The Body, Medicine, and Society

Deborah Lupton

Overview

- Why is more attention paid to women's bodies than to men's bodies?
- How does medicine's power to define the body affect treatment?
- How has medicine contributed to reproducing unequal social bodies?

This chapter discusses ways of viewing the human body as a sociocultural, rather than as simply a biological, phenomenon. The chapter draws upon contemporary sociological, anthropological, and historical research as well as theoretical perspectives to explore how medicine and public health define and reproduce understandings, beliefs, and experiences in relation to embodiment. There is an emphasis on the dynamic nature of concepts and experiences of the body, including changes through history, and differences between social and cultural contexts. The chapter also discusses how medical and public health knowledges and practices have reproduced—and in some cases contributed to—the drawing of distinctions between social groups.

Key terms

- agency
- clinical gaze
- commodity culture
- discourse
- embodiment
- men's health
- norms
- post-structuralism
- public health
Introduction

The human body is generally understood to be, above all, a biological and ‘natural’ phenomenon, and this is the view of the body that predominates in medicine and the allied health sciences. From this perspective, there is little that could be regarded as ‘social’ or ‘cultural’ about the human body, except perhaps such superficial aspects as the type of clothing that is worn, hairstyles, and body shapes. However, sociologists and anthropologists of the body regard the human body as a sociocultural construction; that is, the ways in which we understand and experience the body are mediated through social, cultural, and political processes. Certain aspects of the human body are, of course, given and immutable—for example, all humans are born and must die, and all humans experience pain and illness. However, the beliefs, understandings, and experiences of different groups in relation to phenomena such as birth, death, pain, and illness vary, in some cases dramatically. Sociologists and anthropologists argue that, in many cases, the reasons for these differences are not simply anatomical but a re also social and cultural. Central to understanding the sociological approach to the body is the notion that we both are and have a body. One’s body, therefore, is central to one’s self-identity; it is the thing or container in which we present ourselves to others, and through which we experience the world.

Social theorists who are interested in the body and medicine deny that medical knowledge, or indeed any other type of knowledge, can be regarded as neutral, scientific, or politically disinterested (see, for example, Foucault 1975; D. Armstrong 1983, 2002; Turner 1992; Turner & Samson 1995; Guarnaccia 2000; Lupton 2003). Rather, as with the body or any other phenomenon, medicine is socially constructed, is mediated through social understandings, and has political effects. For instance, while we may think that the version of the human body presented in a medical textbook is ‘scientific truth’ and therefore politically neutral, closer examination reveals conventions of representation that support wider sociocultural and political assumptions and objectives. The body in such textbooks is nearly always that of a young white male, suggesting that this type of body is the ‘real’ or ‘normal’ human body, against which other bodies (those of women, people of non-white ethnicity, or the elderly) are considered ‘abnormal’.

For conceptual purposes, the anthropologists Nancy Scheper-Hughes and Margaret Lock (1987) have defined ‘three bodies’ at three levels of sociocultural analysis. The first is the individual body, or the lived experience of the body as an everyday reality for the individual. Sociologists and other social scientists who are interested in how people understand and experience aspects of embodiment, including health and illness states, focus their attention on this conceptual body. The second is the social body, or the representational use of the body as a symbol to stand metaphorically for other phenomena and vice versa. This notion has been taken up particularly by anthropologists, who are interested in the ways that cultural groups conceptualise features of human bodies as signifying wider meanings for society, and how in turn metaphors derived from the body are used to describe society. An
example is the way that the idea of cancer is used to represent a serious social problem, such as in the statement ‘crime is a cancer within society’. The third conceptual body is that of the body politic, which refers to the social regulation, surveillance, and control of groups or populations of bodies. This concept has been useful for sociologists interested in exploring the ways in which medicine and public health have attempted to regulate and control social groups. While all three levels of conceptualising the body are important and useful, this chapter focuses in particular on the lived experience of the individual body and the ways that medical knowledge and practices serve to define and distinguish between social groups.

Lay beliefs about health and the body

One way that sociologists and anthropologists have explored individuals’ understandings and experiences of their bodies is to elicit their beliefs about the causes of health and illness states. Several studies have pointed to the importance of lay health beliefs in people’s understandings of the body (see, for instance, Radley 1993; Williams 1990; Kleinman & Seeman 2000; Lock 2000) and have demonstrated how health beliefs may vary between different social and cultural or ethnic groups (McElroy & Jezewski 2000; Lock 2000). In these studies it is noted that lay people often adhere to concepts of health, illness, disease, and the body that may differ dramatically from the orthodox medical position. Research involving interviews with older African-American women living in a southern State of the USA, for example, revealed a common belief that a blow to the breast could cause a ‘bruise’ or a ‘knot’ that could result in breast cancer. As a result of this belief, some of the women thought that a mammogram could predispose them to developing breast cancer because they found the procedure painful (Warldow & Curry 1996).

Embodyment is a central theme of both the illness experience and the medical encounter. When illness occurs, aspects of the body that were previously taken for granted and never noticed as part of everyday bodily functioning are brought into sharp relief (Kleinman & Seeman 2000). As the medical anthropologist Byron Good notes, for the person who is experiencing illness or pain, ‘the body is not simply a physical object of physiological state but an essential part of the self. The body is subject, the very grounds of subjectivity or experience in the world, and the body as “physical object” cannot be neatly distinguished from “states of consciousness”’ (1994, p. 116).

Illness is, above all, an embodied experience, bringing us down to earth by reminding us that we are neither invulnerable nor immortal. For those people who experience chronic illness or disability, permanent changes to the body may be constant reminders of their status as ‘outsiders’, as people whose bodies may look different from what is considered to be the norm, or as

public health/

public health infrastructure

Public policies and infrastructure to prevent the onset and transmission of disease among the population, with a particular focus on sanitation and hygiene such as clean air, water, and food, and immunisation. Public health infrastructure refers specifically to the buildings, installations, and equipment necessary to ensure healthy living conditions for the population.

norms

Expectations about how people ought to act or behave.
agency
The ability of people, individually and collectively, to influence their own lives and the society in which they live.

people who are not capable of the range of bodily movements expected of ‘healthy’ or ‘normal’ people (Charmaz 2000; Taleporos & McCabe 2002). These experiences may also serve to make them feel as if they are separate from their body. Disease or pain are often described as ‘it’—as something that is not the self, that is uncontrollable and has its own agency and sense of purpose, and that is foreign from the self and destructive of one’s body. An example is the vivid description that a young man gives of the chronic pain he experiences: ‘Sometimes, if I had to visualise it, it would seem as though … there’s a … demon, a monster, something very horrible lurking around banging the insides of my body, ripping it apart’ (quoted in Good 1994, p. 121).

Sociologists and anthropologists have pointed out that the meanings of embodiment are dynamic. There are manifold bodily experiences that appear to be acknowledged and found in some social groups but not in others. The phenomenon of menopause, for example, is experienced and dealt with differently in Western cultures compared with Japan. The Western notion of menopause includes not only the permanent cessation of menstruation in older women but also a constellation of symptoms such as depression and hot flushes, which are believed sometimes to require medical advice and treatment. However, there is no consonant Japanese concept of menopause. While it is acknowledged that menstruation inevitably ceases in older women, most women tend not to report experiencing symptoms associated with this event, and there is no word for menopause. In Japan, middle-aged women are viewed as entering their prime as ‘good wives and mothers’. The identification of menopausal symptoms has been a postwar phenomenon in Japan, and menopausal problems are still largely viewed as a ‘luxury’, largely confined to particular types of women, especially those who are middle class and urban (see Lock 1993). As this suggests, social expectations about the causes of health and illness are associated with people’s experiences of their bodies.

Even within the same cultural context, notions of the body, health, and disease have shifted and changed over time. In Western societies, for example, a number of conditions or diseases such as chlorosis and hysteria, which were once regularly diagnosed, no longer exist as diagnostic categories, and there are now categories of disease, such as chronic fatigue syndrome, that have only been identified and named in the past few decades. The medical historians Roy and Dorothy Porter (1988) provide a fascinating account of the ways in which people living in Great Britain in the two centuries between 1650 and 1850 conceptualised embodiment in the context of health and illness. They note that in those times, illness was ever-present; indeed, it was far more unusual to experience prolonged periods of feeling well. There was, therefore, a preoccupation with preventive health, but this was understood somewhat differently from today. For instance, many people believed that to ‘fuel’ the body (note the mechanical metaphor to describe embodiment) and to ‘replenish the blood’, the individual needed to eat rich and strong foods, including meat and wine. As the Porters note, ‘the Englishman’s devotion to roast beef was not mere patriotic gloating, gluttony or fantasizing, but, according to the folklore of good health, positively therapeutic’ (1988, p. 48). There is a marked contrast with contemporary health advice on diet, in which rich, fatty foods and over-consumption of alcohol are almost demonised as ‘bad for health’.
The medical encounter, power, and the illness experience

In exploring the relationship between medicine, knowledge, power, and the body, several sociologists of health and illness have taken up the work of Michel Foucault (1926–84), a French historian and philosopher, who wrote about the discourses and practices related to the body in scientific medicine as it developed in Europe from the eighteenth century onwards (see, for example, Armstrong 1983, 2002; Lupton 2003; Turner 1992; Turner & Samson 1995). Foucault argued that medical knowledge had a major role in constructing notions of the body. In early modern Europe it was considered a sacrilege to cut into dead bodies. The desire to look inside the body in the pursuit of medical knowledge, however, impelled anatomists to dissect dead bodies in order to understand their innermost workings. As a result of this new knowledge about the inside of the body, notions of the body began to change.

According to Foucault in his book *The Birth of the Clinic* (1975), an important shift in the medical approach to the body emerged at the end of the eighteenth century, when the clinical examination began to be important for diagnosis and treatment. Previously, doctors often diagnosed illnesses by relying on patients’ own accounts of their symptoms, and did not necessarily undertake a physical examination of their bodies. The clinical examination, however, involved the doctor’s close attention to various parts of the patient’s body and the documentation of what was observed as a guide to diagnosis: ‘the core task of medicine became not the elucidation of what the patient said but what the doctor saw in the depths of the body’ (Armstrong 1984, p. 738).

Foucault (1975) refers to what he calls ‘the clinical gaze’, which he regarded as being a central dimension of the doctor–patient relationship in scientific medicine. Doctors may use instruments such as stethoscopes to listen to the patient’s body, X-rays to view the bone structure of the patient’s body, and surgical incisions to open up the patient’s body to look inside. In return, patients do not have the same access to their doctors’ bodies. Indeed, sometimes they are completely unconscious—under anaesthesia or in a coma, for example—or they may be severely physically disabled and thus unable to express any opinion or preference to counter medical actions and interventions (Armstrong 1984).

For Foucault (1975), the ability of doctors to gain this access to patients’ bodies, along with their superior knowledge about other people’s bodies, is the primary source of medical power. He calls this power ‘disciplinary power’, because he views medicine as having the ability to make pronouncements about how individuals should conduct themselves and treat their bodies through self-regulation. Disciplinary power rarely involves direct punishment or coercive control of people. Rather, it encourages people to behave in certain ways ‘for their own good’. Those individuals who are positioned as ‘experts’ or ‘authorities’, as those who possess superior knowledge, are placed in the position of making pronouncements about how others should behave. In the case of medicine, the belief that ‘good health’ is vital to human functioning and happiness, supports the notions that medical practitioners should be treated as authorities, and

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**clinical gaze**
A term originally used by Michel Foucault (1975) to refer to a doctor’s direct focus on a patient’s body. It is a characteristic feature of doctor–patient interaction, and tends to ignore the patient’s emotions, psychology, and personality.
that their actions and advice are legitimate and should generally be heeded. We allow doctors and other health care professionals access to our bodies based on their authority. They are permitted to touch and invade the body in ways that no others are allowed. The gynaecological examination is an example.

See chapter 2 for discussion of Foucault and post-structuralism

Therefore, not only do medical knowledges contribute to ways of seeing the body, but they also intervene directly upon the body through medical practice. The doctor's or nurse's touching of the patient's body in the clinical encounter, the drawing of blood for tests, the prescription of medicines and drugs, and surgical incisions all serve to influence and shape the patient's experiences of the body, for better or for worse. Patients who are hospitalised are involved in a medical regime that dictates many, if not all, of their bodily experiences, from the time of awakening in the morning, to meals, to the expulsion of bodily wastes. Such individuals are constantly under medical surveillance, with little opportunity to engage freely in bodily movement. This may result in feelings of dependence, embarrassment, anxiety, frustration, and vulnerability, and in the need to invest trust in the medical and nursing staff upon whom these patients are dependent.

Health care workers may also be permitted to ask patients 'personal' questions about their intimate lives if they are thought to be relevant to the condition for which the patient is seeking advice or treatment. For example, it is generally accepted that nurses should not only 'know' the patient's body but should also seek to encourage patients to reveal their innermost thoughts and feelings as part of holistic patient care (May 1992). In other contexts, this could be regarded as an invasion of an individual's privacy, but in the context of medical care it is generally accepted as appropriate and even important.

There are a number of established rituals of medical care and treatment in relation to the body that serve symbolic functions. Z. Wolf (1988), for example, observed and recorded a number of nurses' rituals in relation to washing patients' bodies in hospital. She argues that these rituals act to maintain a semblance of order in a highly disordered environment by maintaining the boundary between cleanliness and dirtiness. In his participant-observation study of an operating theatre, S. Hirschauer (1991) notes that the procedures carried out to prepare a patient for surgery tend to reduce the patient to an objectified, segmented, depersonalised body. These include the anaesthetising of the patient, hooking up the patient to various machines and tubes, marking off the sections of the body that are to be operated upon and painting them orange-brown with disinfectant, covering other parts of the body with blue linen, and obscuring the face from the operating surgeons. The life signs of the patient become visualised through the technical equipment to which the patient is affixed: the electrocardiogram (ECG), the respirator, the laboratory results from regular blood analysis. As Hirschauer notes, 'One must read all these values to see how the patient is “feeling”, what s/he “needs”: water, blood, oxygen' (1991, p. 291).

While these procedures may appear to be brutalising or objectifying, they are necessary to preserve both the patient's health and the patient's feelings. Hirschauer argues that:
A body cut open and laid bare internally—with organs hanging or dragged out—is more than naked. Its inhabitant would be seized with fear and dismay, but would also react with a different social affect already required for states of lesser disarray of one’s appearance: shame. Patients may lose all sorts of organs in the operating theatre; without narcosis they would lose their face. So what seems to sever patients as persons from the social situation also serves to protect them as persons (Hirschauer 1991, p. 305).

Health care professionals, for their part, must approach the task of bodily care bearing in mind the sociocultural meanings attached to certain body parts and functions. Nurses, in particular—who are charged with the responsibility of dealing with the more intimate aspects of bodily care for hospitalised patients—must negotiate the highly sensitive issues of washing the patients’ bodies, helping them with excretion, cleaning up bodily wastes that are considered highly polluting or disgusting, and dealing with dead bodies. Nursing, therefore, is conceptualised not only as ‘caring work’ but also as ‘dirty work’—something that it is difficult to talk about with outsiders because it is seen as socially unacceptable (see Wolf 1988; Lawler 1991).

A discussion of embodiment in relation to medicine need not focus only on the bodies of patients, but also on those who care for them. The work of medical practitioners, nurses, and other health care professionals requires an ability to objectify patients’ bodies to a certain extent, for to allow one’s emotions to intrude too far into the medical encounter can prove disabling. Just as the ritualised procedures in the operating theatre serve to protect patients’ feelings, they also protect the surgeons from feelings of shame, disgust, or guilt that may arise from cutting into the patients’ bodies and thereby causing them injury. If patients were not rendered anonymous, turned into bodies rather than maintained as people, it would be more difficult to operate upon them (Hirschauer 1991, pp. 305–6).

One of the most confronting experiences faced by medical students is their encounter with the cadavers they are required to dissect as part of their training in anatomy. For many aspiring doctors, this encounter is a profoundly shocking experience (Good 1994, p. 73). Health care professionals must train their own bodies to avoid the shrinking back, the disgust, fear, guilt, and anxiety that accompanies dealing with others’ bodies at such an intimate level and in a potentially harming way. They must also learn to ‘see’ the human body in a different way from lay people, reconstructing it through the lens of medical perception so that they can deal effectively with patients.

**Body maintenance and the disciplined body**

It is not only the patient in hospital or in the doctor’s surgery who is the subject of disciplinary power in relation to medicine. Less directly, medical and public health knowledges and practices influence the ways in which individuals in Western societies conceptualise and experience embodiment. These knowledges have played a central role in regulating the body by prescribing bodily practices through which health should be accomplished and illness avoided (Lupton 1995).

In Western societies, the ability to exert control over one’s body—to regulate it and engage in strategies of self-discipline—is regarded as highly important. This is related to other
The world of advertising and commercial marketing. taken-for-granted assumptions about rationality and the need for the mind to have control over the potentially unruly body. There is a distinct moral underpinning to these distinctions between rationality and irrationality, between mind and body, and between control and unruliness. Those who appear to be unable to exert this self-control—who seem to lack rationality—have been regarded as inferior. In medical and public health discourses, as well as in commodity culture, bodies that are overweight, flabby, disabled, aged, or sick are considered to be highly undesirable and socially deviant (see chapter 11).

Body maintenance

People with disabilities, for example, are constantly relegated to the margins, becoming the subjects of repulsion and fear. If not treated as ‘freaks’ and openly subjected to discrimination, they are dealt with as if they were invisible by the able-bodied—they are subjected to the averted gaze (see Davis 1995; Lupton & Seymour 2000; Taleporos & McCabe 2002). Likewise, the bodies of older women and men are virtually absent in popular representations of the body. Few characters in television drama, for example, are older people, and if they are shown, older people are often depicted as frail, ill, pathetic, and dependent. In a society in which older people are treated with pity, disgust, fear, condescension, and neglect (Featherstone & Hepworth 1995; Hepworth 2003), it is perhaps not surprising that early signs of ageing may be a source of consternation. The horror of ageing in Western societies is such that people entering middle age may experience a disjunction between the older self they see in the mirror and the eternally youthful body that they feel themselves to remain ‘inside’. Ageing, like obesity and disability, represents an inability to keep one’s flesh unsullied and signals the inevitability of mortality (see chapter 13).

Similarly, people who are overweight or obese are thought to lack personal control. Their excess of flesh is read as a potent sign that they ‘overindulge’—that their greed overcomes their powers of rationality. In contrast, the thin body bespeaks its owner’s ability to maintain strict discipline over the consumption of food. It is not solely the issue of ‘health’ that is important...
here; there are also intertwined notions of physical attractiveness and moral assumptions about control of the body. The emphasis in public health and commodity culture in Western societies upon the importance of maintaining a slim body is such that many people feel guilt, anxiety, remorse or lack of control when they feel that they have ‘overindulged’ in food (see Bordo 1993; Lupton 1996). Since ancient times, diet and exercise have been linked to health states. In contemporary Western societies, medical and public health prescriptions about the deformation and care of the body abound. Perhaps more so than in any other era, individuals living in contemporary Western societies are expected to devote a great deal of time and attention to their bodies, whether for the sake of their physical appearance or for their health. How much food people should eat, what types of food their diet should consist of, how much they should weigh in proportion to their height, how much exercise they should do, how they should engage in sexual activity to avoid pregnancy and infection with sexually transmissible diseases such as AIDS, how much alcohol they should imbibe, how many hours of sleep they should have each night—medicine and public health provide precise recommendations for each of these bodily requirements.

Mike Featherstone has described these requirements as ‘body maintenance’ (1991, p. 182). This term again suggests the currency of the mechanical metaphor for understanding the human body. Just as cars and other machinery require regular maintenance to keep them working well, it is assumed that human bodies need regular care and attention to prevent malfunction. The discourses of body maintenance do not only draw on medical knowledge for their authority, but are also derived from commodity culture. In Western societies, health, physique, youth, and attractiveness are all seen as contributing to the ‘ideal body’. The slim, young body is physically fit and healthy but also conforms to notions of sexual attractiveness. As a result, health promotion campaigns often seek to prevail upon people’s desire to achieve or maintain sexual attractiveness and to prevent signs of ageing, while advertising for commercial commodities ranging from jogging shoes to low-fat or low-salt foods frequently uses health and physical fitness as selling points.

**Distinctions between bodies**

Throughout the history of scientific medicine, medical and public health knowledges have been employed to distinguish and differentiate between ‘normal’, ‘healthy’ bodies and those that are regarded as ‘abnormal’, ‘diseased’, or ‘deviant’ (Lupton 1995). The male European body has been represented as the archetypical normal, healthy body, at least for heterosexual men and those from elite social groups. By way of contrast, the female body, the bodies of the working classes or the poor, non-white bodies, and homosexual bodies have been singled out as diseased, passive, contaminating, dirty, and lacking self-control (Petersen & Lupton 1996, ch. 3). There is a symbiotic relationship, therefore, between identifying the bodies of particular social groups (such as women, non-whites, the working class, or homosexuals) as being uncontrolled, dirty, and as a result, more susceptible to illness, disease, and early death, and the reproduction of the notion that such groups are inferior to the dominant social group (that is, well-off, white, heterosexual men). The tendency for medicine and public health to emphasise self-control has reproduced and intensified many of these distinctions between social groups.
The bodies of non-European peoples have also been typically represented in Western medicine and public health as far less capable of self-regulation than those of Europeans. Since the eighteenth century, Africa has been portrayed as the breeding ground of disease—a place of dark, dank pestilence, where white travellers should be ever-vigilant. It has been argued that the ‘dirty’, ‘greasy’ bodies of Black Africans are a major source of infection for Europeans in Africa (Comaroff 1993). The Orient has also been regarded as an exotic place where health risks lurk, and has been seen to be peopled by unruly ‘coloured’ bodies that fail to exercise proper control in order to avoid the spreading of disease. In contemporary Western public health discourses, this tendency remains. Certain countries, such as Thailand, for example, are represented as ‘danger sites’ for Western men because of the possibility that they might contract AIDS through having sex with local sex workers. There is little concern about the possibility that the male clients themselves may infect the sex workers, who are considered to be less worthy and important.

The bodies of women have been the subject of far more medical and public health attention than have the bodies of men (Petersen & Lupton 1996, ch. 3). Compared with the male body, the female body has been represented as sickly, weak, and susceptible to illness. Women are typically described in the legal, medical, and early social scientific literature as possessing problematic and unruly bodies, with their sexual and reproductive capacities requiring constant surveillance and regulation (see chapter 9). Particularly in the nineteenth and early twentieth centuries, medical assumptions about women—for example that they were prone to uncontrolled emotional outbursts, which in turn were produced by the uterus, or that their natural place was in the home rather than participating in the public sphere—have contributed to the control of women and their confinement to the domestic sphere (Ehrenreich & English 1974).

Not only are women expected to care for their own, physically ‘inferior’, bodies, but they must also look after the bodies of those individuals for whom they are expected to take responsibility: their husbands or partners, their children, and older members of the family. To use a telling example from the popular media, advertisements for cold and ‘flu’ remedies typically feature the wife and mother as the caring figure, doling out cough mixture or other remedies to her sniffling husband and (often male) children. In such advertisements, very rarely, if ever, is a woman depicted as ill and receiving the caring ministrations of her husband. There have been a number of public health campaigns over the years that have been exclusively directed at women, from the late nineteenth-century campaigns that exhorted women to keep their homes free of flies and dirt in order to prevent the spread of disease, to contemporary campaigns that attempt to persuade women to avoid smoking and drinking alcohol when pregnant and to attend for breast cancer and cervical cancer screening programs. The proponents of such campaigns generally contend that women should engage in such preventive practices not simply for themselves, but also for the sakes of those for whose health they are responsible.

By comparison, men’s bodies have rarely been the direct subject of medicine’s attention, for they have been assumed to be ‘normal’ and ‘healthy’, requiring less in the way of medical advice or intervention, unlike the ‘weak’, ‘sickly’, ‘less controlled’ bodies of women. The male body is culturally represented as ideally invulnerable, disciplined, strong, physically able, and machine-like. As a result, illness, disease, ageing, or disability may undermine or destabilise masculinity (Connell 1995, pp. 54–5; Petersen & Lupton 1996, pp. 80–3; Davis 2002; White 2002). One result of this
link between masculinity and physical health and prowess is that issues of men’s health are only now slowly being recognised in medical and public health forums, and in the popular media. It is only very recently that public health campaigns have been directed specifically at men, and that an emphasis on the vulnerability of men’s bodies has emerged.

More and more news stories are directing attention towards men’s health. For instance, in the late 1990s a Sydney newspaper reported the findings of an Australian Institute of Health and Welfare report which noted that men are three times more likely to die young than women, are four times more likely to commit suicide, and are three times more likely to die in vehicle accidents (reported in Sweet 1996). So, too, there has been increasing attention directed towards men’s physical appearance. One example is a cover story that was published in the Australian newspaper’s Weekend Magazine in July 1996. The heading on the front cover of the magazine read, ‘Man Maintenance: Jill Margo’s Guide to Men’s Health’. The cover featured a close-up of a young man’s superbly muscled and toned body, suggesting that ‘health’ equals ‘youth’ and ‘physical fitness’ (note also the use of the word ‘maintenance’ to describe preventive health endeavours). A glossy magazine entitled Men’s Health is published monthly in Australia, which again focuses not only on health issues but also on men’s physical appearance, their sexuality, and their sporting activities. What is more, in Australia and elsewhere, advertisements are now appearing for clinics offering cosmetic surgery techniques aimed at men. In one such advertisement, published in an Australian women’s magazine in 1995, a centre for ‘aesthetic surgery’ in Sydney claimed that ‘All in the aim for [sic] better self image and greater self esteem, cosmetic surgery has a lot to offer the “average” male’. The advertisement went on to list procedures such as nose reshaping, eye-lifts, liposuction, and penis enlargement.

Conclusion

This chapter has emphasised that in order to understand how people perceive and experience their bodies, we must understand the ways that embodiment is shaped through sociocultural processes and contexts. It has been argued that medical and public health—as knowledge systems that are considered to be authoritative in relation to the body, health, and illness—have made a central contribution to representations and understandings of the human body.

Summary of main points

- The human body is not simply a biological or anatomical phenomenon; it is shaped and experienced through social and cultural processes.
- In Western societies, medical and public health knowledges have played a major part in contributing to people’s understandings and experiences of embodiment, health, and illness.

men’s health

Running parallel to women’s health initiatives, the men’s health movement recognises that certain elements of masculine identity and behaviour can be hazardous to health.
Knowledges, understandings, and experiences of embodiment in relation to health and illness have changed over time and are culturally contextual.

The Foucaultian critique argues that the source of medical power is the ‘clinical gaze’, or doctors’ focus on patients’ bodies.

Doctors and other health care workers, such as nurses, have privileged access to others’ bodies.

Illness is above all an embodied experience, forcing us to confront the physical reality of our bodies.

The illness experience and medical treatment may serve to objectify or segment the patient’s body.

Health care workers must exert control over their own bodies as part of their work.

Medicine and public health have drawn, and continue to draw, distinctions between different types of bodies. These distinctions are often based on moral judgments and assumptions.

Sociological reflection: Social determinants of body image

Most societies have idealised notions of human beauty for women and men. Briefly reflect on the following questions.

- In contemporary developed societies such as Australia, what are the socially desirable body images for women and men? Why do they differ?
- What are some of the social determinants of body image?
- What health problems can you identify that may result from the social pressure to conform to body image ideals?

Discussion questions

1. Why is the notion of embodiment so important in understanding how people conceptualise and experience health and illness states and medical care?
2. What are some of the lay health beliefs that circulate in relation to the body? How might these health beliefs influence the way people behave?
3. What are some of the dominant metaphors that are used to describe the human body in relation to illness and disease? What do these metaphors convey about how we conceptualise embodiment?
4. How are the bodies of different actors in the health care setting (for example, patients, medical practitioners, nurses) viewed and treated differently by other actors in this setting?
5 How are the distinctions between various actors maintained (for example, with the use of clothing, hospital regulations, and so on)?
6 Why have medicine and public health tended to direct more attention towards monitoring and controlling women’s bodies than men’s bodies? Why might this difference in emphasis be changing?

Further investigation

1 What are the major similarities between the ways in which nurses engage with patients’ bodies and the ways in which doctors do so? What are the major differences, and why do these differences exist?
2 How do medical practices and knowledges that are related to the body reproduce and perpetuate medical power?

Further reading and web resources


Web sites

BodyIcon: <http://nm-server.jrn.columbia.edu/projects/masters/bodyimage/>
Eating Disorders: <http://www.eating-disorders.net>