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'The body in question': presence, paradox and the practice of nursing

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'The body in question': presence, paradox and the practice of nursing (title slide)

Pro-vice chancellor, in my 30th year of being in nursing, it is very special to stand here today in front of family, friends and colleagues – both past and present – and give my inaugural lecture.

Occasions like this are, of course, rites of passage, marking the transitions we make in life, from one status or position to another. But today is not merely a celebration of my **own** rite of passage to professorship. I want it equally to be a way of formally acknowledging the investment **others** have made in my journey of becoming. My family who have **always**, through thick and thin, supported my academic ambitions and aspirations. And of course colleagues both past and present, who have over the years and in many different ways influenced my thoughts and actions. This inaugural is therefore a celebration of **all** our efforts.

I wonder what some of you might have thought, when you read the summary of the lecture content on the posters and invitations. Were you interested? Intrigued? Did you understand it? My family told me there were too many big words! So, I hope that in delivering a theoretical inaugural lecture, I can make it understandable, thought-provoking, entertaining and, perhaps most importantly, relevant to our practice as nurses and educationalists. So, let the lecture begin!

With respect to the title, the lecture could be about a whole number of different bodies: the body of nursing, the statutory regulatory body, bodies of knowledge, bodies of evidence, professional bodies, a body of people, the body of the nurse, or the body of the patient. However, what I'm going to focus on is what might be described as the 'literal' body (as opposed to metaphors of the body) – the body of the patient in particular, and also the body of the nurse.

There has been an explosion of writing over the last 20 years, across a range of disciplines on the body and embodiment – that is what it means to live *in* and *through* the body. As a predominantly 'body-based' profession, nursing serves to benefit significantly from these theoretical insights and yet, with a few notable exceptions, theoretical and empirical investigation of the body in mainstream nursing has remained largely neglected. So, despite the body being so *obvious* in the work of nurses – the body of the person 'to-be-healed' (the patient) and also the body of 'the healer' (the nurse) – its presence is strangely absent. This inaugural lecture is all about this paradox.

It is arranged in three parts. The first part – 'presence' (**click**) – locates my own interest in this area and briefly describes the centrality of our bodies to our existence and identity and how our presence in the world is all body-based. In the second part – 'paradox' (**click**) – I set out a brief history of the development of different forms of authoritative, body-knowledge before reaching the hub of my argument, which is that despite increasing interest in 'the body', the emphasis on 'body theory' has, paradoxically,

left bodies out. In the final section – ‘practice’ (**click**) – I ask why all this matters and how, through a process of embodied engagement, we might (with thanks to the sociologist Arthur Frank) ‘bring bodies back in’ to nursing.

PAUSE

Presence (click**)**

I’ve always been interested in bodies! As an older child, medical programmes on the television always held a fascination, for example Jonathan Miller’s history of the rise of the medical profession - *The Body in Question* – from which I borrowed this lecture’s title. I’m still interested in them now, and *Embarrassing Bodies* (**double click**) is a **real** favourite because it publicly reveals aspects of our bodies that are usually private and hidden from view. I also like body makeover programmes like *Ten Years Younger* (**click**), *What Not to Wear* (**click**) and Gok Wan’s *Looking Good Naked* (**click**) – they all take ‘the lived body’ as their primary material. In addition to these, there are others that take the **dead** body as the primary focus, dramas like *CSI*, *Waking the Dead* and the more recent forensic anthropology documentaries *History Cold Case*, where a team from the University of Dundee reconstruct the skeletal remains of long-dead ‘cold cases’ and investigate their origins, lives and living conditions in such a way that, to quote the professor leading the team, ‘dramatic stories emerge from long-forgotten bones’. I enjoy **all** these types of programmes. I also loved pathology books and was often to be found in the school and subsequently

university libraries looking at the illustrations in these books – the gorier the better!

Of course, it's not just a Jan thing! We're all interested in bodies to a greater or lesser extent, as **our** body, **my** body, **your** body, is highly significant for how we go about our everyday lives. It is the touchstone of our existence or what Madjar refers to as our 'basic mode of being in the world'. A quote from Nettleton and Watson captures this centrality of the body:

If one thing is certain, it is that we all **have** a body. Everything we **do** with our bodies – when we think, speak, listen, eat, sleep, walk, relax, work and play we 'use' our bodies.

They go on to say (**click**)

When we wake up in the morning we may automatically leave our beds and go to the bathroom and carry out our morning 'bodily' routines... Once we are 'up' we then prepare our body for public display, we probably groom it and select some clothes which might be appropriate for what we are doing on that particular day...Everyday life is therefore fundamentally about the **production** and **reproduction** of bodies

And of course this production and reproduction of our bodies is a fascinating issue:

- Fit bodies (**click**)
- Mis-fit bodies (**click and click**)
- Shocking bodies (**click**)
- Fat bodies (**click**) and thin bodies
- The pregnant body (**click**)

- The fragile body (**click**)
- The ageing body (**click**)
- The dying body
- And even the dissected body (**click**).

Presence (**click**)

We're all interested in the body because **the** body, **my** body, **your** body, is **crucial** to the construction of identity. They are the vehicles for our sense of self. How we live in the world is manifest through our bodies and our understanding of our body is related to our understanding of ourselves. Our bodies therefore are not just physical entities or vessels but, as Synnott says, are 'the prime symbol of the self'. Our bodies are not just **containers** for our existence but **are** our existence and are central to our agency and identities in the world. This primacy of the body is also illustrated through language and the metaphors we live by, for example the 'foot' of the mountain, the 'heart' of the matter, the 'brain' of the organisation, the 'eye' of the truth and so on. All this serves to demonstrate the way in which the body is **utterly** intertwined in our culture and existence.

In this way then, our bodies mediate the world for us and yet ordinarily we are not aware of them in a minute-by-minute way – they are in that sense transparent or taken-for-granted. For example, as I'm standing here, I'm not consciously thinking of how my feet are touching the ground, or whether my hands are touching the lectern or gesticulating. And you, sitting in this theatre, are not necessarily consciously aware of how you're

sitting, or which parts of your body are making contact with the chair or floor, the position of your hands, or the angle of your head. All this is usually automatic and unobtrusive, which is highlighted by Leder when he says 'whilst in one sense the body is the most **abiding** and **inescapable** presence in our lives, it is also characterised by **absence**'.

In illness or injury however, the body's integrity is challenged and becomes centre stage or as Sartre said, the body 'no longer passes me by in silence'. As a runner, I am particularly attuned to the slightest tweak, pull or tenderness in muscles and tendons, and amazed at how skilfully Marina, the sports masseur I visit monthly, can immediately pin-point these, with great precision, and great pain! And of course in acute or chronic illness, the way in which the body is thrown out of taken-for-grantedness and into full consciousness can be extreme. Bodies can become un-cooperative, misbehaving themselves. The body, no longer a silent partner, can be overtaken, hijacked, and in the extremes of chronic illness, such as malignancy and dementia, can even become a stranger, themes to which I shall return later.

So, perhaps my early interest in the human body was part of what attracted me into nursing in the first place. And once a student, I learned more about the workings of the human body, framed by the dominant perspective of science and medicine. As a practising nurse, I did body-work, what Julia Twigg calls 'working directly on the bodies of others':

- observing bodies,
- learning to 'read' them by searching skilfully for outward signs of inner goings on,
- cleaning and bathing bodies,
- medicating bodies,
- touching bodies,
- preserving body boundaries and employing great care to prevent and manage leakage, and yet conversely, sometimes purposefully breaking body boundaries to insert enemas, injections or nasogastric tubes,
- alleviating pain and then sometimes, of necessity, inflicting it,
- and then, perhaps the ultimate example of body-work, laying out dead bodies.

In short, I learned the art and science of using my own body to minister to the bodies of patients. I was aware back then of the intimate and privileged nature of this body work, and how easily this could be abused by poor nursing care. However, it wasn't until the mid-1990s that I began to engage *theoretically* with the body.

This was in the context of my PhD – a longitudinal study, exploring men's transition to fatherhood. Their accounts of their experience of pregnancy and labour were pretty powerful in respect of the body, not their own bodies of course but those of their partners. They felt left out of the experience because all the action was happening in their partner's body. Consequently they felt distant, remote and 'one step removed' and as a result engaged in a range of what I called 'body-mediated-moments', in

an attempt to gain access to a kind of proxy-embodied experience in what was, and remains, a female-body dominated world. Examples of these body-mediated-moments, included the pregnancy test, listening to the baby's heart beat, feeling the baby move and the primary body-mediated-moment (paradoxically made possible by technology), the ultrasound scan (**click**). From these accounts, I began an investigation of sociological perspectives on the body which took me through the history of medicine and dissection, as well as some of the key contemporary theoreticians spanning a range of disciplines.

In the next section, I outline these different types of body knowledge, illustrating this discussion with reference to the case-study of the antenatal ultrasound scan, in order to arrive at the **hub** of the issue – the paradox - that despite **all** this work on the body, theoretical interrogation has tended to leave **out** the experience of what it is to live **in**, and **through** our bodies.

PAUSE

Paradox (click**)**

Shaped by historical, political and cultural factors, the body has remained a source of fascination throughout history. And these ideas about the body, what it is, who it belongs to, and who, or what, has control over it, have changed across the different historical periods. Prior to the Renaissance the body was regarded as the home or tomb of the soul, its dangerous desires controlled and disciplined in service to God. The Renaissance was characterised by a secularisation of the body – an appreciation of

the body for **itself** rather than in its sacred service to God. During the seventeenth and eighteenth centuries Descartes's work was influential, particularly his use of the metaphor of the body as a machine to articulate what he saw as the struggle between both '**having**' and '**being**' a body (a theme to which I will return). In defining the body and mind as separate – and placing the body in a subservient role – Descartes used the metaphor of the mind as the 'captain' of the ship (the body), controlling it and steering it. This separation of mind and body effectively allocated the soul to the church, and the body to science.

Now located in a contemporary political realm of capitalism, this association of the body and science is still very much alive today with the mechanistic model remaining dominant in medicine – a metaphor paralleling the mechanisation of society itself. The body in the 21st century can be understood then as an elaborate amalgam of social, biological and political metaphors. The body is a machine which can be replaced by spare parts – either from other bodies or man-made – creating composite or cyborg bodies, and confusing boundaries between the physical and the technological (**double click**). This coupling of man and machine, what John Paley calls the 'elastic boundary between body and technology', has been incorporated into popular culture, of course, with characters such as Robocop (**click**) and Terminator (**click**). With recent advances in reproductive technologies, the body can be engineered and chosen. Developments in plastic surgery mean that the body can be remoulded and its sex altered. It can be regulated and surveyed, its interior seen and ultimately it can be switched off.

Paradox (**click**)

But what I want to focus on here, is the role medicine has played in shaping our views of what constitutes authoritative body knowledge and how, through its exploration and opening up of the body to map its interior terrain, we have come to regard the body in 21st century nursing and healthcare.

I first began to explore this, as I said, in the mid-1990s, led by men's accounts of their experiences of the ultrasound scan. As I've mentioned, the men in my study tried to engage in a kind of proxy embodiment during pregnancy. With little physical knowledge of the baby, visual knowledge was their primary means of knowing the baby with the ultrasound scan being key to creating this visual knowledge. It became their window or gateway into the interior of the woman's body and **simply** because it was visual appeared to extend the strongest 'evidence' (**their** words) of the baby. These data led me on a journey of discovery to try and unpick **why** it was that visual knowledge was so powerful. In so doing, I examined the development of vision as the primary way of knowing in Western society in general, and medicine in particular. And finally, and importantly, I examined how ultrasound, as a technology of vision, altered ways of knowing the baby. This may seem at a tangent from the heart of this lecture, but over the course of the next few minutes I'll persist with this example of the ultrasound scan to illustrate the rise of the dominance of medical, scientific, authoritative, body knowledge. What I present here is a brief and simplified canter through some pretty heavy-weight issues. So bear with me, all will become clear – I hope - in the end!

The move from oral to literate traditions in ancient Greece signalled the ascendancy of vision as the primary way of knowing, and Western scientific traditions have continued, as Jordanova states, to place 'looking at centre stage'. Empirical science, firmly rooted in the positivist paradigm, privileges vision so that only that which can be seen can be believed. In its pursuit of valid, uncontaminated knowledge, science has assumed that it is possible to capture reality as empirical data which are removed or bracketed from their original context in order to render them objective and scientific. Empirical science in the 18th and 19th centuries continued this pursuit of allegedly value-free knowledge, and the desire to understand the body interior led to an increasing reliance on **seeing** as the principle mode for generating legitimate, medical knowledge. And at this time, dissection (**click**) was the primary method of opening up the body to the medical gaze, beginning the process of what Foucault called, 'the surveillance of the body'. In the 21st century, the medical gaze is no longer dependent on the corpse for its mapping of the human body. Corporeal dissection has been replaced by, for example, CT scans (**click**), MRI and ultrasound which all provide a new and ever-more detailed map of the body interior. In contrast to dissection, which by definition was a passage onto **a** body, these new technologies now mean that our bodies can be dissected live, providing the opportunity to experience our **own** interiority first hand. So, not a passage into **a** body, but rather a passage into **my** body. And it is at this point, the juncture between **any** body and **my** body – that the whole issue of how we have come to understand the body begins to get interesting!

Paradox (**click**)

But staying with the example of ultrasound for a few more minutes. The ultrasound scan is a way of bringing knowledge of the baby into the light. From a **medical perspective**, the baby is removed from the mother's uterus and placed on film for inspection, treating it as a patient to be given a routine check-up. It creates the potential for the extension of medicine's control beyond the conventional body boundaries of one person and another and, along with other technologies, has led to a relative new area of neonatal medicine. From the **expectant father's** point of view, ultrasound is an enabling mechanism that opens up their partner's body, giving fathers access to a way of knowing about the baby that hitherto was unavailable. This way of knowing about the baby, resulting from a coupling of human and machine, is in stark contrast to the **embodied** knowledge of the woman.

And it is this contrast of different ways of knowing that is important. The use of ultrasound in this context introduces a tension between different forms of authoritative knowledge – the **embodied, subjective** knowledge of the woman, and the **observed, objective** vision of medicine. The emphasis on seeing as the principle mode of enquiry, has shifted the perspective **away** from a reliance on the woman's **embodied** knowledge, to one oriented through technology and vision. The woman's knowledge is gained through her **embodied, felt** experience of **living with** the developing baby and all the markers, experiences and changes that come with that. But with

the medicalisation of childbirth, rather than relying on the woman's **felt** experience of pregnancy, **technological** experience has **displaced** embodied experience and has become **the** authoritative knowledge. It is this shift in emphasis that is really important in this whole debate and is powerfully described by Boulter, as (**click**)

'a fracturing of different knowledges, whereby the woman's traditional authority to confirm her pregnancy through quickening (the feel of the fetus inside) has been usurped by the more objectively verifiable medical technologies. The authority to establish pregnancy and the stage of pregnancy is invested in the **machine**, the **operator** and the **visual reproduction** of the fetus.'
Boulter, 1999, p.6.

As instruments of science and medicine, the use of such technologies alters epistemologies, or ways of knowing, about the woman, the baby and the different meanings the respective spectators attach to the scan. Different paradigms or worldviews are at work here. The medical paradigm regards the ultrasound scan as a screening and sometimes diagnostic event, an opportunity to collect data about growth and viability. In this respect it is a **public** photograph with a **fetal** subject. For the parents, it is often regarded as a **social** event – a first opportunity to literally **see** the baby. In this respect it is a **private** photograph with a **baby** subject. So, it is possible to see here two distinct view-points (**double click**). At one end of the spectrum, there is an **objective/medical/public** account of **a** body (**click**), and at the other a **subjective/social/private** account of **my** body (**click**).

I have taken time here, using the case study of ultrasound, to illustrate how the dominance of the rational, objective, empirical and scientific tradition has privileged subjective and embodied accounts so that it has become **the** authoritative knowledge. In this privileged scientific tradition, the **embodied** account, the knowledge we have about what it is to live **with** and **in** a body tends to be marginalised. Sakalys, in a seminal nursing contribution in 2006 wrote (**click**)

'In the Western tradition, primary understanding of the body is dualistic: the body as a **physical** entity or the **object** body, and the body as a **subjective** experience or the **subject** body. The object body commonly is understood as the body that can be known by a third-person observer. It is a **fixed, material entity**: a **passive object** to be **seen/observed/manipulated**, the body as **'it'**. In contrast, the **subject** body is defined as the **phenomenological** body: the body known from the **inside**, the body that is **experienced**, the **lived** body, the body as **'me'**.'
Sakalys, 2006, p.17.

And in its desire to imitate a scientific, evidence base like medicine, nursing is also guilty of misplacing the body in this way.

Paradox (**click**)

So, the **paradox** here, is that despite our scientific and medical understanding about the body, and the increasing volume of theory of the sociology of the body, our emphasis on the **object** body has tended to leave bodies out, by ignoring, or not placing sufficient emphasis on, the voices emanating from the bodies themselves. So in other words, peoples' accounts of what it is to

live **in** and **through** a body, and in the context of health and illness what it is to live in a body turned over to **dis**-ease, have been marginalised.

I do not wish to appear to dismiss the rational, objective knowledge, it is indeed important. We would not have made the many significant discoveries that have revolutionised our 21st century lives if it were not for empirical science. But scientific knowledge is not everything. It allows us to know about only **some** aspects of the body and provides little space for an understanding of embodiment. In **this** sense it provides only a partial view. We do not need to reject this view rather we need a balanced view. What I am calling for therefore, is a reconciliation of **both** forms of knowledge which together, create a holistic concept of embodiment. In the final part of this lecture, I outline the implications of this and how we might bring bodies back in to nursing practice.

PAUSE

Practice (click)

I hope that what I have presented so far can lead us to conclude that what is required in order for nurses to execute meaningful, person-centred care, is an integrated view of the body and embodiment. So, not just an appreciation of the scientific knowledge which informs us of how **the** body, **a** body, works in health and illness, but also an **equal** appreciation of the experiences of what it **means**, what it **feels** like, to live in and through **my** body or **your** body. In other words, an emphasis on

humans as **embodied** rather than on humans who **have** bodies, and therefore a re-connecting of the object body and the lived/subject body.

In this final section, I want to present the concept of embodied engagement as a tool to bring bodies, or more accurately, embodiment back into nursing (**click**). This requires us to **re-**turn to the body, to turn toward the body and embodiment in a fresh and more holistic way with respect to both practice and theory.

With respect to practice, the concept of embodied engagement has much to offer. As nurses we work on the frontline of carework but as we have seen, we tend to lose sight of our patients' embodied experience of illness and disease, privileging instead treatments, dressings, diets, fluids, observations, interventions and so on. The focus on the measurable indicators of the progression and outcomes of illness, means that the **embodied** experience is in danger of being overlooked.

This favouring of the object body over and above the patient's lived experience can mean that the body a patient **experiences** and the body a practitioner **treats** are often not the same.

But it is **so** important for us to recapture the primacy of our patient's embodied experience. As I've already mentioned, illness alters the taken-for-grantedness of the body, throwing it centre stage and into full consciousness, where patients can become estranged from or, as Ray says, 'out of step with the body'. As

part of the experience of living with illness, patients have then to adapt to this different embodiment, coping with pain perhaps, or limited mobility, or some other kind of loss. In extreme instances the body can be experienced as 'other' when perhaps body boundaries are altered in such significant ways that the distinction between the body and what is self becomes blurred. Coming to terms with, or adjusting to illness, sometimes requires a dependency on others – nurses, carers – either momentarily or prolonged, a process Jocelyn Lawler calls 'handing over'. And it is in this handing over that nurses occupy a privileged and powerful role, one that needs to protect the patient from becoming known only as an object body, and ensures that the subject body – the experience of living with this illness or disease – is equally valued. We must at all times ensure that the person does not become lost behind the patient (**click**). So, privileging the embodiment of our patients as the **essence** of caring, should be at the heart of our nursing practice.

But of course, nursing is not just about the body and embodiment of our patients - it is as much about **our** embodiment too. As nurses we are, our bodies are, the primary instruments of our practice. Although this might seem rather obvious and perhaps unremarkable, the concept of nurses' bodies as tools of their work has received even less theoretical attention.

So the way we use our bodies as we go about our nursing practice is crucial. It's not just **what** we do as nurses, but **how** we do it - becoming attuned to our own bodies, developing

expertise, judging touch, using technological instruments skilfully so that they become extensions to and inseparable from, the nursing body. All this is about 'hands-on' experience, becoming skilled and, in essence, acknowledging that our bodies are our most important instruments for our practice.

I made reference earlier to the way in which I am acutely aware of my body as a runner and the way in which Marina, my sports masseur, is able through touch – the expert laying on of hands – to pin-point precisely the offending muscle knot, tendon, etc. And of course with respect to nursing, expert touch is a powerful example of the way in which, through the instruments of our hands, we come to **read** the body of another and skilfully go about our business (**click**).

'Nurses are not generally gentle with their clients, in the sense of very soft, delicate touching. Because they are used to the weight of the human body, the toughness of skin, the resistance created by stiffened bones and muscles they know how to move firmly and strongly. But the very **sureness** and **power** of their touch leads to a paradoxical tenderness. The skilled nurse knows that touch needs to be powerful enough to create a sense of security.'

Groenhout, Hotz and Joldersman, 2005, p.151.

In order for us to authentically recognise this embodied engagement, I would like to argue that the mantra nurses should remain emotionally detached from their patients is misplaced at best, and tragic at worst. Nurses **have** to be involved, for to be a compassionate nurse, practising person-centred, embodied care, I believe it is not possible to strip the person from the nurse (**click**). If this were to happen we would, to quote Sally

Gadow, 'become objects ourselves, faceless beings, practicing neutrality, without place or context'.

So, now, what about theory and research? If we accept the argument that there needs to be greater emphasis on the experience of embodiment, then this merits theoretical attention in nursing. But despite the body-based nature of nursing, nursing has been ambivalent about the body, and the body and embodiment in particular, have received relatively little theoretical attention. This is not just a contemporary observation. Despite Florence Nightingale's association with modern nursing (**click**) – and her image as an icon 'embodying' the nurse – she, too, makes no reference to the body in her famous *Notes on Nursing*, published in 1859. Furthermore, in nursing models (which dominated theoretical thinking in nursing in the 1970s and 1980s), the body was a subdued aspect of nursing theory. For sure then, the body has a lack of space in nursing theory.

Nurses therefore need better theoretical understanding to inform their practice. Of course, there have been a number of key contributors in this field – for example

- Jocelyn Lawler and her influential books *Behind the Screens* and *The Body in Nursing*,
- Julia Twigg and her examination of the bath and its significance in community care,
- and Sally Gadow, who was perhaps one of the first nurses to pose theoretical questions about the body, embodiment and nursing.

These writers have grounded theoretical insights in the nitty-gritty, messy and unpredictable world of nursing practice. Others, such as Patricia Benner and John Paley, have written more philosophical and abstract accounts which I personally found less accessible. While preparing for this lecture, I located a number of important papers advancing thought and debate in this area, spanning a range of scholarship areas, including nursing philosophy, religion and faith, sociology of health and illness, psychiatric care, social science and medicine, and human caring. The point I wish to emphasise here, is that these ideas and concepts need to find their way into '**mainstream**' nursing – **not merely** high impact international journals – but a wider range of **easily** accessible forums for students and practitioners of nursing, such as presentations, professional journals, curricula. In this way we can get these ideas **firmly** in the practice arena. I, along with other nurse educationalists in the room, bear some responsibility for this! On this issue, it is interesting to note, with thanks to Gary Rolfe, a further paradox here of trying to integrate a 'body-based' discipline like nursing into a 'mind-based' institution such as the university.

In addition to theory, there is a clear need for future nursing research into embodiment, as it relates to the experiences of our patients, and the bodies of ourselves as practitioners. As our own colleague Pam Shakespeare noted in 2002, 'Nurses' bodywork is not a current project in nursing scholarship...and there is almost the "shadow" of nurses' bodies and embodiment waiting to be discovered'. A good place to start would be to bring together, in a rigorous way, existing related research and scholarship, in

order to create what Sakalys calls 'an integrated interpretation of embodiment that is more substantive than that contained in isolated works'. An excellent example of this drawing together of related research is a recent interpretive literature review by Thorpe and colleagues on bodily change following faecal stoma formation. Such approaches to gathering together in one place, what is already known about a particular aspect of embodied experience, are tools we should use more often.

Embodiment and embodied care that are firmly rooted in nursing practice are areas ripe for future research. This might include exploration of the experience of the changing body in, for example, pregnancy, following surgery, chronic disease, ageing and dying. What *is* the experience of living with a body whose boundaries are disrupted when they have become permeable and leaky, or when they have had to embrace life-saving technology? What *is* the patient's experience of what Lawler called 'handing over' the body? How does it feel to be dependent on others? And with respect to our own embodiment as nurses, how do we develop the skills of body reading? And how do we help our patients come to terms with their no longer taken-for-granted body?

In conclusion, I have argued that the historical development of science and medicine has resulted in a dominant discourse that has privileged the generation of knowledge about the *object* body, and that knowledge of the lived experience of the embodied, *subject* body has remained in the shadows. I hope I have made a rallying call for a repositioning of the place of

embodiment in nursing, recognising the lived embodied experience of patients and the embodied skill and knowledge of the nurse.

At a significant juncture in nursing's history, when there is greater focus on the quality of care, an increasing emphasis on outcome measures, changes in the workforce skill mix, and the move to a graduate profession, a re-engagement with the bodies of our patients – in practice, theory and research – is **absolutely** essential. And to quote Sakalys again (**click**)

'Nursing's reason for existence is **precisely** its focus on the body, bodily dysfunction, and the dialectic between object body and subject body. Embodiment is the **locus** of nursing practice and the **central** focus of caring ... it is time to attend to the primacy of the embodiment of patients' experiences and in caring practice, and to bring embodiment ... and the body back in.'
Sakalys, 2006, p. 21.

Final slide

PAUSE

On occasions like this it is important to thank those you have, in some way or another, visible and invisible, played a significant part in this inaugural. In doing so, one always runs the risk of forgetting someone, and if I have, please forgive me!

I would like to thank Demarisse Stanley and Kate Morgan, for the way they have organised this event and to the AV technicians, Adrian and Mark. To Gary Rolfe who offered critical friendship on

the first draft of this lecture, and whose insightful observations I have tried to incorporate here. Thanks to Wendy Stainton-Rogers who organised the flowers and, along with other Faculty professors, passed on inaugural lecture survival tips! To all my colleagues in the Faculty of Health and Social Care, and the Department of Nursing in particular, who have tolerated me for the last two and a half years, and inducted me into this strange, but wonderful world, that is the OU. To all my **past** colleagues, associates, and partners in crime (you all know who you are!), who have all, in their own ways, contributed to my being here today – particularly Jenny Hockey, my PhD supervisor, who back in the mid-90's, steered me towards the sociology of the body. Special thanks go to Liz Clark, with whom I've worked for almost ten years, and who has been and continues to be mentor, critical companion, role model, master craftsman (when I was a young apprentice learning the ropes of distance learning at the RCN), a colleague and **always** a friend. And last, and **most** importantly, all my extended family, present and absent, whose contributions to my arrival at the OU **and** continued survival here, are etched in equal measure to my own. Thank you to you all.