Cadaver Stories and the Emotional Socialization of Medical Students

FREDERIC W. HAFFERTY
University of Minnesota-Duluth


Cadaver stories are narratives describing "jokes" played by medical student protagonists on unsuspecting and emotionally vulnerable victims. In these stories, medical students physically (and thus symbolically) manipulate whole cadavers or certain cadaver parts—often extremities or sexual organs—for the dual purpose of shocking their intended victims and deriving humor from their victim's distress. The victims in cadaver stories are either lay people or what the narratives portray as emotionally vulnerable medical students. Cadaver stories circulate most freely among medical student aspirants and initiates, and are told as true accounts of actual events. They are also told with the expectation that peers will view their telling as a source of humor. In this paper, cadaver stories are viewed as part of the oral culture of medical training. Two questions are raised: Under what conditions do we find these stories being told (and thus what do these stories, and their telling, tell us about the experience of anatomy lab)? What functions are served by the telling of cadaver stories? A central focus of this paper is the role of cadaver stories in the emotional socialization of medical students.

Sociological studies of medical education and of the socialization of health care providers occupy a prominent position in the medical sociological literature. Beginning with the classic studies by Merton, Reader, and Kendall (1957) and Becker, Geer, Hughes, and Strauss (1961), a number of studies have focused on undergraduate medical education (Bloom 1973, Broadhead 1983, Haas and Shaffir 1987), nursing (Olesen and Whittacker 1968, Simpson 1979), and graduate medical training (Bosk 1979, Bucher and Stelling 1977, Light 1980, Mizrahi 1986, Mumford 1970). Within this literature, several themes and trends are important for our purposes. First, researchers tend to focus on the clinical rather than the preclinical years of medical training. In some cases this emphasis reflects little more than the numerical dominance of the clinical training years (including clerkship and residency training) over that of basic science coursework. In other cases, this preference is based more on the belief that the locus of socialization is best studied in the patient-centered years of clinical training (Konner 1987, Light 1983). Work in the "clinic" also appears infinitely more dramatic and more exciting than work in the classroom. Whatever the cause or the constellation of causes, the outcome is a relative neglect of earlier but formatively important stages in the socialization process (Conrad 1986). This paper seeks to address this bias and argues that the anticipation of, approach toward, and early involvement in the medical school subculture is a critically important phase of the socialization of physicians. Furthermore, this paper will argue that a fundamental ingredient in early medical socialization is the transmission and internalization of rules about feelings and emotions.

Acknowledgments: I wish to thank Arnold Arluke, Mary Zimmerman, Irving Zola, the reviewers, the editor and the special editor, for their comments on earlier versions of this paper. Address correspondence to Frederic W. Hafferty, Department of Behavioral Sciences, Duluth School of Medicine, University of Minnesota, Duluth, MN 55812.
Cadaver Stories

ing, they tell each other stories or tales highlighting issues of common concern or anxiety. Conrad's (1986) insights into the myth of cut-throats among premedical students is one example. Another is Haas and Shaffir's (1987) analysis of how medical student hopefuls craft an acceptable applications package and admissions interview. Cadaver stories are a third type of oral culture. Each of these three types of oral culture (stories about tricks played by admissions interviewers on students, about sabotaged organic lab experiments, and about the emotionally vulnerable being victimized in anatomy lab) plays a pivotal role in transmitting group culture to newcomers, establishing orienting principles, defining areas and elements of social control, and setting up lines of demarcation, particularly in differentiating insiders from outsiders and marking one's progress from one camp to the other.

In addition to serving as critically important sources of information, these stories also provide storytellers and their audience with an opportunity to demonstrate an awareness of, and commitment to, the underlying norms and traditions of this new and highly desired (medical) culture. This body of oral culture both anticipates and mirrors a number of other oral traditions in medicine which function at later stages of training and practice. Leiderman and Grisso's (1985) discussion of the "gomer phenomenon" is one example. Others are Dingwall's (1977) analysis of "atrocity stories" told by British public health nurses about social service workers and Stimson and Webb's (1975) similar examination of stories told by patients about physicians. "Horror stories" also circulate among physicians about medical mistakes, the management of error, and the structure of occupational rituals designed to cope with uncertainty in medicine (Arluke 1977; Bosk 1979). Friedson (1975) notes the use of hearsay, stories, and gossip among physicians as a form of social control. An oral tradition also can be found in "rescue" stories, which circulate among animal lab caretakers engaged in biomedical research (Arluke 1988). Nonmedical accounts of oral culture include typification stories of tenants by janitors (Gold 1952), storytelling among jazz musicians (Becker 1963), and corporate culture in high-tech computer companies (Kelly 1985).

A third theme in the medical socialization literature is the role of emotional socialization within the overall process of professional training. Socialization in medicine involves more than the transmission of technical skills and knowledge about diagnosis and treatment and the internalization of attitudes, values, and outlooks with respect to such skills and knowledge (Merton et al. 1957). Socialization also involves one's feelings about that work, and in particular how one manages one's emotions and expresses one's feelings in and around troublesome areas of work (Bosk 1986). In this regard Parsons (1951) developed the concept of "affective neutrality." Fox (1979a, 1979b) prefers the term "detached concern." Whatever the label, it is important to differentiate between the transmission of technical skills and knowledge and the transmission of rules regarding the experience and expression of feelings. Bosk (1986), for example, differentiates between "public" and "private" curricula. The former involves the mastery of cognitive knowledge and technical skills. The latter deals more with existential problems centering around uncertainty, limitations, and emotions. Bosk argues that for the technical demands of work, controls are external, formal, and explicit. In contrast, the moral or normative dimensions of medical work involve controls that are internal, informal, and implicit. Most important, Bosk maintains that these latter norms often are transmitted by allusion, parables, or mock or ironic jokes. Furthermore, Bosk, along with such observers as Fox (1957, 1979a, 1979b, 1980) and Light (1979, 1983), links the problems of uncertainty, limits, and emotions to educational settings that are distinctly medical, namely the anatomy lab and the autopsy.

A number of other individuals, including Knight (1973), Coombs (1978), and Finkelstein (1986), have identified a variety of stressful stimuli associated with anatomy lab and/or the autopsy, including the particularly anxiety-provoking perception of the cadaver as a human reference. Finally, many of these authors also note the use of gallows humor (Obrdlik 1942) as a routinized coping mechanism in times of stress, particularly in situations or settings involving death and dying. Thus we may view cadaver stories not only as a descriptive source of information (both for ourselves and for medical student initiates) about one such type of stressful situation, but also as a vehicle for normative rules that mandate gallows humor as an...
appropriate coping device. Inasmuch as cadaver stories function to tell medical students how to “deal with” rendering whole and dead human beings into largely unidentifiable pieces of tissue and bone, they function as a source of “feeling rules” (Hochschild 1979, 1983) in a process that Shott (1979) terms “emotional socialization.”

This paper has three goals: first, to delineate some of the structural characteristics of cadaver stories and to locate their telling as an important part of the oral tradition of medical training; second, to establish the role of these stories in the early emotional socialization of medical students; and third, to highlight the importance of humor in this process.

METHODS

The data for this paper have been collected over a 14-year period. I first encountered cadaver stories during a study of exposures to death and dying in the first year of medical school (Hafferty 1976). The basic methodology of this study was participant observation, supplemented by semistructured interviews. Directly before the beginning of the anatomy lab phase of this study, I was approached independently by several students who proceeded to tell me stories about jokes played by medical students on unsuspecting victims via the manipulation of cadavers and cadaver parts. All of these stories were told to me as faithful accounts of true events that had taken place at some other medical school, and they were told with knowing smiles and laughter. As I listened, I had the distinct impression that I was supposed to find them humorous, and that my ability to share an insider’s frame of reference was being tested. Curious about the circulation of these stories, I added several questions about cadaver stories to my interview schedule. I wanted to know more about students’ familiarity with such stories, their content, the circumstances around their telling, and what reaction(s) the students had on hearing them. Thus more than 100 students were questioned formally about cadaver stories. Additional recountings or mentions of cadaver stories also were collected in the field (in lab).

After completing this study, I continued to collect cadaver stories as a part of several other investigations. These subsequent studies included an investigation of fourth-year students taking an elective in anatomical dissection and a study of medical residents rotating through an elective in pathology. In addition, over a four-year period I drew on the topic of cadaver stories in classroom discussions during a required medical sociology course for first-year medical students. All the members of one of these classes were interviewed formally about the role and place of humor in lab, including their familiarity with cadaver stories. Also during this 14-year period, but in a much more informal manner, I asked practicing physicians, including a few retired physicians, whether they could recall hearing or telling cadaver stories when they were in medical school.

All told, the data for this paper are drawn from nearly 200 formal interviews and an equal number of informal interviews and conversations held during this 14-year period. Two of the medical schools at which data were collected are private (the first and the third); two are public. The four schools are in different parts of the country: (the East Coast, the West Coast, the Midwest, and the south central region.) In all four of these schools, anatomy lab is scheduled in the first semester of the first year.

All data, both field-generated and interview-based, were gathered when either the lab or morgue was in session. The amount of detail gathered about any given cadaver story was guided by the “saturation” methodology outlined by Glaser and Strauss (1967). As might be expected in any oral tradition, I found that no two stories were told in exactly the same manner or with exactly the same details. As also is true in oral culture (Dingwall 1977), the detail needed to convey the information contained in these stories was found to diminish as initiates became more involved in the culture. For these reasons, I did not make a literal count of the “different” cadaver stories. Instead, I developed a rough typology as I encountered new stories and as I established the fundamental structure of these stories.

THE STRUCTURE AND TYPES OF CADAVER STORIES

“You hear about those guys at Columbia?” said Harry. “It was in the papers. They went to a subway change maker and when he gave...
them the token they put an amputated hand underneath the glass to pick it up. But as soon as he saw it, the guy had a heart attack and died. . . .

“So they were kicked out?” . . .

Claudia’s and my eyes met over the cadaver. A chill went between us. Could that really take place . . . actually handed over to the outside world, never to return? . . . all that careful preparation of one’s mind, to be wasted because of the accidental demise of someone who had nothing to do with medicine at all, who was just . . . just a token collector? What could juries of outside people understand of Lineweaver-Burk plots and membrane potentials and three-factor crosses, all the colossal volumes of facts we absorb in bulk at such great cost to our daily lives? No, no—that kind of thing just wouldn’t be allowed to happen . . . (LeBaron 1981, p. 190).

This quote, abstracted from Charles LeBaron’s autobiographical account of his first year at Harvard Medical School, is telling for two reasons. First, it is a rare example of a cadaver story in print. Second, the cadaver story itself is embedded in another dialogue about anatomy lab and the culture of medical school. In this second exchange we witness a conversation between two medical students and find, in their reflections on a distant and nonunderstanding lay culture, how far they have traveled from an identity and a frame of reference (lay) that recently was theirs.

Cadaver stories are composed of four basic elements: medical student perpetrators, unwitting, unwitting, and emotionally vulnerable victims, cadavers, either whole or represented by particular body parts, and a storytelling device that I call “reality anchors.” This device is composed of references to “real” people, places, and things, and is used to convey a specific setting or context to the story. Examples include references to locations (“at Columbia University”), printed sources (“the newspaper”), people (“my cousin told me that . . .”), and time (“last fall”). Most cadaver stories contain multiple reality anchors. Cadaver stories can be characterized further by whether the victims are lay people or other medical students. In this paper the stories with lay victims will be referred to as “out-of-lab” stories, and the stories with medical student victims, “in-lab” stories.

There are at least five different types of cadaver stories. In one commonly told type, medical students carry whole bodies or body parts out of lab in order to shock lay victims. LeBaron’s story is an example of this type. The variations are endless. The body part may be a hand, a leg, an ear, or a sexual organ. The setting (if we are dealing with toll collectors) might be the subway (in New York City), a specific bridge (in San Francisco), or a toll road. Other variations include organs sent by mail to “friends,” fingers dropped in shopping bags, and legs or arms placed in public toilets. Regardless of the body part or the victim, the punch line centers around the victim’s shocked reaction upon encountering the severed body part. In contrast, the medical student perpetrators, rolling with laughter, almost always escape unencumbered either by the body part or by any feelings of guilt, remorse, or empathy with their victim.

A second type of cadaver story centers around the manipulation or mutilation of sexual organs; these are told most often as in-lab stories. Here the victim is an emotionally weak and vulnerable (and thus laylike) medical student. In an almost legendary story of this type, a group of male medical students cut off the penis of their cadaver and insert it into the vagina of a nearby cadaver. The emotional coup de grace comes when the unsuspecting victim enters lab, undrapes that cadaver, and screams or faints at the sight. A variation on this basic story line describes how medical students link two whole cadavers in a sexual embrace. In another story a cadaver’s penis is fitted with a condom and again is left to provoke the emotional reaction of some unsuspecting and vulnerable victim.

A third and similar story type describes incidents in which cadavers or cadaver parts appear to be, or become, more alive or lifelike. In these stories, cadavers are dressed up by students or otherwise manipulated to appear more alive. In one of these “resurrection” stories, medical students dress up their cadaver and take “it”1 to the homecoming football game. The victim might be someone in the stands or an unsuspecting hot dog vendor. A frequently told in-lab version of a resurrection story describes how a medical student takes the place of a cadaver under the wrappings and sits up abruptly as the “body” is undraped. The victim, of course, is both startled and shocked, and usually faints or rushes from the lab.2
another frequently told story, students pump up a cadaver's penis to make it appear erect and turgid.

In a fourth type of story, cadavers are portrayed as food. There are two basic types of cadaver-as-food stories. One type is decidedly cannibalistic, and depicts medical students engaged in eating cadaver flesh or body organs. In a variant of this story type, the student perpetrators only pretend to eat such body parts. In both cases the victims are unsuspecting observers who experience great shock and revulsion upon witnessing a peer engaged in such an activity. The second type of cadaver-as-food story depicts the cadaver (or cadaver parts) as a receptacle for food. Candy, potato chips, or other types of food are hidden in body cavities, ready to be hauled out and consumed in front of unsuspecting viewers. Both of these types of cadaver-as-food stories appear most frequently as in-lab stories. In one story students transform an eviscerated abdomen into a gigantic lunchtime salad bowl. The abdomen is lined with aluminum foil and the cavity is filled with greens, vegetables, and other salad fixings, all of which the students consumed with great relish. An out-of-lab variation on this basic story line portrays a medical student (with a nonmedical student roommate) taking a skull cap home to be used as a soup bowl.

A fifth story type portrays the cadaver as a recently deceased relative or friend. This type deserves special notice not only for its frequency of telling but also because of its fundamentally unique content. In this type of story, a student uncovers his or her cadaver's face for the first time only to discover that the cadaver is a recently deceased parent, sibling, friend, or other relative. Usually the setting is the first day of lab. In one variation the discovery takes place at the end of lab, when "nothing was left to do except the head and neck dissection." In this version the student's shock is compounded because he "hacked his mother to pieces" before discovering who the cadaver "really was." In these cadaver-as-relative stories the unwitting transgressors are always profoundly shocked; many become physically ill. Some must leave lab or even drop out of school. Frequently (but not always), this type of story ends with the statement that the student eventually returns to school and to the anatomy lab, having "worked through" his or her upset. Stories that depict the cadaver as a loved one are unique in that they contain victims, but no perpetrators. In addition, the action described is accidental, not purposeful or manipulated. As a class, these stories are the only ones that routinely feature male medical students as victims and therefore as emotionally vulnerable individuals. They are also the only type in which a shocked emotional response by medical students is presented as both warranted and appropriate.

Two additional characteristics of cadaver stories are worthy of note. First, although it may seem rather odd that medical students can horrify, maim, and even shock their victims to death with impunity, the inclusion of such a consequential ending is actually quite rare (LeBaron's story is an exception rather than the rule). This type of finale appears frequently in stories told by gross anatomy or other medical school faculty members who wish to warn students indirectly about what they would consider inappropriate lab behavior. Stories that cite a medical faculty member as one of the reality anchors ("I had a friend whose anatomy professor told him . . .") are also more likely to end on such a consequential note. The theme of punishment or consequences always appears as an epilogue, and therefore can function only in conjunction with one of the five basic story themes.

Second, protagonists are not only characterized as emotionally detached and "cool" but also are scripted to appear as "fun-loving" members of a closely knit cohort of peers. In contrast, victims are portrayed as isolated outsiders as well as emotionally weak. Although out-of-lab stories occasionally might depict a solitary medical student acting to shock a lay victim or a group of lay victims, in-lab stories virtually always portray protagonists as a group of like-minded peers aligned against a solitary and thus doubly vulnerable classmate.

**STORYTELLERS AND SETTINGS**

Cadaver stories circulate most freely and most frequently among and within two groups of individuals: medical student aspirants and medical student initiates. Correspondingly, cadaver stories are encountered most readily in three settings: the undergraduate "premed" college setting, the medical school setting
directly before lab, and during lab itself, particularly during the first few weeks.

Most medical students first encounter cadaver stories as college undergraduates. As students begin to identify themselves and others as medical school aspirants, and as they become involved in the application process and begin to anticipate what it means to be a medical student, a fertile medium develops for the growth and circulation of these stories. One’s identification as a pre-med is important to the circulation of cadaver stories. Medical students who report a nontraditional background, including applying late or from the work force, or even students who say that they keep their medical aspirations largely secret are less likely to report having heard cadaver stories before entering medical school. Consequently, fellow pre-med students are the most frequent source of the stories heard during this period. Older medical student friends or medical student siblings are reported as additional sources. Less frequently a story is attributed to a professor or teaching assistant. Because virtually all stories are accompanied by reality anchors, a story’s source often is embedded in the story line itself.

The telling of cadaver stories is particularly endemic in that period directly before and during the first few weeks of lab. Stories can be interjected into virtually any conversation about anatomy lab. Although the setting sometimes is related to the story line (cadaver-as-food stories told during lunch, for example), there appears to be little association between the type of story told and the setting or time period. Cadaver stories appear to circulate more freely and more frequently among male medical students, but certain story lines were found to be more current among female cohorts (see “Issues of Gender” below). It was not uncommon, however, to encounter stories that had circulated among members of both sexes. After the students’ initial adjustment to lab, the circulation of cadaver stories enters a dormant phase. They reappear subsequently and briefly, but usually only during times in lab that students find most anxiety-producing (dissection of the sexual organs and the face, and the hemisection of the body). In these situations, the story line or theme appears to be attached more directly to the general source of the stressful stimuli. The “salad bowl” story, for example, was told as one group of students wrestled with a particularly foul and smelly abdomen. Stories of sexual organ mutilation or manipulation also were heard more frequently during the pelvic dissections.

Once lab ends, cadaver stories disappear, but they are not forgotten. In later years a particular story might be told to a colleague (“Remember when...”) to the son (rarely the daughter) of a colleague who is applying to medical school or to a sociologist friend who the physician hears is doing research on “anatomy labs.” These stories are rarely told to outsiders, however. Even so, the demise of this particular type of oral culture does not mark the end of storytelling among students. Cadaver stories are replaced by other types of stories which revolve around other sources of stress in medical training or practice situations. Second-year students tell horror stories about “dog lab” or National Boards. Clerkship students or residents, in turn, circulate stories about undesirable patients, diagnostic and treatment mistakes, and uncertainties in medical practice.

In sum, the act of telling cadaver stories (as well as their content) marks the anxious anticipation of anatomy lab, the initial adjustment to lab, and those periods in lab when the cadaver is most likely to appear as a human referent. During the application process, cadaver stories function alongside pre-med atrocity stories (Conrad 1986) and admission interview stories (Haas and Shaffir 1987) as a major source of oral culture. Cadaver stories differ from the other two types of story in that they focus much more clearly (both in telling and in content) on the transition between the lay and the medical cultures, and on the normative expectation that initiates should distance themselves from former lay attitudes and emotions in their quest for a new and more “medical” identity. The three story types are similar in that they can depict an environment (medical school or the process of getting into medical school) which is hostile, combative, and emotionally dangerous.

THE FUNCTION OF CADAVER STORIES

For both tellers and listeners, cadaver stories serve as a highly developed form of communication about the anatomy lab experience. These stories present versions of what it is like to dissect human cadavers, and how
students should act and feel in that experience. They also reflect a primordial fear held by many students, namely that cadavers can horrify, cripple emotionally, and perhaps even "kill" those who are emotionally weak and vulnerable. For most prospective and entering students, anatomy lab is a place of mystery, a normative void, and the one medical school course that clearly differentiates their undergraduate college curriculum from that of medical school (Fox, 1979b, Reilly 1987). Anatomy lab is special; what transpires within its walls is not simply an extension of everyday life (Klass 1987). In fact, much of what occurs in anatomy lab is the antithesis of everyday social existence. Within the subculture of medical school, anatomy lab constitutes a right of passage, a unique emotional test whose successful negotiation signifies the ability to handle the presence of disease, decay, disfigurement, disability, and death which marks the world of medicine.

In their exposure to cadaver stories, initiates are asked to identify with the emotionally tough, cool protagonists at the expense of the emotionally weak, vulnerable victims. With the exception of cadaver-as-relative stories, all cadaver stories center around the interaction between these two stereotypical character types. The victim is scripted to display the more taboo emotions of fear, disgust, and revulsion, and is cast in turn as the solitary and tormented pawn in a highly stylized drama. Protagonists, on the other hand, appear as happy, fun-loving, in-group members whose emotional equilibrium has transcended the horrors of lab.

Within this dichotomy of emotional repertoires, cadaver stories contain two different levels of feeling rules. These two levels are similar to what Hochschild (1979, 1983) calls surface and deep acting, and what Bosk (1986) defines as public and private curricula.

First of all, cadaver stories convey norms governing the public expression of emotions in and around lab. Behaviors that indicate the presence of anxiety, fear, and revulsion are characterized in these stories as both inappropriate and sanctionable. Conversely, behaviors reflecting humor and "good-natured" camaraderie are characterized as both appropriate and functional. Cadaver stories stress that within the culture of medicine, the cadaver should exist as a learning tool and an object for manipulation rather than as a formerly living human being. In these stories, students who fail to behave accordingly, and thus threaten the emotional equilibrium of lab, are held up to ridicule and to the possibility of further torment at the hands of their peers. More deeply buried within these stories is the additional message that those who are unable to control their emotional behavior in public may court academic disaster as well. Those who must flee lab, or who remain unable to gaze upon their cadaver's face with at least the appearance of equanimity, are considered to be not only undesirable lab partners, unable to carry their own weight, but also individuals who will be unable to master the expected amount of anatomical material presented in lab.

In addition, cadaver stories convey feeling rules that govern the experience of lab. These rules operate on a more personal and more private level; they also represent the ultimate in one's affective adjustment to lab. In cadaver stories, perpetrators represent an ideal in emotional competence. This competence is derived from something more than an ability to maintain a public mask of scientific indifference, oblivious to the cadaver as a human referent. Rather it is grounded in the protagonist's ability to recognize the cadaver as a fundamentally ambiguous entity and to manipulate that ambiguity for his or her own benefit and amusement. The very essence of the cadaver story as a joke requires that the perpetrators view the cadaver both as a human referent and as a learning tool or object for manipulation. Indeed, if protagonists (and, not incidentally, storytellers and listeners) were unable to conceive of the cadaver as a formerly living human being, there could be no planning of the joke and no anticipation of their intended victims' emotional reactions.

In summary, the surface and deep feeling rules embedded in cadaver stories operate in concert both to posit a primary definition of the cadaver and to define how the medical gaze is to operate in the face of decay, death, and dismemberment. In addition, the surface feeling rules function to set a basic, minimal, and public standard for behavior in lab, which condemns the presence of disruptive emotional behavior while it establishes the preferred presence of camaraderie through humor. Perhaps even more important, cadaver stories serve to transmit the message that emotional competence is a necessary precursor to what is described often as the
principal task of preclinical education, namely the mastery of technical information. In the absence of emotional equanimity, these stories suggest that little can or will be learned in lab, whether by the individual affected directly or by his or her lab mates, who find themselves faced with an emotionally distraught lab partner and a countervailing image of their cadaver.

The fact that protagonists use the cadaver's fundamentally ambiguous nature (both as a human referent and as a learning tool) to torment their victims highlights a particularly important dimension of the deep feeling rules conveyed in these stories. In cadaver stories, perpetrators are depicted as identifying neither with the cadaver (as a future me) nor with the victim (as a former me). In this way cadaver stories explicitly define emotional competence as involving both a requisite lack of empathy (entering into) and sympathy (suffering with) for those either unable or unwilling to adopt a medical frame of reference (outsiders). In cadaver stories, victims are not portrayed simply as different from real medical students; they are also presented as deserving objects of derision and abuse.

The abuse and antipathy portrayed in cadaver stories is obscured somewhat by the presence of humor both as a story theme and as a storytelling device. Protagonists are not portrayed as intending to hurt their victims; they only wish to have a little fun. If serious harm befalls the victim, it does so accidentally, and not through any direct or malicious intent by the perpetrator. In fact, any harm is really the victim's own fault, the result of an emotional weakness residing in the victim. Nonetheless, the stereotypical characterization of protagonists and victims contains the message that empathy and sympathy are decidedly dysfunctional emotions in the world of medicine.

The effectiveness of cadaver stories as sources of feeling rules and emotion work is grounded in the fact that they are told as true, and that the story characters themselves are first-year medical students. Both out-of-lab stories and in-lab stories are populated by students who are not much farther along in their training than the medical students and students-to-be who are telling and listening to these stories. Lay victims represent an emotional identity that initiates wish to leave behind. The protagonists represent the triumph of the medical gaze over baser laylike emotions. The emotionally vulnerable medical student, in turn, represents those who have not yet escaped their former lay selves.

Finally, the omnipresent cadaver-as-relative stories function as an important source of balance within this genre. This type of cadaver story depicts a set of circumstances in which the experience and the public reactions of shock and fear are appropriate and to be expected. Thus cadaver-as-relative stories function as a safety valve. This story type shows that the presence of "negative" emotions in lab is not totally outlawed. As noted earlier, this type of story is the only one in which male students are portrayed as emotionally vulnerable. More important, these stories tell how medical students can overcome even the most shocking situations. It would be difficult to imagine anatomy lab without the presence of cadaver stories; it would be equally difficult to imagine the genre of cadaver stories without the counterbalancing messages of the cadaver-as-relative stories.

Although it is not critical to this analysis, it is important to point out that the literal accuracy of "trueness" of these stories lies not in the events depicted but in the symbolic transformation of the actual fears and concerns held by medical students as they approach, and thus begin to experience, lab. Medical students do not dissect their mothers, uncles, or fourth-grade teachers, nor are they required to do so. They do fear, however, that their cadaver will remind them of someone—if not someone in particular, then the human form in general. Similarly, lab does not transform students into gastronomes with a fetish for cadavers, but many students find themselves associating cadaver flesh with uncooked meat. Some experience revulsion (even to the point of gagging) at meals following lab. Medical students also do not battle strong necrophiliac tendencies in lab, but many are disturbed by the sight (or anticipated sight) of so much nakedness, not to mention the sight of so many penises, vaginas, breasts, and nipples permanently shorn of their sensuality by death. In short, cadaver stories take those concerns which medical student initiates and aspirants harbor and transform them into something much more horrible and more grotesque. In this way students gain distance from that which is truly troubling by offering themselves some-
thing even more grotesque as a normative source of humor. These stories contain a dual layer of humor; most are told as humorous tales with the expectation that they will evoke humor, and the story line itself depicts protagonists experiencing humor at their victim’s distress. The humor provides students with several sources of emotional distance. First, the presence of humor in these stories functions to shield the students from the basic content of the stories and from the normative messages contained therein. Without the normative presence of humor, these stories, told as true, would be a striking indictment both of the medical education system and of medical students. Second, the humor embedded in cadaver stories serves to distance medical students from the dominating symbolic presence of the cadaver as a human referent. Third, the presence of humor provides listeners with an alternative and sanctioned source of emotions in lab. In all three instances, the distance is accompanied by a sense of situational control and by a growing identity within the culture of medicine.

ISSUES OF GENDER

In addition to their stereotypical differentiation between emotional competence and emotional weakness, most cadaver stories are sexist in content. Traditionally, cadaver stories depict males as the emotionally transcendent and detached perpetrators, and cast women most often (particularly in the case of in-lab stories) in the role of the emotionally vulnerable victim. If a story depicts a medical student eating cadaver flesh, mutilating a cadaver’s sexual organs, or hiding in a body bag, the protagonist is virtually always male (mind) and the intended victim is almost always female (heart). In this sense notations of gender serve a metaphorical purpose in cadaver stories. Cadaver stories depict not only the perpetrator-playing-cadaver becomes not only the victim but a cadaver as well. In a similar variation on another traditional story line, the female victim does not faint with shock when she discovers a penis stuck in her cadaver’s vagina. Instead she masterfully escapes the intended victim status by turning to the expectant male audience with a cavalier, “I see one of you pulled out too quickly last night.”

These two stories, as well as similar variations, were told to this investigator by women. Stories of this type also were reported to circulate more among female students than among male students, with little cross-gender recitation (except as a comeback to male students who were overheard telling one of the more traditional male-dominant varieties of cadaver stories). This theme of turning the tables has great appeal for many female medical students, perhaps even more so than the portrayal of women as perpetrators. The most fascinating aspect of these newer stories is their clearly evolutionary character. They were constructed by grafting new and ironic endings onto more traditional
story lines rather than through the construction of altogether new story types. In these updated versions, women are portrayed not only as less victimlike but also as the match for any male medical student who fails to recognize that women in general, and female medical students in particular, are no longer emotional foils or ready victims of emotional abuse.

In many respects, however, the sexist nature of cadaver stories has not changed fundamentally during the study period. Cadaver-as-food stories, for example, continue to circulate today just as they did decades ago, with males continuing to populate the ranks of the perpetrators. Similarly, I have not encountered stories in which women are portrayed specifically as eating body parts, nor have I found women shocking unsuspecting toll collectors to death. In regard to content, women have yet to be accorded the status of the cold and unfeeling perpetrator. At best, cadaver stories have become more gender-neutral in that the perpetrators' sexual identity simply is not mentioned, but once again, this is more the exception than the rule. Even when women are portrayed as triumphant nonvictims, the telling (and thus the presence) of such stories still represent a minority of the cadaver stories told. The telling and the content of cadaver stories remain largely a male province.

CONCLUSIONS AND IMPLICATIONS

Cadaver stories function as an important vehicle in the social construction of anatomy lab. By telling and listening to cadaver stories, medical student aspirants and initiates construct an experience which is both a source of horror and an emotional rite of passage. The highly stereotypical presentation of perpetrators and victims and the presence of the cadaver as an ambiguous entity identify problematic aspects not only of medical training but also in the construction of medical identities. In turn, the feeling rules conveyed in these stories cover not only the behavioral manifestations but also the subjective experience of feelings. Cadaver stories also suggest more appropriate and more functional feelings and behaviors. Thus telling, listening to, and even thinking about cadaver stories (however fleetingly) all constitute an important source of emotion work in which the feeling rules of emotional detachment are initially encountered and internalized in medicine. Cadaver stories also function to validate and perpetuate the traditional gender-based power relations in medicine.

One issue raised by this paper, but not yet addressed, is how might the phenomena of oral culture function as a source of data about situations or settings that otherwise would prove resistant to routine sociological inquiry? In the case of cadaver stories, we have found that such stories convey feeling rules which mandate that information about the affective dimensions of medical work be hidden not only from lay outsiders but also from peers and even from oneself. How, then, are we to gather information from respondents in the face of such normative barriers? What if potential respondents are willing to talk to us but find our questions unintelligible or irrelevant, in view of the consequential presence of deep feeling rules? Goffman's (1961) frontstage-backstage dichotomy is applicable in the case of surface feeling rules, and field researchers have developed strategies for tapping information under such circumstances. When "information about" is restricted to a few insiders, the investigator might seek an informant or might attempt to establish more of an insider status via the role of the participant observer. But what strategies are appropriate in the face of deep feeling rules? Here the situation becomes more complex; our potential respondents are not so much unwilling as possibly unable to describe, reflect on, or otherwise shed much light on that which we consider interesting. Their perspectives may have changed. They may no longer see, feel, or otherwise react to things as they did in the past. Furthermore, the effective deployment of deep feeling rules requires that those so changed see nothing problematic or unusual in any such change.

This dilemma is very much at the heart of earlier studies, which reported that anatomy lab and the dissection of the cadaver were of no particular emotional importance to medical students. What do we do with the medical student who insists that his cadaver is "nothing more than a slab of meat" or "a learning tool"? How are we to determine whether such an assertion is the product of feeling rules internalized over time, or of something else? On the one hand, we might accept the assertion at face value, but then we
would have accepted a one-sided and ultimately distorted view of the cadaver. On the other hand, we might suggest that our respondent is lying, but this course of action is both sociologically awkward and ultimately an insufficient resolution to our problem.

The use of oral culture as a potentially countervailing source of data can represent one possible, if partial, resolution to such issues. To return to the example cited above, what if this student also had told us some cadaver stories? Now a distinctly contradictory element has been introduced into the picture. On the one hand, our student maintains that the cadaver is "nothing more than a tool." On the other hand, he or she has told us a story which requires that both protagonists and victims view the cadaver as a formerly living human being. Furthermore, the normative presence of humor in the telling of this story requires that both the storyteller and the audience also recognize the cadaver in this light. Although this issue of data validity is far too complicated to be addressed adequately here, one finding of this study is that the study of oral culture may offer a rich, and often alternative, source of data in situations dominated by feeling rules.

A second issue important to the study of feeling rules is the distinction between short term benefits and the potential for longer term dysfunctional outcomes. However adaptive cadaver stories might be to those anxiously awaiting lab and actually dissecting human cadavers, the feeling rules promulgated in cadaver stories may promote maladaptive coping strategies in clinical settings. Cadaver stories are one of the earliest forms of oral culture that students encounter in their medical training. The feeling rules introduced in these stories, particularly as they deal with the issue of affect and the social control of empathy, are built on continually in a number of other oral traditions and in a variety of subsequent settings. The very feeling rules that operate to distance initiates from the emotional consequences of dissecting human cadavers, performing autopsies, or killing animals in physiology lab (Fox 1979b) also may distance practitioners from their patients. In addition, feeling rules may come to be generalized to (or to bleed into) other settings or situations (family or interpersonal relationships, for example) quite distinct and separate from their original focus.

Finally, we should continue to think of cadaver stories as dynamic rather than static sources of oral culture. In this study we have found that the content of cadaver stories does change with changes in the broader culture. This observation raises the possibility of further changes in both the form and the content of these stories, and thus introduces the prospect of gathering additional information about this rather private aspect of medical training. It is exciting to consider the possibility that we may continue to learn about the themes of social control and gender relationships in medicine through this source.

NOTES

1. The gender of the cadaver is usually not identified or otherwise referred to in cadaver stories except in those stories describing the manipulation or mutilation of sexual organs.
2. I have also heard a version of this story told by undertakers, in which the body unexpectedly sits up in the casket during a viewing.
3. I have never heard similar stories in which the cadaver was a deceased enemy or hated other, that is, with the element of revenge embedded in the story framework. My thanks to Arnold Arluke for raising this issue.
4. We might hypothesize that the cadaver, as a future self, is the perpetrator. In this case the cadaver-as-relative stories, including the portrayal of a personal relationship between the cadaver and the student, involve an ironic twist in which the initial aggressor (student) becomes the actual victim (see "Issues of Gender" for a further development of this theme).
5. Perhaps this element of consequences must be present because the story does appear in a printed form and is readily available to lay eyes, and thus to lay criticisms.
6. I do not imply that these stories were non-existent 14 years ago, but only that their telling was sufficiently restricted or controlled to escape the notice of this (male) investigator.

REFERENCES


This content downloaded from 68.105.114.80 on Sat, 07 Oct 2017 04:28:14 UTC
All use subject to http://about.jstor.org/terms


