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## Body: II. Social Theories

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## II. SOCIAL THEORIES

Everywhere one looks in medicine, one finds bodies. Not only are bodies ubiquitous, they are essential to the practice of medicine. Whenever something seems to go awry with our bodies, we seek the services of medicine and become "patients." Medical personnel often reduce patients' bodies to the particular problems they present, for example, "the coronary bypass in room 14B" or the "end-stage renal disease case." Bodies are the material upon or through which medicine is practiced: clinicians touch, scan, listen to, cut into, comfort, rehabilitate, alter, and monitor the bodies of patients. Likewise, practitioners bring their bodies with them when they enter the clinic. Clinicians not only interact with patients and families through their bodies (e.g., shaking hands, touching, probing, lifting, bathing patients), they also bring to the clinical setting their own unique embodied experience—gendered, professional, perhaps overtired, young or old, ill or healthy, angry or compassionate, prejudiced, and so on. Thus, the body is an indispensable component of those persons experiencing illness and those giving care, as well as to the dynamics of illness and healing. Without a body, there is no person, no identity, no relationship, no health, no illness, no healing.

Yet despite the fact that bodies are so central to medicine, "the body" is rarely mentioned in the literature of bioethics. Discussions in bioethics generally center on concepts of personhood (Is the patient a person? Is the person competent?), issues related to personhood (such as autonomy, informed consent, rights, confidentiality, choice), and questions of cost/benefit analysis (Do the benefits outweigh the risks? How can we achieve the greatest good for the greatest number at the lowest cost?). A patient's "personhood" is generally understood in terms of rationality or mental capacity (rather than, for example, a beating heart, membership in the species *homo sapiens*, or one's ability to form emotional bonds to others), personal values and preferences (rather than, for example, obligations based on relationships or social roles), and ability to function autonomously rather than, alternatively, one's ability to recognize and to function within our essential interdependence and interrelatedness).

Moreover, because "personhood" has been so narrowly defined, and because bioethics has made personhood its central category, many of the significant problems in bioethics center on bodies whose status as "persons" is unclear, bodies that lack or have lost rationality, for example: "defective" neonates, anencephalic newborns, brain-dead potential organ donors, patients in persistent vegetative state, fetuses to be aborted or experimented on, mentally handicapped and incarcerated individuals to be used as research subjects, or

elderly individuals suffering from dementia or Alzheimer's disease. When these patients have not left rational and autonomous specifications of what their preferences would be (e.g., living wills, organ donor cards), other individuals possessing rationality, preference, and autonomy (either patient surrogates or the courts) decide what to do with their bodies.

There is a growing consensus that this notion of personhood is too narrow, and that by excluding attention to the body, bioethics does not fully take into account all the morally significant dimensions of the practice of medicine. If we cannot be a self or act in the world without our body, then that body must be included into the description of the moral situation. At the same time, there is a concern that, in spite of the rhetoric of freedom, personal fulfillment, and rights, by overlooking the body, medicine and bioethics can become (some would say "have become") avenues through which society restricts the freedom of its members through repression and control.

### The body in medicine and bioethics: Empiricist materialism

The fact that the body is overlooked is due in large part to the ways in which the body is understood by medicine, bioethics, and contemporary Western culture. Richard Zaner has provided a helpful outline of the development of the view of the body that dominates contemporary medicine and is shared by bioethics (Zaner, 1994). This view is called "empiricist materialism" and is chiefly the legacy of, among others, Francis Bacon (1561–1626) and René Descartes (1596–1650). A third philosopher who has also been influential in shaping how bioethics approaches the body is John Locke (1632–1704).

Francis Bacon is credited with the development of the modern scientific experimental method. The development of this method required a new understanding of the meaning of "nature." Bacon demythologized nature, declaring it to be little more than brute, inert, morally neutral, raw material, available to be dissected and manipulated through empirical investigation in order to gain knowledge of its universal laws and regularities. Such knowledge is power, Bacon proposed, for in spite of its status as totally object, nature was also understood as containing within it great power, chaotic power that threatened to undo the orderliness of civilization (take, e.g., the destructive power of tornadoes, earthquakes, and illness). As the human mind gained knowledge of nature, through rational empirical investigation and quantification, this power could be channeled and controlled, thus giving humanity power over nature and making it fulfill human needs.

One aspect of nature affected by this change in understanding was the human body. The body, understood as inert, morally neutral raw material, became likewise amenable to scientific investigation and control. This reconceptualization of the body was accelerated by the work of Descartes. Descartes asserted that the mind (or soul) is both entirely distinct from and morally superior to the body (Descartes, 1968). This view is called "mind/body dualism" and exerted a strong influence on the development of Western philosophy. Allied to this mind/body dualism was Descartes's view of the body as a machine (Descartes, 1968).

This Cartesian metaphor of the body as a machine, in conjunction with Baconian empiricism, has been greatly influential in medical research and contemporary medicine. Medicine has made significant progress by understanding the body as being comprised of separable and identifiable mechanisms. Because the body has been understood as natural and universal, medical science has been able to conduct empirical investigation of the body, yielding statistical standards defining the "normal" human body and methods by which medicine can manipulate and control bodies that diverge from those norms. In fact, some have deemed the body most "human" when it is most completely manipulated, controlled, transformed, or created by human agency (Fletcher, 1971). While medicine has adopted the legacies of empiricism and mechanism, it has been the Cartesian view of mind/body dualism that has most strongly influenced contemporary bioethics, allowing it to focus almost exclusively on the "mind," "self," or "person" when it defines and describes the issues and moral parameters of medicine.

A third influence on contemporary bioethics with respect to the body has been John Locke. In his *Second Treatise on Government*, Locke sought a framework for understanding political society. Locke posited that individuals initially exist in a "state of nature," that is, individual and unconstrained, until they consent to join an ordered society. While Locke's discussion of consent, rights, duties, and so forth are too complex to summarize here (see Copleston, 1964a), these concepts and particularly his notion of private property have notably influenced the worldview of contemporary bioethics. This is especially evident in the way bioethics has become increasingly intertwined with the U.S. legal system and involved in the formation of public policy. While Locke did not discuss the body as such, his views on private property and ownership have been incorporated into the subsequent labor theory of value and applied to contemporary understandings of the body. For Locke, in the state of nature, insofar as an individual invests labor in raw material to produce a product, that individual receives ownership and utilization rights over that product. Correlatively, insofar as the body is a natural

resource, a raw material, and insofar as one's body and the bodies of one's offspring are the products of one's labor, the body in bioethics is often treated under the paradigm of property rights (Campbell, 1992; Englehardt, 1985).

### **A contemporary critique: Social theories of the body**

If a primary purpose of bioethics is to reflect on the moral and ethical dimensions of practices and to resolve issues that arise in medicine and scientific research, one must take into account all relevant factors. How one perceives the issues and problems depends largely on how one describes the situation.

Dissatisfaction with a bioethics that employs a philosophical framework rendering the body superfluous to ethical and moral reflection has resulted in the recent emergence of a number of alternative approaches that seek fuller descriptions of the moral situation. These approaches employ philosophical frameworks that envision relationships—between self and body, between persons and their experiences, and between persons—differently than the framework that draws on Descartes, Locke, and other forebears of liberal political philosophy. These approaches (specifically phenomenology, feminism, an ethics of care, virtue, narrative, and hermeneutics) are critical of a medicine that treats merely "the body" and not "the whole person." They are also critical of a bioethics that reduces persons to their rationality and choice, severing the connections between persons and their bodies. (See for example, Zaner, 1988, and Leder, 1990, who take a phenomenological approach; and Sherwin, 1992, who takes a feminist approach. For fuller discussions of virtue ethics, narrative ethics, phenomenology, and hermeneutics, see DuBose et al., 1994.)

An additional alternative framework for describing "what is going on" in medicine and understanding the function of bioethics is an analytical approach called "social theories of the body." Social theories of the body examine the interrelationships between social orders and the bodies within their jurisdiction. To understand their approach to the body, we must first discuss their broader framework. Every society, they suggest, has an "order," that is, integrated structures of power, institutions, codes of behavior, practices, and beliefs. The "order" of a society is also referred to as the "politics" of the society, that is, the formal and informal relations of power and control that govern a society.

One objective of every social order is to perpetuate (or reproduce) itself. Social orders perpetuate themselves by incorporating new members who assume the roles, espouse the beliefs, support the institutions, and participate in the practices of the society. The primary

way in which social orders incorporate new members is through the social institutions and practices with which they intersect, touch, or agree not to touch human bodies. Social practices comprise a broad range of activities through which a culture regulates the private actions and public interactions of its members: eating customs (e.g., fasting or *kashrut* [kosher laws]), sexual practices (e.g., monogamy or polygamy, prostitution, adultery, homosexuality), economic structures (e.g., capitalism, communism, barter), practices of dress (e.g., Amish "plain and simple," clerical robes), judicial and penal structures (e.g., public hangings, incarceration, excommunication), religious practices (e.g., confession, pilgrimage, ancestor worship), and so on. Clearly, such practices vary significantly both among and within cultures ("subcultures" are groups which adopt unconventional practices—practices that are often meant to counter the dominant culture).

Through these practices, those bodies within the jurisdiction of a particular social order internalize the order's beliefs and become constructed in conformity with the order's structures. In every culture, certain practices are considered the norm or the ideal, although deviations from the norm are generally tolerated as most cultures hold to beliefs that are often contradictory (for example, a culture that idealizes monogamous marriage may also sanction a thriving prostitution industry). By participating in these practices, individuals learn and internalize the beliefs and norms (as well as the contradictions) of the culture. The more a practice impinges upon one's body, especially the bodies of infants and children, the more deeply the norms are internalized or "embodied," the more unconsciously and effortlessly the "politics" of the culture is learned. (For a display of the dynamic between practices, bodies, and social orders, see Douglas, 1966.)

The interaction between social institutions and human bodies may be potential (government), indirect (media, advertisement), direct but intermittent (medicine, religion), or direct and constant (prisons, asylums). Through these institutions, cultures seek to normalize, discipline, and regulate both the bodies of individuals (in Michel Foucault's term, "anatomy-politics") and the bodies of its total population or subgroups ("biopolitics" or "biopower").

In addition, social theories of the body hold not only that through practices individuals embody the beliefs of their cultures. At the same time, they suggest, cultures require different "kinds" of bodies to maintain their power structures or they find themselves faced with different kinds of bodies that need to be located in the social order, and they subsequently "construct" them to fit the needs of the social order. For example, the economic and social order of antebellum Georgia depended upon the institution of slavery. To maintain this order,

a set of practices designed to construct the bodies of blacks as slaves was required to internalize the cultural view that understood them as slaves. These practices included kidnapping and incarceration, physical punishment, rape, total economic dependence upon owners, selling individual family members, marginalized and impoverished dwellings, and so on.

In addition, for whites to participate in these practices in good conscience and for blacks to submit, the practices required conceptual rationalizations that constructed an understanding of blacks as inferior to whites. For example, religious discourse construed blacks as inferior either due to their "heathen" status or due to their descent from Ham, a less privileged son of Noah. Medical discourse, drawing on Darwinian concepts, asserted that blacks were not as advanced as whites on the evolutionary spectrum, or drew normative conclusions from real physiological differences. In short, the order of a given culture requires this interdependence between practices, discourses, and institutions. As will be discussed below, this interdependence is also the location for resistance and change.

While this is a graphic and coercive example of the ways in which the bodies of particular individuals and a particular group were constructed, social theories of the body would maintain that all people's bodies are constructed. Feminist theory has been a major proponent of this view (see Walker, 1991). But because people internalize and generally accept the norms of their culture, they do not generally understand their bodies as constructed. Because of the objective reality of institutions, the official status of discourses, and the embodied dimension of practices, they see the abilities, constraints, limits, perceptions, and experiences of their bodies as "natural," "given," "the way things are," "right," or "true."

The primary analytical and ethical category for social theories of the body is power. Social theories of the body understand bodies as the medium through which social institutions derive power, authority, reality, and meaning as the site upon which power and social control are maintained. Bodies, as Elaine Scarry suggests, are material and real, while political and social configurations are abstractions, precisely lacking material reality. Through the ways in which they intersect human bodies, social orders appropriate the materiality of human bodies and gain the appearance of reality (Scarry, 1985). The most significant analyst of the relationships between power, knowledge, and the body, and therefore the most central figure in the development of social theories of the body, has been Michel Foucault (1973, 1979, 1980).

While not denying that power can and often is exercised in ways that are negative, coercive, or repressive, social theories of the body instead see power as a per-

vasive and necessary part of every social order. They focus on four other characteristics of power, specifically that it is "productive," "local," "continuous," and "capillary." Power is "productive" insofar as it is that quality that enables individuals and groups to act (generally toward their own advantage) and to effect desired ends and goals. Power is "local" because it is exercised at the level of individual bodies through techniques and technologies of surveillance (quantification, examination, classification, statistical ranking) and discipline. Power operates "continuously" because individuals, by willingly participating in official practices of surveillance, classification, and self-discipline, become self-surveilling, internalizing the normative intent of the practices. And finally, power is "capillary" (drawing on the metaphor of arterial and venous capillaries that are the smallest conduits of blood flow, feeding the furthest reaches of the body); power operates through the most common and least formal channels of the social body in everyday practices, such as eating, medicine, and sexuality.

An essential element in establishing systems of power are discourses, as illustrated above by the roles medical and religious discourses played in the institution of slavery. Discourses are verbal and literary constructs through which systems of knowledge are established. Discourses generally belong exclusively to a professional group and are the means by which that profession defines and advances norms for human subjectivity, actions, and bodies. Bioethics would be an example of such a discourse. Bioethics belongs to the professional group of philosophers, theologians, and clinicians who have learned the language. Through this discourse, bioethicists have defined the normative essence of human personhood as rationality, and they have advanced a system of ethical evaluation based on rational autonomous action, and so forth.

When discourses and practices become the exclusive domain of a select group of professionals, domination by that group is almost unavoidable, yet almost imperceptible. Joanne Finkelstein (1990) describes how technology, especially medical technology, is crucial to this dynamic. Through discourse, practices, and technologies, professions cultivate consumer desires and offer the means to satisfy those desires. Yet by exclusively possessing a desired commodity, those providing the service (e.g., in vitro fertilization [IVF]) control access to it. At the same time, since consumers have been cultivated to desire the service (through what Lisa Sowle Cahill has called the "rhetoric of desperation"), they do not perceive the monopoly as dominating or exploitative, even though they (1) are increasing the scope of medical dominance; (2) may bear great burdens and costs in the process (especially women); and (3) may end up with no outcome (for example, there is only a 20 percent success rate with IVF), while the professionals are guaranteed

benefits, such as income, professional status, or social power. When power becomes accumulated in an institution or professional group in such a way that the group can define another's interests, influence individuals to act contrary to their own interests, or influence those individuals to act in ways that simply further the power of the professional group, power becomes domination. (For further discussion of the new reproductive technologies from the perspective of social theories of the body, see Corea et al., 1987.)

### Application: Social theories of the body and bioethics

With regard to bioethics, social theories of the body will prove more critical than constructive. In the above discussion of IVF, we have already begun to show how bioethics looks different when approached from a social-theories perspective. Rather than asking the standard questions of bioethics (Is the patient competent? Who decides? Did the patient give an informed consent? Do the benefits outweigh the costs?), it will ask questions of power (Who benefits most from a particular practice or discourse? Is this a practice of surveillance, and if so, for what end? Who has power in this particular situation?). It will describe how power functions within medical institutions; for instance, power rests mainly with physicians or hospital administrators rather than nurses who provide the hands-on, bodily care (see feminist bioethics, especially Sherwin, 1992; Holmes and Purdy, 1992). It will analyze the dynamics of "choice," suggesting what social factors constrain choices (e.g., in the case of IVF described above), and how individual choices are circumscribed so as to further the interests of institutions and professional groups (Corea et al., 1987). It will illuminate how bioethics, with medicine, functions as an agent of social regulation (e.g., bioethics' emphasis on crafting national policies).

For social theories of the body, medicine has emerged as one of the principal agents of social regulation, the crucial actor in contemporary biopower. In his work *The Birth of the Clinic* (1973), Michel Foucault examines the relationships between medical technologies, practices of surveillance, specialization of knowledge, and consolidation of professional power (see also Turner, 1987). Increasingly, medicine offers treatments for aspects of embodied human life—fertility, height, baldness, death (e.g., euthanasia)—thereby defining an expanding number of human conditions as pathological and amenable to treatment and expanding its own influence. Even when treatments are not available, through seemingly benign techniques of surveillance (especially, for example, genetic testing), medicine seeks to bring all individuals, and increasingly all parts of individuals' lives, into its purview in order to "normalize" individuals

and populations. The Human Genome Project, the massive research initiative founded by the National Institutes of Health to map "the" human genome, which will be employed as a standard of normality, is just one example. In addition, medicine serves to marginalize and control those who are not considered normal. Through the judgment and practice of medicine, the sick and disabled are removed from the center of public space to the margins—to the home, to the hospital, to the nursing-care facility. Moreover, a movement (advocating euthanasia, assisted suicide, and/or advanced directives) encourages that those "disordered" bodies (bodies that do not fit with the order of the culture) be moved beyond the boundaries of the human community, beyond the boundary of life and death.

It can be likewise argued that this function of medicine as an agent of social regulation is bolstered by bioethics. Generally, bioethics seeks to create arguments and algorithms that justify, rather than challenge or critique, medical "advances." The discourse of bioethics often provides an additional lens by which individuals or groups are rendered more or less "normal," often offering medicine and society moral justifications for practices that further marginalize those deemed nonnormative. Bioethicists increasingly seek to create a professional space for themselves, an area of expertise, from which they can exercise benign dominance in the moral evaluation of medical and biomedical practices; this role is increasingly attested to by the frequency of "bioethicists" in news sound bites.

Bioethics from the perspective of a social theory of the body, however, challenges this trend. How might social theories of the body illuminate the analysis of a typical bioethical issue? Joanne Finkelstein offers a cogent example in her analysis of genetics. She notes how genetic science promises to improve the lives of individuals and populations by monitoring and altering human bodies at the subcellular level through high technology medicine. However, these technologies—for all their apparent neutrality—carry with them significant normative power, that is, "the power of determining which human lives are more valuable, or in utilitarian terms, which individuals are potential welfare burdens to the community in the long term" (Finkelstein, 1990, p. 13). Genetic screening is a technique of surveillance, the penultimate extension of Foucault's "medical gaze." Through a combination of screening, intervention to abort defective fetuses, and interventions to alter human characteristics, genetic technologies undergird cultural efforts to define and institutionalize "normalcy." Genetic science has been granted the ability to define which human characteristics are to be defined as pathological or unacceptable, which are open to genetic remediation, and "which populations will become the

experimental subjects used in the future development of the field" (Finkelstein, 1990, p. 14).

One might comment at this point that it seems that even in this approach, one does not hear much about "the body." This illustrates how difficult it is to keep the focus on the body. However, what distinguishes social theories of the body from other approaches is that they consistently begin with bodies—with techniques that are practiced on bodies (e.g., genetic screening), with definitions of bodies or different types of embodiment (e.g., definition of death), with the ways in which the bodies of different groups are treated (e.g., access to health care for the underserved), with the ways in which "political" structures position, appeal to, or ignore the bodies within them (e.g., issues of women's health). For this approach, the point of intersection between institutions, practices, discourses, and human bodies serves as the window through which to analyze political and social structures, relationships of power and dominance, and their moral and ethical effects.

While generally critical and analytical, social theories of the body may also serve a constructive function in the practice of bioethics. For example, analysts may use social theories of the body to identify ideological, oppressive, or coercive power relationships within the practice of medicine; they may then offer alternative "politics" that better embody a preferred set of values. By doing so, they illustrate how bodies, in conjunction with alternative practices, discourses, and institutions, also serve as the context for resistance to domination. Bodies, as the locus for power, are equally the site for control and the site for freedom. However, by illustrating the complexity of embodied social orders, these theories also indicate how difficult resistance can be and how resistance requires community. Those who resist often find themselves *de facto* members of a subculture. Feminist approaches to bioethics are particularly illustrative in this regard (Corea et al., 1987; Sherwin, 1992; Holmes and Purdy, 1992).

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*Directly related to this article are the other articles in this entry: EMBODIMENT: THE PHENOMENOLOGICAL TRADITION, and CULTURAL AND RELIGIOUS PERSPECTIVES. Also directly related is the entry HEALTH AND DISEASE, articles on HISTORY OF THE CONCEPTS, and THE EXPERIENCE OF HEALTH AND ILLNESS. For a further discussion of topics mentioned in this article, see the entries AUTHORITY; BEHAVIOR CONTROL; FEMINISM; FREEDOM AND COERCION; GENETICS AND HUMAN SELF-UNDERSTANDING; LIFE; NARRATIVE; and NATURAL LAW. For a discussion of related ideas, see the entries DEATH; and EUGENICS, article on ETHICAL ISSUES. Other relevant material may be*

found in the entries BIOLOGY, PHILOSOPHY OF; METAPHOR AND ANALOGY; RACE AND RACISM; SEXUAL IDENTITY; and SUICIDE.

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## III. CULTURAL AND RELIGIOUS PERSPECTIVES

Scholarly and popular thought alike have typically assumed that the human body is a fixed, material entity subject to the empirical rules of biological science. Such a body exists prior to the mutability and flux of cultural change and diversity, and is characterized by unchangeable inner necessities. Beginning with the historical work of Michel Foucault and Norbert Elias, the anthropology of Pierre Bourdieu, and phenomenological philosophers such as Maurice Merleau-Ponty, Hans Jonas, Max Scheler, and Gabriel Marcel, however, scholarship in the social sciences and humanities has begun to challenge this notion. Late twentieth-century commentators argue that the body can no longer be considered as a fact of nature, but is instead "an entirely problematic notion" (Vernant, 1989, p. 20); that "the body has a history" insofar as it behaves in new ways at particular historical moments (Bynum, 1989, p. 171); that the body should be understood not as a constant amidst flux but as an epitome of that flux (Frank, 1991); and that "the universalized natural body is the gold standard of hegemonic social discourse" (Haraway, 1990, p. 146).

This scholarly perspective—that the body has a history, and is not only a biological entity but also a cultural phenomenon—goes hand in hand with the increasing number and complexity of bioethical issues in contemporary society, many of which have strong religious overtones. Some decades ago the only such issue arose in cases where religious and biomedical priorities conflicted in the treatment of illness. Within the majority population, various groups such as Christian Scientists, some Pentecostal Christians, and members of small fundamentalist sects occasionally have created controversy by refusing medical treatment on the grounds that faith in medicine undermined faith in God, in other words, that since healing should occur only at the will and discretion of the deity, human medicine was presumptuous upon divine prerogative. This was especially