Article

A Tale of Two Shitties
Extreme Examples of Expert Habitus in an Anal Cancer Prevention Clinic

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Abstract
Based on 12 months of ethnographic data collection in an anal cancer prevention clinic, this article uses the extreme examples of patients involuntarily defecating through the anoscope during the procedure to highlight the relationship between the extreme and the everyday. Despite the rarity of this occurrence, I argue that these extreme examples shed light on the ways daily clinical routines are embodied as an expert habitus. High Resolution Anoscopy procedures are specialized, highly routinized practices that are performed hundreds of times per month at the clinic. These routines result in the development of a clinical habitus that guides physicians in deploying techniques to efficiently conduct the invasive examination. Exemplary examples of ordinary procedures certainly help explain how this expert habitus is enacted through routine clinical practices; however, this expertise becomes especially observable in moments when habituated practices are disrupted, forcing clinicians to react and respond in unscripted ways. I discuss the only two instances of patients defecating through the anoscope that occurred while conducting my research, each with a different clinician. These extreme examples provide rich opportunities to analyze how clinicians with similar procedural habits navigate extraordinary situations in expert and professional but idiosyncratic ways. Whereas exemplary examples of everyday routinized procedures can show the process of developing an expert clinical habitus, these extreme examples more clearly demonstrate how this habitus enacts expertise and professionalism by highlighting the clinicians’ abilities to deftly navigate the technical and socio-cultural aspects of such extraordinary disruptions.

Keywords
extreme example, expertise, professionalism, habitus, clinical ethnography, anal cancer, biomedicine
Introduction

This article is premised on the idea that ‘the extreme’ and ‘the everyday’ are not inherently oppositional. While we may define something as extreme because it exceeds what is ordinary or normal, I argue that extremes can provide great insights into the mundane. To support this argument, I draw on data from ethnographic fieldwork at an anal cancer prevention clinic in the US to show how an extreme example (in this case, the ‘extremely rare’ occurrence of a patient involuntarily defecating through the anoscope) highlights the embodiment of routinized everyday clinical practices of anal cancer prevention.

After reviewing some foundational scholarship for making sense of how extreme examples can be revelatory of everyday practices, I provide a brief description of the research setting and methods. The article then presents a description of a ‘typical’ exam that occurs at the clinic, serving as an exemplary example (Højer and Bandak 2015). Next, I narrate two ethnographic vignettes — extreme examples — of the extremely rare situation of patients involuntarily defecating through the anoscopes during their exams. Finally, I discuss how these extreme examples help to highlight the professionalism and expertise embodied by the clinicians through the daily clinical routines.

Background

The clinic is a social field (Bourdieu 1990) where both broader sociocultural and uniquely biomedical norms and values are co-produced, enacted, challenged, and reproduced. These norms and values include the institutionalization of biomedical expertise as a fundamental authority concerning public life. Scholars have theorized expertise in several ways: as grounded in institutions and social relations, especially through a framework of the division of labor (Abbott 1988; Freidson 1998; Zetka 2011; Eyal 2013); as something individuals gain through interactions with and socialization into expert groups (Collins and Evans 2007); as a set of meanings and practices grounded in the lived experiences of individual human subjects (Young 1997; Cassell 1998) and communities of practice or social fields (Boyer 2005); and as something that is done rather than obtained, enacted through practical actions in particular contexts that actually constitute the thing the expert claims authority over (Carr 2010; Mol 2002).

Within the clinic, biomedical expertise is enacted through the daily practices and discourses that are stabilized by norms and institutions (e.g., medical education and the state) and shared among providers and patients. The social field of the clinic comes with a set of rules and roles that those within the clinic (more or less) follow. The various actors in the clinic (e.g., clinicians, medical assistants, clinic staff, patients, and ethnographer at my fieldsite) are involved in embodied processes of mutual co-constitution with their sociocultural environments (e.g., the exam room, a biomedical clinic, and the geographic location). In other words, their daily activities produce and reproduce their sociocultural roles as ‘patients’ and ‘clinicians’ along with all the norms and values attached to such subject positions. As
providers and patients engage with each other in and through the clinic, they (re)produce internalized styles of behavior expected of such spaces, which they have learned through repeated encounters in medical environments throughout their lives. These acquired styles of behavior, usually but not always non-conscious, are what Bourdieu (1977, 1990) calls *habitus* and Dewey (1988) calls *habit*.

Bourdieu adopted and extended the concept of habitus from earlier scholars (Mauss 1935) and elaborated it to refer to a set of dispositions acquired through socialization into particular social fields. These dispositions are the result of the internalization of norms and rules that allow a person to successfully navigate a social field by invoking or developing different kinds of capital. For Bourdieu, capital refers to the various resources that agents have access to that help them successfully navigate within and/or between fields, and includes economic capital (material resources), symbolic capital (prestige or credentials), cultural capital (such as language competency), and social capital (such as developing friendships or professional relationships). The ability to access, invoke, enact, spend, or appeal to these forms of capital in ‘the right’ ways at ‘the right’ times is indicative of one’s habitus in any particular social field(s).

Dewey’s concept of *habit* is similar to but not entirely the same as Bourdieu’s *habitus*. For the purposes of this work, I consider these two concepts interchangeable. Dewey theorizes habits as ‘constantly in process, subject to revision and change, but they provide the underlying continuity of social life’ (Crossley 2013, 154). Habits are not rigid and unbending; instead, they give a sense of stability in daily life since they can often be transferable across social settings. Habits ‘do all the perceiving, recognizing, imagining, recalling, judging, conceiving and reasoning that is done … We may indeed be said to know how by means of our habits’ (Dewey 1988, 124). This ‘know how’ is our ‘practical sense’ in Dewey’s terms or ‘feel for the game’ in Bourdieu’s (1990) terms. How well we are able to navigate any particular social field depends on how our histories have built up our habits.

Social structures, environments, and their associated habits are changeable ‘both through spontaneous and pre-reflective improvisation and also as a result of deliberative changes to our course of action’ (Crossley 2013, 150). This is because our actions not only depend on nonconscious habits, but also give rise to moments of ‘accident’ or ‘crisis’ to which we must consciously respond. Our responses in such moments are where revisions to and/or re-inscriptions of habits (and environments) occur. It is exactly such a moment I take up in this article: the involuntary defecation through an anoscope during an anal cancer diagnostic procedure led the clinicians to respond to this extreme disruption to their habits in ways that make obvious the expert clinical habitus they have developed over time through repetition and routine.

1 For detailed discussions of the relationship between Dewey/habit and Bourdieu/habitus, see Crossley 2013, Colapietro 2004, and Shusterman 1999.
Medical expertise was historically claimed through jurisdictional conflicts as various interested parties claimed authority over disease, health, and knowledge about bodies (Bonner 1995; Ludmerer 1985, 1999; Starr 1984). The development of medicine as a profession was key to these claims of cultural authority, which resulted in a significant increase in autonomy for medical practitioners (Abbott 1988; Freidson 1998; Butler et al. 2012). The consequent development of professional medical organizations, which claimed jurisdiction over the education and credentialing of new physicians, meant that medical schools became important sites for the socialization of medical students into professional physicians, and this continues in the present (Good & Good 1993; Good 1994; Good 1995; Hafferty & Castellani 2011; Monrouxe et al. 2011; Holmes et al. 2011; MacLeod 2011; Craig et al. 2018).

Building on this literature, I conceptualize professionalism in line with Schinkel & Noordegraaf (2011), who employ a Bourdieuan approach to the concept — in spite of Bourdieu's rejection of the concept of 'profession.' They theorize professionalism as a form of symbolic capital that is utilized in constantly ongoing internal and external power struggles. Biomedical professionalism constitutes a social field consisting of particular kinds of social positions and relations. The construction and maintenance of this field requires a biomedical habitus that becomes naturalized in the body (alongside expertise). This biomedical habitus, acquired initially through medical education but also through the continued socialization of actors within the social field of medicine, enables the acquisition of symbolic capital within and beyond the medical social field. In other words, this symbolic capital—the prestige associated with credentials, more specifically—is not bound to medical spaces; medical professionals are able to use their symbolic capital in non-medical settings because its scarcity makes medical professionalism a highly valued status symbol.

Part of what makes medical professionalism recognizable — what makes it useable as symbolic capital — is its association with a certain demeanor and rules for behavior. An emic definition of medical professionalism is enlightening on this point. Epstein & Hundert (2002) posit that medical professionalism involves ‘the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served’ (cited in Kirk 2007). Here, we see the identification of medical professionalism as being linked to behavior, cognition, and emotion, all embedded within a social context. Those clinicians who internalize this sort of message and act according to the norms of the medical community are considered to have acquired the symbolic capital of medical professionalism. When clinicians use this symbolic capital in their interactions with patients, they are said to be acting professionally.

Related to the symbolic capital of professionalism — and included in the emic definition above — is the idea that part of acquiring a clinician’s habitus is the concomitant development of the clinician as an ‘expert’ of the body. The clinical
habitus I examine in this article is the result of rigorous education and training as well as the embodiment of the everyday routinization of clinical practices. The specialized procedures and associated clinical practices that I describe are repeated several times each day (hundreds of times per month) and are highly ritualized. Medical practices are ritualistic not in a grand public ceremonial sense but in a quotidian sense (Goffman 1959, 1967; Collins 2004). They involve repetitious interactions among people, objects, and environments, which are structured by norms of behavior that have varying purposes. The patient check-in process, the practices of taking medical histories and obtaining patient consent, maintaining and using the exam rooms with all of its tools and technologies, and employing appropriate and avoiding inappropriate discourses for interacting with patients are all standardized. There is a structured pattern the practices are expected to follow each and every time with as little deviation as possible. These patterned activities enact the professionalism and expert habitus of the clinicians. They also encourage efficiency by routinizing workflow that, when working according to the script, enables clinicians to streamline their clinical duties and perform their tasks quickly. These rituals also (re)produce a medical gaze (Foucault 1994) that results in the objectification of the anus; however, it is the same kind of distancing that occurs in all medical environments rather than being a result of the taboo nature of the anus.

While these ritualistic practices are mundane for clinicians, patients experience them as infrequent events steeped in emotion and affect related to the taboo aspects of the procedure. To the patient, the examination is a unique moment foregrounded by the discomfort of making one’s body and its most culturally intimate and taboo traits vulnerable to practical strangers. And even though these infrequent visits to a specialist require patients to act in ways they may not be used to (for example, lying on the exam table in a specific way), especially at their first visit, patients are nonetheless used to the structure of clinical encounters and generally know how to successfully navigate the clinical space. That is, they are able to enact a generalized patient habitus despite the clinic’s specialized nature.

That these clinical practices are quotidian for clinicians but not for patients gives the clinical activities a certain kind of emotional power from the patients’ perspectives. However, to providers these mundane procedures generally lack emotional content or impact. The clinical procedures are basically the same for each patient, and it is this routinization that incorporates the clinical habitus of the clinicians. The clinicians have embodied certain professional dispositions that enable them to know the ‘right’ ways to act as well as guide patients in how to behave. Indeed, patients who have experienced the examination several times are able to revise their patient habitus to incorporate the expected routines of their infrequent visits to the anal cancer prevention clinic. First-time patients often seem confused about how to act ‘correctly,’ which is only heightened by the potentially embarrassing and highly vulnerable experiences they are going through; yet, patients who have been going to the clinic for several years learn the rules, norms, and discourses of the procedure, eventually coming to embody the clinic’s routines as well.
The collection of these repetitive mundane practices to explain the development of a clinical habitus culminates in the production of *exemplary examples*, ‘always less than everything and more than itself’ (Højer and Bandak 2015, 8). Exemplary examples create a sense of stability in the particular social field they are characterizing by building an exemplar from a set of seemingly normal cases. Indeed, further below I do exactly this — I draw on a year of observations of and involvement with daily life in the clinic to construct a narrative of a ‘typical’ exam. The exemplary example of a typical exam given below is a narrative I constructed from countless observations; it is not about any specific exam. Rather, I use it to summarize the routine aspects of the procedures in order to compare the extreme examples with what would be considered an ordinary patient visit in the clinic.

Exemplary examples are widely lauded in anthropology for their ability to help explain phenomena simultaneously both in whole and in part. Yet, exemplary examples can have the effect of abstracting important details and regularities, ignoring irregularities or things that do not fit into the intended exemplar narrative. Critiques of overdependence on exemplary examples are not new. Though he did not use the concept of exemplary examples, Gluckman (1961) proposed the extended case method as a means for challenging the decontextualization of ethnographic data one finds in exemplary examples. Building on Gluckman’s work, van Velsen (1967) argued for the importance of attending to how ‘words, norms, general rules of conduct, are translated into practice’ (136), and he critiqued structuralist methods for ignoring variations and privileging general principles. Simply labeling variations as ‘exceptional’ or ‘accidental,’ he argued, solves nothing since ‘they do occur within, and are part of, the same social order that the ethnographer has set out to investigate and describe’ (136). Burawoy (1998) likewise emphasized the importance of attention to context and variation in ethnographic work and further elaborated van Velsen and Gluckman’s ideas by incorporating the notion of reflexivity by arguing for the importance of selecting cases to challenge and revise existing theory. This article builds on this scholarship by engaging an extended case method approach that aims to give detailed descriptions of variations in the everyday clinical workflow. Examining the ‘norms in conflict’ (van Velsen 1967) among the exemplary and extreme examples allows for a better-contextualized understanding of how and why clinicians employ expert and professional habits.

‘Outliers,’ ‘non-representative,’ and ‘extreme’ examples do sometimes make appearances in anthropological scholarship, but as this special issue makes clear there is great untapped explanatory potential in the use of extreme examples. While it is true that extremes may be most easily recognized by their deviations from the mundane, I show how ‘the extreme’ is in fact capable of exemplifying important aspects of everyday life in a clinical context. Rather than taking the explanatory power of exemplary examples for granted, I juxtapose an exemplary example with two extreme examples to reveal the embodiment of everyday routinized clinical practices. Whereas the exemplary example demonstrates the ordinary scripts by which anal cancer prevention procedures are expected to unfold,
the extreme examples of how clinicians respond to patients involuntarily defecating during their exams make obvious the internalized clinical habitus enabling expert navigation of moments of crisis that disrupt the typical procedural order.

**Setting and Methods**

The arguments in this article derive from 12 months (June 2018 – May 2019) of ethnographic fieldwork at Anal Dysplasia Clinic-MidWest (ADC-MidWest), located in Chicago, Illinois, USA. ADC-MidWest specializes in a procedure known as High Resolution Anoscopy, which is used to detect cancerous and 'pre-cancerous' lesions in the anal canal caused by the human papillomavirus (HPV), the same virus that causes cervical cancer. In addition to preventive exams, the clinic also performs ablation treatment procedures for HPV-related anal disease, including cryotherapy and chemical treatments on external anogenital warts, and electrocautery and infrared laser treatments that burn away internal HPV-related lesions. They also provide other anal infection tests (most commonly chlamydia and gonorrhea) and HPV vaccinations.

The clinic is owned and operated by Dr. Gary Bucher. At his request, the clinic has not been anonymized since it is the only clinic in the Midwest region of the US that offers these specialized procedures, and it would be easily identified through descriptions of the work. Further, Dr. Bucher and the staff are proud of their work, are active in the community, and publicly advertise their services all over Chicago, so he feels no need to conceal their identities. The names of patients, however, have been removed from this work. During the time of my fieldwork, there were six staff members in addition to Dr. Bucher, including: Noah and Brad (two Physician’s Assistants who were certified to conduct the procedures), Cynthia (Registered Medical Assistant), Erick (Clinical Research Coordinator), Keith (receptionist), and Arminius (office/business manager).

ADC-MidWest is the most active site of the ANCHOR study, a national longitudinal anal cancer prevention clinical trial with 15 study sites across the United States at the time fieldwork was conducted. The goal of the clinical trial is to determine whether treatment or close monitoring of pre-cancerous HPV lesions in the anal canal is best for anal cancer prevention. Participants visit the clinic at least twice per year, sometimes more if they are randomized into the treatment group and are required to return for visits to have the lesions removed. The vast majority of patients seen by the clinic during my fieldwork were participants in ANCHOR.²

Most of my time at the clinic was spent working as a medical assistant and as an ANCHOR research assistant. Patients were informed by the clinic staff or myself.

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² For more information on the ANCHOR study, see: https://anchorstudy.org/
of my double role as a clinic assistant and as a researcher and asked for consent to allow me to observe their interactions with the providers. My clinical duties included assisting the clinicians during the High Resolution Anoscopy procedures, processing specimens in the lab, data entry, consenting patients into the ANCHOR study, patient/participant retention calls, and helping with re-stocking of medical supplies. In addition to participant observation, I conducted interviews with the clinic staff and several patients. This article is based on participant observation and supplemented with information from interviews with the providers.

An Exemplary Example: A ‘Typical’ High Resolution Anoscopy Procedure

The clinicians at ADC-MidWest perform a procedure called a High Resolution Anoscopy (HRA), which is a specialized procedure that involves inserting an anoscope (a small plastic tube about 5 inches (13 cm) long, see Figure 2.f) into the anal canal to open it up for visual examination using a high-powered magnification microscope. Learning how to perform an HRA procedure requires several months of training and practice to gain competence for certification and is carried out in decidedly ritualized ways. The HRA procedures generally advance in a similar manner regardless of whether or not the patient is a participant in the ANCHOR study (there are a few extra steps in the process for ANCHOR participants involving tissue sample collection). The procedures are structured according to standards set by the ANCHOR study protocol, which is meant to preserve the quality of the data being collected at multiple sites across the country by ensuring consistency in sampling techniques. Uneventful routine HRA procedures generally take 10-15 minutes, but sometimes they can take 20-30 minutes if there are precancerous or cancerous lesions to biopsy. The ritualized flow of the procedure is strictly adhered to by clinic staff and generally progresses in the following manner.

After patients are brought to the exam room, their temperature, blood pressure, and pulse are documented, blood is drawn, and the clinician collects their medical history. They are asked to undress from the waist down and sit on the edge of the exam table with a thin paper drape covering their lap. The clinician and assistant enter the room a few minutes later to begin the procedure. The clinician does a quick physical exam, palpating the abdomen, checking groin lymph nodes, and sometimes inspecting the genitals of patients with penises for signs of HPV infection. The clinician then instructs the patient to lie on their left side, tuck their knees up toward their chest, and place their feet on the stirrup (see Figure 1). The medical assistant moves the assisting table directly to the right of the clinician, hands a catchment drape to the clinician to tuck between the patient’s left buttocks and the exam table, and uncovers the assisting table with the examination tools (see Figure 2). The clinician pulls down the high-powered microscope, which activates a spotlight, and focuses it on the patient’s outside anal skin. A camera inside

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3 Patients with vaginas usually have seen a gynecologist prior to their anal cancer screening procedures and thus the clinicians at ADC-MidWest do not typically perform a visual inspection.
the scope projects an image of what the clinician sees on a computer screen nearby, which is visible to the patient.

The provider does a cursory examination of the outside anal skin to look for any obvious health concerns and then collects three tissue samples using small swabs (fewer or no samples are collected if the patient is not an ANCHOR participant). Next, the clinician performs a digital anorectal exam to feel for lumps or bumps (potential signs of health problems), and then inserts the anoscope, which has a white plastic plug in the center of the tube. The plug has a rounded end that helps with insertion of the anoscope, and when the plug is removed it allows the clinician to look down the tube through the microscope to see small areas of anal tissue. It also facilitates the insertion of tools required for diagnostic procedures. The insertion of the finger and the scope are aided by numbing lubricant gel. Once the scope is inserted, a swab soaked in vinegar (Figure 2.e) is inserted through the scope, and the scope is withdrawn to leave the vinegar swab in place to soak the skin cells inside the anal canal (the vinegar dehydrates the cells and turns HPV-infected cells white, making lesions more visible to the clinician). The assistant replaces the plug into the anoscope, preparing it for re-insertion. After the vinegar swab soaking for two minutes, the clinician pulls it out and re-inserts the scope.

At this point, the High Resolution Anoscopy procedure begins. The clinician slowly moves around the circumference of the anal canal, focusing on the transition zone where the ‘outside skin’ of the anal canal transitions to the ‘inside skin’ of the colon (this is where HPV infections are most commonly found in the anal canal due to the continual turning over of cells in this area). The clinician uses small swabs (Figure 2.d) to apply more vinegar to aid in the visualization of any HPV-infected cells. Sometimes the clinician will apply iodine to an area to help determine if a suspected area has pre-cancerous changes (affected tissue typically turns yellow as opposed to a deep chocolate brown for healthy tissue). Any suspected areas are biopsied, which involves snipping a sesame-seed-sized sample of tissue. Patients generally do not feel this since the transition zone between the anal canal and the rectum is typically devoid of nerves, though some patients with shorter anal canals sometimes feel a pinching sensation.

Once the biopsies are collected, the scope is slowly withdrawn as the clinician inspects the tissue between the transition zone and the anal opening. With the scope removed, the clinician wipes down the outside skin with water-soaked gauze and then applies a small piece of gauze saturated with vinegar to the outside skin to help visualize any HPV-infected areas on the outside. External biopsies are taken if necessary (these are rare and can be painful), and the patient is given some dry gauze to tuck between their buttocks to absorb any bleeding after the procedure. The clinician and assistant leave the room while the patient dresses. The assistant brings the specimens to the lab to process them, the clinician goes to print any necessary lab or patient paperwork, and the patient checks out and leaves the clinic. After the patient is gone, the assistant sanitizes the room and sets up for the next patient.
This 'typical' visit is an exemplary example of daily life at the clinic. The procedural structure is generally the same, though there are variations depending on the patient’s condition as well as idiosyncrasies among clinicians, who go through the same routine but do some seemingly insignificant things differently. These idiosyncrasies go unnoticed by patients and do not affect the overall flow of the clinical ritual. While a patient who sees Dr. Bucher on one visit and Noah on the next visit (which is uncommon — the clinic strives to keep patients with the same provider at each visit) might notice a difference in how sample collection or scope insertion feels, given the nature of the exam and varying sensitivities among individual bodies, the procedures may be equally uncomfortable regardless of who performs it.
A Tale of Two Shitties

During my yearlong fieldwork in the clinic, I witnessed only two instances of patients involuntarily defecating through the anoscope during the HRA procedure. The appearance of feces during procedures was mostly (though not completely) unremarkable to the providers (patient reactions to its appearance on the monitor varied but were usually in line with notions of the abject disgust of feces; for interesting anthropological work on the abject nature of feces, see the first issue of this journal, ‘Theses on Facees: Encounters with the Abject,’ but especially Kuldova and Chepstow-Lusty 2016; Pfaller 2016; Arya 2016). However, full-on bowel movements were remarkable not only because of their abject qualities, but because they were described by the providers as ‘extremely rare.’ There were no standard protocols for how to deal with these extreme events, leaving it to providers to decide how best to navigate these moments of crisis. Because each instance I observed happened with a different clinician, I had the opportunity to examine how two clinicians — expert professionals who each performed hundreds of HRA procedures a month — navigated such an extreme event while guided by the clinical habitus that shaped their expectations and procedural routines for HRA procedures.

Below, I describe each event in detail by presenting moderately edited versions of my fieldnote entries written up immediately after each occurrence.

Pretend Nothing’s Gone Wrong

On the morning of 1 August 2018, I worked as a medical assistant to Noah, a Physician’s Assistant in the clinic. After the morning staff meeting, I called back the first patient of the day, a white gay man in his mid-50s. I walked him to the exam room, took his vital signs, and then Noah had a pre-examination discussion with him before letting him undress. Noah and I chatted before the exam while the patient undressed, and he told me the patient was ‘a super nice guy’ who was a public-school teacher on the verge of retirement.

When we walked into the exam room a few minutes later, I realized that I’d forgotten to finish setting up the assisting table after the morning meeting, so I began frantically trying to pour the necessary liquids into the appropriate containers. I told Noah about this lack of preparation as I was moving around quickly trying to set up, and he calmly said, ‘that’s okay, we’ve got some time.’ He made small talk with the patient while he did a quick physical exam of the patient’s abdomen and genitals as I finished setting up. Noah then had the patient turn on his side and got him into position for the procedure. The procedure began as usual: he inserted one Pap smear swab and performed a digital anorectal exam, which he told the patient was normal (he did not feel any lumps or bumps). Noah then inserted the anoscope.

When he pulled the plug out of the scope, it was covered in fecal matter. I handed Noah the vinegar swab and watched him start to insert it into the scope, but he suddenly stopped. He quickly tossed the swab back on the assisting table and
grabbed a dry piece of gauze. I looked at the scope and saw thick light brown liquid fecal matter slowly oozing out of the scope down the patient’s buttocks onto the catchment drape. Noah said to the patient, ‘just wiping some gel off.’ He then grabbed a large gynecological swab and started scooping the feces out of the scope. He quietly asked me for an empty cup, so I grabbed one. He put the used gauze and gyne swab into the cup, and I disposed of it in the biowaste bin before grabbing a several more fresh gyne swabs. I then grabbed another empty cup, and Noah continued to wipe up the feces which was still steadily creeping out of the scope like molten lava slowly rolling down a hillside. This continued for several minutes — which felt like an eternity — before it finally ceased.

Noah inserted the vinegar swab through the anoscope and then withdrew the scope to let the vinegar swab soak. By this point, the smell of shit had filled the room, and it was almost overwhelming. Noah, acting as if nothing extraordinary had happened, asked the patient if he had any plans for the rest of the day and they chatted about weekend plans for a couple of minutes while the vinegar swab saturated the anal tissue. After two minutes, Noah removed the swab and placed it on the table, and it was covered in fecal matter. I held out a cup for Noah to get some gel on his finger to re-apply to the patient’s anal canal, and then handed him the anoscope. He inserted it and very slowly pulled the plug from the scope, apparently afraid feces might forcefully spray out. Nothing sprayed out, but more liquid feces came oozing out. I got more gyne swabs, empty cups, and dry gauze, and Noah continued to clean it up as it came out. After another minute or so it stopped, and Noah started the visual exam.

The rest of the exam was routine, and while there was fecal matter all over the inside of the anal canal and inside of the scope, he was able to complete the exam as normal. During the procedure, I removed anything that was covered in feces from the table and placed it in the biowaste bin, and I placed some gauze over the small puddle of feces on the table pad so the patient wouldn’t see it if he sat up quickly at the end of the procedure before I removed everything from the table. I also made two water wet wipes in case Noah needed them, but he only used one to clean up at the end of the exam. He did not take any biopsies and said everything looked healthy. He removed the scope and placed it on the assisting table. I tossed the used gauze and the anoscope into the biowaste and handed Noah a vinegar-soaked gauze to aid his inspection of the outside anal skin, which took about 30 seconds. After that, he left a dry piece of gauze by the patient’s anal opening as he announced that the exam was finished. I quickly scooped all of the remaining materials off the table and put them in the biowaste bin. I dumped the liquids out in the sink, then carefully took off my gloves (which had fecal matter on them), disposed of them, and used some gauze to pick up the Pap smear sample container to take it to the lab.

We left the room and walked down the hallway to the lab. Once in the lab, we started washing our hands. I took a deep breath and made a gesture with my hand like I was centering myself after an extremely stressful event. Noah made a faux
dry heave gesture (as if he wanted to vomit) and said his first thought was that he was so glad his nausea from the previous day was gone. I said, ‘oh my god, my first thought was: I’m so glad Noah doesn’t feel nauseated right now!’ He said, ‘oh, I was close to vomiting a few times, the smell was so strong, but I held it together.’ I said, ‘yeah. You did great. Was that the grossest thing you’ve seen here so far?’ He said, ‘oh, no, I’ve had worse. But that was pretty gross.’

I processed the specimen in the lab and the patient finished getting dressed and left the exam room. I asked Noah if there was anything to spray to make the smell go away before the next patient. He told me to use the scented disinfectant spray from the staff bathroom. I walked back to the exam room and Erick (the clinical research coordinator) walked back with me to help me set up for the next patient. I asked him if he could smell it in the room when we entered, and he said yes. I started sanitizing surfaces, and Erick started laying out the assisting table for the next patient. I fetched the scented disinfectant spray from the staff bathroom and sprayed the room down to try to mask the smell. It didn’t work very well — it basically smelled like a mixture of shit, disinfectant, and a fake floral scent. When the room was done being set up, I waited a few more minutes and then retrieved the next patient from the waiting room, hoping that the smell would dissipate before we returned. It didn’t.

**There’s No Point Pretending Nothing’s Gone Wrong**

On the afternoon of 27 August 2018, I was assisting Dr. Bucher, the head clinician of the clinic, with the last patient of the day, a white gay man in his mid-40s. After taking the patient through the informed consent process for the ANCHOR anal cancer prevention clinical trial, I brought him to the exam room and took his vitals. Dr. Bucher then drew his blood and collected his medical history. About ten minutes later, after the patient was left alone to undress, Dr. Bucher and I walked into the exam room. Dr. Bucher said he forgot to put the blood in the refrigerator, so he handed it to me, and I quickly went down the hallway to put it in the lab’s refrigerator before returning to the exam room less than a minute later.

When I returned, Dr. Bucher was doing the physical exam. I put on some gloves and prepared the assisting table. I moved into position as Dr. Bucher situated the patient on his side for the exam. I handed Dr. Bucher the catchment drape and then handed him the first Pap smear swab. After he processed it in the liquid vial and handed it to me for disposal, I noticed it was dark brown. Sometimes the swabs come out with a light brownish-yellow color, but this was more like a fully coated milk chocolate brown, which was unusual. Dr. Bucher did two more swabs, then performed a digital anorectal exam. When he withdrew his finger, it was covered in fecal matter. He wiped most of it off a little on the absorbent pad on the assisting table and then used a dry piece of gauze to wipe up the outside area of the patient’s anus.

Dr. Bucher then inserted the scope, and as he began to remove the plug, I heard a loud release of air. Dr. Bucher slowly pulled the plug out and there was a sudden
rush of chunky milk-chocolate brown diarrheal feces down the scope. I quickly grabbed some small blue cups from the shelf and more dry gauze and gynecological swabs to help with cleanup. Dr. Bucher continued to scoop up as much of the feces as he could with swabs, handing them off to me rather than placing them in the cups as Noah had done a few weeks prior. Dr. Bucher commented to the patient, ‘just removing some stool.’ The room began to smell strongly of feces, and Dr. Bucher kept scooping up as much feces as he could. After about a minute, the scope was completely full of feces and Dr. Bucher said, ‘we’re going to need a new scope and drape.’ I acknowledged his request and turned around to grab a new anoscope from the shelf (careful to only touch the corner of the plastic wrapping of the scope I was retrieving).

Dr. Bucher placed the feces-filled scope into the catchment drape, wadded it up tightly, and handed it to me to put in the biowaste bin. I handed him a new catchment drape, then put some more gel on the new scope and handed it to Dr. Bucher. He told the patient he was going to insert the scope again, and as soon as he took the plug out, feces started coming out once again, though less volume than before. Dr. Bucher started to scoop it again, but after a moment said, ‘I may need to have you go use the restroom.’ The patient said, ‘I wouldn’t be surprised.’ Dr. Bucher asked, ‘do you feel like you need to go?’ The patient said, ‘I could probably go, yeah.’ Dr. Bucher said, ‘okay, why don’t we have you use the office restroom. You can wrap the drape around your waist and walk there, it’s just outside in the hallway.’

Dr. Bucher removed the scope, and while he wiped the patient’s anal area down with a wet wipe I quickly threw away as much of the feces-covered materials as I could before the patient fully sat up. Dr. Bucher walked the patient out into the hallway to the bathroom, and I followed. I washed my hands in the lab, and then returned to the exam room. Dr. Bucher said he wanted a new scope, so I got one ready and placed it on the table. Dr. Bucher unfolded a dry gauze and laid it over the small bits of fecal matter on the table. He said, ‘I like to do this, so the patient doesn’t see it and feel uncomfortable.’ I nodded and said I tried to clear as much off the table as I could before he got up. Dr. Bucher nodded and then left the room to check on the patient.

While he was out of the room, I removed and replaced the paper covering on the exam table, which had a small brown stain on it. I grabbed a few more gyne swabs and pieces of gauze and placed them on the exam table. I made two new wet wipes out of gauze in case Dr. Bucher needed them. The patient came back into the room and sat back on the table. As the patient was lying back down after using the restroom, Dr. Bucher happily said, ‘okay, ready for round two?’ The patient meekly said yes, and Dr. Bucher started tucking a fresh catchment drape under the patient’s behind.

As he was doing this, the patient quietly confessed, ‘I’m so embarrassed.’ I felt awful for him when he said that (I figured he felt that way without him having to say
it, who wouldn’t?), so I said, ‘hey, don’t worry about it, it’s not a big deal at all!’ Dr. Bucher said, ‘this sort of thing happens, don’t be embarrassed. I’ve had much worse happen than this!’ Dr. Bucher inserted the scope and slowly removed the plug expecting more fecal matter, but none came out. As Dr. Bucher started looking into the scope, there was still some fecal matter in the patient’s anal canal, which Dr. Bucher scooped out with gyno swabs, going through eight swabs until he had cleaned the patient’s anal canal out. I was busy throwing the swabs away and trying to cover the new fecal stains on the table when I heard the patient say, ‘is that my colon?’ I looked over at the screen to see what he was looking at, and Dr. Bucher said, ‘yes, that’s your colon.’ He continued, ‘see that line there?’ in reference to a faintly visible white line in the tissue. ‘That’s your outside skin meeting your inside skin. That’s where your anal canal ends and your rectum begins.’ The patient watched the monitor intently and continued to ask questions about his body and the exam. Dr. Bucher explained that HPV does not live in the kinds of cells that make up the inside skin of the rectum and colon, but they thrive right in the area where the two types of skin meet. ‘The transition zone is what we call it,’ he said in a matter-of-fact tone. The patient said he’d had a colonoscopy and that ‘as soon as I saw the insides on the screen, I fell asleep. I’m glad I get to watch this whole thing.’

The rest of the exam was routine, the patient was healthy and had no evidence of HPV infection or anal cancer. As Dr. Bucher was wiping off the gel with a wet wipe and applying a vinegar-soaked piece of gauze to the outside skin to inspect it for HPV, the patient said, ‘this was a good experience, all things considered. I’m glad I did it.’ Dr. Bucher said, ‘good, that’s what we like to hear!’ I really admired the patient’s ability to be inquisitive and positive under the circumstances.

After Dr. Bucher finished the exam, we left the room, and I went to the lab to process specimens. Cynthia, the clinic’s medical assistant, was in the lab. I told her, ‘I just had my second shit-mergency experience in a month.’ She exasperatedly said, ‘whaaaaaat?’ I said, ‘yeah, there was a lot of shit. Like…a lot a lot.’ She giggled and left the lab to go shut down Noah’s room for the day. As the patient was leaving, he glanced at me in the lab, and I said, ‘it was great to meet you!’ He said, ‘thanks, you too!’ and headed to the front desk. A few minutes later, Cynthia came back to the lab and said, ‘I was gonna shut down your room, but it smells like shit and I don’t want to deal with it.’ I laughed and told her it was no problem and that I would do it. After I finished processing the specimens and closing down the lab, I went and shut down Dr. Bucher’s exam room and then left for the day.

**Extreme Examples of Expert Habitus**

During my time at ADC-MidWest, I observed several hundred HRA procedures that closely adhered to the exemplary example I constructed earlier in this article. Exemplary examples certainly provide opportunities for understanding the clinical habitus in action. Even in those quotidian ritualized practices where there is little deviation from the procedural script, there are opportunities for providers to im-
prove and/or revise their techniques in subtle ways. The ‘typical’ procedure is what is expected and what the clinical habitus works to reinforce. However, when moments of crisis occur, the clinical habitus is also what enables the clinician to successfully navigate the situation (success here being indicated by the completion of the examination).

The clinicians’ reactions were idiosyncratic in many ways, but they both continued operating according to their internalized clinical habits, deftly navigating these extreme situations in ways that novices would struggle with and likely fail to control. What became clear in these moments of crisis was the “practical sense” (Dewey 1988) the clinicians had for how to respond. The myriad adaptations the clinical habitus enables provide the tacit, embodied knowledge that let the clinicians continue manipulating the tools and employing techniques without thinking explicitly about their actions while these disruptions to their routines occurred.

Both Noah and Dr. Bucher maintained a sense of calm professionalism derived from their abilities to expertly handle the examination technologies. Neither of them, for example, had trouble holding the scope in place while removing fecal matter, and both of them creatively used tools for unintended purposes. Having observed Brad, another PA in the clinic, learn how to conduct HRA procedures over several months made it clear that manipulating the anoscope took a great amount of practice to become an expert. Dr. Bucher and Noah could manipulate the scope without consciously thinking about it, which enabled them to focus on the more emergent issue. The ways the two providers adapted the available exam tools such as cups, gauze, and swabs in the moment further exemplified an ability to think quickly about the defecation crisis while letting their habitus guide the manipulation of the procedure tools without bothering the patient or causing further issues.

Their demeanor remained professional; they engaged in professional discourses aimed at maintaining a sense of calm and control over the situation and protecting patients from embarrassment. For example, they both attempted to clean up the flowing fecal matter and continue with the procedure in an attempt to stay on script and avoid more deviation. Both clinicians also encouraged or actively engaged in actions like covering the appearance of fecal matter in an effort to avoid patients feeling humiliated. But the two clinicians took different approaches to their narration of events. By telling the patient that the fecal matter running down his buttock was actually just some gel used in the procedure, Noah chose to pretend like nothing had gone wrong, like everything was still going according to the script. The strong smell of feces that filled the room likely alerted the patient to what had really occurred but none of us — the patient, Noah, nor me — acknowledged it. Considering that this patient had experienced the procedure several times previously, he likely knew what happened. I did not ask him immediately after his procedure, and I was unable to interview him to see if it came up.
Dr. Bucher, on the other hand, explicitly acknowledged what was happening and engaged in dialogue with the patient about it. He did not spend long (relative to Noah) trying to clean up the flowing fecal matter. Instead, he interrupted the procedure and escorted the patient to the nearby restroom. Dr. Bucher was adamant about disposing of or hiding anything that might cause further embarrassment for the patient while he was gone from the exam room. Because of this interruption, when the patient returned there was a bit of discourse concerning the patient’s embarrassment, which was met with encouragement from both Dr. Bucher and me to attempt to allay his feelings of shame. These actions by both Noah and Dr. Bucher exhibit professionalism in action; their behaviors reflect the internalization of the shared normative understandings among medical providers concerning how to properly behave towards patients, especially around the importance of maintaining rapport with patients (Epstein & Hundert 2002; Kirk 2007), which helps them to maintain their professional symbolic capital (Bourdieu 1990; Schinkel & Noordegraaf 2011).

In both of these cases, the main clinical issue with the feces was that its presence interrupted a clear visual inspection of the tissue. Obviously, neither provider enjoyed cleaning up feces spilling down a tube a couple of feet (60 cm) from their faces, but the main concern for both of them in the moment was performing a successful procedure, which meant being able to visualize tissue, capture high-quality images, and take tissue samples for diagnostic purposes. On this clinical task, they were both successful. Noah patiently cleaned up feces for several minutes until the anal canal was clear enough to complete the exam, while Dr. Bucher interrupted the exam to have the patient go eliminate his bowels to try to clear the anal canal. Both of these actions ultimately were aimed at getting the procedures back on track and in line with the exemplary example case.

The clinical discourses after the procedures mostly concerned the olfactory aftermath of these predicaments (no one made fun of the patients themselves), but the activities we all engaged in centered around getting back to the routine and ‘covering up’ the evidence of a deviation. I asked Noah about this in an informal interview and he commented, ‘it’s extremely rare, but it happens, and it is just another thing to deal with in the clinic.’ These extreme moments become background noise to the everyday activities of the clinic; the clinical habitus draws the clinicians back to their rituals and routines.

Finally, I want to reflect on my presence in the clinic and speak to the development of my own clinical habitus, related to but different from those of the rest of the staff. One day about three months into my fieldwork, I realized during a procedure that I had stopped thinking about the fact that I was seeing people’s anus for several hours a day. I noticed that I was thinking more about the visualization of lesions on the computer monitor, the mechanics of the procedure, making small talk with patients or providers, or even what I was going to have for lunch. The flow of these procedures also became routine to me while working as an assistant, and the more time I spent in the clinic the less remarkable the procedures
became. Small variations from the expected procedural routine, which were quite noticeable at first, became ordinary and easily dealt with.

Thus, I developed my own sort of medico-ethnographic gaze, seeing and constructing both medical and ethnographic objects during my time in the clinic. Every little detail at the beginning of my fieldwork was new and noticeable. The sights and smells of the clinic were a little overwhelming for the first several days, and for at least the first six to eight weeks I found myself regularly being conscious of the fact that I was seeing the most intimate parts of complete strangers’ bodies. After a few months, by the time these extreme events occurred, I had become more focused on other aspects of the daily activities of the clinic. From then on, it was mostly the rare moments of crisis, of extreme disruption, in which the expert clinical habitus became most noticeable.

My own experiences during these extreme disruptions to the clinical routines also raise some questions about the distinctions between the expertise and professionalism. While the clinicians enacted expertise and behaved professionally — due to training and socialization as I have argued — I would posit that I also acted in what could be considered a professional manner despite the fact that I am not a medical professional and have not had the opportunity to obtain symbolic capital or internalize the norms of medical training (of which I have none). I had only been engaged in fieldwork for a few months when these cases occurred, but, like the clinicians, I acted toward the patients in a kind and caring manner as if nothing was out of the ordinary. In fact, the patients could not even see the clinicians during the procedure due to their position on the table, so had the clinicians made any facial expressions of disgust (which they did not) the patients would not have even seen that occur. But they could see me and my reactions. I felt an extreme pressure to maintain composure and act as if everything was going as expected. In this sense, my own discourses and behaviors toward the patient were really no different from the clinicians.

Yet, I do not have the training to enact the expertise required to perform the HRA procedure, much less to technically manipulate the tools and bodies of the patients in the manner the clinicians did during these moments. The fact that the clinicians were able to deftly utilize tools for unintended purposes and manipulate the instruments to scoop up fecal matter the way they did speaks to their expertise, whereas the ways we engaged with the patients as people (rather than medical objects) and the kinds of discourses we employed during these extreme situations speaks to professionalism. I received no explicit training on professionalism or bedside manner. I merely acted in concert with the clinicians and took my cues from them, and in this sense, I drew on their symbolic capital to enact my own quasiprofessionalism. I also have a general disposition that makes it difficult to shock or disgust me, which no doubt helped me maintain my composure.
Conclusion
In this article, I have argued that the everyday — depicted through the exemplary example — is not in opposition to the extreme, but rather complementary to it. The extreme examples presented here are capable of explaining a lot about the everyday life at the clinic because they present moments to examine the embodiment of the daily clinical routines. The skillful techniques the clinicians exhibited in those moments are the result of countless hours spent manipulating tools and bodies in their everyday lives. The extreme examples examined here are certainly ‘non-representative’ of what typically happens on a daily basis in the clinic. Yet, by centering these extreme examples in my analysis, I have demonstrated how such ‘outliers’ in our qualitative data are capable of producing quite fruitful analyses of the expert habitus that can otherwise be difficult to detect in the routinized daily affairs of clinical life.

Author Bio
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References


