Chapter 7
The Significance of the Body in Health Professions Education

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7.1 Introduction

> The word body is very equivocal. When we speak of a body in general, we mean a specific part of the material, and set the amount which the universe is composed. But when we speak of the body of a man or woman, we hear any matter which is united with the soul of man.
>
> (Descartes 1649, 11)

The human body is the one thing we all have in common, and its death is our only guarantee. Long held as an object of significance and curiosity, the body occupies an ambiguous status—it is both what we are and what belongs to us (De Vignemont 2007). This ambiguity is a result of the nature of the body, one that is formulated in a number of binary oppositions:

> The body is both the Same and the Other; both a subject and an object of practices and knowledge; it is both a tool and a raw material to be worked upon. (Encyclopedia.com 2021)

Within health, it is both a lived body and an object of scrutiny.

In this chapter, we consider the nature of the human body and the different meanings and discourses ascribed to it. We describe our views on the various discourses of the body, namely the symbolic, aesthetic, sexual, and scientific. In doing so we explore links to philosophy, as well as pertinent considerations for contemporaneous

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curriculum development, and implications for healthcare professionals. We advocate for increased awareness of the imperative to evolve our body lexicon, the need for recognition of the feminist body, as well as inclusivity in bodies, and finally, we explore the potential presence of a hidden curriculum of bodies within health professions education.

7.2 What Is the Body?

What is the body? This seems like an obvious question. The human body is our physical substance. It is a mass composed of living cells and extracellular materials—classified into tissues, organs, regions and systems. The body has long been a subject of social and scientific fascination, critique, and condemnation, from the first documented dissections as early as the third century BCE[1] in Alexandria. Indeed, Anatomy is the oldest scientific discipline of medicine (Finn 2013, 2017). Yet, the body holds more than a biological significance.

One can consider the body within several discourses: symbolic; aesthetic; sexual; and scientific (Finn 2013, 2017). First, the body can be considered as a symbol of self—that is, the body as a being, as oneself. Second, there is the notion of the body within a scientific discourse, the object of scientific study, mapping, and investigation. In this discourse, the body is an eco-system, home to all the organisms that live within it, and on it. Next, we have the aesthetic, or artistic discourse, of the body, where the body is objectified, beautified, and revered for its physical significance. Finally, there is the sexual, or erotic, discourse of the body which concerns the significance of the body held by the beholder, self or other.

Of course, aside from these discourses, the body itself is often viewed as a work of art, with paintings of the body becoming mere representations of the innate aesthetic discourse of the naturally artistic human form (Finn et al. 2020). Considering the aesthetic discourse, the words of theatre critic Kenneth Tynan are poignant:

> The buttocks are the most aesthetically pleasing part of the body because they are non-functional … these pointless globes are as near as the human form can ever come to abstract art. (Tynan 1966, 432)

This quote, itself, provides an example of the simultaneously opposing yet complementary discourses that the body holds, the symbolic, aesthetic, sexual, and scientific.

As an object of philosophical thought, the most cited perspective in reference to the body is that of mind–body dualism, namely Cartesian thinking (Mehta 2011; Buckingham 2011). Dualism is the view that the mind and body exist as separate entities. Representing this philosophical position, René Descartes believed that there is a bi-directional interaction between mental and physical substances (Buckingham 2011). In this duality, the mind controls the body, but the body is also able to influence

[1] Before the Common Era.

an otherwise rational mind (Tim 2012), for example in an act of passion (Mehta 2011; Buckingham 2011). Descartes states that the mental can exist outside of the body, but the body cannot think. In this chapter we wish to consider the multiple, varied, messy meanings and significances of the body and how these meanings and significances manifest within a contemporary health curricula and clinical practice environment.

7.3 How Do We Perceive Our Body as Self? The Symbolic Discourse of the Body

When considering the body as self, we are describing two philosophical stances, bodily awareness and myness. Firstly, let us consider what philosophers call bodily awareness.

Bodily awareness is how conscious and connected you are to your own body. The underlying assumption is that we are aware of our body differently from other objects, such as a chair or stone. For example, we know we have a number of senses: sight; hearing; smell; taste; and touch (Smith 2006). Our senses provide us with a means by which to gather information concerning objects surrounding us, including our own bodies. As well as these five senses, we are aware of our own body in a unique way, set apart from the way we are aware of any other object. For example, we have an awareness of our position, orientation, movement, and size of our limbs, our sense of balance, and our awareness of bodily sensations including pains, pressure or temperature (Smith 2006). These features can be grouped together under the umbrella term of 'bodily awareness' (Bermúdez 2011). As Bermúdez notes, we are embodied, and we are aware of our bodies/selves from the inside through different forms of bodily awareness (Bermúdez 2005, 2011, 2015). Bodily awareness bears a special relation to self, and to self-awareness (De Vignemont 2020). Thus, it needs consideration within healthcare training due to being experienced differently by individuals. For example, communication skills are important when trying to elicit information from patients on how they experience themselves in any given environment.

Further to this bodily awareness is how we then perceive our body to be our self. This is the notion of 'myness', which can be defined as the property of belonging to the subject, and something that has attracted increasing attention in the literature (De Vignemont 2013, 2020). Thus, the central tenant is that one experiences one's body as one's own by virtue of having a feeling of 'myness' (De Vignemont 2020). For example, if we were to fold our arms, we identify the limbs as our own, while concurrently unable to misidentify the arms as belonging to someone else (Bermúdez 2005, 2011, 2015). Shoemaker (1968) noted that this bodily experience is resistant to error through misidentification relative to the person. "We experience our bodies as our own in a virtue of felt 'myness' that goes over and above the mere experience of one's bodily properties" (Bermúdez 2015, 643). Note, myness has also been contested in favour of bodily ownership (De Vignemont 2013).

7.4 Ownership and Disownership of the Body

Traditionally, in seeking health care, the lines or boundaries of 'myness' are breached—at least to some extent. While classes on patient communication or history taking may forefront the importance of 'the patient's story' or of 'the patient's experience', in point of fact, a good part of the diagnostic process requires both patient and provider to privilege or prioritize external measures of bodily properties including those that may be that may be beyond or external to bodily sensations. Yes, you can read in a textbook or class readings that much of what you need to learn about diagnosing a patient's problem can be attained via 'the history', but in practice this often is not what happens. Instead, we routinely turn to diagnostic and treatment modalities that allow 'us' (whomever) to 'read' the body in ways that might be considered by the individual undergoing such procedures as being quite strange, mysterious, or essentially not-of-me (e.g., alien).

We routinely—and have for eons—differentiate between 'symptoms' (what the patient reports) and 'signs' (what all our exogenous tools and tricks tell us)—and we prioritize the latter over the former. We even diminish the veracity or validity of symptoms by using phrases such as 'the patient claims', 'the patient reports' or 'the patient denies' in recording those elements of the 'story' that comes from the patient (after all, we don't write in the patient's chart that 'the test says' or that someone has a blood pressure of x/y 'according to the test').

In sum, and post that initial history gathering, one's sense of self as a biological system, including the uniqueness in which we are aware of our own bodies often is discounted (and routinely so). This includes any claim that we (as the patient and thus 'object" of such diagnostic and treatment modalities) might make (directly or indirectly) as to our uniqueness, given the dominating presence within clinical medicine of treatment protocols and practice guidelines.

Case Study 1: Bodily Disownership

Not all that long ago, one of the authors of this chapter had a foot injury (talus bone) and then subsequently broke a metatarsal bone in the same foot. Not long afterwards, they were taken aback when a family member pointed out that they were saying 'the foot' (as opposed to 'my foot')—all to no small embarrassment that they had been unconsciously externalising and disowning what might otherwise be considered an essential part of their anatomy.

There is a weird tension within Case Study 1 and the aforementioned examples. On the one hand, and on the personal responsibility side, there is the 'my' of 'my cancer' and, on the other, there is the disownership side of 'the cancer'. There is a significant body of literature on ownership and disownership. Briefly, here are four examples. Firstly, is the documented phenomena 'the alien hand sign' whereby patients experience a feeling of estrangement between themselves and one of their

hands (Goldberg and Bloom 1990). There are also instances whereby individuals experience their limb as alien yet still believe that it belongs to them (Sacks 1991; Cole 1996; De Vignemont 2007). Or conversely, individuals experience their limb as alien but then attribute the limb as belonging to someone else (Feinberg et al. 1998). Finally, Phantom limb syndrome, whereby an individual experiences sensations in a limb that has been removed, is a further example of the complexities of how differently the body resonates for people (Flor 2002). The aforementioned examples also link to bodily integrity, the subjective bodily experience of wholeness (Slatman and Widdershoven 2010). The learning for healthcare is that people own and disown their bodies in different ways. Healthcare practitioners should consider how patients own or disown their bodies and be mindful of their language with respect to bodily ownership. This is akin to the Körper-Leib distinction, translations of which include: "physical/material body' versus 'lived/animated body'; or 'objective body' versus 'subjective body' (Slatman 2019). Health requires awareness of the body as object and the lived body as a point of perception and agency (Slatman 2014, 2019).

7.5 The Scientific Discourse of the Body

The body has long been an object of study and a foundational element in the evolution of medicine as a discipline. Take, for example, anatomy, the study of the body as an academic discipline. Human dissection has long been the first encounter a health professions student has with the body. Often deemed a rite of passage, this interaction between the living and the dead is the subject of much anticipation, anxiety, and excitement. Cadavers are regarded by some as 'the first patient' or by others as 'the silent teacher'. For students training to save, improve, or bring new life into society, this early focus on cadaveric form seems a juxtaposition. Further, it is rare that the patient in clinical practice is, in fact, deceased. The scientific discourse of the body risks objectification and depersonalisation—concerningly, the potential is to disempower patients—the owners of the body. Further, the scientific discourse of the body and its associated subjectification can result in alienating learners and patients alike. This can range from tacit messaging to the intentional exclusion of different types of people, and thus different bodies, within both the anatomical and clinical arenas. We will discuss this in our subsequent considerations of the hidden curriculum of the body.

Through the scientific study of the body, and, indeed, through the diagnostic lens of clinical assessment, the body is at risk of objectification. Much of health professions education calls for this objectification as both a desired end point of diagnostic and treatment work, and as a desired cognitive and emotional state of the worker. Within social philosophy, objectification is linked to disavowing the humanity of others. This clearly opposes the patient-centric approaches advocated within health care settings, or, by extension, learner-centric approaches advocated for within modern health professions education. Such objectification could be considered directly at

odds with the biopsychosocial model[2] utilised within clinical medicine and within curricula.

7.6 Blurred Boundaries—Buying Bodies

Perhaps the most omnipresent discourse, the aesthetic of the body, unites the discourses we describe. Whether representing the body scientifically (for example, in biological diagrams), visualising the body erotically, or considering how we look to both ourselves and others, the aesthetic discourse is present. Now more than ever, people pay top dollar to look good—this can range from purchasing apps or watches to track biometric data for fitness purposes, to more invasive cosmetic surgery procedures.

Concerning the relationship between the aesthetic discourse of the body, normativity, and health, two pertinent examples offer different views on the relevance within healthcare. Firstly, biometrics and cosmetic procedures, and secondly, artistic representations of the body within the scientific literature.

Biometric data is available in abundance—you can buy a piece of yourself (Alterman 2003; Tanwar et al. 2019) and quantify reality (Ghilardi and Keller 2012). There are commercial and medical purposes (which are not mutually exclusive). Consumers can buy a view inside their own body from blood tests for thyroid function to smartwatches that track heart rate, steps, or food macronutrients. As well as the commercial access to the body, potentially capitalising on aesthetics, there are also helpful innovations such as continuous blood glucose monitoring with smartphone alerts. This instant access to the body changes the relationship between us and our bodies—there are legal, ethical, personal, and social implications too (Alterman 2003; Tanwar et al. 2019). There are positives, with increased health and fitness, but dangers with bountiful data that people may not understand or know the 'normal' parameters for. Further to this is the increased risk of social exclusion based upon biometric identity data, or a more pertinent example of digital immunisation passports. As such, the duality of the body as object and as self becomes blurred—for example, with the need for ethical guidelines for the timing and use of data that promote equity, public health education, anti-discrimination, privacy, and flexibility (Jecker 2021; Osama et al. 2021). Similarly, there is now shopping mall access to aesthetic procedures such as Botox, fillers, and other more invasive surgical cosmetic procedures. Again, the scientific and aesthetic discourses of the body have become blurred—there is no longer a dichotomy. The desire to be attractive is recognised for attracting interest, as well as economic and social necessity (Aufricht 1957).

Bodily (anatomical) variation is normal, entire atlases are devoted to documenting such variation (Acland 2003; Bergman 2021), yet 'normal' prevails. What does

[2] The biopsychosocial model was first incepted by George Engel in 1977. It is an approach or model which considers and examines the interconnections between biology, psychology, and socio-environmental factors.

normal mean in this context? It means the archetypal representation of something that does not exist within the variability of 'real life'—often and traditionally represented within the archetype of the white male. For example, Cardiopulmonary Resuscitation (CPR) mannequins are predominantly white. So, too, are human biology posters. When inclusivity of bodies is sought, it still is limited and typically manifests a black-or-white dichotomy. However, the field of dermatology has shown some progress away from the narrow demographic of cadaveric and medical models in the strive for decolonisation of health services and portrayal of the variety of skin tones in the healthcare curriculum (Finn et al. 2022). This deficit is being slowly closed with the publication of texts like that by Dr Malone Mukwende, a medical student at St George's University of London who co-authored, 'Mind the Gap', a textbook including imagery and descriptions of clinical signs and symptoms in black and brown skin (Mukwende et al. 2020). Alternatively, Professor Susan Taylor, who published 'Dermatology for Skin Color' warned against the existence of a separate textbook, reporting this as encouraging 'otherism' (McFarling 2020). Moving forward, when we represent the body in textbooks and cadaveric material, teaching staff should reflect, research, and act to provide and incorporate curriculum and core texts which educate students in disease manifestation, diagnostic skills, and health promotion to serve the ethnic mix of the current population. This may take the form of auditing and editing teaching materials with bioinformatics and population data. It is important to note that, throughout this process, representatives of diverse ethnic groups should be consulted before curricula innovations are implemented.

7.7 The Feminist Body

> To men a man is but a mind. Who cares what face he carries or what form he wears? But woman's body is the woman.
>
> (Ambrose Bierce 2008 [1906], 15)

Within all the discourses of the body there is a gendered body. Historically, there has always been a significant focus on women's bodies as 'other' (for more on this, see Chapter 9, which focuses on women as the 'Other'). Traditionally women's bodies were the subject of art, the subject of scrutiny, and the subject of objectification (Lennon 2018). There was recent outrage when the Royal College of Midwives omitted women and postnatal mother from an infant sleeping leaflet, instead, using a collective "postnatal people" in an attempt to be gender inclusive (Carr 2021). Public fury on social media was rooted in the omission of the words 'women' and 'mother', perceived as a reductionist oversimplification and act of cancellation. Although gender-neutrality is not an act of reduction, removal of the word mother was interpreted as misogyny.

From a philosophical point of view, what it means to be human and what the body is has long been viewed as male (Buckingham 2011). De Beauvoir documented a narrative of the body as experienced throughout the different stages of a woman's

life (De Beauvoir 1973; Dietz 1992; Buckingham 2011; For more on De Beauvoir's other works, see Chapter 4). She noted that during childhood the experiences of girls and boys are very different—young girls are trained into a different way of inhabiting their bodies. Distinguishing the changes in the body during puberty, for example, she notes the body becomes a source of horror and shame for girls. They become aware of their lack of physical power and thus begin to exhibit an associated timidity. De Beauvoir proffers an account in which young girls undergo a training in bodily habits which structure the possibilities for interaction with their world. Critics of de Beauvoir lambast her naive use of existentialism, a philosophical approach which emphasises the existence of an individual person as both a free and responsible agent able to determine their own development through acts of the will (Lennon 2018). However, Le Doeuff (1980) argued that de Beauvoir made three notable transformative thoughts with respect to existentialism. Firstly, that she overcomes the limitations of the concepts of woman as object and the Other (La Caze 1994). Secondly, her thinking makes it possible to theorise oppression by taking into account women's concrete situation. Finally, she eliminates images of the female body as 'holes and slime' that are proffered in Sartrian thinking (La Caze 1994). These transformative thoughts that de Beauvoir presents still frame our philosophical thinking in regard to the female body today.

Acknowledging the feminist body is important within healthcare education. The notions of shame, power, inhibiting bodies, and scrutiny noted by de Beauvoir all present challenges that impact on the way the female body is presented in education and healthcare. An example of this can be demonstrated in reference to the field of obstetrics and gynaecology.

Case Study 2: The Feminist Body and Our Body Lexicon

'Geriatric-primigravida' is a term still used to describe a pregnancy when the pregnant woman or trans-man is over the age of 35 years (Royal College of Obstetricians and Gynaecologists 2013).

Emily is 36, she is pregnant for the first time and is currently 14 weeks gestation. She has visited her General Practitioner multiple times with pelvic cramps and some spotting (light bleeding). Ultrasound scans and antenatal tests have revealed a healthy pregnancy with no current complications. She is fit and well. Given her repeated attendance, her General Practitioner asks if she is anxious and she sobs that she is too old to be pregnant that she was referred to at her antenatal appointment as a 'geriatric-mother'.

Let's consider Emily further. In the UK, the Office for National Statistics (ONS 2021) quote 65 years of age as being 'old age' and 'oldest-old' over 85. Old, elderly, and geriatric are interchangeable words. Age is associated with functional decline,

but the terms 'geriatric' and 'elderly' don't seem to be appropriate for a 36-year-old as the old do not (apart from extremely rare exception) bear children. While there is, undeniably, a continuum of risk associated with pregnancy as maternal age increases (Royal College of Obstetricians and Gynaecologists 2013), the wording and terms used to describe the functions of the female body should be used with the same sensitivity as discussing a cancer diagnosis or approaching mental health problems. The statistics support this call for terminology change—geriatric/elderly mother labels should be made redundant in modern healthcare (Spalding 2021).

A further example of how women's health has long been problematised, includes the taboo and stigma of menstruation (McLaren and Padhee 2021; Thapa and Aro 2021; Babbar et al. 2022). The menstruating female body is no longer deemed sexual, and has even been deemed 'ill' (Leviticus 20:18) (Olyan 1994; Wenham 1979). Menstruation has been linked to impurity and a lack of cleanliness—here we see our framing of the symbolic body. Such notions of uncleanliness are well documented within religious texts (e.g., the Bible), such as Leviticus (12:2) who problematises post-partum bleeding, and menstruation (15:20). Historically, women have been labelled as 'unclean'.

In their book "The Revolting Self", Powell et al. (2015) suggest that revulsion is usually developed from admonishment by caregivers to protect a child from disease or harm. Revulsion to one's own body is thought to be an 'undervalued cause of depression' and helps to explain avoidance of health screening behaviours rooted in a negative a-posteriori view of oneself. Other phrases and visual descriptors related to women's bodies in medicine carry subversive disdain of female bodily function. This disgust has historically been applied to menstrual blood. Menstrual blood is rarely shown accurately—as a shade of red in advertising, but the same colour as urine in infant nappy/diaper advertising. Menstrual blood is not akin in any way to urine and advertisement messaging is minimising uterine function. Bleeding is messy, but menstrual blood is portrayal is tightly and neatly controlled. Sadly, a quarter of women report not understanding the mechanism of their monthly cycle and around a fifth are too embarrassed to talk about it to close family friends or a partner (ActionAid 2017). Anecdotally, one author of this chapter notes that in their clinic patients often apologise before they talk about menses. Diminishing or hushing dialogue of the labia, vagina, and uterine function prevents empowerment. Slang terms pertaining to female genitalia are still considered some of the crassest in the English language; similarly, a cervix is sometimes referred to as 'incompetent' and pregnancy can 'fail to progress'. Terminology surrounding penile is a lot less fatalistic when it comes to erectile difficulties, suggesting that the penis is 'dysfunctional'.

Equality and empowerment are not achieved if female body and function lexicons are fatalistic or filled with outdated negative connotation. Healthcare teaching needs to highlight these repressive or minimising descriptions of the value, age, and bodily fluids of the human body, with menstruation education and an empowered lexicon which is both patient-centred and accurate in reality of the body's function.

7.8 Sexual Bodies

Consideration of the sexual discourse of the body presents a multiplicity of challenges, including but not limited to the multiple meanings of sex, the conflation of sex and gender, and the taboo nature of the subject. Before considering the sexual discourse of the body, we must consider the terms pertinent to this discussion. This section considers how we define sex, gender, sexual orientation, and sexuality for the purposes of this chapter and as parts of the sexual discourse of the body.

7.8.1 Sex

One definition of sex refers to the physical differences between people who are male or female (Newman 2021). There are also people who are intersex. A person's sex is assigned at birth—typically based upon their physiological characteristics, including their genitalia and chromosomes (for an alternative view, see Chapter 10). This assigned sex is called a person's 'natal sex'. Sex is typically considered binary, neglecting to consider intersex. However, recent debate has surrounded sex with the idea of two sexes being viewed as simplistic. In a well-cited paper, Ainsworth (2015) describes how "biologists now think there is a wider spectrum than that" (288).

7.8.2 Gender

Gender is how a person identifies. Unlike natal sex, gender is not binary, rather it is a broad and fluid spectrum along which a person may identify. When a person identifies as the same gender as their natal sex, they are cis-gender. Gender may differ from natal sex and could include transgender, nonbinary, or gender-neutral. Further, gender also exists as within a social construct, for example with gender roles or norms (Newman 2021). Newman (2021) describes these as the socially constructed roles, behaviours, and attributes that a society considers appropriate for men and women.

As our understanding of sex and gender evolves (see Chapter 10 for a thorough discussion of this), our lexicon is failing to keep pace with this evolution (Finn et al. 2019, 2021). As Lazarus (2021) describes, within healthcare settings and healthcare education, there is an increasing need to find terminology that accurately reflects the bodies it represents. Yet, healthcare continues to struggle to describe bodies outside gendered terms. Training healthcare professionals to recognise that expression of gender, sex and sexuality may not align to our traditional medical lexicon is of paramount importance.

7.8.3 Sexuality

Sex embodies a multiplicity of purposes, including pleasure, procreation, the formation and definition of relationships, the communication of norms, values, attitudes, and expectations. Sex is also the provision of a major mechanism of subjection, abuse, and violence. Sex is interwoven with sexual orientation. Sexual orientation is a person's identity in relation to their inherent or immutable enduring emotional, romantic, or sexual attraction to other people. It is defined in relation to the gender or genders to which they are sexually attracted.

7.8.4 Implications for Health

Historically, within western philosophy, sex and sexuality have received limited attention. Where it has been discussed, it has been problematised and denigrated. Literature notes that both its pleasures and power can ruin lives. The arguments that sex should be for the purposes of procreation only, and the links to morality, have resulted in a topic that even present-day remains taboo. Within healthcare, this is problematic. For example, avoidance of cervical screening, or a delay or failure to report medical problems pertaining to the bowel and genitourinary area, are well known. Furthermore, it is well established that health inequalities exist for many marginalised groups, including the LGBTQIA+ community (Finn et al. 2021), particularly with, for example, the stigma associated with sexually transmitted diseases or discussing reproductive organs.

We teach communication skills extensively about the hidden agenda and the 'by the way' last minute raising of sexual, genital, or bowel and bladder concerns after a person has ascertained how accessible a clinician is—having built up a rapport over a consultation. Our self-concept including myness develops over time but is influenced by our interactions with others and the beliefs held about our characteristics; our self-esteem, ideal self, and self-image (Baumeister 1999; Argyle 2017).

7.9 The Hidden Curriculum of the Body

As previously discussed within this chapter, students will encounter the body in many forms within their training as health professionals. These forms include bodies (or body parts) as pathological or anatomical specimens, (e.g., cadavers), graphical representations of bodies or body parts via media as such as videos or still images, computer simulations, and via living forms such as simulated patients, healthy volunteers, peers, faculty (as role models), and actual patients.

There are numerous factors and interactions (e.g., communication, logistics, physical examinations, curriculum planning), each with the potential to unfold across an array of formal (intended and structured) and other-than-formal (unintended and unstructured) teaching–learning opportunities. Thus, there is the *potential* for discordance between learning that is intended (often as set by faculty or the training institution) and that which is experienced (by learners). In short, there can be tension between 'the talk' and 'the walk', or between 'policy' and 'practice'. Within the field of education, and in referencing these interstitial spaces, the term most frequently used is the hidden curriculum—which refers to the tacit, implied, unwritten, unofficial, and often unintended behaviours, lessons, values, and perspectives that students learn during their education (Hafferty and Finn 2015; Finn and Hafferty 2020; Matthan and Finn 2020).

An example of a hidden curriculum of bodies is the selection of 'healthy volunteers' or 'simulated patients' within a class on communication skills or diagnostics. We begin by asking whether the bodies learners are being presented reflect the full range of what they will encounter in practice or whether there is a backstage selection process that isn't being made explicit to these learners? Are there screenings or other manipulations so as to present learners with an 'optimal' body type? Are volunteers or actors with slender bodies chosen more frequently? Does the historic white male archetype remain omnipresent? Are there cultural issues at play in the recruitment of 'practice volunteers' that are never spoken about? Perhaps there are implicit screenings that ensure the simulated patients students examine present no 'unreasonable' diagnostic challenges (whether that be for students or the course director or faculty) …

Let's take, for example, arranging simulated patients for a teaching session on the respiratory system. Firstly, using a cis-female patient with breast tissue might be viewed as problematic as the breasts may block access to the lungs. Secondly, teachers may (wrongly) worry the female breast presents the risk of sexualising the context. Thirdly, there is added, and potential, inconvenience associated with a perceived necessity to arrange for chaperones if a female is chosen as the volunteer for a respiratory examination. All these issues may be taking place 'backstage', perhaps even unconsciously, for those arranging the simulated exercise. The subsequent—and hidden—arrangement is that faculty may then opt to utilise male patients or female patients with smaller breasts.

This background manipulation or screening by faculty also extends to the selection of imagery within the curriculum, as discussed by Matthan and Finn (2020; Finn and Matthan 2019). They report a historic absence of variation in presentation of different body morphologies, races, and the spectrum of gender. In digital teaching materials, for example, there are few representations of anorexic bodies, of morbidly obese bodies, of non-white bodies, of female bodies, and of trans-gender bodies (Finn et al. 2022). Instead, what is on offer is, at best, an idealised modal body that represents the middle of the spectrum, and at worst a white male archetypal representation. Learning from idealised versions of bodies runs the risks of perpetuating health inequalities.

We risk students seeing bodies in a clinical environment that they have not seen in training. We risk a hidden curriculum of body normalcy, one in which maleness and athleticism gets privileged. We risk a limiting students' thinking on the body to the binary and to the heteronormative.

Finally, it is important to note that the hidden curriculum of medicine has been misrepresented as space that: (a) includes 'hidden agendas' and thus is driven by intentional deception or backstage motives (the hidden curriculum is more a sociological than psychological construct—although see one exception below); (b) exists only to highlight discordance or to shine a light on negative behaviours and professional misconduct (there can be concurrence between the other-than-formal and formal dimensions of organisational life; (c) is singular (hidden curriculum) and thus unidimensional rather than plural (hidden curricula); (d) is something that is experienced by all individuals in the same way (while there may be common messaging driven by structural or cultural factors, this messaging may not be unilateral and homogeneous; (e) that all disjunctions between the formal and other-than-formal can be resolved by transferring tacit learning into formal instruction; and (f) can be deliberately manipulated to transform what has been tacit and informal into lessons that are and surreptitiously manipulated towards desired ends—something that has been termed 'teaching by stealth' (Aka et al. 2018).

7.10 Conclusion

To summarise, and on a surface level, the body appears conceptually simple—a living organism composed of the Cartesian mind–body dualism. When it is broken, we seek healthcare, often within this dualism (e.g., for mental health *versus* physical health reasons). What we have emphasised in this chapter is that such representations and reproductions within healthcare and healthcare education reflect this rather narrow view of the body. In such ways, the scientific discourse of the body often neglects to consider the symbolic, sexual, and aesthetic discourses. Awareness of such discourses and their potential significance for individuals could go some way towards improving healthcare and reducing the inequality experienced by certain groups based upon having certain bodies, for example female or black bodies. As societal views of the body evolve, our lexicon and teaching of the body within health need to keep pace. We advocate for a more inclusive approach to how the body manifests within healthcare curricula—noting the spectra of gender and race, in particular. For too long, the body has been considered male, with females dismissed as 'other'. We started with the idea of mind–body dualism, and as we know, dualism is reflected in all sorts of things, however, the discussions within this chapter have shown that the body is more complicated and that dualistic framings should be a thing of the past. Healthcare should not default to a scientific view of the body as object (Table 7.1).

Table 7.1 Practice points

1	When developing curricula, create space for consideration of the discourses of the body. Acknowledging that dualistic thinking about the body is no longer a useful lens—the body is too complex for such a reductionist view
2	Advocate for the critical engagement of health professionals and students with their own orientation towards their body—noting that individuals differ
3	Normalise the sexual discourse of the body with health professions education and healthcare delivery. Only through open discourse will the sexual discourse no longer be so taboo
4	Campaign for the use of inclusive language and the need for an evolving body lexicon, particularly with respect to biological, genetic, and anatomical terminology. Educate health professionals and students on the need for a patient-centric lexicon—explaining the nuances and being mindful of the challenges of labelling, diagnostic or otherwise e.g., geriatric mother, obese etc.
5	There is potential for a hidden curriculum of body normalcy or body optimisation for certain educational activities, for example in the use of subconscious or deliberate backstage selection processes of cadavers, simulated patients, or healthy volunteers. Awareness of the potential for tacit messaging is paramount

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