

Corporeal Knowledges and Deviant Bodies: Perceiving the Fat Body

Samantha Murray

The empiricist logic of humanism insists that we can know the essence of something through observation. However, it is my aim in this paper to challenge this notion by asserting that empirical observation is never neutral, but always laden with cultural meanings, specificities and prejudices. I argue that medical science is founded in a humanist empiricism in order to make bodies intelligible as “normal” or “pathological”, depending on a range of bodily markers. In designating a body as “normal”, the clinician uses measures of “sameness” that are underpinned by a deeper concern for normalisation. In upholding the norm/pathology binary in medical discourse, what is effected is a neglect of a *recognition* of the socio-cultural function of the categories of “normal” and “pathological”, and medical participation in the way these terms come to “mean” in lay society, and their sedimentation in pre-conscious practices of perception. The central task of this paper is to examine the “clinical gaze”, and moreover the consultation between the paternalistic and rational figure of the doctor and the patient/subject, understood simply as a malfunctioning machine in need of restoration to normality. Drawing on the work of Linda Alcoff, I argue that what is ignored in medical discourse is the persistence and irrevocability of tacit bodily knowledges that construct us within every context, not least the privileged “objective” space of medical consultation and diagnostics.

Keywords Obesity; embodiment; medicine; normalisation; pathologisation

Introduction

In the West, medicine is held up as an objective science, dedicated to healing the sick, unfettered by social prejudices and biases. Medicine is presumed to examine the body of the patient as separate from the *self*: the body is then reduced to a machine that has malfunctioned and is in need of repair. In other words, medicine is underpinned by the empiricist logic of humanism: a logic that insists we can *know* the essence of something through observation. However, I would contest the notion that medicine, and more specifically its practitioners, can stand outside the cultural context that it/they operate within. Rather, the “clinical

gaze” of the doctor, I would suggest, is grounded in an observation that is never, nor cannot ever be, neutral, but is always already structured in and through the variety of cultural meanings, specificities and prejudices that provide a kind of *lens* through which we perceive others and the world. In the discussion that follows, I will problematise the accepted *objectivity* of the “clinical gaze”, and specifically, by drawing on the work of Linda Alcoff, argue that what is ignored in medical discourse is the persistence and irrevocability of *tacit bodily knowledges* that construct us—*every body*—within every context, not least the privileged “objective” space of medical consultation and diagnostics.

I wish to begin, then, by examining Linda Alcoff’s account of the role of perception in the constitution of identity and difference, normalcy and pathology. In her article “Towards a Phenomenology of Racial Embodiment”, Alcoff (2001) looks at the primacy of perception in the formation of bodies of knowledge, bodies of flesh, social bodies, and the relations between them. Specifically, Alcoff investigates the way some bodies are read and positioned as “Other” based on their “visible” non-white bodily markers. She argues that the way we see, the way we perceive, other bodies is not simply a result of our vision, but of the sedimented knowledges we embody, and body forth. She writes:

... the realm of the visible, or what is taken as self-evidently visible (which is how the ideology of racism naturalizes racial designation), is recognized as a product of a specific form of perceptual practice, rather than the natural result of human sight. (Alcoff 2001, 268–269)

Just as Foucault argued that discourses do not simply *describe* the conditions of one’s existence, but rather are *productive of it*, Alcoff suggests that perception produces the very objects it traditionally is assumed to simply *process*. In other words, perception emerges as a *discursive effect*, rather than as a purely biological function. Perception, she insists, is a learned process in and through which *seeing* and *knowing* are intimately interwoven in historically and culturally specific ways. She writes “... perception represents sedimented contextual knowledges ... there is no perception of the visible that is not already imbued with value” (Alcoff 2001, 272). Alcoff presents us, then, with the concept of “tacit body knowledges”, which she suggests are “carried in the body” (2001, 272). She says, “Our experience of habitual perceptions is so attenuated as to skip the stage of conscious interpretation and intent. Indeed, interpretation is the wrong word here: we are simply perceiving” (Alcoff 2001, 276). In other words, “knowing” is not primarily a cognitive function. Tacit body knowledges are intercorporeal ways of *knowing* and *ordering* the meanings of our various ways of being and our interactions: they are constitutive of our bodily being-in-the-world.

When we perceive a body, be it as “fat”, “aged”, or “disabled”, we constitute it in accordance with the bodily knowledges that provide a backdrop for our perception. However, Alcoff makes the point that these knowledges are indeed *tacit*. By this, she suggests that these ways we have of perceiving and understanding each other are hidden and unspoken. They are inferred without

being directly expressed; they are habitual and embodied without any conscious decisions made about deploying them at any given moment. In other words, we respond to others on a visceral level: we know their bodies implicitly, and what they mean to us. We see a “fat” woman, and we *know* her as lazy, greedy, of inferior intelligence. We may still address her more or less normally, we may smile at her, we may eat lunch with her, or go shopping with her, but somewhere within us these kinds of understandings, these *knowledges*, of what her “fatness” means to us are stirred and brought to the surface in unconscious ways. As Alcoff asserts:

Visible difference, which is materially present even if its meanings are not, can be used to signify or provide purported access to a subjectivity through observable, “natural” attributes, to provide a window on the interiority of the self. (2001, 268)

In short, we internalise all the statements made about certain body types by our society and live them out. These idea(l)s, or discourses, inform the ways in which we understand each other, and govern our experience of, and relations with, the other. We manage our identities through perception—we believe we can come to *know* the essence of a person through the way they appear to us. These bodily knowledges are unspoken, habitual, and are therefore difficult to analyse, and yet a discussion of this “knowingness” about certain kinds of bodies is imperative, and deserves critical attention, precisely because these knowledges inform and shape our interactions, and provide an insight into why we constitute some bodies as pathological, and regard others as normative.

In so far as perception is bodily, then, it inscribes simultaneously the *very being* of the *seen* and the *seer*. In this way, perception *enfleshes*, such that “... visible markers on the body ... are *made* visible through learned processes” (Alcoff 2001, 279; original emphasis). As Alcoff insists, “Visible difference is still the route to classification and therefore knowledge” (2001, 268). Let me explain this point by turning to Nikki Sullivan’s discussion of a story, cited in Montag, and drawn from a 1774 diary entry by Janet Schaw, in which she tells of an experience while en route to her hotel in Antigua:

... a number of pigs ran out at a door and after them a parcel of monkeys. This not a little surprised me, but I found that what I took for monkeys were Negro children, naked as they were born. (Schaw in Montag, cited in Sullivan 2003, 75)

What is interesting to Sullivan here is what Schaw’s “(mis)reading of racial difference” (Sullivan 2003, p. 75) might tell us about the ways in which Enlightenment ideals structured perception. Sullivan writes:

... Schaw’s (mis)interpretation is less a perceptual error, or a moment of perceptual confusion that is quickly rectified once she realises that the figures that crossed her path are really children, and more a mode of perception which (like all perceptions) is already imbued with historically and culturally specific values, fantasies, desires, aspirations, fears, and so on. (2003, 75–76)

In other words, Schaw's error is less an effect of a conscious prejudice than it is of historically and culturally specific tacit body knowledges. What this anecdote shows us is that we make meaning for ourselves according to the ways in which these culturally specific tacit knowledges are embodied *by* us and deployed constantly in our interactions, observances and understandings of others. Further, it illustrates Alcoff's claim that there is no distinction between the mind (as the keeper of cognitive faculties) and the body (as a vessel for consciousness). Rather, as she insists, we are *embodied beings* who move in the world and make meaning primarily at the level of (inter)corporeality. Different bodies always *mean* something to us, and the bodily knowledge we carry with us always structures our relationships with the bodies of others and with our own bodies. These complex systems of knowing (about certain bodies) seem "natural", unquestionable. We embody these knowledges: we live them out and interact with each other based on the visibility of particular bodies and the "knowingness" we glean from those bodies. Sullivan explains:

What this means is that we perceive ourselves, others, the world, and the relation between them, in and through the grids of intelligibility that exist in our culture, and which we have embodied, which, in effect, we are. But this perception occurs, for the most part, at what you might call a subliminal or pre-conscious (bodily) level. (2003, 76)

Thus, Schaw's reading of the Negro children as monkeys can be understood as an effect of (and reproduction of) tacit knowledges about what constitutes the "human" in a particular historico-cultural context. Sullivan suggests that there is an equation in Schaw's perception where "whiteness" equals "humanness" (2003, 77), and, in her response to the children who ran out in front of her, the function of whiteness as a hegemonic discourse of being is revealed as a tacit body knowledge Schaw carries with her. These knowledges, Alcoff argues, are naturalised and structure our perception so as to provide a "necessary background . . . [that] makes up a part of what appears to me as the natural setting of all my thoughts" (Alcoff cited in Sullivan 2003, 77).¹

What I would suggest here, then, is that the same kinds of tacit body knowledges are at work in our readings of "fat" bodies (particularly "fat" women). Just as "whiteness" equates to "humanness" in Schaw's account, I would suggest that normative thinness constitutes the "universally feminine". It is useful to think about a normative "slender" body as not only occupying a space of power and influence, but as a means of projecting onto our perception a kind of "backdrop" of normalcy that structures our readings/constitutions of certain bodies as normative or aberrant.

In their article "Mapping Embodied Deviance", Jacqueline Urla and Jennifer Terry (1995) note the epistemological force of medical discourse, in terms of its

1. In the instance of Schaw's anecdote, Sullivan notes that "Whiteness, then, is rarely spoken as such, but nevertheless functions—in hegemonic and some anti-hegemonic discourses—as the (embodied) 'principle of perfection'" (2003, 77).

reliance on, and reproduction of, such sedimented knowledges. Terry and Urla are especially interested in the effect medical narratives have on social relations, and the enthusiasm with which medical binaries have been taken up and made inseparable from a public consciousness about “proper” and “improper” bodies. The authority of medical discourse acts as a legitimising force in marginalising bodies of difference, and reaffirming the power of the normative body, which is still fundamentally an immaterial body.

Dichotomous logic constitutes the body of the “other” (the “fat” body, which stands at the heart of the current moral panic over the “obesity” epidemic) as that which we claim to simply perceive. Terry and Urla speak about “embodied deviance”, which they argue “is the term we give to the scientific and popular postulate that the bodies of subjects classified as deviant are essentially marked in some recognisable fashion” (1995, 2). Drawing on the work of Foucault, Terry and Urla assert that “what matters is that scientific and popular modes of representing bodies are never innocent but always tie bodies to larger systems of knowledge production and, indeed, to social and material inequality” (1995, 3). This is what is most salient to my argument here: the complex entanglement of medical science and popular perceptions of the body, and the ways in which these seemingly discrete arenas are always inflected by each other; they cannot remain separate, and constantly draw on each other for power, authority and veracity.

Like Alcoff, Terry and Urla affirm the primacy of bodies, and argue that it is at the level of the bodily that we perceive and read other bodies, and it is at the level of the body that other bodies are intelligible to us. As Terry and Urla claim:

The power of empirical observation lies primarily in its ability to render information visible, thus offering a means for controlling deviance through the clinical gaze. The legitimacy of surveillance in both the broad social context and much of scientific practice is dependent upon a rationale of protecting the social body from potentially dangerous forces, and of bestowing upon individuals the responsibility of health and hygiene. Modern surveillance demands the inspection of individuals in order to judge their status, analyse their deficits, and evaluate their function. (1995, 10)

In both medical and popular accounts of “proper” and “improper” bodies, we find what Terry and Urla describe as “the somatic territorializing of deviance”, which, they argue:

... since the nineteenth century, has been part and parcel of a larger effort to organise social relations according to categories denoting normality versus aberration, health versus pathology, and national security versus social danger. (Urla and Terry 1995, 1)

Despite this popular belief in discrete polarised entities, Terry and Urla note that “the spectre of the normal body, be it a white, heterosexual, healthy, or male body, is always simultaneously present—even if in shadow form—in discourses of deviance” (1995, 5). This “spectre” of normativity, as Terry and

Urla describe it, seems to me to give form to the assertion that Alcoff makes about the “background” that tacit bodily knowledges set up in our perceptions of the world and others. We are, in a sense, “haunted” by a “norm” that is nowhere concretely to be found. Despite its concrete “absence”, the epistemological force of the “normative” weighs on us heavily, effecting a range of behaviours such as self-surveillance, and an acute awareness of the coding of certain behaviours as indicative of a tacit agreement to aspire to this normative body. If we imagine the spectre of normativity as a figure of desire and fear, it makes sense that we are driven by a fear of deviance, a fear that is supposed to position us carefully on the “proper” side of the normal/deviant binary. Knowledges and discourses rely on binary structures, which are always haunted, and brought into being by the presence (or absence) of their correlative term.

Regarding “Fat”: The Clinical Gaze

As I have suggested, perception is never simply a neutral or natural mode of absorbing empirical data. Rather, perception as an effect, and a technology of systems of power/knowledge, *constructs* corporeality and (inter)corporeality in historically and culturally specific ways. I would argue that Alcoff’s conception of “tacit body knowledges” could aptly be applied to what I, following Foucault,² refer to as the *clinical gaze*.

The dominant function of the “clinical gaze” was, claims Foucault, to “record and totalize” (2003, 149), to “perceive” and make disease intelligible. He writes:

It was as if for the first time for thousands of years, doctors, free at last of theories and chimeras, agreed to approach the object of their experience with the *purity of an unprejudiced gaze*. (Foucault 2003, 241; emphasis added)

However, the insistence on medical objective distance embraced by disciplinary medicine is a cultural fiction, which, as Foucault notes, reproduces dominant modes of *seeing*, *knowing* and *being*. In other words, the medical professional as the subject of disciplinary medicine both *occupies* the position of the “sovereign” humanist subject who possesses a knowledge marked by rationality, and *reproduces* this ideal. As Foucault argues, this “fine sensibility” characterises *affectively* a medical expertise supposedly marked by an absence of prejudice or subjective investment. Foucault writes:

The clinical gaze is not that of an intellectual eye that is able to perceive the unalterable purity of essences beneath phenomena. It is a gaze of the *concrete sensibility*, a gaze that travels from body to body, and whose trajectory is situated in the space of sensible manifestation. (2003, 148; emphasis added)

2. See Foucault (2003).

In other words, Foucault's account of sensibility *foregrounds* the *affective* condition of *perception*, and calls into question the hegemonic understanding of medicine as a pure objective mode of inquiry that provides access to unbiased and *deeply buried* truths (Diprose 2002, 107). While the clinical gaze is presumed to stand *outside* of power, to be unaffected by the discourses that construct us all as body-subjects, it too is necessarily implicated in the reproduction of dominant ways of knowing and being. As Foucault notes, the clinical gaze is structured by what he calls a "fine sensibility". In other words, in assessing a patient, a doctor must rely on his or her *perceptions* to "know" the patient: via the touch of fingers, the "observation" of lesions or (ab)normalities, the "sounds" of inner bodily functions: the medical "expert" positions the body of the "other" as either "healthy" or "pathological", and this "knowledge" is clearly bodily (*sensible*). As Foucault writes:

... The medical gaze embraces more than is said by the word "gaze" alone. It contains within a single structure different sensorial fields. The sight/touch/hearing trinity defines a perceptual configuration in which the inaccessible illness is tracked down by markers, gauged in depth, drawn to the surface ... (2003, 202)

Certainly a doctor is trained to look for disease: indeed, the Hippocratic oath all doctors must take is committed to preserving life and supporting "quality" of life. However, when a doctor examines a patient, does he simply perceive a "patient", a "diseased body", or is his gaze complicated by the same multiplicity of cultural meanings as we are all subject to? Alcoff's work has demonstrated that there is no such thing as "simple perception", understood as the unmediated processing or absorption of visible/visual data. Perception is a knowledge-making process. Perception is *productive*, and it is necessarily a function of power/knowledge. The doctor's gaze is *always already* structured by the world in which his subjectivity is *constituted*. This subjectivity is not pre-cultural: it does not exist prior to one's immersion in-the-world, subsequently to be changed by one's intersubjective experiences.

Let me provide an illustration here. On more occasions than I care to remember, medical practitioners have diagnosed the various maladies from which I was suffering as a direct result of what they perceived as my "fatness". Mobilising their "fine sensibilities", and applying various technological apparatuses aimed at enhancing their perception (blood pressure monitors, stethoscopes, X-rays, ultrasounds, etc.), these "experts" were forced to conclude (albeit somewhat disappointedly) that my blood pressure was in fact "normal", my lung capacity was "good", and my internal organs were in working order. Nevertheless, under the medical gaze, the eminent visibility of my "diseased", "obese" body functioned as a signifier of *pathology*, my "bodily being" was perceived by those concerned, as a negative, "problematic" mode of embodiment, and I was repeatedly advised to lose weight as a matter of urgency, despite my otherwise apparently good "health". But, as my discussion of the work of Alcoff, Terry and Urla, and Foucault has clearly indicated, these encounters did

“... not take place in a context-free clinical setting separated from the rest of society, but [as] part of its social reality and its structure” (Svenaeus 2000, 44).

At this point, I want to suggest that clinicians are unable to leave their embodied being, their own culturally constructed (tacit) understandings of (“fat”) bodies and selves, normalcy and pathology, *behind* when treating their patients. In fact, I would argue that the body of the clinician is also *(re)constituted* in and through this encounter in accordance with the normative criteria he or she assumes.

In their article “The Effects of Obesity on the Clinical Judgements of Mental Health Professionals”, Young and Powell (1985) detail an experiment they conducted in order to ascertain the attitudes of mental health professionals towards “obese” female clients. Medicine often amplifies the understanding of the pathology of the “fat” body, by asserting the presence of a psychological disturbance that serves to explain the reason why “obese” subjects maintain their “fat” bodies. The authors are interested in investigating the number of “obese” women in therapy compared with those of a “normal” weight. Young and Powell suggest that:

Many severely overweight individuals are cognizant of others’ feelings of disdain toward them and, having internalised these sentiments themselves, accept the discriminatory treatment of them as appropriate and just. Consequently, the percentage of the obese seeking mental health assistance may exceed the percentage of the general population that obtains treatment. (1985, 234)

In light of this, Young and Powell examine the assumptions made about the mental health of “obese” individuals, and the way a client’s weight may affect clinical judgement. However, it is worth noting here that the authors’ critique is not directed at what they see as the prejudicial “erroneous” beliefs of some medical practitioners, beliefs that potentially could be replaced with “correct” diagnoses. Instead, their concern is with the damaging material effects that assumptions about normalcy and pathology *produce* in relation to those perceived as “obese”. In other words, the authors’ analysis is subtended by the thesis that I have elaborated in this article—that “pathologising” perceptions are never purely descriptive, but indeed are constitutive of (ill) “health”.

Citing Allon’s (1979) investigation of health professionals’ attitudes towards the treatment of patients perceived as “obese”, Young and Powell note that:

... doctors expressed a preference not to advise and/or treat the extremely overweight patient in part because the physicians viewed obesity as an indicator of several undesirable qualities, including lack of control. (1985, 234)

They further substantiated this finding via a study of mental health professionals, male and female, whom they presented with a case history of a middle-aged white married mother of two, who was severely depressed, and felt resentful and aggressive towards her family (Young and Powell 1985, 237). Accompanying this

history was a photograph of the female subject. However, the photograph had been modified to produce three different versions of the same woman: one depicted a woman of “average weight”, one of a woman “slightly overweight”, and the last of an “obese” woman. The mental health professionals were split into three groups, each of which was given a different photograph. Thus one group believed the case history described a woman of “normal” weight, one believed it described a “slightly overweight” woman, and the last group believed they were dealing with an “obese” subject. Young and Powell evaluated the different responses of the mental health practitioners in each group and asserted that the “findings indicate that diagnosis is affected, or confounded, by the weight of the client” (1985, 233), and that “obese clients are evaluated more negatively than are their normal weight counterparts” (1985, 241). They state:

...as long as the woman remains within an acceptable range from best weight... mental health workers will not view her as psychologically deviant. Only when she exceeds the latitude of acceptable weight is her weight viewed as causing problems. (Young and Powell 1985, 241)

Moreover, Young and Powell found that female mental health professionals were more critical than their male counterparts of those women they perceived as “obese”, rating them “more harshly for a variety of symptoms, including addiction, antisocial behaviour, inadequate hygiene, and sexual dysfunction” (1985, 241). The expectation of a stringent maintenance, regulation and control of women’s bodies constructs a particular bodily awareness among women in the West. The pressure to present a body that proclaims its adherence to the feminine standards of beauty and sexuality means that the very presence of another female body that is “fat” and therefore is clearly transgressing these “norms” is an affront, a defiant symbol that can elicit anger, disgust and resentment. Young and Powell conclude that:

These negative evaluations [of the obese client]...are less a function of objective clinical judgment based in theory and research than a function of societally stereotypical images of the obese woman. (1985, p. 242)

The medical responses Young and Powell cite are clearly informed by fundamental gendered notions of normative female appearance. Moreover, the differing responses of male and female medical practitioners indicate that the gendered being of the health professional is always already implicated in every clinical encounter at a tacit level. The “clinical gaze”, then, as a particular mode of perception, is inevitably intercorporeal: it does not simply function to constitute the “other”, but is also fundamental to the reaffirmation of the “self”, and the idea(l)s on which the self is founded.

Let me continue this interrogation of the ways in which perception is gendered and (en)genders by turning to a rare candid autobiographical account by psychotherapist Irvin Yalom, who tells of his own anti-fat prejudices and the

ways in which they inform his clinical encounters. Yalom recounts his encounter with Betty, whose body presents an immense obstacle for him in fulfilling his medical duties in treating her. As he tells it, Yalom finds it extremely difficult to be in the same room as Betty, finds her conversation banal, and cannot disguise his disgust in the face of her “abject” body. He writes:

I have always been repelled by fat women. I find them disgusting: their absurd sideways waddle, their absence of body contour—breasts, laps, buttocks, shoulders, jawlines, cheekbones, *everything*, everything I like to see in a woman, obscured in an avalanche of flesh . . . How dare they impose that body on the rest of us? (Yalom 2005, 184)

The real question Yalom asks is “What right does Betty have to exist?”, given that her very being is a source of utter revulsion. The tacit body knowledges that *constitute* Yalom’s being absolutely *overwhelm* his being in Betty’s presence. The encounter with Betty’s flesh does not simply obscure Yalom’s clinical gaze, or blind him to his role as medical practitioner, but rather illustrates my claim of the inextricability of the medical gaze from popular understandings of gender impropriety. Yalom continues:

... When I see a fat lady eat, I move down a couple of rungs on the ladder of human understanding. I want to tear the food away. To push her face into the ice cream. “Stop stuffing yourself! Haven’t you had enough, for Chrissakes?” I’d like to wire her jaws shut! (2005, 185)

Failing to recognise the immediate, tacit and affective dimensions of this encounter, Yalom asks (somewhat belatedly) “how could I relate to Betty? To be frank, she revolted me” (2005, 189). More pressing than the question posed by Yalom is the question of why Betty’s body so repulses and threatens him. Despite Yalom’s claim that it is Betty’s body that disgusts him, I want to suggest that it is the *affect* engendered by the tacit body knowledges that are fundamental to Yalom’s very being that undermine his position as an objective medical practitioner. The anger Betty’s physical presence allegedly elicits in Yalom threatens his own self-control, compromises his position as the authoritative, rational and objective subject, and thus impels him to position her as the abject “other” to his “proper” self. In doing so, Yalom reinstates a necessary distance between himself and the “other” that both *haunts* and *threatens* his very sense of self. Ironically, Yalom’s hysterical response to his encounter with Betty undermines his attempt to deny the intercorporeal nature of identity and difference, and foregrounds the fragility of his own allegedly “proper” body.

What is interesting about Yalom’s account of his encounter with Betty’s “fat flesh” is that his response is one we might expect to find *outside* of the clinic: it is uncontrolled, angry and prejudicial, not at all “objective”, “rational” or “unbiased”. In other words, Yalom’s response to Betty’s body does not conform to the dominant understanding of the “objective distance” doctors supposedly mobilise in their consultation with patients. We might generally expect these

negative, violent responses to “‘fat’ bodies” in the street, and I myself have been the object of this kind of disgust regularly beyond the clinic. However, it is inside the walls of the clinic that these ideas about normalcy and pathology are authorised, formalised, rationalised and given credence. The kind of medico-scientific readings of the body presented in this section of the chapter are embodied by western “lay” society, and deployed in every social space. Foucault describes this “collective” clinical observation as the “unity of the medical gaze”. He writes:

What now constituted the unity of the medical gaze was not the circle of knowledge in which it was achieved but that open, infinite, moving totality, ceaselessly displaced and enriched by time, whose course it began but would never be able to stop . . . But its support was not the perception of the patient in his singularity, but a collective consciousness, with all the information that intersects in it, growing in a complex, ever-proliferating way until it finally achieves the dimensions of a history, a geography, a state. (Foucault 2003, 33)

Within this repetitive deployment of medical knowledges and discourses of health in the form of a disciplinary gaze, discursive power and authority is effected. The policing of “improper” bodies mobilises medical narratives and imperatives beyond the walls of the clinic into everyday intersubjective spaces and corporeal exchanges that are always discursively mediated by the authority of medical expertise and the concurrent moral value attached to maintaining one’s body to attain/maintain health and normativity. As Foucault argues:

. . . medical space can coincide with social space, or, rather, traverse it and wholly penetrate it. One began to conceive of a generalized presence of doctors whose intersecting gazes form a network and exercise at every point in space, and at every moment in time, a constant, mobile, differentiated supervision. (2003, 35)

At this point, it must be stated that the “collective” clinical gaze only functions in accordance with a discursively constructed understanding of the system of reward/punishment that operates alongside the classification of bodies using the binary distinction between “norms” and “pathologies”. In this way, all bodies can be made intelligible (within the walls of the clinic, and beyond them in every intersubjective space) via their “processing” and “reading” through the perceptual lens of the “healthy” and “pathological”.

Conclusions

The empiricist logic of humanism insists that we can know the essence of something through observation. However, as I have shown, contrary to humanist thought, empirical observation is never neutral, but always laden with cultural meanings, specificities and prejudices. In establishing and deploying a universal “standard” to measure all bodies against, humanist medicine produces an

insistence on “sameness” that fundamentally belies a deeper concern for normalisation. Margrit Shildrick notes:

... the point emerging from Foucauldian analytics is that in the production of truths there is no distinction to be made between empirical and normative disciplines. Rather, the so-called hard sciences are intermeshed with disciplinary practices. (1997, 45)

Shildrick suggests that it is the *tacit* positioning of certain discourses as dominant that makes them so irrefutable. The dominant position of medicine and science has become a “naturalised” ideal, whose authority may not be questioned. The seeming “transparency” of empiricism deployed in medicine is fundamental here: what the eye sees, what the doctor observes, cannot be challenged. He is simply “seeing” pathology, but the question remains: in his clinical gaze, how can he divorce himself from the “perceptual backdrop” of hegemonic knowledges that *structure* the very way in which he *sees*?

In upholding the norm/pathology binary in medical discourse, what is effected is a neglect of a *recognition* of the socio-cultural function of the categories of “normal” and “pathological”, and medical participation in the way these terms come to “mean” in lay society, and their sedimentation in pre-conscious practices of perception. The central task of this paper has been to demonstrate this complicity. To position the human subject centrally as the possessor of reason, and capable of all things, an assumed commonality obscures the lived realities of people’s lives that are necessarily complicated and structured in and through discourses of gender, race, class, sexuality, health and pathology. In this discussion, I have attempted to problematise the seeming “one-way relationship” (Grosz 1995, 105) between the paternalistic and rational figure of the doctor presiding over the patient/subject, who is relegated to a malfunctioning machine in need of restoration to normality. Underpinning this relationship is the problematic neglect of the lived embodiment of the “patient”, and the dichotomous positioning of bodies along a “healthy/aberrant” binary in order to maintain the humanist power of medical discourse. What is ignored in medical discourse, as I have shown, is the persistence of tacit bodily knowledges that construct us within every context, not least the privileged “objective” space of medical consultation and diagnostics.

Macquarie University, NSW, Australia

References

- Alcoff, L. M. 2001. Towards a phenomenology of racial embodiment. In *Race*, edited by R. Bernasconi. pp. 267–283. Malden, Mass.: Blackwell Publishers.
- Diprose, R. 2002. *Corporeal generosity: On giving with Nietzsche, Merleau-Ponty, and Levinas*. Albany, N.Y.: State University of New York Press.

- Foucault, M. 2003. *The birth of the clinic: An archaeology of medical perception*, translated by A. M. Sheridan. London: Routledge.
- Grosz, E. 1995. *Space, time & perversion: The politics of bodies*. St. Leonards, Sydney: Allen & Unwin.
- Shildrick, M. 1997. *Leaky bodies and boundaries: Feminism, postmodernism and (bio)ethics*. New York & London: Routledge.
- Sullivan, N. 2003. *A critical introduction to queer theory*. Edinburgh: Edinburgh University Press.
- Svenaesus, F. 2000. *The hermeneutics of medicine and the phenomenology of health: Steps towards a philosophy of medical practice*. Dordrecht, Boston & London: Kluwer Academic Publishers.
- Urla, J., and Terry, J. 1995. Introduction: Mapping embodied deviance. In *Deviant bodies: Critical perspectives on difference in science and popular culture*, edited by J. Terry and J. Urla. pp. 1–18. Bloomington: Indiana University Press.
- Yalom, I. 2005. Fat lady. In *Scoot over, skinny: The fat nonfiction anthology*, edited by D. Jarrell and I. Sukrungruang. pp. 183–229. Orlando, FL: Harcourt Books.
- Young, L. M., and Powell, B. 1985. The effects of obesity on the clinical judgments of mental health professionals. *Journal of Health and Social Behaviour* 26: 233–246.

Copyright of Social Semiotics is the property of Routledge and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.

Copyright of Social Semiotics is the property of Routledge and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.