadaver dissection. However, many students value cadaver dissection experience and apply to the University of Alberta because of its full anatomy programme.

⁸ A trailer of this video piece can be viewed at: <http://www.kaisukoski.com/about/preclinical-body>. The full-length version is available on request. The piece is the official selection of the SCINEMA 2012 Science Film Festival in Australia.

⁹ Once a year, the Faculty of Medicine and Dentistry at the University of Alberta organises a Thank-you ceremony to honour the people who have donated their bodies for the anatomy programme. The hymn 'Amazing Grace' is sung at this ceremony.