

*Question 1B): Because of my having taught Geog 512, and because of my interest in linguistic precision, I would appreciate a brief foray into 2 phrases used in your 1st paragraph. A "recognizing the human body as both a materially and discursively created natural object", uh, discursively, how, why? what's the matter with socially? B "holistic perspective.... sophisticated poststructuralist and feminist understanding of the human body that.... integrates... subjectivity and embodiment" etc.... Why and how is a feminist understanding of the body different from a masculinist understanding? I'm serious about this. Doesn't it set up an essentialist dichotomy that at best is a cliché?*

A) "...recognizing the human body...as both a materially and discursively created natural object..."

Nothing at all is the matter with referring to the human body as a socially created or socially situated 'natural object.' Replacing 'discursively' with 'socially' in this phrase would create a statement I definitely would agree with. For indeed, we, as mammals who are of necessity nursed and reared by others of our own species, *are social and socially created creatures in every way*—just as our primate and many of our non-primate animal cousins are as well. With my diction of 'discursively created', I had in mind the medium by which the thick sociocultural dimensions of a living, embodied human being come to be expressed, communicated, and understood in intersubjective encounters such that the unique, subjective aspects of embodied human life come to be duly acknowledged and appreciated. Being that medical geography is one of the medical social sciences (which also include medical anthropology, medical sociology, medical psychology, medical economics, medical history, and medical ethics), with my chosen phraseology I especially have in mind a 'recognizing' of 'the human body' that seeks to deepen and strengthen the intersubjective encounter between a health/medical care provider and a patient-citizen (Sullivan 2003). While these 'clinical' encounters certainly

are social encounters between natural, biophysical, material objects—bodies—which are also socially created human subjects, it is through intersubjective and interpellating discourse, both verbal and nonverbal, that the humanistic aspects of the ‘clinical encounter’ take shape. The human body is the object of a vast amount of knowledge and information; this constellation of facts and theories, which is discursively passed on, prefigures the clinical encounter. But it by no means determines it. Thus, by saying that the body is ‘discursively *created*’, I am referring to the discursively *mediated* ongoing recognition and appreciation of a human being’s vast, underlying inner world of subjective complexity lying ‘beneath’ outward biological and material appearance.

Here, I must admit that I am putting myself in the role of a health-care-provider/medical geographer-in-training who is seeking to understand the lived experience of other subjects. In my training thus far, I have witnessed clinical encounters that serve as good examples to demonstrate why ‘discursively created’ is appropriate phraseology in describing the body. One example I would like to share was my observation of a clinical encounter in 2004 with a gentleman who was seeking medical asylum. This man from Romania claimed that he had been subjected to brutal forms of torture and punishment such as beatings and electrocution during a period of politically-motivated incarceration. This highly charged history, discursively communicated with the aid of an interpreter, was then cross-checked by my attending physician via examination and clinical judgment. Bodily markings, scars, and other signs were cross-referenced with the patient-citizen’s narrative of torture and abuse to check for consistency. His body thus was both materially and discursively created and understood. What is critical to recognize about this example is that the asylum seeker offered a

narrative discourse that is politically at odds with official pronouncements of Romanian government representatives and other members of the asylum-seeker's social milieu. If given the opportunity, they would question the patient-citizen's narrative and vehemently deny any abuse allegations. It is only with the patient-citizen's interdigitating discursive acts and bodily presentation in the clinic that the prevailing governmentally sanctioned social narratives about his life could be challenged. A similar discursive and material bodily co-construction occurs when a care provider grants a recommendation for the medicinal use of cannabis to a patient-citizen. Marijuana medical decision-making is often predicated on a patient-citizen's attestations of relief felt with the use of cannabis preparations, many of which may not be easily objectively verified not to mention legally sanctioned. Dr. Jerome Kassirer, former editor of the *New England Journal of Medicine*, put it this way: "The noxious sensations that patients experience are extremely difficult to quantify in controlled experiments. What really counts for a therapy with this kind of safety margin is whether a seriously ill patient-citizen feels relief as a result of the intervention, not whether a controlled trial 'proves' its efficacy" (1997). To this bit of editorializing, I would add that this is the case for all patient-citizens, whether "seriously ill" inpatients or generally well outpatients in no acute distress. Only through discursive acts on the part of the patient-citizen can relief felt from noxious sensations come to be known by another. Discourse about therapeutic benefits from cannabis use is certainly at odds with present official pronouncements about 'marihuana' from numerous government agencies. Even with social mores in some places 'against' marijuana, patient-citizen discourse can allow for the disruption of such static and prevailing notions and the expression of antithetical knowledge (Said 1981). Thus, from these examples, we

see that the notion of the body as a ‘discursively created natural object’ allows for both socially- and individually-derived categories of bodily inscription and description.

However, being attuned to discourse in itself does not automatically allow for the awareness that prior socially prevailing notions are challenged in the lived body of the patient-citizen. Critical thinking must prevail. As Foucault (1972) writes: “We must question those ready-made syntheses, those groupings that we normally accept before examination...we must...obscure forces by which we usually link the discourse of one man with that of another...they must be driven out from the darkness in which they reign” (p.22).

B) “holistic perspective.... sophisticated poststructuralist and feminist understanding of the human body that.... integrates... subjectivity and embodiment, in addition to strictly objective and material ones, in theorizing states of health and illness.”

Can we grant that there is such a thing as a ‘feminist approach’ or a ‘masculinist approach’? Do these categories even exist? Certainly, we can at least agree that there exists an essential biological category of ‘sex’ whose differentiation is driven by genes, mediated by hormones, and knowable upon anatomical inspection. Perhaps we would also agree that there is such a concept as ‘gender’ which, being more of a psychosocial phenomenon, connotes the embodied experience and constructed nature of sex identity. What of feminist and masculinist approaches? These concepts have no respective essentialized mappings onto women and men. Feminist approaches, while they arose historically from the writings and lived experiences of women, are not in any way relegated simply to women or only knowable through living as a woman. Likewise for masculinist approaches. All women do not employ feminist analysis, and all men do not

apply masculinist analysis. Feminist and masculinist approaches are, in my estimation, nothing at all like sex and gender roles but rather better understood as social theoretical, political, and moral movements that urge the adoption and appreciation of certain clusters of perception and ways of knowing (“Masculinism”). They are discursive strategies to generate appreciation of alternative, non-dominant viewpoints. Feminism does not critique maleness, but rather male-dominance, machismo, and patriarchy. Likewise, masculinism does not critique femaleness, but rather discursively seeks to shatter stereotypes about men’s ‘rough-and-tumble’ activities as necessarily equated with violence, domination, and competitiveness. Both discourses have emancipatory potential and are not opposites of each other.

However, in this present historical moment, moving towards a better understanding human health and illness, in all its shades of complexity, properly requires an infusion of feminist discourse to counter prevailing mechanistic, disembodied, and distanced notions of health and illness (Haraway 1991). The feminist perspective’s persistent focus on embodiment and partial/situated knowledge helps to locate states of health and illness as lived experiences that are only partially knowable. This helps to counter the one-size-fits-all approach to therapeutics and health status evaluation. A masculinist approach to understanding states of health and illness is also possible. But I do not think that it is lacking. Feminist understandings help to restore fluidity and balance to a sociomedical view of health and illness that can be rigid, strictly objective and disembodied. Thus, my view is not based in dichotomous essentialism, but rather a purposeful application of multiplicity-making discourse.

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