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Rhetorical Bodywork: Professional Embodiment in Health Provider Education

Lillian Campbell

Hi group members,

This is very much still a work in progress. It is a draft of an article I'm working on that aims to develop a theory of rhetorical bodywork drawing on the case study of clinical nursing simulations. Right now I don't have much of the lit review drafted, but I've picked some indicative examples for analysis. Most of your feedback, then, will probably help me to evaluate how well those examples are working and how I can dig into them further to develop this theory. A few more specific questions:

- Thoughts on **context**? Places with too much or too little? I always struggle with how much background readers need about simulations to understand my analysis. For this, I feel like they need a lot, but would like to know how it worked for you.
- **Examples**: do you understand what's happening? Do you see the connections to bodywork as I've explained it? Are there details I should pay more attention to in analysis? What am I not noticing because I've spent too much time with these?
- Does this theoretical framework seem useful to you? How do you see it applying to your own research/ teaching? This will help me think through my **implications**.
- Thoughts on **venue**? (I've been thinking Journal of Business & Technical Comm)

Many thanks in advance!

- Lilly Campbell

Rhetorical Bodywork: Professional Embodiment in Health Provider Education

As the general population ages and life expectancy increases nationally, demand for health care providers is also on the rise ("Health Care Employment," 2018). Meanwhile, electronic health records and other technological innovations are changing the ways in which health care providers communicate with one another and their patients (Popham & Graham, 2008; Teston, 2012). Physical interactions are decreasing as health care moves into virtual spaces and yet, a provider's embodied experiences are still central to how they know their patients and move towards diagnosis (Campbell & Angeli, forthcoming; Morrison et. al, 2011). The field of rhetoric of health and medicine can

contribute to this changing landscape in part by attending to the educational experiences of health care practitioners (Campbell, 2018).

Health provider education must teach physical regulation of the provider's body, physical engagement with the patient's body, and emotional management of self and other, alongside practice in how to write and speak in that profession. Consider one junior year nursing student's response when I asked her what she had learned about a nurse's role from observations in the clinic and simulating patient care with her peers:

> [*Nurses] would get labs back that were critical […] and in front of the parents they would be serious and say, 'You know like, this isn't necessarily the sign that we're looking for' and they would explain and be very professional and logical about it and then they leave the room and the door closes and they're running trying to find someone else because whatever they saw is a big deal and that isn't okay. So that kind of, how to carry yourself, throughout the hospital and depending on who you're talking to too.*

This description of nursing practice emphasizes a wide range of embodied action from emotional modulation in front of the parents to running down the hall as soon as the door closes. However, the description is also clearly rhetorical, demonstrating a flexible awareness of how these actions change "depending on who you're talking to" and encompassing professional texts (interpreting labs), verbal communication, and physical interaction with surroundings.

This article introduces "rhetorical bodywork" as a theoretical framework for understanding the physical, emotional, and discursive training that occurs in experiential health provider education. The sociological concept of bodywork describes "the labor performed on other's bodies (and products from the body), emotional labor, and the effects of work on one's own body" (Fisher 2009, p. 2669). Using the case study of clinical nursing simulations – structured classroom scenarios where students practice care

on a robotic patient – I will demonstrate how health provider education provides lessons in rhetorical bodywork.

After introducing research on the sociological concept of bodywork and putting it in conversation with recent work on embodiment in the rhetoric of health and medicine, this article will proceed through an analysis of three components of rhetorical bodywork using indicative example: physical bodywork, emotional bodywork, and discursive bodywork. In doing so, I will attend to the following research questions:

1) How do students learn to **move like a nurse** through physical interactions with the people, objects, and environment of the simulation labs?
2) How do students learn to **modulate their own emotions** and the emotions of their patients, especially when negotiating differences related to race, gender, or disability?
3) What role does rhetorical bodywork play in the communication and documentation practices of nursing students? In what ways do students **discursively capture** their bodywork and prompt future bodywork from other providers?

Finally, the conclusion of the article will consider implications of these findings for embodied teaching of writing in disciplinary contexts more broadly. As such, it asks: how do the experiences of nursing students in clinical simulations help us to understand the role of rhetorical bodywork in disciplinary learning more broadly? Ultimately, this article will call writing scholars to reimagine classrooms as sites to both practice disciplinary bodywork as well as to unpack and critique it. Examples from clinical simulations demonstrate how these lessons in bodywork are deeply rhetorical—fundamentally concerned with communication and persuasion—and not easily separated from students' discursive experiences within the field.

Literature Review

This section is not drafted yet, but I'm planning to use these three categories (from a grant application) to organize my arguments/ideas.

Overall, this project offers unique contributions to a number of current conversations in writing studies, rhetoric of health and medicine, and technical and professional writing:

1. Rhetorical View of Bodywork:

Despite growing interest in understanding embodied writing experiences (Clayson, 2018; Knoblach, 2012; Rifenburg, 2018; Rule, 2017), this is the first rhetorical project to draw on the concept of bodywork. Bodywork offers writing scholars a way of conceptualizing the body's role in social practice that is well aligned with recent work in rhetorical genre theory and material rhetorics and offers valuable contributions back to these conversations. While genre research has long emphasized the relationships between social context and communication, which is central to theories of bodywork, recent work also calls for researchers to better attend to embodied uptake (Campbell, 2017; Emmons, 2010; LeMesurier, 2016). Meanwhile, theories of bodywork center the body and other non-human actants, in line with recent work in materialism, but also emphasize power relationships in ways that can be elided by material frameworks (Booher & Jung, 2018, Teston, 2017). On the other hand, a rhetorical view of bodywork emphasizes its relationship to written and verbal communication, which has received less attention in the sociological research (Wolkowitz, 2006).

2. Embodied Perspective on Disciplinary Discourse Acquisition:

Given this project's focus on physical experience in shaping health provider's learning, it offers an embodied focus on disciplinary discourse acquisition that is unique. Sociological theories of bodywork emphasize how it is devalued within social and institutional systems and frequently gendered as "women's work." The dirtiest bodywork is often allocated to the most marginalized populations (Gimlin, 2007). Bringing a

rhetorical theory of bodywork to the study of disciplinary discourse acquisition, then, offers more than just a way to conceptualize writing education as material and embodied. It also calls attention to who is allowed to perform different kinds of bodywork, how different individuals are expected to control their bodies and emotions to conform to societal expectations, and how interaction with bodies can be a source of marginalization or prestige (Acker, 1990; Coffey, 2013; Wainwright, 2010).

3. Pedagogical Focus on Rhetoric of Health and Medicine:

While ethnographic studies of writing and scientific practice are on the rise (Graham, 2015; Owens, 2015; Teston, 2017) this project's research site is positioned prior to students' participation in their field as professionals. As such, it offers suggestions for creating change in health care professionals' education by identifying problematic and productive lessons in rhetorical bodywork that emerge during training. This shifts attention from "science-in-the-making" (Barad, 2007) to scientists-in-the-making, a shift which I argue could help other researchers in rhetoric of health and medicine to identify new possibilities for their findings to shape future practice (Campbell, 2017).

Simulation Context

Northwest University's Clinical Performance Lab (CPL) occupies 20,000 square feet on the fourth floor of an urban medical center and is used by undergraduate and graduate nursing students. The CPL includes five low-tech (called "low fidelity") simulators used for teaching basic assessment and skills, seven mid-fidelity manikins used for simple simulations and basic assessment (lung sounds, heart sounds), and two high fidelity simulation suites with manikins that can run over ninety different scenarios

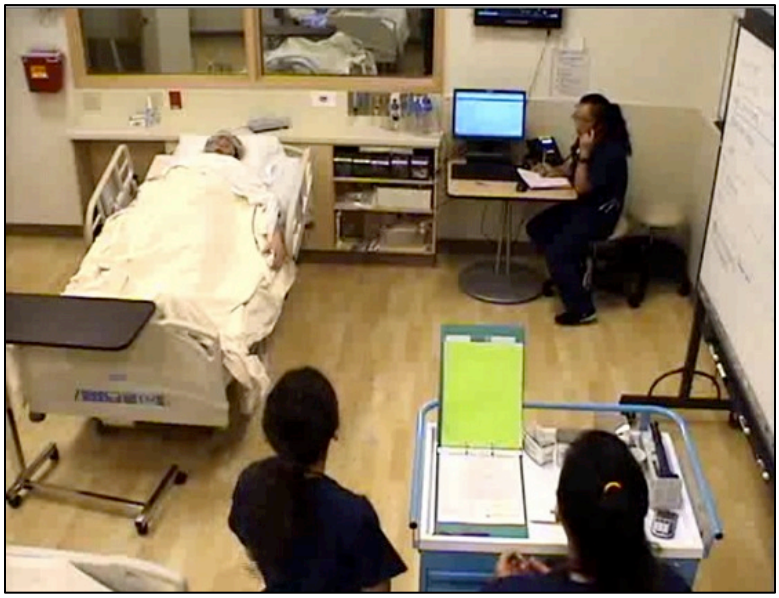
(the neo-natal intensive care unit and adult intensive care unit). Undergraduate nursing students begin working with the simulators during the last quarter of their sophomore year of study. They start on the low-tech manikins, practicing communication, basic drug administration, and bed changing. By the end of their junior year, they are practicing in both the high-tech adult and infant simulation suites. Meanwhile, they are also enrolled in coursework and beginning their clinical placements at local hospitals.

During simulations, students are immersed in a particular narrative set up by the simulation coordinator that provides them with an opportunity to take on the roles of nurses providing care to a patient. The simulation coordinator at Northwest University was Lee and her full-time job was designing and organizing materials for the simulations, orienting students to the process, and running simulations for all nursing students at the university. In the simulations I observed, three groups of 2-3 students each took turns caring for the patient for approximately twenty minutes, while the patient's condition worsened. During their turn, students practiced conversations with one another and with the patient, engaged in critical thinking to problem solve, identified possible causes of complications, and decided on interventions. They also had physical interactions with the simulation environment and the manikin– applying sanitizer, putting on latex gloves, adjusting the patient's dressing gown, checking wounds, etc. While one group provided care, the other two sat in a nearby classroom watching a video stream of the simulation on a screen. After each group's turn, the students, clinical instructor, and simulation coordinator reconvened in the classroom to debrief on the simulation sequence.

The two simulation suites each include a patient simulator – Joe/ Josie in the adult suite and Hal in the OB/pediatric suite. These high-fidelity simulators can sweat and cry,

have nasal and oral secretions and reactive pupils, and make breath, bowel, and heart sounds. During her brief tour of the room, Lee reminds students of the location of all of the supplies they will need for care (gloves, a sharps container for used needles, oxygen, catheters, blood drawn IV's, etc.). There is also a computer in each room with Lexicomp online, so students can look up any medication in the same way they would in a hospital setting. Next to the computer is a phone that connects into the control room. Students verbalize who they are calling and an instructor fields the call.

Figure 1.4: Layout of the Adult Simulation Suite. Video Screenshot.



The "medication room" is a cart on the other side of the room, which creates some challenges for students who felt that private conversations they might have about medications were now within the patient's earshot. There is also a large white board in each room that the students use to collaboratively chart the patient's information. Before the simulation, Lee gave the whole group time to reacquaint themselves with the

simulator and agree upon a template for charting. Student perspectives on charting will be discussed in more depth in section 3.

Analysis

This section is still very much in progress. I've included at the beginning of each section my plans for how to use the examples for analysis. Right now, the analysis isn't as connected to bodywork as it needs to be because it's coming from previous writing. But hopefully you can see where I'm hoping to take it and offer feedback accordingly.

- **Physical Bodywork:** This section will demonstrate that student movement is prompted in simulations by objects, the environment, and people (both instructors and fellow students) by describing how two students are prompted to move during a stressful simulation sequence. Ultimately, I argue that all three contribute to disrupting student expectations for movement and teaching them to embody nursing practice in rhetorically responsive ways.

During their orientation to the simulation room, Lee reminds students that even though the patient is hooked up to a telemetry machine that projects vital signs like heart rate, respiratory rate, temperature, etc., that they should not rely on telemetry for information. Instead, she emphasizes that "just like in clinicals, you should have hands on, ears on, eyes on the patient at all times." What this means in practice is that the simulator, specifically, and the simulation environment, more broadly, have an active rhetorical role in the simulation as well and that they persuade in a range of physical, visual, and auditory ways. Thus, lessons in bodywork are driven by both the human participants and interactions with persuasive objects in the simulation.

In the following excerpt from the second round of simulations, student nurses Sean and Maura make up the third shift caring for Jason, a 22 year-old patient who has just had surgery in both of his femurs after a car accident. The students are anticipating that the blood clot the previous shift located in his left calf is going to move to his lungs. However, the simulation coordinator, Lee, has decided to add an allergic reaction to one

of his medications as an additional complication. The following conversation unfolds as Sean and Maura negotiate Jason's allergic reaction and offer possibilities for treatment. Visible in this excerpt is the way that simulations teach student to move through interactions with other students, instructors facilitating the action, the manikin they physically interact with, and the space they move through.

Sean: [*Rubbing anti-bacterial gel on his hands and addressing Jason.]* Yeah, Maura will double-check the medications. We're going to try and get that taken care of for you right away. I understand what it feels like to be itchy.
Jason: It's really annoying it's just...
Sean: And you said it's all over, no particular area? Not maybe just your leg? [*Pulls latex gloves from the box nearby the head of the bed and walks around the bed to Jason's right-hand side.*]
Jason: No I mean I just feel that it's like my stomach and my neck.
Sean: [*Putting on latex gloves*.] Alright, I'll hold off on the folie and I can take a look at your skin. Would you say um, can you describe the itch a little bit more to me? Is it just... you said it was annoying, is it painful or anything?
Jason: No it's just literally itchy.
Sean: [*Uses both hands to feel neck on both sides*] Itchy around your neck? [Jason: Mhm.] And your stomach you said? [Jason: Mhm] Do you mind if I take a look?
Jason: Almost kind of everywhere. Sure.
Sean: [*Folds down the blanket so that Jason's torso is uncovered*.] I'm going to expose your stomach here. [*Lifts up the patient's dressing gown. Touches the top part of Jason's chest lightly with his right hand while he holds the dressing gown up with his left*]. There is a little bit of... would you say its bruising?
Maura: [*Walks from the medicine cart to the side of the bed next to Sean*.] That's from the accident.
Jason: Yeah it's a little tender there. I have that seatbelt bruise.
Maura: [*Comes behind Sean to check the IV bags hanging from Jason's pump*]
Sean: [*Gently touches different spots around the torso*] As I'm touching it, what are you – can you describe to me what you feel?
Jason: Well it just feels like a bruise, you know.
Sean: Sorry, your abdomen.
Jason: Ohhhh. Oh it's okay.
Sean: Its okay? [Jason: Yeah] Does the itching get relieved when I touch it?
Jason: Uh no not really. It doesn't make a difference.

Sean: [*Turns to Maura who is walking towards the medicine cart and reaches over to grab medication*.] What do we have for the...?

Figure 3.1 Sean Investigates Jason's Itching Skin. Video Screenshot.

Maura: [*Walking back towards the bed*.] So I was reading that itching can be a side effect of the Lovenox [Sean: Lovenox] Yeah. [Walks back towards the medicine cart]

Sean: [*Pulling Jason's gown back down and blanket back up over his torso*.] And is um [*Gestures to the medication Maura is holding*] that can heighten the...

Maura: [*Reading off the physician's orders at the medicine cart*] Yeah, twenty-five milligrams IV push every six hours, yeah.

Sean: So Jason we've got, I don't know if you overheard our conversation. Maura was talking about how itching could be a side effect of the Lovenox that the previous shift gave you.

In this excerpt, students move around the physical space of the simulation room, apply sanitizer, put on latex gloves, check the physician's orders in the binder at the medicine cart, and adjust the patient's blankets on his bed. They also physically interact with the

manikin patient, adjusting his dressing gown and touching his neck and chest. In this way, the simulation setting offers affordances for practicing the physical movements of nursing, in addition to nursing discourse.

Still, the simulation environment also enforces certain limitations on the nursing performance. Because it all takes place in one room, the medication "room" is actually just a cart in the back of the room. Students are told to pretend that this is a separate space, but it is often hard for them to negotiate when the patient can or cannot overhear their conversations ("*So Jason we've got, I don't know if you overheard our conversation…"*). The manikin's body is similarly limited. While internal vital signs are controlled with the computer so that Lee can easily adjust things like heart rate, breathing, and pupil dilation, the manikin's surface is more difficult to change. With preparation ahead of time, Lee can add things like the bruises on his chest from the car accident. However, the spontaneous itching side effect that Lee decided to add to the simulation is not physically visible on his skin. Thus, Sean mentioned in debrief his confusion about how to assess the patient's skin when there were no visible symptoms.

Visible in this example is both how the physical space of the simulation provides lessons in bodywork, but also how critical the instructor is in prompting the students' physical experiences. Since I was sitting in the instructor room behind a one-way mirror with Lee, I was able to observe the ways that she physically immersed herself. One of the things that made her such a successful coordinator was that she was a performer that would deeply immerse herself in the patient's character. I found it particularly fascinating to watch her play the patient role because sometimes she would physically respond to the experiences of the patient, scratching her neck, for example, while the patient complained

of itching, or pumping her foot as she talked to the students about a pain in her leg. At the same time, because she had her mouth to the patient microphone at all times, Lee's involuntary physical responses became the patient's. When she sneezed, the students in the simulation would say, "God bless you" to the simulator. When she yawned while a student was listening to heart sounds, he became concerned about the inconsistency of the patient's breathing. During a sensitivity test where a student was poking the simulator's foot with a pen, Lee had to stand up and strain to try to see when the poke was being delivered and then respond effectively. The links and disconnects between Lee's body and the simulator's body were an important part of the simulation's rhetorical context that prompted student action and also helped support Lee's responsiveness to student care. Overall, Lee's rhetorical responsivity, her immersion in both the verbal action of the simulation and the physical exchange (even though she was not in the actual clinical room), was a critical part of teaching student lessons in bodywork.

- **Emotional Bodywork:** This section will focus on a single uncomfortable student-patient exchange. I analyze how race, gender, and disability come to the forefront in simulations and necessitate that students both foreground and background their own and the patients' emotions at different moments. This section will demonstrate both affordances and limitations of using experiential scenarios to teach emotional responsiveness to "others" and discuss how pedagogical lessons in bodywork can transform professional discourse.

It is the end of a nursing simulation and tensions are high as three junior-year students care for their Asian male patient, who has had a post-surgery blood clot move to his lungs. "What should I do?" Jason Less gasps through a vocal-box projecting an instructors' voice. One student in the simulation, Alice, had really latched onto Jason's Chinese heritage in her conversations with him, drawing on her own experiences with Chinese culture. In fact, Alice put Lee's cultural knowledge to the test when she asked

Jason what his favorite food was for Chinese New Year celebrations. Lee, who was unfamiliar with these celebrations, was lucky that a student intern happened to be in the instructor room at the time and was able to suggest moon cakes. Now Alice picks back up on their shared Chinese heritage suggesting: “Think about... think… imagine that you're Buddha,” she stammers. And continues on, “You're Buddha. Imagine that you're Buddha. Imagine - you know how he stayed underneath that tree for forty-nine days? [Yeah.] Just imagine that just, channel your inner inner Buddha.”

This was a strange and unique moment during my simulation observations. Despite the fact that two of the three simulation characters – Eliana and Jason – were ethnically marked in the pictures that accompany their patient profile and their last names, I found that students largely ignored race in their exchanges with the patient. Similarly, Lee rarely leveraged opportunities to make race or ethnicity a point of conversation when she interacted with students in the patient role. On the other hand, she made much more of a point of encouraging students to address gender and age. Patients would make comments about being more comfortable talking to a nurse of the same gender about a catheter, for example, or older patients showed a propensity towards modesty and not complaining about pain.

This exchange felt uncomfortable for observers because it seemed presumptuous to make assumptions about Jason’s religious background and any spiritual guidance probably should have been based in images that he had already identified as comforting. That said, Alice was still actively immersed in the simulation and engaging seriously with the patient in an effort to calm him down. She was both modulating her own emotional reaction to the stressful situation and also managing the patient’s emotional state. In the

final moments of the simulation, however, after a bit of joking had ensued between the respiratory therapist (their instructor) and the Eye in the Sky, Alice left Jason with the comment, “Imagine buddha, but not too hard. Don't go to buddha.” Here, the facade of the simulation had been removed and the cultural reference that had served as a point of connection between patient and nurse became a source of humor about his death. The instructor laughed and touched Alice affectionately on the shoulder at this point and it was clear that she and both students had removed themselves from the seriousness of the simulated moment.

In an interview, one of my focal students, Kira, mentioned Alice’s interactions when I asked if she remembered anything about other groups’ communications with Jason. She responded, “Yes. Yes. Go to Buddha,” clearly indicating that this had been both a memorable and problematic moment for her across the groups. Kira attributed it to the simulation context, saying “I think they just got thrown off by the Sim and it just — it just went so bad.” I did not press further into what made Kira react so strongly, but she appeared to share in my experience of these comments as jarring and inappropriate, even though we knew the group had transitioned out of the simulation exchange. The joke’s cultural insensitivity coupled with the dismissiveness about death made it an upsetting moment that seemed to undermine patient-nurse relations in its humor. In his article, “The Human Simulation Lab—Dissecting Sex in the Simulator Lab: The Clinical Lacuna of Transsexed Embodiment,” Ben Singer begins with a similarly troubling anecdote about a group of nursing students laughing after arranging a simulated body so that the top half was male and the bottom half was female. Singer argues, “The laughter of these students, if neither purposeful nor malicious, reveals that trans-specific embodiment is

unthinkable, hence invisible, in clinical settings" (250).

Thus, humor among students as they negotiate the boundaries between the real and the simulated can be a productive disruption that fosters meta-awareness. Without the ability to move flexibly between the simulation and reflection, students would not have the space to negotiate the context or to critically problem solve. But this flexibility and levity can also be problematic when they reinforce stereotypes about non-normative body types or cultural backgrounds, as in the two examples above, and do not hold students accountable for empathetic exchange with their patients. That is, humor and flexibility become problematic when they overshadow the important learning about emotional modulation that is a primary focus of lessons in bodywork.

- **Discursive Bodywork:** This last section builds on sociological research on bodywork to attend to the relationship between bodywork and genre uptake. I describe student use of a patient chart during a handoff between two groups to demonstrate how student-designed charts and communication must capture physical and intuitive knowledge about the patient or "patient sense" (Angeli & Campbell, 2017). To document their care, I argue that students must find ways to discursively capture their bodywork and prompt future bodywork.

At the end of one group's geriatric shift, they gathered together to document care for the following group. This group had not done much charting throughout their shift and had struggled to prioritize some of the physician's orders. They administered morphine so that they could do a wound change and catheterization but then when they went to wrap the patient's ankle, they realized they needed to call for an x-ray first. Calling for the x-ray and attempting to properly use the SBAR genre of physician-nurse exchange prompted them to recognize that they had not done much of an assessment on the patient at all. However, as they stood at the board deciding on priorities for the next group, they were able to check in about embodied patient knowledge that each of them

had gained over the course of the simulation and to decide on next steps together. Becky documented while the other group members stood next to her at the board discussing (emphasis added):

> Christian: Did you assess her vitals yet, after we administered the medication?
> Mia: No I was only able to get her pain levels.
> Christian: Okay we gotta, *so for the next people, assess her blood pressure***.**
> Becky: But we didn't get, *oh for the next group we definitely need to have them do the dressing change or they…*
> Christian: Yeah, yeah so we gave the morphine but um also to assess her blood pressure and her respiratory as well because we gave her morphine and also her pain level once before they do the dressing change and the catherization.
> Becky: *So monitor for side effects from morphine?*
> Christian: Yeah, like really low blood pressure…

These students are negotiating priorities using not only the physician's orders but also their physical and verbal encounters with the patient throughout their simulation. They are able to account for the information that has been gathered through these patient encounters – pain levels – and the interventions that have been made in response – administering morphine. At the same time, they recognize the gaps in their care and the need for further patient information, particularly in regards to blood pressure rates and respiratory rates that may have been altered by the morphine. In addition, drawing on Becky's verbal interactions with the patient during which she admitted to dribbling on her dressing wound, they collaboratively prioritize dressing change and catheterization. On their board, this group's conversation is visible in the notes for the following group. In addition to charting their administration of the morphine, under interventions they noted, "premedicated for dressing" and bolded the note to "change." Under "Additional Info" they indicated that the group should "monitor for side effects from morphine."

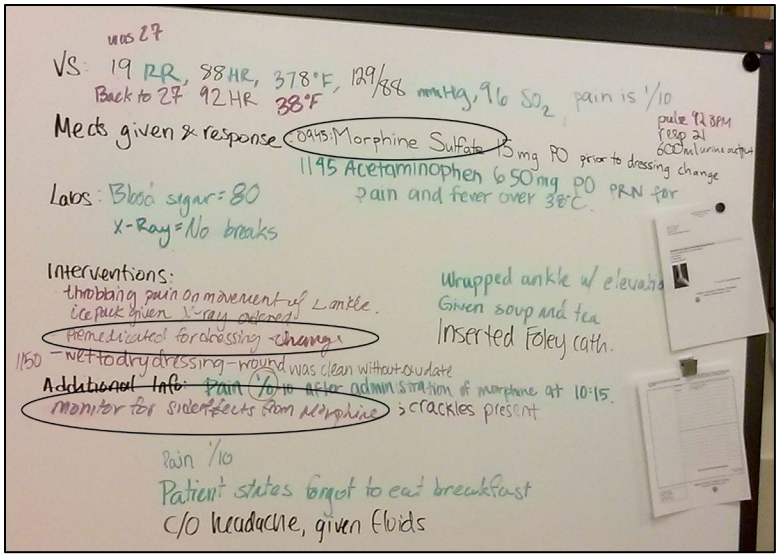


Figure 2 Student Charting of Eliana. Circles added. Photo by author.

Once the group has translated their bodywork gathered over the course of the simulation into a professional vision on the patient medical record, the record becomes a primary object of reference in the hand-off to the following group. Both groups gather near the board, with the incoming nurses facing with their backs to the board, and the nurses who had just charted facing the board (emphasis added):

> Becky: Oh yeah, so anyway she's post-op two weeks, right, from her pem-pempop [*group laughs as she struggles to pronounce the surgery's name*]. As she came in this morning, she also hurt her left ankle. We ordered an x-ray for it because the doc wants us-- she said that they did not evaluate in the ED and the doc wants us to wrap it. Just wanted to make sure nothing's broken.
>
> Mia: Um we administered morphine about an hour ago and in about an hour or two if you guys want to do a catheritization because she is incontinent and we want to do a dressing change in a few hours, after - like an hour after that *just so the incontinence doesn't leak into her wound while we are changing it.*
>
> Christian: Also we just want to asses her pain and um after we administered the morphine we didn't really check about like um the effects afterward so please check her blood pressure, for any respiratory depression, and just like you know like *how conscious she is and stuff* so yeah please check for that as well, *make sure she's good...*
>
> Becky: [*One of the students in the incoming group turns around to look at the board. Becky gestures towards the board and other two incoming students turn to look as well.*] And then her last set of vitals are on the board there so... [Ok great].
>
> Mia: And she is also diabetic and she took her insulin this morning and she had a...

> Michelle: *Have you guys taken her blood sugar after that since she's been here?*
> Becky: No, she hasn't eaten yet. She... did you assess her lungs?
> Mia: Yeah, she had wheezing in her lungs last time I checked, which was about an hour ago and yeah...
> Michelle: Okay great [*two incoming students turn to look at the board again*] Alright great, thank you for the information guys.

During this conversation, the outgoing group is seen elaborating on their charting in the medical record to call attention to aspects of the patient's condition that will be particularly relevant for incoming nurses. They emphasize specific physical phenomenon that incoming nurses should be aware of – the leaking of urine into a newly changed wound dressing. They also emphasize emotional bodywork by highlighting a sense of the patient's well being: "how conscious she is and stuff… make sure she's good." In this way, the professional vision that is being communicated across the group of nurses shapes the bodywork of the incoming nurses, alerting them to embodied patient knowledge that they will want to acquire during their shift by verbal or physical means. Some of this information is written into the student's medical record, but the narration by outgoing nurses also emphasizes what is "beyond the words" to return to Ryan's phrase. Thus, the nursing students have to practice rationalizing their choices and the means for this rationalization often brings them back to their embodied patient encounters.

At the same time, as the incoming nurses take in the professional vision they are thinking through its implications and possibilities, questioning for their own purposes where they will need to have heightened attention or awareness. Michelle's question about blood pressure is a clear indication of this thought process in action. With knowledge that the patient is diabetic, Michelle is already thinking about the questions she will ask and patient sense she will seek, drawing on an intuition about patient needs that occurs even prior to physical or verbal interaction (Campbell & Angeli,

forthcoming). Her question calls attention to an aspect of patient care that the previous group has failed to account for in their charting and explicitly identifies a gap in the bodywork they suggest for the next group. Interestingly, even though Michelle was able to recognize this gap during the hand-off, her group still jumped into a series of interventions at the beginning of their simulation – catheter insertion, assessing respiration and blood pressure, and wound changes – and it was not until the patient complained of a headache that they were prompted to test her blood and provide food.

When miscommunications happened in simulation, the medical record could also become a site where errors in bodywork were carried from one group to the next. For example, during a pediatric simulation one group asked about Eric's skin. Lee responded that it was "warm and moist," intending to indicate that it was normal, but the students misinterpreted this response to mean that the baby was sweating. This was an instance, in fact, where the artificiality of the simulation context (the robot's inability to sweat) interrupted students from having an embodied interaction with the patient that would have provided them with the physical sense that he was healthy. These students later determined that his blanket felt wet as well and during a phone call to the physician described Eric as "sweating profusely." Their decision to prioritize keeping the baby dry showed next to "Skin" on the board with the note "Warm/Moist," and also listed under "Plan," "Keep pt dry and comfortable." During their debrief, their instructor clarified that the baby was not, in fact, sweating but his blanket was just moist from coughing up formula, so ultimately this information was not passed onto the following group during the hand-off. The debrief provided students and instructors an opportunity to both recognize those misinterpretations and also become aware of the processes by which

knowledge from bodywork could become crystallized into the patient's record, part of the nurse's knowledge about the patient that is communicated to the physician and other nurses rather than just a sensory experience.

Across these examples, the simulated patient medical record is a site for collaborative translation and negotiation of patient sense into professional nursing knowledge. The chart's size and visibility on the white board provides material affordances for its role as mediator in many of these conversations. Meanwhile, as groups of students stand around the board providing rationales for their care and filling in gaps in knowledge, they embody the interpersonal role of the medical record. In this way, the simulated medical record creates unique experiences of genre embodiment that do not mimic those of the hospital, but have direct connections to the way that medical records mediate relationships between people and things in a hospital contexts as well. At the same time, the process of translating patient sense into professional knowledge that students are negotiating together at the board is precisely the same rationalizing, organizing, and prioritizing they will have to work through when they transition into electronic charting as well.