

*Handbook of*  
SOCIAL STUDIES IN  
HEALTH  
AND MEDICINE

edited by

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## 1.4

# *The Social Construction of Medicine and the Body*

DEBORAH LUPTON

### INTRODUCTION

This chapter examines the social construction of ideas, knowledge, and individual's experiences of health and medicine in Western societies, using an interdisciplinary approach. The central argument of the chapter is that health, illness and disease, and health care may all be viewed as sociocultural products, and that it is therefore important to analyze the nature of their social and cultural representations and the symbolic meanings that surround them. In addressing these issues, the perspective of what may loosely be called 'social constructionism' is employed.

There is not the space here to cover the full range of social constructionist analyses of medicine, health, and illness, particularly as this perspective is found across a range of disciplines, including history, sociology, anthropology, gender studies, cultural studies, and social psychology. Instead, the chapter will focus on several key areas to which social constructionism has brought some interesting insights to bear on the nature of human embodiment in relation to health and medicine, thus serving to illustrate the epistemological and methodological tenets of this approach. The term embodiment is used here to describe the daily lived experience for humans of both having a body and being a body. Humans perceive the world as embodied subjects with particular arrangements of limbs, sensory organs, and so on, and all knowledge is therefore developed through the body (Leder 1992; Merleau-Ponty 1962). Our identities are interbound with the dynamic processes of

embodiment, including incidents of pain, illness, and medical care.

For most social constructionists, the types of knowledges that are developed and brought to bear upon health, illness, and medical care may be regarded as assemblages of beliefs that are created through human interaction and preexisting meanings. This perspective contrasts with the traditional view of medicine, which sees disease as being located in the body as a physical object of physical state that can be objectively identified and treated as a physiological condition by scientific medical knowledge (Good 1994: 116). However, there are varying approaches along the social constructionist continuum. At the most extreme end of this continuum, it is believed that it is impossible to extricate physical bodily experiences from their sociocultural contexts, for the ways in which we think about, treat, and live our bodies are always and inevitably socially and culturally shaped. There is no such thing, therefore, as the purely 'natural' body, the body that may be separated from society and culture. This is not to argue that the material world or 'real' phenomena such as pain, disease, or death do not exist. Rather, it is to contend that we can only ever know, think about, and experience these realities through our specific location in society and culture. At the other end of the continuum social constructionism takes a weaker form, simply seeing human bodily experiences as influenced to some extent, and in some contexts, by social and cultural processes. The analyses reviewed in this chapter tend to be located more towards the 'strong' rather than the 'weak' versions of social constructionism. They also tend to adopt post-

structuralist theoretical perspectives that emphasize the importance of discourse.

#### DISCOURSE AND POWER RELATIONS IN THE CONTEXT OF MEDICINE

The social constructionist perspective as applied to analyzing health, illness, and medicine was initially strongly influenced by writers on phenomenology, cultural anthropology, and the sociology of knowledge who addressed the questions of how shared notions of reality are created through acculturation and social relationships. The work of Berger and Luckmann (1967) on the social nature of knowledge and its role in constituting reality and social life has been particularly influential for social constructionism in sociology. They argued that humans and their social world exist in a dialectical relationship in which each creates the other. Although the material and social worlds are experienced by most individuals as objective, preexisting realities, Berger and Luckmann and others have pointed out that these realities involve the reproduction of meaning and knowledge through social interaction and socialization, and rely upon shared definitions. They emphasize that because of the continually constructed nature of reality, its meanings are precarious and subject to change.

Many of the more recent scholars taking a social constructionist approach have drawn upon the work of poststructuralist theorists, particularly the writings of Foucault on power, knowledge, and discourse. Poststructuralism builds upon the earlier work of writers like Berger and Luckmann. Like other 'strong' constructionist approaches, poststructuralism sees the social world, knowledge, meanings, and notions of reality as contingent and dynamic rather than fixed. It draws particular attention to the role played by language in constituting notions of reality, including our understanding and experience of embodiment. The concept of discourse brings together language, visual representation, practice, knowledge, and power relations, incorporating the understanding that language and visual imagery are implicated with power relations and the construction of knowledge and practices about phenomena. The term 'discourse' is commonly used in poststructuralist writings to denote the patterns of ways of thinking, making sense of, talking or writing about, and visually portraying phenomena such as the human body, medical and nursing practices, sexuality and reproduction, illness, disease, and death.

Discourse is viewed as a form of social practice; a mode of action as well as a mode of representation (Fairclough 1992: 63). Discourses may be said to be textual, or expressed in texts, or intertextual, drawing upon other texts and their discourses to achieve the meaning and context embedded in particular social, historical, and political settings. The word 'text' as used here does not mean simply a product of writing, but more broadly refers to verbal interactions, visual images, built structures, physical actions, and practices. For some writers, the human body itself is seen as a text that is 'written' upon by discourses. Grosz, for example, refers to the body as an 'inscriptive surface,' which various adornments, practices, and actions mark more or less permanently (Grosz 1994: 138).

Cultural analysts adopting a poststructuralist perspective argue that there is an inescapable relationship between power, knowledge, discourse, and what counts as 'truth.' Discourses are both delimiting, structuring what it is possible to say or do, and productive. Discourses bring into being, make visible, render malleable, useful, functional, or dysfunctional, and differentiate between various types of bodies – the female and the male body, the young and the old body, the normal and the deviant body, the homosexual and the heterosexual body, the thin and the obese body, the healthy and the ill or diseased body, the sane and the mad body – to name a few. Specific discourses relating to phenomena may be identified, such as a discourse of hope in relation to cancer, a discourse of activism in relation to HIV/AIDS politics, a discourse of nature in relation to alternative therapies, a discourse of science in relation to medicine. These discourses may be articulated and acted upon in a range of contexts, from patients' lay explanations and beliefs about their illness, to mass media coverage of an illness or disease, to medical textbooks and curricula.

A discourse, however, is sited within a broader matrix of sociocultural and historical meaning and thus extends beyond its context. For example, the discourse of science, as it is expressed in relation to medicine in contemporary Western societies, has a long history, developing over the last few centuries as science and medicine has – as systems of knowledge emerged and developed. A number of underlying assumptions derived from a broader Western tradition of thought contribute to the discourse of science in medicine. These include the assumptions that the mind is separate from the body, nature is separate from society and culture, nature/truth is universal, individuals are distinct from society and culture, and illness is a threat to rationality (Gordon 1988; Kirmayer 1988; Stein 1990). At the end of the twentieth

century, in which notions of fate have largely been replaced by modernist ideals of order and certainty over the chaos of illness and disease, the discourse of science in medicine has a particular resonance, as it appeals to contemporary beliefs in the efficacy of the rationalist approach to containing disorder.

Those discourses that tend to dominate over others are those emerging from powerful individuals or social groups, helping to further their interests in shaping the ways in which phenomena are represented. The discourse of science in medicine relies, in part, on the assumption that it is politically and culturally neutral, unlike some other knowledge, such as that articulated in lay or alternative therapy discourses. As Rapp asserts: 'The language of biomedical science is powerful. Its neutralizing vocabulary, explanatory syntax, and distancing pragmatics provide universal descriptions of human bodies and their life processes that appear to be pre-cultural or non-cultural' (Rapp 1990: 29). The discourse of science serves to underpin the powerful and high status role of orthodox medical practitioners, who claim that their system of knowledge is superior to that of other health-care providers. Dominant discourses, however, are constantly subject to challenge. While, for example, the discourse of science may currently dominate understanding of the body and health states in Western societies, it may be challenged by the counter discourses expressed by proponents of alternative therapies, who use the discourse of beneficent nature to oppose what they see as being the objectifying nature of scientific approaches in medicine. As this suggests, 'Power struggle occurs both in and over discourse' (Fairclough 1992: 56), and this struggle is an important feature of social change.

The methods of research that are typically employed in constructionist analyses are qualitative and interpretive. All social constructionist analyses are directed at uncovering, or 'deconstructing,' the underlying values, meanings, and discourses in systems of knowledge and practice such as biomedicine. There is no single or main source of data used in social constructionist investigations. For those researchers interested in medical and health topics, in-depth interviews or focus group data, mass media texts, diaries and letters, articles in medical or public health journals, medical textbooks, conversations between patients and doctors, death records, statistical tables, and medical case notes are some of the sources of data that have been 'deconstructed' for their underlying sociocultural meanings. Some of these data are preexisting (for example, articles on diseases in medical journals), while others are created by the researcher especially for the purposes of the

research project, such as interviews conducted by the researcher with research participants about the topic he is investigating. Once gathered or selected by the researcher, these data become 'texts' for the purposes of analysis.

In one analysis, Prior (1997) used a variety of preexisting texts, mainly those constructed by health-care workers, to examine the ways in which 'Freddie,' a particular patient he observed, was 'constructed' as a psychiatric case. Certain aspects of Freddie's demeanour, physical attributes, and state of mind were recorded on such documents as the medical file produced by his psychiatrist from clinical interactions and test results. Other documents included nursing care notes from when Freddie was hospitalized and social work records from when he was under the care of social workers. Prior notes that:

In each case the discourse that describes him is drawn together from different threads. Thus, the psychiatrist, in large part, draws his threads from the vade-mecum knowledge contained in psychiatric texts. Nurses draw on one of their many 'models of nursing' and social workers draw their threads from their professional texts. (Prior 1997: 77)

Such written texts, following Freddie wherever he went for health care, came to constitute him in certain defined ways that in some situations proved more influential than his actual behaviour. Prior notes, for example, meant that because Freddie was labelled as schizophrenic on his medical records, he was constantly referred to as such by health-care and social workers even when none of the symptoms of this condition were present at the time.

As well as using written or audio texts, analysts may adopt an ethnographic approach. This is similar to the fieldwork of anthropologists, and involves spending an extended period of time observing the practices and noting the verbal exchanges of social actors in a specific setting, such as a hospital, clinic, patient self-help group, or medical consumer organization. Atkinson (1995), for example, conducted an observation study of haematologists working in the United States and Britain, with a particular focus on identifying and analyzing the medical discourses that were employed as part of these specialists' everyday working practices. In doing so, he followed the haematologists on their routine hospital rounds and attended their in-house conferences, tape-recorded proceedings, and observed them taking fieldnotes. He also recorded individual interviews with staff members. Atkinson analyzed the transcribed data produced by focusing on such aspects as how the medical discourses he identified were reproduced from senior to junior staff and students,

how they affirmed the participants' membership of a professional culture, and how they served to construct particular narratives about patients as 'cases.'

In recent social and cultural theory, an interest in the ways in which place and space operate to shape practices and notions of selfhood and embodiment has developed. These writings go beyond a focus on language in acknowledging the importance of physicality, motion, and the material world. Space and place are understood as constructed through sociocultural processes rather than as objective and given. Kearns and Joseph (1993: 712) refer to this approach as a sociospatial rather than a geometric view of space. These perspectives have been adopted in medical geography and the sociology and anthropology of health and illness to explore how spatial and temporal dimensions interact in producing and reproducing the discourses and practices and, thus, the meanings and experiences of health, illness, and medical care. Again, the writings of Foucault have been influential here, particularly in relation to his writings on the role played by a specific form of architecture (the panopticon) in monitoring the inmates of public buildings such as prisons, schools, and hospitals, thus bringing them into a specific field of visibility. Such features of medical care as the architecture of the clinic or hospital, the physical layout of operating theatres, and the bodily movements and interactions of medical staff and patients within the bounded spaces of the clinic/hospital have been studied (see, for example, Armstrong 1988; Fox 1997; Hirschauer 1991).

#### THE BODY AND NOTIONS OF HEALTH AND ILLNESS

Recent writings in the sociology, anthropology, philosophy, and history of the human body have made important contributions to understanding the ways in which embodied experience changes across historical periods and social and cultural contexts (see, for example, Armstrong 1983; Good 1994; Grosz 1994; Herzlich and Pierret 1987; Leder 1992; Schepers-Hughes and Lock 1987; Shilling 1993; Turner 1992, 1996). As such, they have insights to offer sociocultural analysis of health, medicine, and illness. Like other writers adopting the constructionist perspective, these scholars view the body as both 'natural' and 'cultural,' acknowledging that there is no clear boundary between the two categories.

The term 'body image' has been used to denote the ways in which the lived experience

of the body is brought together with sociocultural meaning in the ways in which we think about and imagine our bodies. The body image is central to ways of experiencing and conceptualizing states of health, illness, and health care. An individual's body image is developed throughout her lifetime, and is dynamic, and constantly subject to revision and transformation. 'The body image establishes the distinctions by which the body is usually understood – the distinctions between its outside or skin, and its inside or inner organs; between organs and processes; between active and passive relations; and between the positions of subject and that of object' (Grosz 1994: 84). It is embedded within social, cultural, and historical settings as well as responsive to everyday embodied experience. Thus, dominant discourses circulating within the sociocultural context in which an individual lives are important to how he constructs his body image. Individuals' own experiences of the body – the sensations they feel, the perceptions they make through their bodies – are also important, however. The body is not simply passively inscribed by discourses. Rather, bodily experience and perception themselves contribute to the production and reproduction of discourses, just as discourses shape the ways in which bodies are thought about and experienced.

Distinct changes, as well as congruities, in ways of thinking about and representing the body, health, and illness have been identified by cultural analysts. In medieval and Renaissance Europe, for example, very little was known about the internal constituents and workings of the body, for dissections were banned as blasphemous (Mucheble 1985: 26). It was thought that illness and disease entered the body through the skin and bodily orifices. People took care not to allow water – especially hot water – to touch the body, for this was thought to open the skin to unhealthy miasmas, or vapours, bearing disease. They believed that the body could best be protected against such vapours by wrapping oneself in tightly woven clothing, reinforcing the 'closed' nature of the body (Thomas 1997; Vigarello 1988). Care was taken not to allow vapours in through one's bodily orifices, and a set of taboos existed in relation to disposal of bodily fluids as a protection against this (Mucheble 1985). Urine was believed to be a particularly potent bodily fluid, thought to bear the essence of a person and to be a conduit between the inside of the body and the outside world, and therefore the path of possible contamination. Among the peasantry of medieval France, it was believed that urinating against the same wall that a leper had urinated



upon could result in contracting leprosy oneself (Muchembled 1985: 72).

Concepts of body image as they relate to health have shifted significantly even within the past half century, incorporating centuries-old ideas as well as bringing in new ideas often introduced by scientific or medical discoveries about the body. Martin (1994) has identified signs of a change since the 1940s and 1950s in popular and medical accounts of the body in relation to the immune system and its effects on health. In her analysis of interviews with lay people and of popular representations of the body, she found that conceptualizations of the inside of the body frequently made references to the immune system. According to Martin, in the 1940s and 1950s concepts of health in American society tended to represent the body as a castle or fortress, with distinct openings that required protection from external invaders. Hygiene was a dominant strategy for defending the body from the 'germs' that sought to enter through its orifices and subsequently cause disease. During the 1960s and 1970s, however, the notion of the body as harbouring an interconnected immune system developed, drawing on changing biomedical knowledge about immune response. This resulted in a shift in emphasis from the outside of the body, with its envelope of protective skin, to what was happening on the inside. By the early 1990s, discourses on the immune system had become central to body image in relation to health and illness. People were now exhorted to take care of their immune system as a means of protection against ill health and disease.

Contemporary notions of the body and health states, as Martin's work demonstrates, combine centuries-old ideas relating to body openings and hygiene with newer ideas concerning the microlevel of bodily function. The body image, therefore, may be understood as a complex intertwining of traditional and novel understandings of the ways in which the body functions and relates to other bodies, objects, and spaces that produces possible ways of thinking about and living in the body.

As noted earlier in the chapter, the discourses of scientific medicine are very dominant in contemporary understanding of, and practices related to, the body, health, illness, and disease. The result of this dominance is that the ways in which individuals in Western societies tend to think about health, illness, health care, and their own bodies is very much influenced by the discourses and practices of scientific medicine. Medical knowledge, however, is just as subject to change and variation as are other systems of knowledge, including lay knowledge. Comparative analyses of medical discourses

and practices in different cultural settings often reveal the ways in which the same knowledge system (in this case, scientific medicine) is understood and practiced in strikingly different ways. For example, one detailed analysis of the practices of French and American physicians treating patients with HIV/AIDS and engaging in HIV/AIDS research (Feldman 1995) noted strong differences in approach between doctors in the two countries. Feldman notes that 'AIDS in France is a different disease than AIDS in the United States' (1995: 236). This is not only because of the different health-care funding systems (the French socialized system versus the American privatized system), but also because of underlying assumptions about the nature of patienthood and the doctor-patient relationship. In France, she found a more paternalistic model of the doctor-patient relationship, in which trust is privileged, accepted, and supported by both patients and doctors. In contrast, American doctors and patients tend to highlight the importance of patient 'empowerment' and the provision of information to patients. Often, French patients are not told of their diagnosis of AIDS by their doctors, while American doctors almost always inform their patients. French patients tend to rely on their doctors for more emotional support and advice than do American patients, rarely questioning prescribed treatments or suggesting alternatives, as HIV/AIDS patients in the United States often do.

According to Feldman, medical treatment is also different in the French and American settings, based on differing concepts of disease and the body. In the United States, 'aggressive' medical treatment for HIV/AIDS and other illnesses is supported: health is seen to be regained through immediately attacking the disease 'invader' and removing it through surgery or drug therapy. For the French physicians, argues Feldman, protecting and improving patients' overall constitution and resistance is viewed as important. Therefore, French physicians tend to be more reticent about the early use of toxic drugs to treat HIV/AIDS. Good (1995) has identified similar differences between American physicians' treatment of cancer, on the one hand, and the approach of Italian and Japanese physicians. She notes that American doctors are far more ready to inform their patients about their disease than are Italian and Japanese doctors, and place much more importance on patient autonomy. The Italians and the Japanese, in contrast, subscribe more strongly to a paternalistic and protective model of care and are less supportive of the notion of patient autonomy.

Rather than see biomedicine as a singular entity, therefore, it has been argued that it

should be viewed as 'a plurality of biomedicines that are socially and culturally situated' (Good 1995: 462). While a series of overarching paradigms that serve to unite biomedicine may be identified, it is taken up in a variety of different cultural contexts, in which such factors as the economic system, assumptions about the doctor-patient relationship, and ideas about health and illness, among other elements, shape its manifestations.

#### THE MEDICAL GAZE AND THE ROLE OF TECHNOLOGY

The discourses and practices of medical knowledge produce and work on specific kinds of bodies. One way in which they do so is through the use of spatial and temporal dimensions. In the context of the clinic or hospital, the body of the patient becomes subject to the medical gaze. For Foucault (1975), it is through the medical gaze that the patient's body is constructed as a particular archetype of illness. The medical gaze is a product of a dominant discourse in scientific medicine that champions the importance of expert medical practitioners using visual cues to assess and monitor patients' bodies. This approach to diagnosing and treating the ill body is a result of changes that took place in the late eighteenth and early nineteenth centuries, in which scientific medicine, reliant on systematic measurement and identification of visible signs of disease and comparison, emerged. The fields of pathology and anatomy, employing the hitherto taboo practice of dissection of human bodies, began to underpin medical knowledge, opening to the medical gaze what was previously hidden (Armstrong 1983; Foucault 1975). Where once physicians relied on a patient's account of his symptoms to diagnose illness, they now used technologies such as stethoscopes and X-rays to construct their knowledge of the body by seeing or listening to what was going on inside it: '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: 738)

As part of the processes of medical examination, diagnosis, and treatment, patients are brought into a visibility that differentiates and judges them, comparing them to a norm and attempting to restore them to that norm. Medical surveillance and treatment practices, therefore, perform a disciplinary function upon the body of the patient, reading the body as docile and productive, the product of medical discourse and power. The use of the term 'disciplinary' in this context does not necessarily

imply an interaction that involves punishment or coercion, but rather conveys the sense that patients' bodies, usually voluntarily, conform to and are shaped by medical practices and knowledge. So, too, are patients incited by medical practitioners and other health-care workers to reveal their experiences and feelings as part of diagnostic and treatment routines. This is a dominant aspect of the discourse of 'patient-centred medicine,' which has become viewed as the most appropriate approach for health-care workers to interact with their patients (Osborne 1994). This transfer of knowledge about one's body and one's self, however, is very much one-way: doctors and other health-care workers do not reveal their bodies to patients, and rarely do they reveal their private feelings and thoughts. The medical gaze, therefore, is not reciprocated.

Individuals become constituted as particular subjects through the discourses and practices of medicine and other health or welfare professions. For example, the ritual procedures carried out on patients when they are being prepared for surgery – such as rendering the patient unconscious through general anaesthesia, using linen to cover certain parts of the body, painting other parts orange-brown with disinfectant and obscuring the patient's face – turn the patient's body into a particular object for the examination and use of the health-care workers (Hirschauer 1991).

In the clinic, a range of medical technologies is brought to bear to monitor and measure bodily signs, to diagnose and 'bring into visibility' the body of the patient. This is the apotheosis of the extension of the medical gaze into the interior of the body. The various technologies available to survey and visually document aspects of the human body – such as magnetic resonance imaging, X-rays, ultrasounds, CT scanners, nuclear tracing, and electrocardiograms – present different nuances and representations of the body. These accounts are subject to expert interpretation, as are diagnostic tests of sample tissue (Atkinson 1995). Novice clinicians and clinical pathologists must learn to look for and see these images and specimens that are fragments of bodies and then to interpret and name what they see to make sense of them. This comes through a gradual process of acculturation into the 'ways of seeing' of the clinic (Atkinson 1995: 74). In some situations, the data produced by the medical technologies hooked up to the patient come to stand for the patient's body, while the fleshly body itself may be largely ignored by doctors and nurses monitoring the patient's progress (Hirschauer 1991). Atkinson notes that via such practices of bodily segmentation, representation, and interpretation, the body of the

patient is dispersed and even disembodied, and read at different sites: 'The patient thus may have a multiple existence within the clinic' (Atkinson 1995: 89).

The medical gaze may itself be internalized by patients in some cases, changing their perceptions of their bodies. The cultural theorist Jackie Stacey wrote of her changed perceptions of her own body and that of others following an operation to remove a cancerous growth when she awoke feeling as if she had actually witnessed the operation:

The clear sense of my internal body occupied my mind, and indeed, remained with me for several months. I felt sure I had seen inside myself and thus had an awareness of my body as 'flesh and blood' in a more literal way that was quite new. On leaving hospital, I began to see everyone through this physiological lens... I began to see everyone through these new X-ray eyes: the woman in front of me in the supermarket queue suddenly comprised skin, intestine, bladder, liver, lungs and kidneys. (Stacey 1997: 97–8)

While Stacey did not, of course, witness her own operation, it is evident from her description that she is drawing upon medicalized or anatomical images of the inside of the body she had previously seen in constructing her new image of her own body, and the bodies of others, through a new lens of perception – the medical gaze. Her preexisting knowledge of the inside of the body (perhaps drawn from such texts as documentaries on surgical techniques, television dramas showing simulations of surgical procedures, or biology textbooks) had risen to prominence over other ways of seeing the body, catalysed by the traumatic embodied experience of undergoing a serious operation.

As Stacey's observations suggest, lay people may come to see themselves differently via their interaction with medical technologies. The experience of interacting with medical technologies may lead to a sense of disruption of body image that is distressing. For example, those who undergo a diagnostic screening test, such as for HIV, or prostate, cervical, or breast cancer, often find themselves entering a liminal state when waiting for the result. When previously they may have had no signs or symptoms of disease, once having undertaken the diagnostic test they are forced to reconsider the notion of themselves as 'healthy' (Lupton 1994: 98–100). The notion that diseases that require a diagnostic test are 'hidden' and 'secret' within the body, giving no clear sign of their presence except via a diagnostic test, may lead people to feel anxious about the integrity of their own knowledge of their bodies.

Technologies may also be productive of bodily capacities. When hooked up to medical (and other) technologies, the patient's body becomes a cyborg, a juncture of human flesh and machine. These technologies become part of the individual's body image, extending the body in space (Grosz 1994: 80). In Western societies we feel extremely ambivalent about our relationships with technologies, disliking the idea that we should be dependent upon machines or have some sort of symbiotic relationship with them that blurs the boundaries between self and other (Lupton 1995a). The idea of having a prosthesis may inspire feelings of disquiet, or even horror, disgust, and revulsion for its 'unnatural' and liminal character, its location somewhere between human and machine, its constant reminder of the failings of one's body (Wilson 1995). Nonetheless, the potential offered by technologies and their ability to give us knowledge of our bodies, alleviate the failings or sufferings of the body, and fend off senescence and death, at least for a time, are seductive.

The capacities of the human body may be extended or even replaced by technologies, as in the case of spectacles or contact lenses, artificial respirators, heart pace-makers, cochlear implants, and artificial limbs, for example. Sobchack has written vividly about having a prosthetic limb fitted after her leg was amputated and of adapting a mechanical device into her body image and embodied experience:

I love my prosthesis with its sculpted foam cosmetic cover – particularly the thigh which has no cellulite and is thinner than the thigh on my so-called 'good' leg. With much effort, I have learnt to walk again, the stump first thrust into the socket of a leg held on by a suspension belt and now into what is called a 'suction' socket of a leg that – when it or I am working right – almost feels like 'me.' This new socket has also allowed me a kind of experience with 'artificial orifices' that has none of the pain of surgery and all of the erotic play of technology. (Sobchack 1995: 207–8)

Such accounts demonstrate the ways in which notions of the 'natural' and the 'cultural' body, of self and nonself, come to blur in relation to medical technologies.

#### THE CIVILIZED BODY AND THE LOGIC OF CONTROL

One of the most dominant logics organizing ways of thinking and acting in Western societies at the end of the twentieth century is that of control. Individuals constantly engage in activ-

ities in the quest for control over their lives. It is believed that most aspects of life are malleable and amenable to the exertion of will. We see ourselves as a continuing unfinished project, requiring work and effort to shape and improve, seeking to impose order and certainty upon what is perceived to be a chaotic, uncertain, disorderly world. Foucault (1988) referred to such practices as the 'technologies of the self.' The 'technologies of the self' involve the voluntary internalization of norms governing appropriate behaviour in the interests of achieving the best possible self, including the quest for self-knowledge, self-mastery, and self-care (Lupton 1995b; Rose 1996). Engaging in the 'technologies of the self' involves seeking out and employing knowledge and the constant making of choices.

Nowhere is this desire for control more evident than in the ways in which people conceptualize embodiment, health, and illness. For the late-modern individual, the body is viewed as signifying the self and demonstrating one's capacity for self-knowledge, self-mastery, and self-care. The ideal body is that which is tightly contained, its boundaries stringently policed, its orifices shut, kept autonomous, private, and separate from other things and other bodies (Bordo 1993; Shilling 1993). Good health and 'normal functioning' of the body is commonly viewed in contemporary Western societies as the product of careful self-regulation and self-discipline. Behaviours that are seen to be linked to 'lifestyle' choices and therefore under the control of individuals, such as alcohol consumption, cigarette smoking, diet, physical exercise, and sexual activity, have been singled out in public health campaigns. Such campaigns exhort members of the 'target' audience to engage in 'body maintenance' activities (Featherstone 1991). Under the discourse of self-control, citizens are urged to turn the medical gaze upon themselves, and engage in such technologies of the self as monitoring their own bodies and health states and taking preventive action in accordance with medical and public health directives (Herzlich and Pierret 1987; Lupton 1995b; Petersen and Lupton, 1996).

The notion of the 'civilized' body, emerging in early modern Europe, is particularly important to contemporary understandings about the ideal body (Elias 1978; Shilling 1993). The 'civilized' body is understood to be that which is self-controlled, which is autonomous and self-regulated. Its boundaries are kept contained from the outside world and from others. In contrast to this ideal notion is the 'grotesque' or 'uncivilized' body, the body that lacks self-control and self-discipline and is constantly breaching its boundaries. The body that is suffering pain or illness, that is deformed or disabled, that is dying, tends

to conform far more closely to the 'grotesque' body than the 'civilized' body.

A further perspective drawn from anthropological and psychoanalytic theory is that which acknowledges the ways in which individuals construct a sense of body boundaries and define themselves as self in opposition to 'other.' This perspective has provided insights for those scholars who are interested in how such notions as 'health,' 'illness,' and 'risk' are used to deal with central anxieties and fears about contamination, the blurring of bodily boundaries and death. The work of anthropologist Mary Douglas has been highly influential in our understanding of the symbolic role played by body image and notions of the body boundaries. In her book *Purity and Danger* (1966), Douglas argued that the human body serves a conceptual means of distinguishing between self and 'other.' Just as the body is seen to have defined boundaries between 'inside' and 'outside,' with rules regulating what matter comes in, what comes out, and in which ways, all human societies construct understandings of which people and things belong 'inside' and which should be maintained 'outside.'

All humans, as they are socialized into their cultures, learn the appropriate cultural norms about how to police and control their bodily boundaries. Douglas pointed out the anxieties that cohere around the margins of boundaries and the subsequent rules for control that have been developed to control margins at the level of the individual body and at the broader level of the body politic:

All margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. Any structure of ideas is vulnerable at its margins. We should expect the orifices of the body to symbolise its specially vulnerable points. Matter issuing from them is marginal stuff of the most obvious kind. Spittle, blood, milk, urine, faeces or tears by simply issuing forth have traversed the boundary of the body. So also have bodily parings, skin, nail, hair clippings and sweat. The mistake is to treat bodily margins in isolation from all other margins. (Douglas 1966: 121)

The orifices of the body constantly present a challenge to individuals to exert control over the movement of bodily fluids from 'inside' to 'outside.' In Western societies, we are particularly disgusted by notions of the inside of the body and the slimy viscera, organs, and fluids it contains. Actions or accidents that expose this inside matter break down the boundaries between 'inside' and 'outside' that we are exhorted since early childhood to preserve as part of our accomplishment and maintenance of the 'civilized' body. Hence, 'The disgust that arises when the body is sliced open with a knife

or pierced with a bullet is more than just a function of the muck that pours out, it is a function primarily of the inappropriateness of destroying the integrity of the body's seal' (Miller 1997: 58).

In infancy and extreme old age and in illness or some forms of disablement, these bodily boundaries are constantly breached. Other bodily changes, such as pregnancy and menopause, may also involve loss of control over the body. Menopause, for example, confronts some women with shame, embarrassment, and anxiety in relation to unexpected flushing of the face, sweating, or uterine bleeding. The loss of control that women in mid-life feel when they experience these symptoms can be profoundly distressing and challenging of their sense of self (Lupton 1996). The appearance of reviled body fluids at socially 'incorrect' times or places demonstrates a frightening and disturbing loss of such rational control, signalling a return to a state of bodily chaos of infancy. The dribbling, incontinent elderly or disabled body is a nightmarish vision for its childishness and its supposed loss of humanity. Unlike the ideal of the 'civilized' body, the ill or dying body, the body in pain, the deformed or disabled body is that which lacks control. It is also that which lacks autonomy because it is dependent on others, and that which constantly threatens to breach its boundaries through pain, spasms, or the expulsion of bodily fluids at 'inappropriate' times. Such bodies arouse disgust because they bring the 'inside' of the body 'outside.' Ill, disabled, or dying people are the 'other,' those from whom the healthy, young, and able-bodied seek, often unconsciously, to differentiate themselves because of the fears, anxieties, revulsion, and dread they harbour of the incipient chaos and dissolution of their own bodies.

Grosz (1994) has taken up both Douglas' writings to analyze the symbolic nature of bodily fluids, with a particular focus on gender implications. She claims that because the female body is conceptualized as more marginal, indeterminate, fluid, borderline, and liminal, as seeping fluids that are considered to be 'dirty' and therefore as less controlled, it is viewed as more dangerous, defiling, and diseased than the male body (Grosz 1994; see also Heywood 1996). Indeed, femininity has been strongly associated with both embodiment and disease. Women's bodies have been traditionally portrayed in medical and other discourses as inferior to men's bodies: as smaller, frailer, weaker, and more disorderly, and as more defective and more prone to illness (Bordo 1993; Ehrenreich and English 1974).

So, too, other types of bodies have been typically represented, both in medical and more popular discourses, as 'inferior' because they are regarded as being unable to properly regu-

late their body boundaries. These include black or brown bodies, homosexual bodies, ageing bodies, and working-class bodies. Comaroff (1993) has shown, for example, how nineteenth-century British colonialist and medical discourses in South Africa portrayed black Africans as inherently dirty and diseased, as 'savage' rather than 'civilized,' and as both morally and physically degenerate. In describing black Africans as 'dirty' and 'greasy,' the British portrayed the black body as porous, odorous, and damp, and therefore as potentially contaminating to those who came into contact with it, in stark contrast to the ideal of the white European as clean, contained, and controlled (Comaroff 1993: 316). Standing for normality and self-discipline is the white, heterosexual, youthful, middle-class, masculine body. The male body is culturally represented as ideally invulnerable, disciplined, strong, contained, healthy, and physically able, and therefore as more 'civilized' than other bodies (Petersen and Lupton 1996).

#### MORAL MEANINGS AND BODY REGULATION

The emphasis that is currently placed in Western societies on the importance of the regulation and disciplining of the self and the body has implications for how ill people are conceptualized in moral terms. In the 'new morality' of preventive health, falling ill has become viewed as a sign of moral failure, a source of blame. States of health, therefore, are inherently associated with moral meanings and judgements (Crawford 1994; Greco 1993; Herzlich and Pierret 1987; Lupton 1994, 1995b; Stein 1990). Not to engage in risk-avoiding behaviour is considered 'a failure of the self to take care of itself – a form of irrationality, or simply a lack of skilfulness' (Greco 1993: 361).

These ways of representing the ideal human body are themselves the products of notions that have emerged over the course of Western history and intensified in recent centuries. There is a long history in Western societies of the association of moral meanings with health states. Since antiquity, those who have fallen ill have often been judged to be morally culpable for allowing illness into their bodies by failing to conform to cultural regulations and taboos. Sinfulness has been linked to illness for centuries (Thomas 1997). In early modern England (spanning the sixteenth, seventeenth, and eighteenth centuries), for example, Christian thought regarded sinners as being ultimately punished by God for their sins. Each of the seven deadly

sins was associated with its own embodied pathology. Pride was thought to cause swellings such as tumours and inflammations, sloth was believed to result in dead flesh and palsy, and gluttony in dropsy and a large belly. Lust led to fluxes and discharges, leprous skin and the pox, avarice was associated with gout or dropsy, envy with jaundice, venom, and fever, and wrath with spleen, frenzy, and madness. It was common at this time for individuals who had fallen ill to examine the conduct of their lives to determine how they might have brought this condition upon themselves (Thomas 1997: 16-17).

Susan Sontag wrote about the contemporary moral meanings of illness in her important essay *Illness as Metaphor*, first published in 1978. She points out that 'Nothing is more punitive than to give a disease a meaning – that meaning being invariably a moralistic one' (Sontag 1989: 58). As she observes, cancer is commonly viewed as being caused by the repression of emotion, 'afflicting those who are sexually repressed, inhibited, unspontaneous, incapable of expressing anger' (1989: 21). Like leprosy in medieval times, cancer evokes the meanings of horror, contamination, corruption, and blame. Sontag argues that these meanings also influence the type of treatment given to cancer patients and the words used to describe both the disease and its treatment. Cancer treatment is 'aggressive,' used to 'attack' the cancer that has 'invaded' the body, 'bombarding' the body with radiation. With the use of these military metaphors, the patient's body becomes thought of, and treated, as a battleground (1989: 64-5).

In the two decades since Sontag's essay was first published, cancer has also become strongly linked to such activities as cigarette smoking, a diet high in animal fat, sun exposure, and in the case of breast cancer, bearing children late in life or not at all. As Stacey (1997) notes in her more recent book on the cultural meanings of cancer, because the disease is that of one's own body cells 'turning against' the body and multiplying out of control, it is viewed as autopathogenic, caused in some way by the individual who has it. It is now very difficult for a person diagnosed with cancer not to feel as if they have in some way played a part in bringing the illness upon themselves. Many go through a process whereby they search their past behaviours to identify what might have caused the disease. As one woman who survived treatment for breast cancer wrote: 'The guilt of responsibility – could I have wished this on myself... What did I do wrong? Can I make it up again?' (Malchiodi 1997: 53)

People with cancer often seek to regain control of the uncertainties associated with cancer treatment, for example, by seeking out informa-

tion voraciously. People with cancer (and other illnesses) are also expected to be 'heroes' and to 'battle' with their illness and exert will-power to overcome it. Not to do so is considered to 'give in' to the 'enemy,' relinquishing the attempt to regain the 'civilized' body from the chaotic ill body. In this discourse championing 'fighting' one's illness, 'dying is a defeat, a sign that individuals cannot transform themselves' (Coward 1989: 86).

Since the early 1980s, HIV/AIDS has become one of the most reviled and dreaded diseases in Western societies. Because the routes of transmission of HIV are associated with behaviours that are considered by many people to be socially 'deviant,' such as homosexuality, sexual promiscuity, and intravenous drug use, the syndrome itself and those who have it have become labeled 'deviant.' Sontag herself recognized the power of the cultural meanings of HIV/AIDS and wrote a sequel to *Illness as Metaphor* entitled *AIDS and its Metaphors* (1989). She and other cultural critics have drawn attention to the ways in which HIV/AIDS is strongly associated with blame and shame, particularly in the distinctions that are routinely drawn between 'innocent' and 'guilty' people with HIV/AIDS. Those who are deemed to be 'innocent' are typically seen to have become infected with HIV through no 'fault' of their own (for example, infants who were infected in their mothers' womb or haemophiliacs infected through contaminated blood transfusions). Those who are viewed as 'guilty' are seen to have somehow invited the virus into their body by engaging in risky activities.

Some alternative medicine approaches emphasize the responsibility of the person with illnesses such as cancer and HIV/AIDS even more than do orthodox medical and public health discourses, focusing particularly on 'destructive' inner feelings and thoughts that have been repressed, linking cancer to certain personality types (Coward 1989; Stacey 1997). Alternative therapies, in general, have a strong focus on lay people 'taking control' of their health by engaging in activities deemed to prevent illness. Many alternative therapies draw strongly upon the discourse of 'nature' in representing illness as an imbalance within the body (Coward 1989). A dominant assumption in the self-help discourses of many alternative therapies is that good health is a product of strength of will, and 'wrong attitudes' are punished by illness. A healthy body becomes a sign of personal achievement; illness is the sign of failure and weakness. In many ways, therefore, alternative medicine shares with scientific medicine the tendency to cast moral judgement upon those who are ill, positioning them as having failed to engage properly

in self-regulation. Indeed, it has been argued that the discourses of alternative medicine broaden the 'pathogenic sphere' and in doing so extend the medicalization of everyday life into areas that are currently left largely untouched by biomedicine (Coward 1989; Lowenberg and Davis 1994; Rosenberg 1997).

Notions of 'healthiness' also often appear in the popular media in the context of selling commercial products. Such media as advertising and other forms of publicizing commodities often elide distinctions between 'healthiness' and 'attractiveness.' Thus, for example, advertisements for 'low fat' food frequently portray the product as desirable both because it is 'good for you' in terms of promoting health and because it contributes to a slim body shape. As this suggests, while health discourses are directed primarily at the 'inner body' in their emphasis on function and disease, prevention and consumer culture discourses are directed at the 'outer body' in terms of its appearance (Featherstone 1991: 171). These discourses intersect with each other in significant ways. Both public health media campaigns and commercial advertising campaigns address the same ideal of the body: as conforming to current notions of attractiveness as youthful, vital, and healthy. While health and medical discourses may involve limiting consumption of some commodities (those deemed to be 'unhealthy'), they encourage the consumption of other commodities (for example, exercise shoes and clothing, diet foods, vitamins). Both are directed at the notion of the individual who is keen to engage in activities to care for, work upon, and improve the self and the body as well as indulging herself. As Featherstone has argued: 'Within this logic, fitness and slimmness become associated not only with energy, drive and vitality but worthiness as a person; likewise the body beautiful comes to be taken as a sign of prudence and prescience in health matters' (1991: 183). The suggestion is that the pleasures of consumption are heightened by improved health and physical capacity for hedonism.

In contemporary Western societies, therefore, notions of the ideal body conflate health, beauty, youth, and normality. Health tends to be culturally linked to beauty, erotic attraction, and truth as well as morality, and illness and death to ugliness, grotesquerie, falsity, repulsion, and immorality. As Gilman argues 'We experience the body as seemingly in control through the world of the visual. We censor out the association with the world of the ugly and of decay – the mark of our own decay, our own gradual collapse' (Gilman 1995: 179). Very old bodies, ill bodies, disabled bodies, and obese bodies are either stigmatized in mass media representa-

tions, or else are simply absent, treated as unworthy of portrayal because they are deemed to be deviant, unsightly, or dependent (Davis 1995; Featherstone and Wernick 1995).

Presenting realistic images of the diseased, mutilated, or dying body in the popular media often results in controversy. When, for example, a self-portrait of the artist Matuschka displaying her mastectomy scar was published on the cover of the *New York Times Magazine* in 1993, some readers were offended, although some women who themselves had breast cancer were supportive of such images receiving public attention (Malchiodi 1997: 56–7). In creating this self-image, Matuschka was setting out to demonstrate that a woman's body, lacking one or both breasts, need not be considered ugly, diseased, or deformed, noting of her purpose that: 'When men come home from war bandaged and broken, they are considered symbols of strength, even sexy. Could I actually show a mastectomy woman who looks beautiful, who has pride and dignity? A picture evoking not self-indulgence, but power and strength?' (Malchiodi 1997: 58).

Others with conditions such as HIV/AIDS, cancer, and disabilities have sought what they consider to be oppressive images of the condition in popular or medical representations, replacing them with more positive images. HIV/AIDS activists have become well known for their challenges to mainstream representations of people with HIV/AIDS. By identifying features of the politics of representation of HIV/AIDS, they have worked to 'resist the AIDS mythology' (Boffin and Gupta 1990), countering images of people with HIV/AIDS that represent them as passive, grotesque, living out an inevitable death sentence, and as deviant outsiders deserving of their fate (see, for example, the essays and images in Boffin and Gupta 1990; Crimp 1989; Klusacek and Morrison 1992). Crimp (1989) has referred to these activities as 'cultural activism,' based in cultural analysis.

Similarly, photographer and activist David Hevey (1992) mounted a strong critique of the images of people with disabilities that appear in such forums as charity advertising. He argued that in attempting to arouse pity for disabled people, such advertisements tend to be patronizing, supporting the notion that the disabled are freaks, pathetic, marginalized, and dependent on others' help. As he notes, apart from charity advertising, images of people with disabilities are rare in the popular media. They are 'admitted in culture,' Hevey argues, 'only as symbols of fear or pity' (1992: 54). His own photographic work with disabled people set out to achieve 'positive disability imagery,' allowing them to project their own perspective on the world in ways that sought to go beyond

the clichéd 'brave battler' or 'helpless, dependent victim' portrayals.

#### CONCLUDING COMMENTS

As this chapter has demonstrated, much research and scholarship relating to the socio-cultural representations and meanings of health, medicine, and the body has been published in recent times. It has been particularly invigorated by the incorporation of poststructuralist perspectives and a growing interest in the sociology and history of the human body. One of the most important insights of sociocultural analyses is the identification of the link between knowledge, discourse, power, and notions of reality. Their value lies in challenging the status quo by deconstructing taken-for-granted perspectives and representations, and in the process producing new ways of seeing, thinking, and acting.

Critics of social constructionism and poststructuralism have criticized those who adopt these perspectives for taking a relativistic and nihilistic approach, avoiding attempts at reform and achieving improvements in health status for disadvantaged groups. They ask that if all knowledge is a social product, what are we to take as 'truth,' and whose view should we accept as valid? In response to these critiques, advocates of social constructionism and poststructuralism contend that it is important to be aware that any knowledge claim is underpinned by the desire to shape a debate, and that no such claim can be accepted as politically neutral. They argue that while the project of deconstructing taken-for-granted assumptions may be seen as destabilizing and challenging, this is precisely one of its achievements. As Leder put it: 'If we are to understand the strengths and limits of our medicine and envision its alternatives, we must come to grips with the world-view it assumes' (1992: 17).

Constructionist inquiries need not reject political causes or avoid any adherence to values such as democracy, equality, and social justice. As this chapter has shown, for example, feminist writers and advocates for people with cancer, HIV/AIDS, and disabilities have fruitfully employed deconstructionist analyses to challenge taken-for-granted meanings that they see as being oppressive or stigmatizing. Their intention is to demonstrate the ways in which the voices and activities of the members of certain social groups constantly take precedence over, and subjugate, the voices and activities of marginalized groups. Identifying discourses and showing how the use of discourses contribute to assumptions about social groups, including

assumptions that contribute to their disadvantaged status, is not in itself a strategy for dealing with social inequity. It is a vital starting point, however, for attempts to 'do something,' for deconstruction serves to destabilize unifying assumptions that themselves are part of the establishment and maintenance of social inequality.

Social constructionist analyses conducted thus far have provided a richness of material that challenges the objectivist perspective on medicine and the body that reigns in medicine. Much scope remains for further inquiries into how lay people understand their bodies in relation to the dominant discourses emerging from such influential institutions as medicine, public health, and the mass media. The relationship between these preexisting discourses and the meanings developed through individuals' own life experiences of embodiment, illness, and medical care has yet to be fully explored and understood. There is much potential for future empirical studies that seek to identify aspects of this relationship and investigate the different perspectives and experiences relating to embodiment, health and illness of subcultural groups in society.

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