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The role of living models in the teaching of surface anatomy: Some experiences from a UK Medical School

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Abstract

Background: Despite recommendations stemming from the 1930s espousing the value of a living anatomy component in undergraduate medical education, living anatomy remains relatively under described.

Aim: In this article, we explore the role of the living anatomy model in living anatomy teaching.

Method: Our report is based on a larger ethnographic study of living anatomy classes, undertaken at Peninsula Medical School between 2002 and 2004. A Research Fellow participated as an observer in 24 Year One and Year Two anatomy classes in which living anatomy models were employed. The findings are based on field notes and conversations with models, students and tutors.

Results and conclusions: Within the supervised context of the anatomy class the living models assisted students in the learning of structure, function, surface anatomy and body variation. Far from being ‘passive sites’ for the students to practice their anatomical knowledge, the living models were active participants in class, assisting students with their communication skills, sharing anatomical knowledge, offering guidance to staff and sharing their past medical history and experiences. Living anatomy models can foster an additional dimension of humanitarian thinking within the anatomy class; however, further research needs to focus on the power messages implicit in the organization of sessions.

Introduction

The use of the living human body to teach aspects of anatomy (living anatomy) has been recommended in undergraduate medical courses for many years. For example, in 1930 the General Medical Council recommended that ‘the demonstration of structure and function in the living’ should form an integral part of medical students’ professional training (Waterston 1931). In 1931 and 1948 respectively, texts by Waterston and then Lockhart provided early examples of resources developed for teachers and students. In 1968, Barrows et al. (1968) explored and recommended the use of life models in anatomy teaching. And a decade later, Stillman et al. (1978) published a study from which they reported that ‘live models were rated superior to using cadavers, especially in demonstrating superficial anatomy and landmarks’.

More recently, it has been argued that anatomy is most commonly encountered by medical practitioners in the form of living anatomy on the one hand, and medical imaging on the other and that this therefore is how anatomy ought to be taught in the early years of the undergraduate curriculum (McLachlan et al. 2004; McLachlan & Régan de Bere 2004; McLachlan & Patten 2006). Furthermore, the Anatomical Society of Great Britain and Ireland continually reiterates the necessity for identifying structures in the living throughout their ‘Benchmark’ core curriculum (Anatomical Society 2004).

Despite the above recommendations, whilst living anatomy has been recognized as a ‘method’ of teaching anatomy (Brenner 2003; Patel & Moxham 2006) and despite several medical schools utilising body painting in their anatomy curriculum (Op den Akker et al. 2002), living anatomy as a teaching technique has received relatively little attention. With the exception of a number of articles relating to the benefits of teaching anatomy through peer physical examination (Rees et al. 2004, 2005; Wearn & Bhoopatkar 2006; Rees 2007), recent reports citing living anatomy have focused mainly on medical imaging. Thus, within these the value of the living body has been referred to only in terms of the value of its combined use with, for example, the Visible Human Dissector programme (Patten 2007).

Indeed, despite the recent finding by Patel & Moxham (2006) that living anatomy was rated third amongst 112 anatomists in Europe, scoring higher than didactic teaching and the use of (plastic) models with respect to meeting the

Practice points

- In addition to helping with the examination of sensitive body regions, living anatomy models acted as informal guides to students assisting in unexpected ways.
- They raised and addressed clinical and communication skills issues.
- They shared life and medical histories.
- They possessed a wide range of body morphologies.
- They offered feedback to teachers.
aims of anatomy courses, living anatomy continues to be deemed relatively unimportant. For example, with regard to the above papers recommending the use of living anatomy there are no Web of Science citations, which suggest continued use of professional living anatomy models by others, although Metcalf et al. (1982) and Barnette et al. (2000) cite them with reference to the use of peer physical examination in anatomy teaching. A recent survey of anatomy teaching in the UK (Heylings 2002) did not include living anatomy as a separate category in the questionnaire (in contrast to medical imaging, for instance) and a search through Timelit (http://www.timelit.org) from the years 1949–2006 revealed 276 references to anatomy teaching, none of which related specifically to the teaching of living anatomy. Further, Web of Science searches for ‘living anatomy’ and ‘surface anatomy’ from 1975–2004 revealed only three relevant articles relating to undergraduate teaching.

In this article, we focus on the process of teaching living anatomy. Specifically, we consider the ways in which living anatomy models can contribute to anatomy lessons. Our report is based on a broader ethnographic study undertaken at Peninsula Medical School (now part of Peninsula Colleges of Medicine and Dentistry) between October 2003 and 2004.

Background

Living Anatomy within the Peninsula Medical School curriculum

At the time of the study Peninsula Medical School incorporated in its curriculum an extensive programme of living and surface anatomy, with students experiencing 39 small group sessions in the first 2 years of the teaching programme. The primary aims of living anatomy were: to reinforce students’ anatomy learning; to assist in their appreciation of the three-dimensional structure of the body, and of natural variation; to introduce them to clinically significant features of the body surface; and to enable them to become adept and comfortable at dealing with the living body without embarrassment or awkwardness. It is important to note that living anatomy took place within a broader scheme of anatomy teaching and learning, which included clinical anatomy, medical imaging, structure and function and microstructure. Also, the anatomy programme at Peninsula Medical School was studied in the context of problem-based learning, with cases arranged in a life-cycle curriculum (running from events before conception to old age and death). Within problem-based learning each case explicitly included anatomical objectives, and the case, including the anatomy, was integrated with clinical skills and clinical placements.

At the time of the study, living anatomy at Peninsula Medical School was characterized by the use of ‘peer examination’ and ‘living anatomy models’. Each student in Years One and Two had one compulsory living anatomy session each week, lasting for 2 h and the sessions were taught by a clinically qualified anatomy tutor. Alongside the living anatomy model, each class comprised small groups of eight or nine students. Typically, living anatomy models would be dressed in either dressing gowns and slippers or loose clothing depending on the subject of the session and the students, who expected to locate anatomical features on one another, would also be wearing loose clothing.

For ethical reasons, the peer examination component of living anatomy was described in an induction session. A written statement was distributed, informing students of their right to withdraw from being examined, and consent from those who wished to participate was obtained in writing. Students were advised in advance that breast in female and groin and buttocks in both sexes would not be part of the peer examination programme (Rees et al. 2004). Instead, students were informed that the living anatomy models would be provided so that these areas may be examined. Internal examinations were taught in Clinical Skills, not as part of the anatomy programme. As such the living anatomy models were employed primarily for assisting with the aims of the anatomy teaching programme.

Obtaining and employing living anatomy models

The living anatomy models were originally recruited using the Plymouth College of Art and Design’s maintained register of life models for art classes. Art models were employed for their experience and consequent self-confidence in being undressed in a public yet professional setting. This was felt to be beneficial to the students, who when faced with co-operative living models may be more likely to gain confidence to examine human surface anatomy thoroughly within a comfortable environment. Models of both sexes, with a variety of ages, body morphologies and personal histories, were employed. In view of the under-representation of female anatomy in standard texts (Martin 2001; Lawrence & Bendixon 1992; Petersen 1998) there were more female than male models. The models were paid at a rate of £9 per hour for each set teaching session and for participation in related activities such as training and demonstration sessions as they arose. Travel costs were reimbursed. Living anatomy models were generally not employed over study periods and holiday periods. Each model attended a two-hour induction session, and was engaged for 15 min before and 15 min after each session (hence for 2.5 h) for induction, preparation and debriefing.

Methods

The broader research from which this report is drawn took place between October 2003 and October 2004. Having gained ethical approval from the PMS Research Ethics Committee, a series of observations was undertaken in first and second year living anatomy classes. The research was carried out by a postdoctoral sociologist (TC). The observer was not part of the teaching or assessment team, to ensure that student responses were not influenced by a perceived need to please staff. Twenty-four 40-min stations were observed, 12 with first years and 12 with second years. Prior to each observation the students were informed that the objective of the research was to gain an insight into the nature of teaching anatomy using life models. Consent for the researcher to participate in the class was then obtained from each student.

In keeping with an ethnographic approach, as an observer the researcher’s aim was to blend in to the class, and
occasionally participate, rather than sit overtly on the outside looking in (Atkinson & Pugsley 2005; Pope 2005). The intention was to limit as much as possible any disruption to the natural setting (and therefore to the behaviours of each individual). This ability to ‘blend in’ was assisted by the fact that the researcher became familiar to many of the students through repeat sessions. None of the students objected to the presence of the researcher and towards the end of the research it appeared that her participation in classes was taken for granted. In addition to observing the living anatomy classes the researcher had a number of informal conversations with the students, staff and life models regarding their experience of living anatomy and their thoughts regarding its value.

The findings from the living anatomy classes took the form of written field notes, although on two occasions, classes were taped and transcribed. All of the findings were analysed using the method of content analysis. Thus, after careful reading and rereading, the raw findings were sorted into main themes and sub-themes. This process was undertaken in collaboration with the principal investigator (JMcL).

Results

The versatility of the life model as a resource for learning anatomy

One of the most striking findings was the number of ways in which the living anatomy models were incorporated into living anatomy classes. The expectation had been that they would be used only in the examination of sensitive body areas and where students required a partner during peer examination. However, in all of the sessions observed, the living anatomy model was central to the learning taking place. For example, many sessions began with the tutor revising anatomical parts through asking the students to identify them on the living anatomy model. After this, students would perhaps do pair work, examining one another in order to locate on the body surface, certain anatomical parts. However, the living anatomy model would frequently act as a partner if there were an odd number of students or act as an examinee for a group of students. At the end of the session, the tutor might demonstrate on the living model how to palpate for a certain anatomical part and then ask a student to practice on the living anatomy model in front of the group.

The centrality of the models in living anatomy appeared to be related, in part, to their versatility as a resource and the creativity of the tutors. For example, models were incorporated into group, paired or individual work and work could either be exploratory or carried out under the guidance of the tutor. Moreover, the tutor frequently used other resources alongside the model in order to enable students to better visualize the anatomy under the skin. Examples of this included the use of projected images of anatomical parts onto or next to the life model, placing life-sized models of skeletons and/or plastic anatomical models next to the life model, using text book illustrations and life-size colour transverse cryosections from the Visible Human, use of body paints and the use of a stethoscope.

Whilst each individual model proved to be extremely valuable in terms of the ways in which he or she could be utilized, the potential of the living model as a resource was maximized by PMS having a ‘pool of models’. For example, male and female models proved useful for demonstrating the location or function of secondary sexual characteristics, and during the ‘Fetal Case Unit, pregnant life models participated in the session. Also, on occasion several models were used to demonstrate variation in anatomy.

The living anatomy model is not ‘just a body’

The versatility of the models was not simply restricted to the use of their bodies to demonstrate the location and function of anatomical parts. Indeed, far from being ‘passive objects’ available for students to examine, the living anatomy models participated actively in the sessions typically guiding and encouraging students and ‘stepping in when needed’. This is apparent in this statement made by a life model at the course induction:

I represent more than half of the population. I am female and I am slightly overweight. If you can find things on me you can find things on most people. I am bomb proof and I will tell you if you hurt me. If you don’t understand something ask me and I will help. I will help all I can.

Similarly, field notes taken in a second year class read:

I was interested to see the way the students interacted with (C, the living anatomy model). When they were examining her I had assumed that she would lie still and passive. Actually the whole thing was a much more jovial and human affair. (As C reminded me, it is ‘live’ anatomy after all.) For example one student’s hands were cold and C said ‘hang on a minute, you can warm those hands up for a start!’ The interaction between C and the students seemed very equal and natural. C seemed to be taking real pride in the fact that the students were developing useful skills and attitudes.

Living anatomy models appeared to contribute to the students’ learning in the following specific ways:

Offering students guidance on anatomical content. Many of the models had some knowledge of anatomy (one was a nurse), or had acquired it after taking part in a station several times. This knowledge appeared to complement that of the tutors. Thus whilst they made it clear that they were not experts, the models often knew enough to assist students when they are attempting to locate anatomy on the surface of the body, and of course, could sometimes ‘feel’ when the students were correctly locating a structure. Examples taken from field notes read:

Example 1. (Living model) said ‘No, the subclavian is higher’

Example 2. (Living model) was actively taking part in the session and was telling students how to remember the names and locations of heart valves.
Example 3. Some of the students practice knee examination tests on each other voluntarily. The living anatomy model watches them: when they are having difficulties she goes over and tells them what she has learnt from the tutor and then the tutor comes over and confirms.

Example 4. (Living model) talks to the student as she is examining her, she says: 'carry on following the inguinal ligament, there, now you have the pubis, now find the top of the pubis symphysis'.

Offering the students individual feedback on their approaches to examination. The living models often made an effort to encourage or build confidence in those whom they perceived needed it. In one instance for example, the living model stayed behind so that a student with little confidence could practice palpating areas of her body. In another instance the living model checked a student’s skills by asking him to practice locating an anatomical part on her during Peer Examination. More generally, the models offered feedback to individual students during examination. For example, while a student was palpating the lower abdomen the living model commented ‘What aren’t you asking me? Something very essential? Have I emptied my bladder?’ During another session, a living model, with her hand on top of the student’s hand, stated: ‘Use your hand like that, flat, now you have got good contact, that’s reassuring for you and the patient’. One student remarked:

It’s good because (the living model) helps. Sometimes you forget it’s a real body and (the living model) reminds you.

Reinforcing the humanity and individuality of the body. As suggested above, the presence of the living model also reinforced strongly the idea that ‘patients are people too’. In addition to their often lively and reassuring commentary to students whilst being examined, living models often wore make up, jewellery, had tattoos or other body art, or, if not students whilst being examined, living models often wore addition to their often lively and reassuring commentary to reinforced strongly the idea that ‘patients are people too’. In

Example 2. Major vessels of the heart (second years)

Example 1. Fetal case unit (first years)

Life model E was 38 weeks pregnant. Her husband was with her. E lay on the bed uncovered to the waist except for a bra. The students were gathered round the bed. A Powerpoint projection of a foetus was projected on to the wall. The tutor asked the students about the relevant anatomy. At the end of the session the students stayed around the bed talking to E and her husband. They wanted to feel the bump and ask her questions. ‘Is it a boy or a girl? Is this your first? ’ ‘What is morning sickness like? ’ ‘What will you call it? ’ ‘Are you scared?’ E explained that she had had morning sickness throughout her pregnancy (‘It’s not always like it says in the books’) and that she had not had ‘cravings’. The presence of E’s husband appeared to have an effect. The two of them together added a dimension of caring and partnership: he said he was nervous and excited about the baby’s arrival. One of the students commented that she had ‘never felt a pregnant belly before’. The whole session appeared to take the abstract to the real. A few weeks later the baby was born. The parents sent a photo of him in which was placed on the wall. On it was written ‘To the first years, good luck from baby E’.

Example 2. Major vessels of the heart (second years)

Part of this session involved the use of two living anatomy models. Each was lying on an examination couch. The tutor (S) gave each group of students a
stethoscope and asked the students to listen to each living model’s heart. One of the models (J, aged approx. 32) had had aortic surgery and her heart therefore sounded different. The students were asking J about her operation, when she had it, what it was like, how having a valve affects everyday life. This was all unplanned and spontaneous. J explained how her heart valve clicks at night when she is lying down. On the basis of the students’ questions, J got her cards out of her handbag and explained that she has to go to hospital sometimes as frequently as every month, ‘to have my M.O.T as she put it. The students asked her how much she could drink and whether she misses it and how she coped in every day life. They asked her whether she takes tablets and what she takes and how many times she has to take them.

Observing living anatomy sessions and feeding back to staff: Experienced living anatomy models in particular, played an observational role in class, spotting whether sessions could be improved and checking to see if there were any students who were reluctant to get involved, who had little confidence, or who had not learnt a certain aspect of anatomy. Through participating in classes the living anatomy models were often able to feed information back to the tutor. This working relationship between the tutor and the living anatomy models appeared to benefit students inasmuch as responses to students than real patients. In particular, the life models were not unwell, and had agreed to engage wholeheartedly in the process of medical education. In addition, the life models were not unwell, and had agreed to engage wholeheartedly in the process of medical education. They were therefore likely to give fuller and franker responses to students than real patients. In particular, expressing constructive criticism to students is not something which real patients do on a regular basis. In this sense, we conclude that exposing students to these opportunities is extremely valuable even though all students do not receive the same experience. However, whilst this study has found practical humanitarian value for living anatomy models beyond their role as ‘bodies for practising anatomy’, the study raises further issues about the extent of this humanitarianism. For example, whilst on the one hand the living anatomy models provided an insight into and ‘knowledge of’ patients and their experiences, did their presence as inter-

Indeed, the living anatomy models contributed significant feedback on teaching sessions which led to the course being modified. For example, one of the living anatomy models drafted a document on examining living anatomy models, which is now given to students in preference to the previous staff written document. It should also be noted that employing living models for regular teaching sessions appeared to strengthen the sense of ease between the models, staff and students leading to such dynamic feedback.

Discussion

The findings described above revealed that far from acting as passive sites for anatomical exploration, the living anatomy models worked in partnership with tutors and were actively involved in the teaching programme. Whilst admitting that the position of the living anatomy model can pose a number of challenges those participating in the study spoke of their role mainly in terms of ‘gain’. Beyond the financial incentive, the benefit of the role included, ‘learning about anatomy’, ‘making a statement about the body and body image’, ‘a sense of resourcefulness’, ‘a sense of value’, ‘a sense of working for an extremely worthy cause’, ‘a sense of empowerment’ and ‘a sense of warmth from the students’. For one individual recovering from major surgery, working as a living anatomy model induced ‘a sense of catharsis’. Despite recommendations to the study of living anatomy stretching back over many years, this activity still seems to be under represented, in UK medical schools at least. In particular, use of professional living anatomy models seems an underused approach. We found the living anatomy models to be a valuable addition to the teaching environment, who in many cases took on the role of an intermediate level teacher. This participation is particularly valuable in four areas – assisting communication skills development in students, sharing of anatomical knowledge with students, spontaneous sharing of past medical history and responses to it with students, and offering guidance to staff. In terms of a medium for learning anatomy the life models provide a real, live, three-dimensional body that appears to assist students in their ability to visualize anatomy within the body and make learning both meaningful and memorable. With regards to ‘what is learnt’ the life models assist in the learning of structure, function and surface anatomy and provide an insight into body variation. At a deeper level the incorporation of life models appeared to foster humanitarian thinking about the body with respect to the idea that ‘patients are people too’. As such, within the setting of the classroom, they provide an additional experience for students than the encounters they have with standardized patients in communication skills sessions. At the same time they do not appear to detract from the teaching of anatomy. And whilst not all students gathered the same experience, in this sense the sessions were more like sessions with real patients. In addition, the life models were not unwell, and had agreed to engage wholeheartedly in the process of medical education. They were therefore likely to give fuller and franker responses to students than real patients. In particular, expressing constructive criticism to students is not something which real patients do on a regular basis. In this sense, we conclude that exposing students to these opportunities is extremely valuable even though all students do not receive the same experience. However, whilst this study has found practical humanitarian value for living anatomy models beyond their role as ‘bodies for practising anatomy’, the study raises further issues about the extent of this humanitarianism. For example, whilst on the one hand the living anatomy models provided an insight into and ‘knowledge of’ patients and their experiences, did their presence as intermediate teachers and bodies to practice on reinforce ideas of doctors as more powerful? Moreover, how do students interpret the models: as cultural stereotypes or as individuals with specific histories? Further research would be valuable to tease out these issues.
Limitations

This study has provided an insight into the role of living anatomy. It is intended as an initial exploration: a starting point and the themes generated are not generalizable to other students outside the research setting. A further issue is the one of research bias. Whilst measures were taken by the researchers to suspend bias, it is impossible to be value free (Weber 1949). It may be the case for example that the social science background of the researcher led her to miss some of the nuances of medical education and the medical student experience. Moreover, her employment in the medical school may have led to favourable reporting on the use of living anatomy models.

As such the trustworthiness and validity of these initial findings will need to be determined by further research. In particular, themes generated here and elsewhere need to be turned into measurable outcomes so that the extent to which medical students learning is improved can be measured quantitatively. This is currently being planned as a second stage of the research.

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Appendix: Life modelling, life sciences and the lived body: A model’s view

‘As an experienced life model in fine art, when I first started modelling in the LSRC, I was immediately struck by the difference in the practice of being a model in these two contexts. As an artists’ model and also a dancer, I am used to expressing myself through my body, both through movement and the striking of a pose. The role of the life model lies somewhere at the intersection between being and acting, at the same time being both subject and object, active and passive, a physical body but also a social body, subject to cultural discourse, a somatic body of lived experience, both presenting and being presented. It is a performance of both the self and not self, an interplay between how one defines one’s

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body and how one is defined. My body, whilst a physical body in existence, one of spatial relationships and internal and external structures, is also a social body, a lived, lived in and living body which expresses who I am. It is the outward expression of inner contents: the clothing of the self. The way I move, look, hold a pose and relate to the gaze of the artist is the embodiment of me and my life’s experiences which in turn is presented in interpretation by both artist and viewer.

But of course this is of direct relevance to the role of the model in life sciences. The students are observing my body in the demonstration of particular aspects of anatomy and/or diagnostic procedures. They are communicating with me as a living person, observing my body, not an ideal body in the Platonic sense, but one which, whilst presenting and being presented as ‘normal’, is also a lived body, whose responses are directly affected by and effect who I am. From the commencement of their studies in medicine, the students have to get used to communicating with and touching a live person. For some, this appears to be a bit of a shock, but it is a practice they have to get used to. Having been at Peninsula for two years, it is interesting to see how the students have matured and most take it in their stride, although it has to be said that generally, the female students seem more at ease than the male students.

Recently I was complemented on being a ‘good model’ by a first year medical student. In the education of medical students, what exactly did this mean, I wondered? In the context of fine art, being a good model is relatively easy to define: holding a pose, being able to arrange and effect one’s body in a visually interesting way, flexibility, being at ease with one’s body, the ability to convey movement in stillness and stillness in movement, professionalism – of course – and the least easily definable quality, performative presence. In order to work as an artists’ model, I need to adopt a detachment which enables me to step outside myself and perform in role. In the context of life sciences, the quality of the model is greatly dependent upon the effectiveness of the tutor’s ability to engage, the students’ ability to be active, interested participants in the learning process and the models’ willingness to be more than just a body and a passive resource. In this particular session, the tutor demonstrated on my body how to locate the correct positioning for a lumbar puncture. As I had recently experienced one myself, I was able to talk to the students about what this was like from a patient’s point of view. Far from learning from a passive resource, the students were able to engage with me and learn from my empirical experience.

Whilst I am at ease with my body in an art context, I do not always find it easy modelling in life sciences. For me, it is at times a strange experience, for whilst being physically present, one is nearly always being observed in relation to something else. For example, to have anatomical projections focused on the body – whilst it is not my anatomy, me – that is being examined, I feel a strange sense of vulnerability, as if the layers are being peeled back and the interior of my being is up for examination and scrutiny. Likewise, being photographed (for the anatomical atlas), I find it extremely difficult just to be, to stand still, emotionally neutral, devoid of (self) expression. I exist, but I do not quite exist either. I have no medical background prior to modelling at the Peninsula Medical School. Whilst the students learn from my body, I too am on a steep learning curve. As an artist, I am interested in the autobiography of the body and how we embody life’s experiences. I am also interested in the relationship between the body and identity. As an artists’ model, I am used to seeing how others see me, but how do I see myself? How does what I am on the inside relate to who I am on the outside – and vice versa? I am excited by what I am learning in life sciences and I am looking forward to working with successive groups of students, and exploring the issues being raised in my art practice.'