The Body as Border

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In this paper, I argue that the modern medical paradigm, biomedicine, has produced a relationship between race, gender, and disease that legitimates violence against gendered and racialized bodies through the creation of a health norm based on a “universal” subject that is white, male and heterosexual. This relationship has been upheld through a biopolitical state that perpetuates and sustains the life and health of “normative” subjects at the expense and death of “non-normative” subjects. Central to biopower is the cultural production of difference as pathology in which appearance and essence are collapsed under the medical gaze thereby ontologizing non-normative subjects as pathological, deviant and abnormal and justifying violent and harmful medical interventions on their bodies. In the second half of the paper I explore the possibility of embodiment as a collective technique to resist biopower and the pathologizing of difference.

Introduction

Elizabeth Grosz (1994) writes that, “The [female] body has thus far remained colonized through the discursive practices of the natural sciences, particularly the discourses of biology and medicine. It has generally remained mired in presumptions regarding its naturalness, its fundamentally biological and precultural status, its immunity to cultural, social, and historical factors, its brute status as given, unchangeable, inert, and passive, manipulable under scientifically regulated conditions.”¹ What Grosz proposes as a counter is, “A completely different set of perspectives—this time based on women’s specificities, experiences, positions, rather than those of men, who hide themselves and their specificities under the banner of some universal humanity.”²³

Drawing on Grosz’ critique, the central purpose of this paper is to show how deployments of power are directly connected to women’s bodies and to explore ways in which female subjects might resist those deployments. I look at the effects of

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¹ Grosz 1994, p.x.
² Ibid.
³ Foucault 1978, p.152.
biomedicine as a technique of biopower which, I contend, has legitimated violent physical interventions on the bodies of women, especially racialized women. I argue that biopower operates through biomedicine to pathologize women in order to control them and their (re)productive capacities. This is possible due to a norm within the field of biomedicine which establishes the heterosexual white, male as the paradigmatic body against which all others are measured.

Undergirding this health norm is the Cartesian duality which separates mind and body rendering body as that which is controlled by the mind or consciousness. This duality has been gendered insofar as white men have been portrayed without bodies as the conscious and rational counterparts to unthinking, passionate female bodies. While this issue has been dealt with by feminists primarily trying to reclaim consciousness and the mind as a domain relevant to women, to the extent that the body has been taken as a secondary or subordinate factor in these efforts, the mind/body duality has been reinforced in their critiques. In an attempt to develop a different set of perspectives to such dualistic and disembodied thinking, I propose embodiment as a way to confront biopolitical limitations through re-valuing that which biopower seeks to regulate, that is, the social body through the individual body. While embodiment is not a final or complete answer, it is one method for reframing and reclaiming the physical and material aspects of the individual and social body which have become the sites of struggles for power in the modern state.

I take embodiment to mean the lived experience of an individual in a social structure as well as the effects of that social structure on individual experience. It, therefore, includes individual perception and sensation while also accounting for the
biological, cultural and social environment. Put differently, embodiment is a strategy for integrating the mind-body-emotions with the social, political, economic, and cultural dimensions which bear on the individual subject in a social context. Embodiment, then, is a way to recuperate the body without losing or down-playing the cognitive and emotional components of subjectivity, nor eschewing the contextual factors which inform lived experience. Given its links to the social and cultural environment, I propose that embodiment is as much a collective as an individual experience. By developing an understanding of collective embodied subjectivity, a new site for exercising and understanding political agency becomes apparent.

In making this corporeal turn (Tamborino 2002), I engage the debates on modernity and post-modernity insofar as there seems to be a clear distinction between the essentialized and universal notions of the body in modern thought and the discursively produced, non-essential body of post-modern and post-structuralist thought. I suggest that while both modern and postmodern representations of women’s bodies make important contributions to our understanding of the body, they are short-sighted insofar as they posit one paradigm over the other, and therefore, each in its own way contributes to the physical and psychic fragmentation of women (Alarcón 2003; Irigaray 1985).\(^4\) In order to recover the ‘missing’ body (Williams and Bendelow 1998) I argue for a more nuanced understanding, one which holds on to the body as a changing and malleable site where discourses intersect producing subjectivity, but also as a site which produces its own

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\(^4\) Butler (1990) is instructive here when she inquires whether fragmentation is indeed oppressive. Certainly in postmodern conceptions of the subject, fragmentation is not a negative thing. However, to the extent that the postmodern body’s fragmentation occurs within the psychic or cognitive domain, it reinforces the Cartesian divide which I am trying to break down. Thus, fragmentation is not necessarily oppressive in itself. Rather, it depends on what kind of fragmentation is occurring. For example, objectifying women’s bodies as separate from their minds is an unhealthy fragmentation. Emphasizing the non-unity or complexity of women’s subjectivity is a helpful fragmentation.
knowledge, integrating and resisting externally imposed definitions and understandings. I suggest holding on to both the foundationalist or realist ontologies of the body that modernity provides while also adopting a social constructionist approach to health, illness and healing which emphasizes situated knowledges and hybrid identities. What is needed are more complex understandings of the way in which lived experience is informed by the physicality of embodiment, the social and contextual circumstances in which the embodied subject lives, as well as the political techniques used to subjugate embodied subjects.

To pursue this methodological and epistemological course is to problematize the mind/body duality proposed by Cartesian thought by making mind, body and emotions equally important in comprehending the lived social, political, economic and cultural experience of women. In the words of Deidre Sklar (1994), “rather than underline the fact that thinking can be abstracted from corporeality, I am underlining the fact that thinking depends on it.” In this view, corporeal properties can no longer be reduced to their materiality by objectifying the body and its parts, but must include the effects of thoughts and emotions, movement (Sklar 1994) and inaction (Norbeck and Lock 1987), speech (O’Neill 1989) and silence (Zavella 2003; Chávez Leyva 1998; Gal 1991) in the lived experience of women. At the same time, taking embodiment seriously means being attentive to the communicative processes (Briggs 2005) and discursive strategies which emanate from inside the body as well as those which bear on it from without. Subjective experience of one’s embodied social position is at the center of my concern.

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5 Sklar, Deidre, 1994, pp. 9-22.
6 When I refer to the body, I am using it as a term to invoke all of these phenomena at once.
Accordingly, when using the term “health” I mean it more in terms of “a flourishing condition; well-being, vitality and prosperity” than “the condition of an organism or one of its parts in which it performs its vital functions normally or properly.” In Buchanan’s (2000) words, “Rather than viewing health as something that can be produced through the application of effective techniques, well-being may be better thought of as a way of being in the world, a kind of presence in which participation in certain kinds of social practices promotes —and other practices retard—the realization of human flourishing.” A healthy body is, therefore, not a discrete fixed outcome, but a continual process of becoming--prospering and flourishing--within a social environment. Insofar as it is the result of unequal social relations and it involves a struggle for physical, social, economic and cultural survival, health is also political.

Because I do not see physical and emotional pain as two different and differently treatable manifestations, I am looking for ways to heal painful experiences without further exacerbating them. I am, therefore, looking for approaches that do not distinguish the pain of breast cancer from that of racism, or diabetes from homophobia since the physical dimensions of pain have cognitive and emotional, as well as social and political dimensions. While the manifestations of pain may be different and differently felt across individuals and groups, because of the pervasiveness of a physical and social norm regarding healthy subjects, I contend that each painful experience brings with it its own embodied experience of feeling and being made to feel “Other,” “different” or abnormal. For this reason I am searching for healing approaches which do not treat complex human beings as fragmented manifestations of health or illness. Rather than emphasize

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8 Buchanan, 2000, p.104.
approaches which “isolate the illness” (which could either be a physical body part or a social group), I stress connection within the physical as well as the social body with an emphasis on what is right rather than what is wrong.

Given this understanding, it should be clear that I am not after a functionalist definition of health, particularly one which is defined and delimited only within the field of biomedicine. Strictly “scientific” approaches have tended to regard health, implicitly if not explicitly, as a category of the phenomenal world that is ontologically detachable from both power and subjective experience (Popay et al. 1998). I want to stress both the power and the lived experience of the health subject in defining her well-being, as well as the structural forces which contribute to health and illness.⁹ Health is, therefore, neither separate from the social relationships one has nor from one’s embodied experience of those relationships. It is determined by social struggles, but also by the internal experience of those struggles. This definition of health is akin to what Lourde (1997) calls the erotic. The erotic is an assertion of the lifeforce of women; of that creative energy empowered.¹⁰ She explains,

...when we begin to live from within outward, in touch with the power of the erotic within ourselves, and allowing that power to inform and illuminate our actions upon the world around us, then we begin to be responsible to ourselves in the deepest sense. For as we begin to recognize our deepest feelings, we begin to give up, of necessity, being satisfied with suffering and self-negation, and with the numbness which so often seems like the only alternative in our society. Our

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⁹ In emphasizing the role of women in providing for their own health, I want to stay away from the idea that women should be the primary caretakers of themselves and their families because of an inherent or “natural” capacity to care. Rather, I would stress, with Hurtado (1996) that the variations in knowing how to care for the self and others between men and women lies in the division of labor and the value attached to those divisions in our society. Thus, “those special ways of knowing” are deeply rooted in discrimination based on categorical group memberships such as gender, sexuality, class, race and ethnicity rather than any inherent biological characteristic.

¹⁰ Lourde, 1997, p.278 in Conboy et al.
acts against oppression become integrated with self, motivated and empowered from within.\textsuperscript{11}

Health, like the erotic, implies the decolonization of mind, body and emotions through internal and external integration and connection.

By making embodiment central to women’s health, I propose a view of women as complete and multiple subjects whose existence can not and should not be fragmented and compartmentalized into a distinction between their biological functions, sociological characteristics, cognitive or psychic processes and their lived experience.\textsuperscript{12} In arguing this, I am not proposing, however, that women are homogenous composites made up of four discrete but interactive functions. Rather, I want to argue for a wholeness which is not a unity but a constant state of becoming, thereby avoiding any theorization of embodiment or lived experience as a static and quantifiable or diagrammable process.

Although I see the body as producer of knowledge and as being produced by knowledge, I do not see these productions as occurring in a dialectical relationship. Rather, the view I advocate is one in which there is no dialectical whole to be achieved between structure and agent whose resulting effect is “the body.”

Butler (1990) has argued against imposing an ontological unity on women. In fact, she is critical of the use of term “woman” at all. While I agree with her that it is a limited and limiting term, I find it heuristically useful to understand the ways “women” are constructed and how they subjectively experience those constructions in relation to the biological functions and processes occurring in their physical body. While the term itself has limitations, it also makes possible the invocation of the complex configuration

\textsuperscript{11} Lourde 1997, p. 281
called “woman.” Its deployment has political implications for the decolonization of women’s bodies, since, as Butler herself asks, if there is no female subject, or woman, to emancipate, who is left to emancipate from oppression? Thus, while I agree with her that there is no interior fixity or unity that inheres in women, I use the term to invoke that subject which has been socially constructed as woman, the subjective experience of that construction and the biological/anatomical characteristics as they have been established to define the female body.

Accordingly, I see the body as captured by the discourses which define it, but also as a presence operating on multiple and incomplete registers beyond any reductivist account of it. It is both always being captured by biomedical models, historical and sociological categories, even the sensory perception of others, while at the same time it can never fully be captured in its complexity and multiplicity by those looking into it or those looking out from it. Women’s bodies, then, are inappropriate(d) figures (Minh-ha 1989) which are at once physical, material beings regenerating (Haraway 2004) themselves while at the same time being produced in myriad other ways through discourse, technology and history.

Although it is not a final or definitive answer to biopower, I suggest embodiment as a possible counter-technique in the on-going battle to resist the domination and subjugation of women’s bodies. I, therefore, see it as a possible method for showing how bodies extend or at least seep beyond the frameworks which attempt to contain them in order to resist the domains of control imposed upon them (Grosz 1994). Foucault is instructive in this regard. He writes, “Suddenly, what had made power strong is used to attack it. Power, after investing itself in the body, finds itself exposed to a counter-attack
in that same body (my emphasis).” One of the ways that power can be refigured is by using the individual body to connect with other bodies. That is, to use the fragmenting and pathologizing techniques of biopower to create coalitions and affiliations with bodies who have been similarly “Othered,” to embrace one’s embodiment and find connection with others through it. However, as Foucault points out, any strategy of resistance will be met with counter-resistance. He writes, “… the impression that power weakens and vacillates here is in fact mistaken; power can retreat here, re-organise its forces, invest itself elsewhere…and so the battle continues. Embodiment, then, as an individual and social experience, must be malleable in order to engage in the on-going battle to resist subjugation and domination. It can not, therefore, be rooted in essentializing physical or sociological categories, but can draw from them as a starting point to develop a broader and more flexible connection with others.

The broad questions which I ask in this paper and which will be more thoroughly elaborated through ethnographic fieldwork include: How has biomedicine contributed to our understanding of women’s bodies as dangerous and pathological? How does this system influence our understanding of a healthy individual and healthy social body, and to what extent might these two concepts be at odds with each other? How might embodiment be deployed against biopower? Through what other frames might we come to understand women’s health and what, then, are the implications for health promotion in the modern state?

In the next section I elaborate on Foucault’s description of biopower, its relation to the individual and social body, and the way it is used by the state to regulate populations. In the third section, I look at the way in which biopower operates through

13 Foucault 1972, p.57.
biomedicine to regulate and control the bodies of women, especially racialized women. In
the fourth section, I explore the concept of embodiment as a collective counter-strategy to
biopower. Finally, in lieu of the ethnographic fieldwork I will draw from in the future, I
conclude this paper with a section that briefly outlines a few collective practices of
embodiment in the women’s health movement and in the practices of women of color as
a demonstration of how an embodied approach might work.

**Biopower**

According to Foucault, in the classical period there was the emergence, in the
field of political practices and economic observation, of the problem of the birthrate,
longevity, public health, housing, and migration. Hence, there was an explosion of
numerous and diverse techniques for achieving the subjugation of bodies and the control
of populations, marking the beginning of “biopower.” He explains that through bio-
power, life itself has become the issue of political struggle.\(^{14}\) To that end, biopolitics, the
political exercise of biopower, is “focused on the species body, the body imbued with the
mechanics of life and serving as basis of the biological processes.”\(^{15}\) In contrast to
sovereign power which exercised the right over death, biopower exercises power over
life. Thus, it is the power which decides whether to let live or die.

Two of the central concerns of biopower are the birth rate and illness (Foucault
2003). These two issues are important because they directly affect the productive force of
the population. In order to regulate and protect these forces, “security” mechanisms such
as forecasts, statistical elements and overall measures, “have to be installed around the
random element inherent in a population of living beings so as to optimize a state of

\(^{14}\) Foucault 1978, p. 139.

\(^{15}\) Foucault 1978, p. 139.
life…to maximize and extract forces.”

Foucault developed the term noso-politics to discuss the relationship between capital and health. Nosology, or the categorization and classification of disease, intersects with politics when the consideration of a disease is a political and economic problem for social collectivities which they must seek to resolve as a matter of overall policy. Insofar as sick bodies are non-productive bodies from which a profit can not be extracted, disease and illness is a political issue which must be addressed at the level of public policy. Accordingly, a particular system for separating the normal and the abnormal was set up (Foucault B/P1972) thereby “distinguishing those bodily interests that can be represented in the polity from those which cannot, from those against whom society must be defended.” This system operated such that those defined as abnormal, pathological, and as a danger to society were described as having little or negative value and were therefore permitted to die. Those who were considered to hold some value for society, whether productive or reproductive were allowed to live.

Biopower thus draws from biology to implement a political strategy based on life and death. Stoler (1995), whose work draws on Foucault’s lectures delivered at the Collège de France from 1971 to 1984, has shown that racism is one of the defining factors in terms of those who must live and those who can be permitted to die in the biopolitical state. She explains that racism, “fragments the biological field, it establishes a break (césure) inside the biological continuum of human beings by defining a hierarchy of races, a set of subdivisions in which certain races are classified as “good,” fit and superior.” Indeed, it is the task of the biopolitical state to preserve those races deemed good and to let die those considered inferior. More importantly, she goes on to say,

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16 Foucault 2003, p. 246.
17 Stoler 1995, p. 84.
“[racism] establishes a positive relationship between the right to kill and the assurance of life. It posits that the more you kill and let die, the more you will live.”

Allowing dangerous or less valuable members of the polity to die thereby establishes a biological confrontation between my life and the death of others. “It gives credence to the claim that the more “degenerate” and “abnormals” are eliminated, the lives of those who speak will be stronger, more vigorous and improved.” Indeed, “racism is the condition that makes it acceptable to put [certain people] to death in a society of normalization.”

Racialized and female bodies have been those most likely to be targeted by the biopolitical state because of their purported non-normativity. This is possible because of a standard which makes white males the paradigmatic healthy subject. Paradoxically, through medicalization and the biomedical paradigm, bodies are produced as racialized, sexualized and gendered. This means that biopower not only permits particular groups to live or die, it also produces those groups which it defines as valuable or worthless to the modern state.

Inda’s (2002) work on biopower, reproduction and the migrant woman’s body demonstrates how race and gender come together to define the value of particular bodies for the modern state. He shows how undocumented Mexican migrant women in California who are perceived as less valuable are consequently subject to multiple strategies which not only let them die a physical death at the border, but also a social death in the United States through discriminatory social policies. He explains,

the biopolitical logic of the modern state necessitates a decision on the value or non-value of life. Every society necessarily makes a decision about those lives that deserve to be lived and those that do not. The logic here is that the death of

18 Stoler 1995, p. 84.
19 Stoler 1995, p.85 drawing on Foucault.
the other, the death of those lives unworthy of being lived, will make life in
general more healthy and pure. This death does not have to be direct death (or the
literal act of putting to death). It could also be indirect death: the act of exposing
to death, of multiplying for some the risk of death, or simply political death,
expulsion, rejection and exclusion.\textsuperscript{21}

As Inda’s work shows, undocumented migrants have been construed as enemies who
threaten the body politic and it is, therefore, on behalf of the national population as a
single body with a singular state of “health” that the attempts to efface Mexican migrant
women from the nation are justified. In this context, “The care and governing of the
population thus becomes one with the fight against the enemy where the enemy is defined
as the body of the undocumented, female migrant.\textsuperscript{22} However, as Hoy (2004) has
pointed out, “the discourse [of biopower] may not be explicitly adversarial and may not
posit others as outright enemies. Rather, as in the case of colonialist racism the intention
is not so much to eliminate adversaries who are equal, but to purify the population of
inferior biological strains.”\textsuperscript{23}

In the case of racialized women, their reproductive health is taken up as an issue
regulating not only their right to remain alive or be allowed to die, but also the right of
their unborn children to be allowed to live. Thus, through the various policy measures
which attempt to control the reproduction of undocumented migrant women, “the lives of
immigrants [and their offspring] have implicitly been judged as not worthy of being lived
or at least as not worthy of being lived as U.S. citizens.”\textsuperscript{24} Therefore, by attempting to
prevent undocumented migrant women from accessing reproductive health services, and
particularly prenatal care, the biopolitical state not only regulates who shall live, but how.

\textsuperscript{21} Inda 2002, p. 102.
\textsuperscript{22} Inda 2002, p. 105.
\textsuperscript{23} Hoy 2004, p. 80.
\textsuperscript{24} Inda 2002, p. 105.
That is, insofar as they are permitted or denied vital health services, the quality and quantity (how long, how many, etc.) of their lives and that of their children is also being regulated. This topic will be more thoroughly elaborated below.

One of the primary means through which biopower is exercised is through medicalization. That is, the expansion of medical jurisdiction which “involves individuals, groups, and cultural institutions viewing (or coming to view) a domain or problem or condition or life circumstance in medical terms.” Zola (1978) explains,

\[\ldots\text{medicine is becoming a major institution of social control, nudging aside, if not incorporating the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts. And these judgments are made, not in the name of virtue and legitimacy, but in the name of health. Moreover, this is not occurring through the political power physicians can hold or can influence, but is largely an insidious and often undramatic phenomenon accomplished by “medicalizing” much of daily living, by making medicine and the labels “healthy” and “ill” relevant to an ever-increasing part of human existence.}\]

Foucault explains that there has been an overlap between the medical and the civil domains of life insofar as medicine has become a regulatory discourse and institution for controlling human behavior. He writes, “medicine is the practical science whose truth and success are beneficial to the whole nation” because it reveals the inseparableness of the human being with the material conditions of existence and therefore represents “the point of contact between the art of healing and the civil order.” Health and politics come together at the site of material, biological bodies insofar as bodies are the physical guarantors of the health, production and prosperity of the State.

\[27\] Foucault 1973, p. 70.
\[28\] Foucault 1973, p. 72.
Women’s bodies have been central to the political health of the State given that they are seen as the means for reproducing and, therefore, guaranteeing the social and economic future of society. For this reason, they have been carefully monitored and are unduly subject to medicalization. Unmarried and racialized women have been especially targeted for medical interventions insofar as they are seen as less valuable social and political subjects representing more of a burden than a benefit to the nation. Through medicalization, women’s public and private lives have been governed by biomedical norms because as workers and mothers they are subject to a moral imperative to stay healthy. As Foucault explains, “the hysterization of women, which involved a thorough medicalization of their bodies and their sex, was carried out in the name of the responsibility they owed to the health of their children, the solidity of the family institution, and the safeguarding of society.”

Medicalization has contributed to the representation of women as the caretakers of their own health, that of their families, as well as society. For this reason, biomedical knowledge developed about women has primarily focused on reproductive health rather than other aspects of women’s health. Biomedicine’s focus on women provides a reductionist view of female bodies representing them only in terms of their reproductive organs. Within this perspective, female subjectivity only becomes a salient factor when it presents women as over-emotional and hysterical due to biologically determined characteristics, i.e. their reproductive organs. The cultural production of women as ontologically pathological has legitimated violent and abusive medical interventions. As I will explain below, this has been justified through scientific paradigms which link biology, ontology and social identity.

29 Rabinow 1984, p.268.
The biomedical body

In this section, I look at biomedicine, one of the primary paradigms through which modern bodies have been represented and “understood.” I see biomedicine as a technique of the biopolitical state which provides life for those citizens deemed desirable at the expense of those labeled as undesirable or without value to the State. I argue that while biomedicine has made significant contributions to disease and illness prevention, it has legitimated many violent acts against women’s bodies under the guise of health “care.” Because women, and especially women of color, have been deemed as pathological and therefore dangerous to the social body, their physical bodies have been subject to control through medical interventions, including limiting but not limited to their reproductive capacities.

Biomedicine has been the predominant model for studying and practicing health and healing in the United States since the late nineteenth century when, relying on “science” to legitimate their medical practice, elite practitioners, medical researchers and the emergent industrial capitalist class permitted regular medicine to transform itself into biomedicine and to establish political, economic and ideological dominance over rival systems (Baer 2001). Its pervasiveness in society since then has been so extensive that it has come to be the commonsense view for health and healing in U.S. society. Mishler (1981) has argued convincingly that “the dominance of this model in medical theory and practice is universally recognized. Its assumptions are so deeply interwoven with ways of thinking and working in medicine that health professionals tend to forget that it is a conceptual model, a way of thinking about the world. That it, the biomedical model is
treated as *the* representation or picture of reality rather than understood as *a* representation.”

Because of its centrality and pervasiveness in the modern world, biomedicine can be taken as the paradigm for representing and understanding health and the body in modernity. Although I am locating biomedicine in a historical period, I do not mean to imply that modernity is a prior historical moment to post-modernity. Rather, what makes bio-medicine modern are its affiliations with Enlightenment notions such as self-reliance, rugged individualism, independence, pragmatism, empiricism, atomism, privatism, emotional minimalism, and a mechanistic conception of the body and its ‘repair’ (Stein 1990).

Notions about the biomedical body are informed by the Cartesian separation between mind and body where the physical body is an extension of the rational mind and is therefore controlled by it. In this model, “body is thus what is not mind... It is what the mind must expel in order to retain its “integrity.” It is implicitly defined as unruly, disruptive, in need of direction and judgment, merely incidental to the defining characteristics of mind, reason, or personal identity through its opposition to consciousness, to the psyche and other privileged terms in philosophical thought.”

Thus, the body is defined in opposition to the mind and is seen as deterring from and disruptive of the workings of rational thinking. Because of its unruly character, the body is seen to be in need of control and discipline. It is the rational mind which must discipline the unruly body.

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31 Stein 1990, p. 21.
32 Grosz, 1994, p.3.
The mind/body duality facilitates the perception of the body as an object, as the property of the mind. Despite the claims to universality of this mind/body relationship, not all bodies are objectified, however. As will be explored below, white, male bodies are more valued because they embody what is taken to be the paradigmatic or universal rational mind. In contrast, female and racialized bodies become ever more visible as an unruly threat to society. Their bodies become equated with danger and uncleanliness as opposed to the purity of Anglo, male bourgeois society. One of the ways that this threat is manifested and controlled is through biomedicine.

In biomedicine, the medical subject, reduced to her biological components, is perceived as a physical object that is broken and can be fixed (Grosz 1994) (separate from any other social or cultural factors or variables) through substance-to-substance “curing” activities (Strathern 1996). “During the process of diagnosis [in biomedicine], the body is viewed in isolation from the patient’s social environment, life history, beliefs, values and emotional states. With his or her subjective understandings dismissed as irrelevant, the ill person is transformed into a diseased body dependent on the active skill and agency of his or her physician.”34 This healing method is in line with what Annandale (1998) has outlined as the three components which make biomedicine different from prior medical models.

First, biomedicine adopts a reductivist approach which assumes that health and disease are natural phenomena which exist in the body rather than in the interaction of the individual and the social world. This perspective draws from an Enlightenment view which sees nature, in this case the “natural” or biological body, as given and independent of the knower. In this view, the biological body is taken to be a universal, stable entity,

outside of history, culture, geography and language (Price and Schildrick 1999). As Annandale explains, “from this perspective the clinical signs that are presented to the physician are seen as objective and independent of the symptomatic experience of the patient (e.g. the sensation of pain).”35 This component of biomedicine relies heavily on the Cartesian separation between mind and body thus revealing the overlap between Western philosophy and biomedicine and consequently the particularity of this purportedly universal worldview. Because of its philosophical underpinnings, biomedicine has perpetuated a belief in the universality of human experience. Hoy (2004) explains that it is only recently that race, class and gender became salient topics for Continental philosophy. While it is out of the scope of this work to further explore the exclusion of sociological categories in philosophy, it is a topic which bears significantly on perceptions of the body in biomedicine

The second component draws from the doctrine of specific aetiology. In this view, disease can be introduced by exposure to a single specific factor, such as a virulent micro-organism into a healthy body. This perspective leads to the belief that a lack or deficiency in vitamins, hormones, etc. in the medical subject could lead to illness and disease. It reinforces a cause/effect model where a single cause is directly linked to a single effect. Here, health is perceived in negative terms as an absence or lack, rather than as a positive entity which evokes the presence of well-being or vitality. This view concentrates on looking for problems or deviations from the norm in individual bodies where the body is viewed as the carrier of disease, rather than of health. It, therefore, sheds more light on what’s wrong with the patient than what is right. The deficiency or lack theory has also been extended to the social identity of the individual such that certain

social actors are seen as biologically deficient. This has been particularly the case with women who are perceived as lacking those biological traits which men naturally possess (male reproductive organs in particular). By concentrating on physiological deficiencies, the doctrine of specific aetiology disregards the socially mediated aspect of medical knowledge in which non-biological factors can contribute to ill health. It also overlooks the fact that not all who are exposed to particular pathogens get/are sick. Finally, it ignores the socially constructed definitions of health, illness and the body.

The third component is its claim to scientific neutrality, “i.e. that medicine can be rational, objective and value-free, treating each individual according to their need and irrespective of any sense of moral worth.” Biomedicine has been centrally concerned with objectivity, neutrality and that which is visible or observable. As Daston (1992) has pointed out, scientific objectivity, which emerged in the latter half of the nineteenth century, morally compelled the scientist to maintain accuracy. What can be known about the body in this paradigm is deduced from outside of the medical subject by the objective experts who focus on the “natural” phenomena of the physical body without attending to their own or the patient’s subjectivity. Lay knowledge, the symptomatic experience of the patient and the social context informing ill health are considered too subjective and are, therefore, ignored by these “experts” who are more concerned with discerning biological processes and objectively treating illness rather than subjectively interacting with individuals. In sum, the “ideal of objectivity attempts to eliminate the mediating presence of the observer.”

37 Daston, 1992, p.81.
Insofar as these three components inform biomedicine, the physical body is viewed as unthinking material to be studied, dissected, and treated as an object separate from the subjective experience of “living.” It is also seen as a deficient repository of disease, as opposed to the possible site of health and well-being. The obsession with objectivity was driven by a desire to find “truth” in nature, where the body is equated with nature and in opposition to the mind. The body is not viewed as a producer of emotion or meaning since those are regarded as psychological (i.e. mind) and not biological (i.e. body) processes. Therefore, the all-too-human scientists must, as a matter of duty, restrain themselves from imposing their hopes, expectations, generalizations, aesthetics, even ordinary language on the “natural” body which is considered an image of nature. According to this view, “the essence of life [is] in the unplumbed depths of organic being, to be grasped through the invasive thrust, the looking and naming, of the new biology.”

Thus it is through techniques of observation and categorization that human “nature,” i.e. the body, could be known by the scientific, i.e. rational mind.

The biomedical paradox: Universal bodies defined according to specific social roles

Given the drive to objectivity and neutrality in biomedicine, how did race/gender/sexuality/nationality become symptoms to be read on the body as transcriptions of disease (Foucault 1973)? How does this reading legitimate violence against non-normative bodies under the guise of health and healing? I suggest that the drive to neutrality and objectivity led to the development of categories and standards which could be used to measure and compare biological bodies. Thus, in order for scientists to focus on the “natural” or biological components, the object of observation had to be fixed and standardized for, as the thinking went, “unrefined natural objects are

too quirkily particular to cooperate in generalizations and comparisons.”
Therefore, “the very fixity of the body is what allows for its measurability.”

In the nineteenth century, measuring physical attributes such as skull size, jaw protrusion, brow height, etc. (Comaroff 2003) with tools such as craniometers, stereographs, and sliding bars was employed to compare and contrast different bodies (Seth 2003). Accompanying the development of these tools was a new vocabulary associating racial and sexual difference with different populations making it possible to medically categorize different bodies according to social identities such as race and sex. This biological fixity intertwined with a cultural fixity associating particular physical and biological attributes to specific geographical and cultural groups, a perception which has subsequently informed biological racism and the eugenics movement. Despite the focus on the universal and socially unmarked body in biomedicine, it was through its drive to objectivity that social categories became explanatory variables for medical science because they were considered to be easily discernable, fixed and self-evident categories. Indeed, it was biomedicine that created these fixed categories and then declared them as self-evident. Therefore, despite biomedicine’s purported attempts to distance the body as medical object from the body as social subject in theory, in practice this relationship has been emphasized since its inception.

Emphasizing identity categories seems paradoxical given biomedicine’s insistence on studying the human body objectively. As Stein (1990) argues, however, despite its pretensions, biomedicine is not an objective and neutral science. In fact, biomedicine as the modern health paradigm has been central in defining identity. The

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Seth, 2003, p.83.
purported absence of scientific subjectivity produces what Haraway (1997) has called “a conquering gaze from nowhere” which is not neutral and objective, but is socially and culturally mediated. Through the medical production of physically ill bodies, it became possible not only to identify social subjects from different groups, but to discern which of those groups was abnormal or pathological and which normal or healthy, as well. The medical “experts” could then identify which groups were threats to the public health and alert the State who could then react with public and social policies to minimize the threat.

Rimke (2003) explains that the morally compelled objectivity of the scientific medical gaze produced the pathologization of morally and ontologically corrupt subjects through an exterior reading of the body as text—as a decipherable, knowable, and (re)presentable object—which both expressed and confirmed the existence of pathological interiorities.”41 Rimke’s work shows the connection between morality and medicine in her discussion of 19th century psychology where etiological schemes held individuals, especially poor, racialized and gendered subjects, morally responsible for their pathologies. She writes, “although all classes were identified, the class-specific explanatory schemes were informed by ontologized conceptions of the working classes as “filthy,” “unruly,” and “disorderly” or naturally predisposed to moral madness which indirectly also served to legitimate their poorer lot in life.”42 Thus, non-normative medical subjects were pathologized through the objective medical gaze because of their social (race, class, gender) rather than biological non-normativity. Gender, race, geography, etc. all become explanatory variables in diagnosing groups and individuals as pathological where white men were categorized as the health norm. It is for this reason,

Rimke suggests, that we must develop an alternative understanding of the normal and pathological based not on the control of social deviance, which would imply pre-existing pathological groups, but rather the cultural production of difference as pathology.

The paradigm against which normativity and deviance were judged was the white male bourgeois subject. Rimke (2003) explains, “the study and measurement of external features revealed and indicated the temperament and moral faculties in which the white bourgeois scientists used themselves and their kind as the ideal type of heuristic device; bodies deviating from “the average white man” were thus used as empirical evidence to prove the inferiorities, both externally and internally, of different cultural identities.” The medical authorities who are seen as the only (or the most) legitimate authorities having the appropriate authoritative knowledge and control over the means and personnel to apply that knowledge to the medically defined “problem” (Pauly Morgan 1998) are also those who set the paradigm of normativity based on themselves. Haraway explains that far from emanating from unmarked subjects, “the “expert” gaze that mythically inscribes all the marked bodies, that makes the unmarked category claim the power to see and not be seen, to represent while escaping representation…signifies the unmarked gaze of Man and White.”

Since the inception of modern medicine, medicalization has taken explanatory power about embodied experience and legitimacy for naming such experience out of the hands of women and has placed both in the hands and minds of medical “experts” who have traditionally been white men. As Grosz (1994) explains, medical, biological and chemical analyses of bodies “have thus far represented the energies and interests of one

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44 See Ehrenreich and English (1984) for a discussion of how female midwives were pushed out of childbirth practices by male doctors.
sex alone…Women’s contributions have never been acknowledged or represented in the term chosen by women themselves.” As a result, women have been pathologized as hysterical, weak, unstable, ill and generally unable to meet the standard of health established by and based on white males. She elaborates, “Mysoginist thought has commonly found a convenient self-justification for women’s secondary social positions by containing them within bodies that are represented, even constructed, as frail, imperfect, unruly and unreliable, subject to various intrusions which are not under conscious control. Female sexuality and women’s powers of reproduction are the defining (cultural) characteristics of women, and at the same time, these very functions render women vulnerable, in need of protection or special treatment, as variously prescribed by patriarchy.”

Because their normativity and health were taken for granted, Anglo men became the invisible health subjects against which all others were judged. White males were therefore produced both medically and culturally as healthy and unproblematic. According to this categorization, the farther the ill person deviates from the social norm the more problematic and potentially pathological. In this scheme, women of color, who are held to be the binary opposite of Anglo males, are perceived as the most deviant and therefore the most pathological and problematic. This thinking has justified myriad medical interventions in the lives and bodies of women of color as I will discuss in the next section.

Cultural representations of disease have contributed to the conflation of disease and stigmatized bodies. Building on the work of Susan Sontag (1978), Nancy Scheper-

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Hughes (1986) describes the “double” or second reality “expressed in cultural images, metaphors, and collective representations that gather around particularly dreaded and mortal wounds and diseases.” This reality creates a double affliction—the original illness and the stigma, rejection, fear and exclusion which comes with it. She explains, “The disease and its double force the patient, now twice victimized, further into the cage of his or her illness: shunned, silenced and shamed in addition to being very sick.” This double affliction is exacerbated in the case of women, especially minority women, who by the fact that they are female and racialized are already stigmatized as abnormal, unpure and ill. To counteract this tendency, Scheper-Hughes suggests changing the images and meanings of sickness, pain and suffering. She argues this against Sontag who advocates stripping diseases of their symbolic content and their cultural meanings altogether so that they can be understood as biological entities alone, as things-in-themselves. Although well-intentioned, Sontag’s suggestion would reinforce a strictly “scientific” conception of health and disease, which as I have suggested above is not neutral but itself charged with cultural meaning.

In addition to this difficulty, as Troy Duster’s (2003) work on the concept of race in science teaches, stripping away all cultural meaning would mean that valuable data on the differences in health outcomes would be lost. The social value of tracking the use of sociological categories as they are “biologized” is an important aspect of tracking racism and sexism in health practices. Further, as his work on race shows, there are biological differences which are defined as occurring either through genetics or through feedback loops. For example, hypertension, can be a biologically or socially determined health condition, because it is influenced by the way one is regarded in society and/or results
from genetics. Given the interplay between the social and the biological, Duster argues that, “by heading toward an unnecessarily binary, socially constructed fork in the road, by forcing ourselves to think that we must choose between “race as biological” (now out of favor) and “race as merely a social construction,” we fall into an avoidable trap.” The trap is to reinforce the distinction between the biological and the social as biomedicine attempts to do.

The equation between disease, body and risk is heightened in the case of women and racialized subjects where, by virtue of their social and physical characteristics, their entire subjectivity is defined as diseased. As Briggs (2005) has shown, “persons on whom stigmatized social identities are imposed come to be seen as reservoirs of [bacteria, viruses, parasites and the diseases they cause].” Thus, through discourse, race and medicine, biological processes become attached to social subjects who are already discriminated against thereby defining their social identity, rather than biological body, as diseased. This conflation between biological characteristics and social identity is taken a step farther and becomes the foundation for imputing a contaminated, deviant and sick ontology to already socially stigmatized persons. Thus, a conflation of identity, appearance and ontology occurs such that the ill physical individual body is read as a representation of a diseased and pathological ontology occurring in the particular cultural group with which that body is associated. This elision is so facile that the causal arrow no longer needs to begin with the disease to justify social pathology. It can begin with the social subject and read disease into and onto her body. This conflation is not a harmless mistake, however. The social taxonomies developed in medical science have served to

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inform and legitimate violent physical “medical” interventions on bodies in modern society.

In the following section, I look at the way biomedicine has contributed to the pathologization of women. As a technique of biopower, biomedicine has been used to physically and psychically control women contributing to the idea that their bodies are a threat to themselves and to the larger social body. I suggest that biomedicine has also played a role in determining who should live and how, as well as who should die or be prevented from living.

**Women as pathological**

*Historically, science, particularly medicine, has been used as a weapon against women.*

How has biomedicine informed our understanding of women’s bodies as pathological and dangerous? How has biomedicine, a science meant to heal and care for human bodies contributed to the violent violations of women’s bodies? Due to its Cartesian underpinnings, biomedicine fragments the female body turning women into objects which can be dissected under the medical gaze of science. Further, women are “treated” as objects separate from the social, political, economic and cultural environment in which they live. Paradoxically, social categories are used in biomedicine as explanatory variables for ill health. Gender or sex is often used to discuss health outcomes as a separate “variable” from race, ethnicity, class and sexuality. When sex or gender (terms which are often used interchangeably and indiscriminately in public health and some medical sociological literature) are invoked, they are generally used to refer to women and to signal this variable as a deviation from the male norm. Even in paradigms

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48 Nechas and Foley, 1994, p.15.
which are sensitive to race/ethnicity, males are still invoked as the unmarked norm against which women are measured.\footnote{See David Hayes-Bautista (2002) in which he calls for a Latino Health research agenda based on Latino health norms. He claims that “once the norms for Latino populations are established, the variations from the norms can be identified, and then the risk factors that cause these variations can be sought.” The primary variation he identifies is gender, by which he means women. By calling for a race/ethnicity sensitive health agenda but making gender a “variation” he is re-inscribing men as the standard against which women’s health and women’s bodies should be judged.}

Nechas and Foley (1994) write, “because women’s bodies differed from men’s, what was natural for women was seen as unnatural.” Hence menstruation, menopause and pregnancy all become medically treatable, pathological states. This way of thinking has legitimated diagnosing natural physical functions as threatening and dangerous, and has contributed to the understanding of women as physically and emotionally unstable and therefore in need of chemical, psychological and/or bio-medical intervention.

Baer (2001) has discussed the modern view of bodies as “organ systems” which inform the slight variations between men and women where female bodies were held to essentially share the male anatomy with the exception of their reproductive organs. This view gave way to the idea that femininity, in the form of female reproductive organs, was biologically based (Schildrick & Price 1999), a view which led to “the assertion that men’s and women’s social roles themselves were grounded in nature, by virtue of the dictates of their [natural] bodies.” The “organ system” theory has so influenced modern health paradigms that female subjects are not only reduced to their organ systems, but to their reproductive organs. Women and reproduction become synonymous while simultaneously de-emphasizing the role of men in reproduction. As nineteenth-century
physician Rudolph Virchow, M.D., explained, “Woman is a pair of ovaries with a human being attached, whereas man is a human being furnished with a pair of testes.”

Biomedicine has been gender-biased since its inception. Martin (1997) describes the gendered history of scientific ideas and the way science explained the differences between male and female bodies. She informs, “It was an accepted notion in medical literature from the ancient Greeks until the late eighteenth century that male and female bodies were structurally similar” although not equal. Men’s bodies were the physical norm against which women’s bodies were compared. “What could be seen of men’s bodies was assumed as the pattern for what could not be seen of women’s bodies.” This perception of structural similarity was based on assumption rather than empirical evidence because the medical gaze could not explore the inside of the human body “out of respect for the bodily container as metaphysical entity marked by the secrets of life and death.”

However, in 1800, this perspective came under attack. Contra the structural similarity argument, “writers of all sorts were determined to base what they insisted were fundamental differences between male and female sexuality, and thus between man and woman, on discoverable biological distinctions.” Accordingly, the medical gaze shifted from the individual to the social body and biology and sociology became overlapping frameworks to discuss health. Contestation against this frame which questioned the “natural,” that is biologically determined social roles of men and women was understood as a struggle against nature itself (Martin 1992).

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50 Reference
51 Martin 1997, p. 16.
52 Martin 1997, p.
53 Martin 1997, p.18.
In the nineteenth-century, the taboos on looking into the body were lifted and modern medicine was born. Annandale (1998) writes, “Modern medicine was born during the nineteenth century during the period of significant social change associated with industrialization, the movement of the population from countryside to cities, and the rise of capitalism.” In this context, anatomy provided a theoretical (and observable) representation of the inside of the body, rendering it a clear and distinct configuration, a visible and intelligible structure. Given these new in-sights, new metaphors were developed to describe the functions of the body. Not surprisingly, these metaphors were informed by capitalism and industrialization.

Economic metaphors where the body is akin to a small business trying to spend, save or balance its accounts were predominant. Cells were discussed in terms of balancing expenditure and income, accumulating wealth and losing business. Thus the body was described as the site of cellular production, like a factory producing pins. Frederick T. Gates, an engineer of scientific medicine, developed a metaphor equating the body with industrial society. He states, “It is interesting to note the striking comparisons between the human body and the safety and hygienic appliances of a great city.” He goes on to compare nerves to telephone wires, sanitary glands to police systems and marvels at the body’s “complete and elaborate sewer system.”

A primary component of these modern analogies is a view of the brain as a signaling system commanding the processes of the body. Martin draws a parallel between the body as information-transmitting system with a hierarchical structure controlled by

56 Martin, 1997, p19 in Conboy et al.
57 Martin, 1997, p19 in Conboy et al.
the brain. When the body does not respond to central command it is tantamount to a breakdown in the system of authority. Thus, the body, like a factory filled with rebellious workers, becomes a system of production gone awry. The solution to this malfunction is either breakdown in which decay and atrophy ensue, or continued, albeit chaotic, activity which leads to unmanaged growth and disaster. In concrete terms, this breakdown metaphor has been applied to menopause. Martin explains that “part of the current imagery attached to menopause is that of a breakdown of central control. Inextricably connected to this imagery is another aspect of failed production.”  

Women who experience menopause are encouraged to prevent this natural life change which “burns out their ovaries,” and renders them “devoid of hormones.” As one 1965 text put it, “…some would regard the menopause as a possible pathological state rather than a physiological one and discuss therapeutic prevention rather than the amelioration of symptoms.” Prevention of a natural biological function for women in this case implies devising a rational system in order to make women’s bodies function more like men’s.

These industrial metaphors of the body reinforce a mind/body distinction where the breakdown of the system of production equals a rebellion against authority, rationality and productivity. This can be read as much in terms of the physical body disrupting the mind, as it can refer to those unruly bodies in the polis challenging political authority. Grosz (1994) critiques these mechanistic models for construing the body as an instrument, a tool or a machine at the disposal of consciousness, a vessel occupied by an

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58 Martin 1987, p.51.  
59 Martin 1987, p.51.  
60 Martin, 1987, p.51. This drive toward prevention is still prevalent today where estrogen replacement “therapy” which has very harmful side effects is prescribed for women to prevent the symptoms of menopause.
animating, willful subjectivity.\textsuperscript{61} She takes issue with them because of their affiliation with the liberal political tradition in which “the body is seen as a possession, a property of a subject, who is thereby dissociated from carnality and makes decisions and choices about how to dispose of the body and its powers (in, for example, the labor market).”\textsuperscript{62} Her critique is precisely on target insofar as bodies are regarded as productive machines and objects to be possessed by rational minds in the biopolitical state.

The relationship of capitalism and health has been explored through more than metaphorical means. Scholars have argued that studies of health and health care must be placed within a broader political and economic framework.\textsuperscript{63} They contend that since capital invades all aspects of life, its role must be taken into account when studying health and the body. McKinlay (in Annandale 1998) explains, “capital operates in the field of health in the same way that it does in all other areas of society” invading, exploiting, and ultimately despoiling any field of endeavour—with no necessary humane commitment to it—in order to seize and carry away any acceptable level of profit.\textsuperscript{64} The relationship between capital and health, or noso-politics to use Foucault’s term, is particularly salient in the case of women whose bodies are both of central concern in maintaining social production and reproduction. Because of this relationship, women’s health has been and continues to be a political issue in the United States.

In opposition to the rationality of the male, women’s bodies have been regarded with suspicion as the site of unruly passions and appetites which might disrupt the pursuit of truth and knowledge (Shildrick and Price 1999) thereby jeopardizing the productive

\textsuperscript{61} Grosz, 1994, Pp.8.
\textsuperscript{63} See Annandale 1998 for a review of these works.
future of the nation. Techniques of regulation and control were developed in order to curb unruly female bodies. Rothman (1984) informs that “one of the earliest uses of the developing field of gynecology was the overt social control of women through surgical removal of various sexual organs.” Surgical removal of the clitoris (cliterodectomy) which was practiced regularly from the late 1860’s until as recently as the late 1940’s was used to terminate sexual desire or sexual behavior. Removal of the foreskin, or circumcision, was done on women of all ages to stop masturbation until 1937. Oopherectomies, or removal of the ovaries, for “psychiatric” reasons were done in the United States between 1872 and 1946 not because women were too female, i.e. passive and dependent, but because they were too masculine—assertive, aggressive, unruly.65

Rothman (1984) explains that “Simply by virtue of gender, women were (and are) subject to illness labeling.”66 Labeling women and their bodies as deviant has had serious implications in the health field. Representations of healthy women as sick, deviant and abnormal have become the justification for invasive and disabling health practices such as those listed above. In addition, Pauly Morgan (1998) provides a list of how women have been mistreated by the medical system due to these perceptions, citing such practices as overmedication; high rates of unnecessary surgeries including hysterectomies, breast surgery, and cesarean sections; estrogen replacement therapy; the absence of “legitimate” alternatives to crisis-oriented, technology-managed hospital births; suppressed information about the legality of abortion and access to abortion services; and negligence, avoidance and trivialization of female rape victims by physicians and health care professionals in emergency rooms.

65 Rothman 1984, p.73.
66 Rothman 1984, p.73
Because women’s bodies have been regarded as a risk both to themselves and to the rational social order which they threaten to corrupt through their passionate, over-emotional and hysterical disruptions, it has become the responsibility of the rational and scientific (read male) mind to control them through medicalization. These medicalized techniques of control intersect with race, sexuality and class where women of color, who are often low-income, are seen as particularly at risk of losing control of their bodies thus becoming a threat to the larger social body and therefore in need of medical intervention.

Comaroff (1993) explains the direct relationship between biomedical science and imperialism in the colonization of Africa. She explains that “medicine drew upon social images to mediate physical realities, giving colonial power relations an alibi in the ailing human body. And colonial regimes in turn drew upon medical icons and practices to impose their domination upon subjects and collectivities.” As her work has shown, these medical/social taxonomies were used to link the black body with degradation, disease and contagion while reinforcing the European body as pure, clean and healthy. African women were seen as especially threatening to the European males because they “served widely as an icon of sexually transmitted disease in the late nineteenth-century European imagination.” Disease, race, sexuality and geography were brought together such that, “etiology found meaning in immoderate sexuality, the uncontained body of the African female seeming a tangible threat to European male viability.” Medicine, therefore, “gave the validity of science to the humanitarian claims of colonialism, while finding confirmation for its own authority in the living laboratories enclosed by expanding imperial frontiers.”
Closer to home, Roberts (1997) work on reproductive rights in United States has shown the violence wrought against black women’s bodies under the guise of medical science. Her work discusses the violence’s perpetrated against black women’s bodies under slavery as well as the ways in which black women’s reproduction has been controlled through “negative eugenics.” A central tenant of this movement was the prevention of “socially undesirable people” from procreating. She writes that, “White Americans had for over two centuries developed an understanding of the races as biologically distinct groups, marked by inherited attributes of inferiority and superiority. Scientific racism predisposed Americans to accept the theory that social characteristics were heritable and deviant behavior was biologically determined.” In light of this, forced sterilization was seen as the means to “weed out undesirable citizens.” Government programs like free family planning which were put in place under the guise of helping poor black women and improving community health became methods of perpetrating racial genocide.

In her book, *Reproducing Empire*, Laura Briggs shows how black and Puerto Rican women were held to possess similar cultural pathologies thereby justifying medical interventions in their reproduction. So threatening was Puerto Rican female fecundity that, as Briggs informs, only through strong measures such as sterilization, high doses of hormones, or perhaps a contraceptive agent in the water could stop her from reproducing.67 As a result, Puerto Rican women have been subjected to sterilization procedures dating back to the 1930’s. By 1965, thirty-four percent of all married Puerto Rican women ages 20 to 49 were sterilized (De Castillo 1980).

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Puerto Rican women, by virtue of their immigrant status in the United States and their poverty were seen to be caught in a “tangle of pathology” such that they “were dooming themselves and their communities to lives of alienation from mainstream society, and hence to drug addiction, crime, and deviant sex.”\(^{68}\) Consequently, it was held that, “they would be individually unmoored to either the wider (“American”) culture or located in thriving, assimilating immigrant communities—morally adrift, a social problem.”\(^{69}\) Signaling Black and Puerto Rican women as pathological, sexually deviant and morally adrift legitimated a campaign to target low-income and minority women for “voluntary” sterilization. Del Castillo (1980) explains,

Arguments by some would claim a major impetus behind these operations derives from profiteering motives on behalf of the medical profession, but such arguments fail to explain why victims are almost always indigent or members of minority groups. They fail to explain why the forced sterilization of black and poor white populations of the southern and northeastern regions of the United States parallels experiences in the Southwest where Indians and Mexicans are coerced or fooled into accepting sterilization as a necessary means of birth control.\(^{70}\)

She concludes by saying, “The impetus behind this abuse derives from the portrayal of victims as marginal human beings.”\(^{71}\)

Negative eugenics was repeated between 1971 and 1974 in the case of twenty-four Mexican women in Los Angeles who were sterilized without their consent. Evidence shows that they were pressured by hospital staff into signing consent forms in the early stages of their labor by having their pain medication withheld. Those who were unable to read or understand English were deceived into signing sterilization forms presented to them as something else. In some cases, husbands were pressured to sign consent forms

\(^{68}\) Briggs, Laura, 2002, p.177.
\(^{69}\) Briggs, Laura, 2002, p.177.
\(^{70}\) Del Castillo, 1980, p. 65.
\(^{71}\) Del Castillo, 1980, p. 69.
for their wives without their wives knowledge. When this issue was taken to court, the judge ruled in favor of the doctors arguing that “cultural differences” legitimated the doctor’s custom and practice, and the fact that they were unaware that sterilization would affect these women in such an adverse manner. As a result, “both the sterilization of the physical ability of a group of ethnic minority women to procreate, and the resultant cultural sterilization of the same group of women were in fact provided legitimization by the court.” Thus, through medicalization “cultural difference” between the medical doctors and women of color was produced and control of their procreative capacities was sanctioned by the law. This kind of biopolitical technique demonstrates that violence is not outside of the law, but is indeed a central component of it. Sterilization is not an outright display of state aggression, however. Rather, it is a highly regulated and controlled violence which is perpetrated under the guise of health and healing. It is a technique which purports to protect the greatest number of people by sacrificing the bodies of a few.

These are a few examples of the way women’s bodies have been the site for exercising power in the biopolitical state. However, given the hierarchy of races established by biopower, not all women are subject to the same medical interventions. Bourgeois white women have been deemed more valuable as the mothers and wives of bourgeois white men and thus have not been labeled enemies of the state. Indeed, they are held up as the paradigmatic (re)producers of the nation. Thus, while they have been subject to medical intervention in order to tame their passionate ways, they have not been the targets of medical extermination. Minority women, on the other hand have been targeted not only because they are seen as responsible for “perpetuating social problems
by transmitting defective genes, irreparable...damage and a deviant lifestyle to their
children”\textsuperscript{72} but because by virtue of their status as poor and ethnic, they “...have come to
be seen as social misfits and an economic drain on the state.”\textsuperscript{73} That is, they are less
productive bodies and therefore fall into the category of those that the biopolitical state
will let die both social and physical deaths.

\textit{Lessons from modern bodies}

How does biomedicine influence our understanding of a healthy individual and
healthy social body, and to what extent might these two concepts be at odds with each
other? Despite their obvious shortcomings, the medical/social taxonomies of biomedicine
have important explanatory value and political implications for understanding health and
the body in modernity. Modernity’s positivism has provided a certainty of categories
which have been helpful as much as they have been constraining. The discrete
sociological categories used to describe and define groups and individuals are powerful
political tools for social subjects insofar as they can be used to demonstrate health
outcomes for racialized and gendered populations. They have provided the grounds to
create coalitional politics along the lines of race, gender, sexuality and class. These
categories have also been used to detect racial and gender bias in medical treatment, as
Duster’s work has shown. Indeed, it is because of these categories that I first became
interested in the absence of women as research subjects in medical testing and the
impacts of racism on health. In addition, physical illnesses can be detected and treated
based on the scientific contributions of modernity. It can, therefore, be argued that these

\begin{footnotes}
\item[72] Roberts, 1997, p.3
\item[73] Del Castillo 1980, p.65.
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lenses, while constraining and harmful, have also contributed to political and social justice for many people.

Nonetheless, women as embodied subjects with emotional, cognitive and physical dimensions which are affected by the social, cultural and political environment in which they live has not been a lens that biomedicine has ever adopted. Rather, it has contributed to reinforcing a mind/body separation and a distinction between individual and social body. These fragmenting and dissecting practices have contributed to women’s self-perceptions. Jean Comaroff (1993) writes, “We are yet to recognize the central role of healing processes in constituting a powerful image of selfhood, and in reproducing the symbolic basis for our perceptions of progressive alienation.”

As Comaroff signals, health and medical paradigms have played a powerful role in the way women are perceived and in the way we perceive ourselves.

The stigmatization of women’s bodies has resulted in a heightened sensitivity to the responsibilities they have to society to guarantee the proper functioning of their bodies so as not to become a physical, financial and social burden. Women are therefore attuned to the signs of a healthy body which in these terms is both a body that is productive internally in terms of appropriately creating, secreting and producing necessary fluids, cells, etc., but also in terms of its ability to function and (re)produce in the world. Protecting this (re)productive capacity is the focus and definition of health care in bio-medicine, and one which links the individual to the social body, but also contributes to her alienation from herself and others. Self-care becomes an individualized project undertaken to protect one’s health, but also to avoid social stigma. Comaroff (1993) describes the conflict that is born of a personal responsibility to health,

74 Comaroff, 1982, in Wright and Treacher, p.63.
Western bio-medicine’s concern with ‘scientific’ intervention in natural disease processes has ostensibly liberated mankind from the moral burden of aetiologies which implicate him in the cause of illness, or which define him as the mere victim of insurmountable divinity. However, this apparent liberation is in fact the center of modern medicine’s ideological role. For rather than dispel guilt, it actually serves to deflect it from an externalized to an internalized moral discourse—from a view of illness as the product of social and cultural conflict in [wo]man’s relations with his/[her] context to one of psychological conflict with [her/]himself.75

Women become conflicted within themselves when their moral responsibility to remain healthy is not matched by the physical reality. Indeed, how can the two ever match when the standards established for health in biomedicine make that which is most natural and healthy in women seem unnatural? Paradoxically, since women have been defined as deviant and abnormal within the biomedical model, despite their best and repeated attempts to take care of themselves, they will continue to experience the psychological conflict which comes with the feeling of not doing enough to meet the individual and social health norm.

The perception in biomedicine that women’s femininity is biologically determined has led to regimes of health which actually increase the chances that women will become sick. In this context, it is hardly surprising that women come to fear their own bodies as a social health risk for their failure to meet the norm against which they are compared and can only ever be defined as deviant. This has led women to seek out medical intervention which are more harmful than helpful in their attempts to be what has been held up as a “normal” healthy person. Voluntary hysterectomies, chemical interventions for menopause, scheduled cesarean sections, plastic surgery, etc. all become methods to negate the embodied experience of being “feminine” and to meet what is by

75 Comaroff, 1982, in Wright and Treacher, p.61
all definitions an impossible and unfair standard of health. It is perhaps the most insidious and paradoxical of biopower’s productive effects that in extreme cases, those interventions meant to improve and extend life can also be life-threatening.

Bordo (1997 in Conboy) describes the effects of trying to meet the standard of femininity which self-care requires of women. She writes,

> Through the pursuit of an ever-changing, homogenizing, elusive ideal of femininity—a pursuit without a terminus, requiring that women constantly attend to minute and often whimsical changes in fashion—female bodies become docile bodies—bodies whose forces and energies are habituated to external regulation, subjection, transformation, “improvement”…Through these disciplines, we continue to memorize on our bodies the feel and conviction of lack, of insufficiency, of never being good enough. At the farthest extremes, the practices of femininity may lead us to utter demoralization, debilitation and death.  

Because biomedicine links femininity to biology, women can never reach the model of health. Returning to Annandale’s aetiology of disease, we learn more about what is wrong with women and their bodies, than what is right. In this context, women will always be lacking or insufficiently healthy and will therefore always be in need of medical intervention. Thus, paradoxically, the more women continue to employ self-care methods in order to be as productive and healthy as possible according to the biomedical norm, the more they are at risk of becoming ill. Given this, biopower will continue to operate in conjunction with the biomedical paradigm and will be especially effective on already stigmatized populations continuing to alienate them from themselves and from the larger social body.

Insofar as biomedicine perpetuates biopower, its formative tenants must be re-evaluated and new concepts of health and the body must be proposed. Insofar as modern views of the body contribute to increased alienation, particularly as these processes are

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76 Bordo 1997, p.91 in Conboy et al.
informed by capitalism and social re-production, health and healing is not only an individual, but also a social and political issue which must be concerned with reframing the perceptions of women’s bodies in such a way as to emphasize connection and affiliation rather than alienation and fragmentation. It should also strive to address the fragmenting sociological categories which make race a separate issue from gender, for example. Indeed, as Roberts (1997) has pointed out, books on racial justice tend to neglect the subject of reproductive rights; and books on reproductive freedom tend to neglect the influence of race. She argues that we can not begin to talk about racial injustice or women’s procreative freedom without addressing race as well as gender. I would add that class and sexuality are two other components which need to be brought into the discussion when discussing women’s health. As I propose in the next section, embodiment may be one method for resisting the fragmenting and harmful effects of biopower.

What is embodiment?

In their exploration of “the illness experience,” Scheper-Hughes and Lock (1986) have found that our methods for discussing the complexity of embodied experience have been lacking. They explain that,

…as we struggle to explore the illness experience from an integrated critical perspective—one that entails an appreciation of humans as simultaneously physical, social, economic and symbolic beings—we find ourselves entrapped in our own Cartesian epistemological legacy. We are without language to address mind-body-society interactions and so are left hanging in mid-air, suspended in hyphens that testify to the radical disconnectedness of our thoughts. We resort to such fragmented concepts as the bio-social, the psycho-somatic, the somata-social as a feeble way of expressing the complex and myriad ways that our minds speak to us through our bodies, and the ways in which society is inscribed on the expectant canvas for our flesh and bones, blood and guts.
As Scheper-Hughes and Lock make clear, discussing embodied experience is no easy task in modern society, particularly as it pertains to illness and healing. This is partially due, as they point out to the Cartesian underpinnings of medical models which continually fragment the medical subject from herself and her social environment. In this section I outline several perspectives on embodiment in an attempt to build a definition which addresses the concern of Scheper-Hughes and Lock. I conclude, with them, that despite the corporeal turn in the social sciences, finding ways to discuss lived experience which incorporate the mind-body-social interactions continues to be conceptually challenging. Nonetheless, I find it to be an idea worth exploring.

Merleau-Ponty is recognized as the primary scholar to develop the phenomenological idea of embodiment in *Phenomenology of Perception* (1962). His work, which drew from that of Husserl, “sought to recover the body from both its Cartesian reduction to an ordinary object and its isolation from consciousness by considering the body a necessary condition of the knowing subject.”

His phenomenology is concerned with providing a direct description of human experience in which we cannot separate ourselves from our perceptions of the world. For him, the world is a field for perception. Perception is the background of experience which guides every conscious action and human consciousness assigns meaning to the world. All knowledge of the world is gained from a particular embodied point of view. He writes, “

I am not the outcome or meeting point of numerous causal agencies which determine my bodily or psychological make-up. I cannot conceive myself as nothing but a bit of the world, a mere object of biological, psychological or sociological investigation. I cannot shut myself up within the realm of science. All my knowledge of the world, even my scientific knowledge, is gained from my

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own particular point of view, or from some experience of the world without which the symbols of science would be meaningless.\footnote{Merleau-Ponty 1958, Preface}

Although his work does point up the importance of perceptive experience, he has been criticized on several fronts. Firstly, feminists like Iris Marion Young (1990) and Judith Butler (1989) have pointed out that his work universalizes the embodied experience and thus does not account for the ways in which different subjects are embodied differently based on their social position. Thus once again the male body becomes the paradigmatic expression of phenomenological expression. The other account on which he has been criticized is closely related to the first. His work has so closely focused on individual embodiment that it has fetishized individual sensation and perception to the neglect of social structure and discourses in influencing lived experience. Thus, the historical and cultural dimensions of the body’s situatedness is ignored (Hoy 2004). Nonetheless, what Merleau-Ponty’s work does offer is a way to discuss the individual perception of one’s lived experience. Thus, as opposed to paradigms which emphasize the influence of external sources and structures, a phenomenological perspective makes room for the individual experience of those sources, as well as establishes the body as a site and source of meaning. Several scholars have built on his work showing how phenomenological perception offers one a situated perspective within a social environment.

Davila Judovitz (2001) uses Merleau-Ponty’s work to describe the way in which an embodied subjectivity gives one a perspective from which to understand the world. She explains that, “It is the embodiment of the subject of knowledge that determines the subject’s capacity to take a position and attain a point of view on the world, a knowledge
that by virtue of this inherent positionality will be contingent, fragmentary, and incomplete.\footnote{Judovitz, 2001. Pp.6.} Judovitz’s definition embraces situated knowledges (Haraway 1991), the positionality of the embodied subject and the incompleteness of knowing that attains to embodied experience. Her work critiques the Cartesian “knowing” and replaces it with an embodied knowledge that does not always “know” or communicate in a conscious and rational way.

In his book, \textit{The Communicative Body}, O’Neill (1989) builds on the notion that the body makes meaning, or communicates, without conscious directives, and that the actions we take are often informed by the social structure within which we live. He explains that not only does the social structure inform our embodied experience, but our embodied experience also informs the social structure. Thus, “on the one hand, we have the bodies we have because they have been inscribed by our mythologies, religions, philosophies, sciences and ideologies. But, on the other hand, we can also say that we have our philosophies, mythologies, arts and sciences because we have the body we have—namely, a communicative body.” The communicative body is not the Habermasian ideal in O’Neill’s account, rather it is the phenomenological experience of human subjectivity which is communicated through and with the body where the human body is the metaphysical subject of the world and thus of history and politics. O’Neill’s account which draws heavily from Merleau-Ponty offers more of a glimpse into embodiment as being informed in and by the social structure. However, it still takes the body as the primary base for lived experience.
Andrew Strathern’s (1996) work also emphasizes the role of the communicative body which is neither modern nor postmodern. He suggests that embodiment “represents a kind of hybrid, a heuristic protoparadigm that … is perhaps preeminently suited to a historical period in which established dichotomies no longer work and the modernist/postmodernist debate, particularly, has run its course.” He explains that embodiment is a term that belies itself by combining the abstract in the form of senses and feelings with the concrete. Because it can be seen, the concrete is of concern to science. By contrast, the abstract is that which is not always observable and thus often goes unrecognized in discussions on the body. Strathern’s definition of embodiment is useful because it breaks down the dichotomies which describe the internal and external, the structure and the agent, the emotional and the cognitive as separate. His is a unified perspective of the embodied subject. Drawing from the work of Margaret Lock and Nancy Scheper-Hughes (1987) on “the mindful body” he sees the body as producer of meaning, yet without the conscious mind always having to “know” what meaning it is producing.

An example of this kind of embodied knowledge is demonstrated in the work of Deidre Sklar (1994). She proposes what she calls a body-centered approach where “movement alone can create emotion without reference to verbal concepts.” She argues that movement is a corporeal way of knowing embodying socially constructed cultural knowledge in which corporeality, emotion and abstraction are intertwined. She explains that “talking can not replace the deep somatic experience of movement.” What her account shows is that physical activity is not always explicable or articulable. Through

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81 Sklar, 1994, p. 12.
movement, the body is present in its emotional and physical states without ever having to “know” or think. Dancing, touching, moving together are all ways that people can share a collective embodied experience which is not informed by a rational or cognitive process.

What these theorizations of embodiment share is a focus on the ways in which the body can and does produce meaning without consciously or rationally deciding to communicate. Building on the work of Merleau-Ponty, they critique the Cartesian duality which puts the mind in control of the body. This is a vital component of embodiment given that it makes the body a central part of subjectivity. Nonetheless, what these theories risk in putting so much emphasis on the body is neglecting the importance of the social structure in embodied experience. While these scholars rightly emphasize the role of the body in confounding rational communication, they do not go far enough in describing other aspects of embodiment, particularly as it can be experienced in a social environment, or as a collective phenomenon. To further develop this point, I turn to the work of Bruno Latour.

Bruno Latour (1993) gives us three paradigms for discussing embodiment. The first of these, naturalization, focuses on the body as object and has been discussed at length in the biomedical model above. It is important to signal that the natural body is not the same as the perceptual body since naturalization is undergirded by the Cartesian distinction between the mind and the body and informs scientific paradigms such as biology, anatomy and biomedicine. The phenomenological body, by contrast, breaks down the Cartesian duality and focuses on the perceptual experience of having a body. Naturalization homogenizes the experience of having a body by defining physical matter as an object (based on a universal male norm) to be controlled by the mind.
According to Latour, the problem with naturalization is that in addition to reinforcing the mind/body binary, it offers a view where “societies, subjects and discourses vanish”\(^8^2\) and all that is left are the material objects called bodies. Judovitz (2001) explains with more detail, “With Descartes, the body ceases to function as the expression of embodiment, since its materiality no longer references the subject of knowledge, nor its modalities of existence as a representational entity” thus, “the foundational disembodiment of the subject of knowledge, entailed in its definition as a thinking subject, reduces the body to a pure object of knowledge, defined as matter and extension.”\(^8^3\) Naturalization has become the default paradigm for health and healing in the West ignoring or devaluing other models and approaches. Despite its shortcomings, however, naturalization has made great contributions to health and healing through scientific and technological advancements. Insofar as naturalization points up the importance of the physical and biological, that is, material base for lived experience it is useful for understanding embodiment.

The second paradigm, socialization, emphasizes customs, habits and forms of discursive or gestural expressions. Bourdieu’s (1977) work on embodiment is perhaps the best example of this perspective. As his work in Kabyle shows, socialization gives us the tools for comprehending how social structures bear on health and healing and shape embodied practices. Socialization is the effect of the cognitive functions of the individual and the motivating (i.e. social) factors informing her actions, or what Bourdieu calls “habitus.”\(^8^4\) Bourdieu draws from Merleau Ponty’s work insofar as he emphasizes perception, but unlike Merleau-Ponty, Bourdieu does not consider the social structure to

\(^{8^2}\) Latour 1993, p.6.  
be secondary. Where Bourdieu and Merleau-Ponty overlap is in their agreement that the agent does not necessarily need to know in a cognitive and rational way in order to act. Rather, “action is theorized as stemming much more from the body and its opaque dispositions than from conscious intentions.”

Although socialization is helpful, it does not address thoughts, actions, emotions which reside outside of the socially defined context, or field, or within the embodied subject. Thus that which has not been defined within the context or can not be articulated within the established field can not be attributed to socialization. As David Hoy (2004) points out, “the field does not determine every move that agents make, but it makes any particular move intelligible.” Thus, the field is what provides a grid of intelligibility to people’s actions. Nonetheless, although the field informs the habitus, it does not determine it, nor does it explain what it feels like and looks like from within the inhabited habitus. Rather, the emphasis in socialization is on what can be observed in terms of behavior, practices and customs from the outside, hence the emphasis on intelligibility. This paradigm therefore suffers from a similar short-coming to that of naturalization where external observation imputes a social ontology from without to agents within a particular field.

With respect to this, Moira Gatens (1997) work shows the constraints that women experience in trying to articulate themselves within a male dominated field. She explains that because the body has been based on an anthropomorphic model, that is based on man, “if woman…speaks from this body, she is limited in what she can say.” This is because the female body “is still the exception, the deviation, confined literally to the margins of man’s representations. It is still “anthropos” who is taken to be capable of

representing the universal type, the universal body. Man is the model and it is his body which is taken for the human (my emphasis) body; his reason which is taken for Reason; his morality which is formalized into a system of ethics.”

Her primary point for our purposes is that “our political vocabulary is so limited that it is not possible, within its parameters to raise the kinds of questions that would allow the articulation of bodily difference; it will not tolerate an embodied speech.” Thus, within an anthropomorphic structure, it is possible that some perceptions and sensations remain invisible or inarticulable because there is no way or place for women to express them.

To give a concrete example of how socialization might break down, I draw from Wendy Seymour who discusses the problem of “leaky bodies,” or bodies that “let us down” in her essay “Containing the Body.” Because continence is seen as a private and personal responsibility, public incontinence is seen not only as a lack or personal responsibility, but also of the inability to fulfill a social obligation. Seymour’s essay is concerned with the interaction between the phenomenally experienced incontinent body and the social body. She describes many situations where the body does not respond to the social and cultural norms imposed upon it either because of loss of muscular control or because of pleasures, appetites and desires which “subvert years of careful socialization.” In either case, the lack of responsiveness to the social and cultural norms around bodily containment put into question the freedom of choice which seems to be a part of models of embodiment that emphasize cognitive dimensions and those that emphasize socialization. Thus, theories which see the body under the control of the mind or the social structure fall short when one has a “leaky body,” for the kinds of movements

86 Gatens 1997, P. 84 in Conboy et al.
87 Gatens 1997, p. 86 in Conboy et al.
and communications coming from the physical body do not operate in one to one symmetry with the cognitive or social processes attempting to control and manage them. This is particularly pertinent in the case of women whose menstruation challenges the very concept of mind over matter.

Socialization is an important component of embodiment because it does not relegate the social structure to a status secondary to individual perception. In fact, insofar as it draws on the work of Bourdieu, it is a paradigm which emphasizes the mutually informing relation between agent and social structure. Indeed, so significant is the overlap that the structure becomes like a second nature to the agent such that she is not aware of its influence in her practices and habits. However, because of the limits of the field, not everything can be rendered visible or be communicated within it. In addition, socialization misses a primary component of phenomenology, that is, one’s experience of the social structure which may or may not be intelligible within a particular grid of intelligibility. Latour’s critique of this frame is also instructive. He explains that “when [socialization] speaks of fields of power, then science, technology, texts and the contents of activities disappear.” Thus while this perspective makes visible the relation between social structure and agent, it neglects the biological components emphasized by naturalization as well as the effects of discourse on lived experiences.

Latour’s third paradigm is deconstruction. Derrida’s (1978), Foucault’s (1973, 1977, 1978) and Butler’s (1993) work on discursive and performative constructions of the body all fall into this category. Deconstruction shows how individual and social bodies have been formed over time. That is, it shows that what has been taken as natural or as necessary is really contingent and historical thereby demonstrating that things have

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been and can be different than they are perceived to be. This is an important critique given that phenomenology is based on the perception of that which is taken to be real, i.e. the body. Since perceptions of the body have changed over time it calls into question the phenomenological reliance on perception. Yet insofar as one experiences one’s body in relation to the body’s of others in a particular historical moment, deconstruction and phenomenology seem to complement rather than oppose each other.

Deconstruction is valuable for looking at embodiment because it shows how categories, health norms and even healing technologies produce a truth about the body which is only one of many possible truths. It throws into question that which is called medical expertise as well as universal paradigms of the body. Despite its critical edge, however, as Latour explains, when deconstructionists speak of truth effects, then brain neurons and power plays both become “unreal” social constructions. In other words, both the materiality of the body and the power that can be exercised on the body rest at the level of discourse without accounting for the way they all interact as lived, i.e. embodied experiences. As critics of this approach have pointed out, constructionist narratives risk relativizing all situations since everything is held to be socially constructed and thus, resistance, like domination and subjugation, also becomes another discursive construct. However, when one’s particular perspective or position is considered, relativity gives way to situatedness and loses its “everything is equal to everything else” characteristic.

To overcome these seemingly discrete paradigms, Latour suggests keeping facts, power and discourse on the table. While I agree with his suggestion, I would trade “facts,” which are socially and discursively produced, for materiality. I find Latour’s

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three paradigms helpful, especially when taken together and not as discrete systems as they point up the ways lived experience is informed individually and socially. The one area that I find his assessment lacking, however, is in illuminating the phenomenological aspect of the natural, social and discursive practices which inform the embodied experience because of its emphasis on the body as an important site of and source of meaning. For this reason I would add the work of Merleau-Ponty to his three paradigms.

What these four paradigms of embodiment give us, then, is an idea of the way in which the individual as a biological and social subject is constructed within and in relation to a social environment. Given this, embodiment can not be an individual experience, but necessarily draws on the social or collective body for individual perceptions, actions, practices and understandings. In other words, embodied subjects come to perceive and understand themselves according to the definitions and perceptions of others in their social context. This is particularly salient for those that have been “Othered” because it points up the collective experience of being marginalized because of (pseudo) biological characteristics, but it also holds promise for collectively revaluing marginal social positions particularly as they have been linked to biology. Because biopower is interested in the social rather than the individual body, it is important to look for ways that embodiment as a collective phenomenon can work against its normalizing and subjugating techniques. In the next section I look at several ways that collective bodies confound the limitations of biopower.

**Embodiment as collective resistance**

*Faced with what some have described as “sexocidal” tendencies in medicine—evidenced by massive pharmaceutical experiments on women, excessive*
gynecological surgery, and so forth—it is not surprising that the overwhelming concern of the women’s health movement is survival.\textsuperscript{91}

How can embodiment help the individual and social body transgress the limitations which the regulatory and normalizing techniques of biopower impose on them? David Hoy (2004) explains that resistance does not appeal to values that transcend biopower. On the contrary, it invokes the same “right” to life and health that is inscribed in biopower. He claims that, “Resistance to the underside of biopower in the name of life itself is thus once again a strategy of turning the system back against itself.”\textsuperscript{92} Foucault outlines how this might be possible in his later work, particularly in Volume 1 of The History of Sexuality where he turned to the body as not only the site of subjugation, but also of resistance. Although he is clear that any resistance to power is met with counter-resistance, it is significant that he posits the body as containing the potential to counter-attack that which would subjugate it. I build on Foucault here by adapting the individual body which resists to a collective social body, one which uses the identifying biological and sociological characteristics imputed to it by a regularizing and normalizing biopolitical state, as well as practices and customs common within it to counter the techniques of biopower. This ability to draw from commonalities, whether biological, social or cultural, whether imputed from without or perceived from within, is at the heart of embodiment.

Lupton (1997) explains that one major problem with Foucault and those that draw on his work is their tendency to neglect examination of the ways that hegemonic medical discourses and practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximize their health status, avoid physical distress

\textsuperscript{91} Eherenreich & Ehrenreich 1978, p.40 in Ehrenreich ed.
\textsuperscript{92} Hoy 2004, p.81
and pain. This critique is well-deserved insofar as Foucault does not offer specific examples of racialized and gendered subjects being produced through biopower. However, the critique is also unfair due to the fact that Foucault’s project was more concerned with a genealogical history of the unfolding of ideas and events. A “Genealogy does not seek out the origin of things or events, or the exact essence of things in their purest possibilities and their carefully protected identities”\(^93\) and, therefore, a genealogical history is only concerned with particulars in the abstract. It is, thus, up to others to empirically test Foucault’s ideas using the theoretical tools he has provided. It is in this vein that I take up the notion of embodiment. Although ethnographic fieldwork will ultimately show its usefulness for disrupting the hegemony of biopower, in this section I would like to draw from two different women’s movements to show how collective embodiment might work.

Nancy Scheper-Hughes and Margaret Lock teach that, “as patients, all of us can be open and responsive to the hidden language of pain and protest, rage and resistance, or we can silence it, cut it off by relegating our complaints to the ever-expanding domains of medicine (“it” is in the body) or psychiatry (“it” is in your mind). Once safely medicalized, however, the social issues are short-circuited, and the desperate message in the bottle is lost.”\(^94\) In their work, Scheper-Hughes and Lock describe the work of self-help and patients’ rights groups including gay and feminist health collectives who struggle to break up and reinterpret the private and individual experience of illness into a more potent and collective experience of solidarity and heightened social and self-

\(^{93}\) Grosz, 1994, p. 145.
awareness. Their work highlights embodiment as I envision it, an individual experience of one’s social position and the social experience of one’s individual body.

In contrast to what is commonly held in biomedical paradigms, knowledge about one’s health does not have to, and indeed should not be reserved for the “experts”, especially in light of the fact that biomedical indicators have often contributed to unjustifiably pathologizing women, especially women of color, and imposing unnecessarily harmful medical procedures and conditions on them. For this reason, “lower social classes, racial and ethnic minorities, and women have often utilized alternative medicine as a forum for challenging not only biomedical dominance but also, [insofar as medicine is run by corporate and medical elite], the hegemony of corporate class in America. Members of these social categories have often found that folk and religious healers tend to provide them with more culturally meaningful, personal and holistic health care than biomedical and other professionals.”

As an example of the way in which the techniques of biopower have been appropriated by women to take control of their individual and collective bodies, I will briefly draw on the use of the text Our Bodies, Our Selves published by the Boston Women’s Health Collective. This group was at the forefront of the women’s health movement in the United States and continues to influence feminist health practices throughout the world.

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95 See Adelaida R. Del Castillo 1980 for a discussion of the involuntary sterilization of minority women in the United States; The Boston Women’s Health Book Collective 2005 for a discussion of multiple unnecessary procedures that medical doctors perform on women; Sargent and Brettell 1996 to understand how seemingly value-free descriptions of physiological processes are layered with cultural meaning which are gendered and racialized; Nechas and Foley 1994 for a discussion of how women have been invisible as medical subjects and the serious repercussions this has had on health interventions for them; Katz Rothman 1984 for a discussion of the relationship between medical procedures and the sexual and social control of women. This list could go on and on.

96 Baer 2001, p.44.
Through self-help groups and alternative medicine, women without formal medical training have developed enough health expertise and in a variety of ways so that they can care for themselves without always seeking medical interventions from the experts. The Boston Women’s Health Collective has demonstrated this fact. In their text *Our Bodies, Our Selves*, the over four hundred contributors of the Boston Women’s Health Book Collective (BWHBC) speak from their own research and experiences about their bodies, health and medical care. Their efforts primarily focus on providing knowledge for women about women’s bodies. As Thayer (2000) explains, “The Boston Women’s Health Course Collective, founded in 1969 in the heyday of the women’s liberation movement, was one of the earliest advocates in the United States of women’s empowerment through knowledge of their own bodies.”

In this respect, these women were engaged in reclaiming expertise about their bodies from medical professionals in order to empower themselves through knowledge to heal and care for themselves. This means both that power was wrested from the primarily white, male doctors and that medical institutions and state policies could not exercise immediate power over women’s bodies. The political possibilities inherent in this approach are contained in the fact that women have more control over the images, terminologies and discourses used to represent their bodies, as well as over the

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97 Thayer 2000, p.205.
98 Thayer 2000, p.205.
procedures and interventions used to heal them. In addition to drawing on the symptomatic experience of women rather than solely relying on the knowledge of medical “experts” to describe and define bodily functions, the BWHBC showed how “lay” medical knowledge and individual embodied experience can also be used as resources for connecting with other women not only about medical, but about larger social and political issues.

Thayer’s (2000) research shows how *Our Bodies, Our Selves* extended beyond the borders of the United States and became a resource for feminists in Brazil to politicize gender struggles, locating them in a context of broader efforts for social transformation. By changing the discourse from women’ bodies to gender and citizenship, members of SOS Corpo: Grupo de Saúde da Mulher (SOS Body: Women’s Health Group) engaged directly with the state in a quest for bodily rights. They emphasized that health and health paradigms were gendered and therefore that health was not solely a women’s issue, nor an individual issue. A focus on gendered health paradigms also meant that women’s health could be seen as part of a larger struggle for social rights and against social domination. As Thayer explains, “knowledge of the body and health practices took on a new meaning; no longer only a vehicle for women’s autonomy and empowerment, now they were also a means to full participation in a new social order.”

This corporeal turn in Brazil took place at a time when the dictatorship was coming to an end and a political generation had seen many of its members physically “disappeared.” Thus the emphasis on embodied citizenship, as Thayer asserts, “may have also served as a means of reasserting ownership over their corporeal selves and their right

99 Thayer 2000, p. 204.
100 Thayer, 2000. p.224
to exist in the world.”\textsuperscript{101} Additionally, embodied health became a link around which women from diverse backgrounds could come together and build alliances. She writes, “unlike “class,”…the discourse of “women” (and of “the body”) offered a bridge across the “cultural abyss,” as well as across the stark economic differences that separated the SOS founders from the women they sought to reach. Both groups of women shared, at least apparently, fundamental concerns about sexuality and reproductive health.”\textsuperscript{102}

As we have seen in the Boston Women’s Health Book Collective and the work of \textit{SOS Corpo}, they both operate from a premise of empowering and connecting women through health and their bodies which is in direct contrast to the biopolitical model which fragments and subjugates women through medicalization. This re-visioning of health and embodiment was achieved through a collective effort to re-value the female body and to bring this re-valuation to the attention of the larger social body to make claims around citizenship and rights.

In a second example, I draw from one of the foundational texts for women of color feminism, \textit{This Bridge Called My Back}. This text is significant because it is a response from women of color to a regulatory biopolitical state which devalues the biological and social bodies of women of color. In contrast to the use of \textit{Our Bodies, Our Selves}, it begins with struggles for social rights and against social domination and links these to women’s health. It is therefore a representation of how embodiment, that is, a focus on the lived experience of one’s social position and the social experience of one’s individual body can inform a new paradigm of health. This re-visioning of health and women’s bodies is based on re-valuing those characteristics considered abnormal or

\textsuperscript{101} Thayer 2000, p.213.
\textsuperscript{102} Thayer 2000, p.213.
pathological, and looking for ways to support life and vitality among a population that has been designated as those the bipolitical state would let die.

Theory in the Flesh

As one of the formative texts for women of color feminism, *This Bridge Called My Back* sets forth a method for understanding the inter-relation between mind and body, agent and social structure. In this text we see and feel the embodied experience of women of color as they develop strategies for survival in the racist, sexist, classist and homophobic social structure of the United States. Survival means confronting physical and emotional pain, being labeled as abnormal, deviant, and finding ways to care for themselves internally and through identification with others, battling “the self-abnegation, the silence, the constant threat of cultural obliteration”\(^{103}\) that often has physical manifestations. In sum, it means battling between health and illness and finding ways to heal individual and collective wounds. These authors do not distinguish between physical pain and social ills such as racism and homophobia. The lived reality of all of their painful experiences manifests itself within their bodies. Cherríe Moraga explains,

> The materialism in this book lives in the flesh of these women’s lives: the exhaustion we feel in our bones at the end of the day, the fire we feel in our hearts when we are insulted, the knife we feel in our backs when we are betrayed, the nausea we feel in our bellies when we are afraid, even the hunger we feel in between our hips when we long to be touched. (Moraga & Anzaldúa 1981, pp.xviii).

This materialism is what the authors call “Theory in the Flesh.” That is, a way of dealing with the painful experience of being “Othered” through racism, classism, sexism, and homophobia. This theory draws together the psychic, emotional and physical ills which are based in and upon the materiality of these women’s bodies. A “Theory of the Flesh”

\(^{103}\) Moraga & Anzaldúa 1981, p.5.
becomes both a way of dealing internally with painful experiences, as well as a way to turn negative ascription into political power. Thus, they not only use this theory to recover their completeness and complexity as individuals in a world which would compartmentalize them based on their sociological identities—lesbian, black, Mexican, woman— but this theory also becomes a tool for finding similarly “Othered” women to “create a politic born out of necessity,”\textsuperscript{104} to heal their individual and collective wounded body.

Healing alliances and political coalitions are forged across the bridges of colored and gendered bodies in pain. Whether healing from breast cancer (Lorde 1999; Kosofsky Sedgwick 1999), a racially motivated beating (Littlebear 1981) or an exclusive and racist women’s movement (Moraga & Anzaldúa 1981), women can turn to a Theory of the Flesh to restore themselves and each other to health. Chrystos, one of the authors in \textit{This Bridge} explains that it is in “pursuing a society that uses flesh and blood experience to concretize a vision that we can begin to heal our ‘wounded knee’.” The wounded knee she speaks of is not only a metaphor for the psychic pain of being “Othered,” its invocation is a call to recognize the embodied experience of painful events, present and past, “In the scars on my knee you can see children torn from their families, bludgeoned into government schools, You can see through the pins in my bones that we are prisoners of a long war.”\textsuperscript{105} The long war has been fought with and because of bodies that have been “Othered,” labeled deviant, dangerous and in need of control.

A Theory of the Flesh turns the controlling gaze of society back on itself, normalizing abnormality. For example, Gloria Anzaldúa (1987) embraces rather than

\textsuperscript{104} Moraga & Anzaldúa 1981, p.23.
\textsuperscript{105} Chrystos 1981, p.57.
rejects the half-man, half-woman categorization placed upon her and other lesbian
women. She shows that it is the limitations of others, not her own that makes her hybrid
sexuality deviant. She writes,

Contrary to some psychiatric tenents, half and halfs are not suffering from a
confusion of sexual identity, or even from a confusion of gender. What we are
suffering from is an absolute despot duality that says we are able to be only one or
the other. It claims that human nature is limited and can not evolve into something
better (my emphasis). But I, like other queer people, am two in one body, both
male and female. I am the embodiment of the hieros gamos: the coming together
of opposite qualities within.

Anzaldúa rejects limitations on her identity by re-appropriating the limited categories
used to define her and using them as a source of strength to reconfirm her sense of self.
She offers a postmodern conception of her body as that which is not reducible to a
homogenous and discrete category—woman--while at the same time using familiar
gender categories to find strength, meaning and history in her “difference,” reframing that
“difference” as positive rather than negative. She writes, “there is a magic aspect in
abnormality and so-called deformity. Maimed, mad and sexually different people were
believed to possess supernatural powers by primal cultures’ magico-religious
thinking.”

She, therefore, draws on a construction of difference where the deviant,
anomalous, or monstrous “still possess the classical sense of something wonderful,
fantastic, rare and precious.” By reinscribing her body in this way, she offers another
way to conceptualize difference that does not pathologize it or reduce it to fragmented
parts of a whole.

She is able to propose a non-consistent hybrid identity by developing a synthesis,
a third element which is greater than the sum of its severed parts. This third element is the

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107 Braidotti 1997, p.68 in Conboy et al.
mestiza consciousness. Mestiza consciousness is where “the possibility of uniting all that is separate occurs. This assembly is not one where several or separated pieces merely come together. Nor is it a balancing act of opposing powers”\(^\text{108}\) which force her to “choose” between her male or female identities. Mestiza consciousness allows for the embodiment of both and more. “The work of mestiza consciousness is to break down the subject-object duality that keeps her a prisoner and to show that in the flesh and through the images in her work how duality is transcended.” This synthesis is not a static, fully formed and discrete identity, however, since it gets its energy “from continual creative motion that keeps breaking down the unitary aspect of each new paradigm.”\(^\text{109}\)

Mestiza consciousness is a seemingly cognitive process, but as Anzaldúa explains, it “takes place underground--subconsciously. It is work that the soul performs.”\(^\text{110}\) Yet it is also inscribed in and on the flesh of the mestiza. Thus, in her mind, body and soul she is negotiating between “lo heredado, lo adquirido, lo impuesto” (the inherited, the acquired and the imposed), in order to bring about a rupture with all oppressive traditions of all cultures and religions.\(^\text{111}\) What is perhaps most significant about mestiza consciousness for our purposes is that it is a collective consciousness which is born of the embodied experience of belonging to an “Othered” social group. It is a way to collectively address the experience of being labeled a deviant, abnormal body, that is, a body which the biopolitical state would let die.

Through works like *This Bridge Called My Back*, women of color have been engaged in redefining the paradigms used to describe them, creating new knowledge

\(^{108}\) Anzaldúa 1997, p.236 in Conboy et al.

\(^{109}\) Anzaldúa 1997, p.236 in Conboy et al.

\(^{110}\) Anzaldúa 1997, p.235 in Conboy et al.

\(^{111}\) Anzaldúa 1997, p.238 in Conboy et al.
formations out of their lived, embodied experiences. These new paradigms re-value characteristics considered abnormal or pathological in order to ensure their individual and collective health. The health they wish to restore is located in the physical, biological body as much as in the social body. It is not a health which is based on a biopolitical norm, but one which emphasizes flourishing and vitality so that each group and individual can live. This definition of health, especially as it applies to women of color, is in direct contrast to that put forth by the biopolitical state.

Conclusion

To presuppose bodiliness, solidity, and materiality as an inevitable ontological status of persons is as misguided as to eschew it.\textsuperscript{112}

Given biopower’s use of health as a technique of domination, it is pertinent to ask what are the implications for health promotion in the modern state? As the above two examples show, there are ways of focusing on individual and social health that do not reduce women to their physical bodies, but in fact point up their role as embodied social and political subjects. This conception of health requires a re-valuing of women’s bodies and the discourses used to define them. It entails confronting the racial and patriarchal legacy of biomedicine while not eschewing the scientific and technological advances that modern medicine has offered. Further, it requires the promotion of a concept of health that is not based on a norm or paradigm, but rather that is informed by women’s diverse individual and social experiences where difference is not defined as pathological or abnormal.

As has been shown above, embodiment entails physical, cognitive and emotional, as well as social, symbolic, cultural, economic and political components. Women’s

\textsuperscript{112} Young, Katherine, 1994, pp. 3-8.
bodies transgress the limitations imposed on them when they refuse, either consciously or unconsciously to adhere to constraining physical, social and discursive limitations. One of the primary ways they can do this is by reaching out beyond their individual experience to share a collective experience of embodied subjectivity. Creating movements which join together to re-value abnormal or pathological bodies, or to heal social and biological wounds is a way to counteract fragmenting and “normalizing” practices and discourses. Collective embodiment does not mean downplaying the individual experience, but rather drawing from one’s lived experience as an embodied social subject to establish coalitions and affiliations. This may or may not be a conscious process.

Insofar as modernity has been focused on the visible, the observable, the measurable and the categorizable, and postmodernity has emphasized representation, articulation and communication, I have attempted to build on both by advocating a frame which also makes room for the lack of observable action and for that which is not or can not be articulated. This means being attentive to those embodied experiences which may not be communicated through words or even articulable, that is, not always available on a conscious level. I have, therefore, tried to show how the impossibility of communication or the paucity of language for capturing every experience should also inform these frames.

In light of the techniques deployed by the biopolitical state and as a counter to the biomedical paradigm which has colonized both women’s bodies and the epistemological frames used to describe them, larger frames of intelligibility which would allow women to construct their own epistemologies and ontologies, and to obtain the interpretive
agency with which to communicate them on their own terms (Alarcón 2003) need to continue to be explored. I suggest that it is at the interface of constructionism and materialism, experience and representation that new paradigms can be built. Bodies are transgressive and non-dualist, but this does not mean that we should discount the foundationalist ontologies or phenomenological readings of the body as ongoing structure of lived experience (Williams 1998).
References


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