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The postconventional body: Retheorising women's health☆

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ABSTRACT

We propose that women's health—both theory and practice—is a powerful arena in which to re-align and change the modernist theoretical underpinnings of current biomedical paradigms, which limit our understanding both of concepts of health and illness and of the impact of health care technologies on the body. We highlight the necessity of a move to a more dynamic paradigm for health and illness in the clinic, as well as a theoretical fluidity that allows for the real messiness of lived bodies. We argue that postmodernist thought, within wider feminist theory, is one of many perspectives that can contribute to contemporary biomedicine by providing theoretical underpinnings to develop 1) an understanding of bodies in context, 2) an epistemology of ignorance, and 3) an openness to the risk of the unknown. While these all entail a commitment to self-reflection and a willingness to be unsettled, which may not seem practical in the context of medical practice, we argue that self-reflection and unsettledness will provide pathways for grappling with chronic conditions and global bodies. Overall, we suggest that women's health practice can serve as a site in which both sides of the humanistic/scientific divide can engage with a human self in all its corporeal variety, contingency, and instability. More specifically, by providing a space within the clinic to examine underlying ontological, epistemological, and ethical assumptions, women's health can continue to contribute to new forms of biomedical practice.

Introduction

> [B]io-medicine is still caught in the clutches of the Cartesian dichotomy and its related oppositions of nature and culture, natural and supernatural, real and unreal. If and when we tend to think reductionistically about the mind-body, it is because it is "good for us to think" in this way. To do otherwise, using a radically different metaphysics, would imply the "unmaking" of our own assumptive world and its culture-bound definitions of reality. To admit the "as-ifness" of our ethnoepistemology is to court a Cartesian anxiety—the fear that in the absence of a sure, objective foundation for knowledge we would fall into the void, into the chaos of absolute relativism and subjectivity.
> (Scheper-Hughes & Lock, 1987: p. 30)

The practice of women's health is now woven into the mainstream of traditional biomedicine. From its early origins in self-care and the de-pathologizing of women's bodies, the practice of women's health has grown to be a major sector of the health care industry, often consisting in specialist clinics for women's reproductive, heart, and bone health—which are seen as distinct from those of men (for example see: Rosenfeld, 2001). From the days when it was supported by the early, lone voice of the Boston Women's Health Collective (1976), women's health has come to have advocates in US Congress, the National Institutes of Health, Health and Human Services, and the Canadian Institutes of Health Research. Consumers can engage with women's health centres through such on-line women's health sites as 'Women's Health Matters' (http://www.womenshealthmatters.ca/index.cfm) and 'Gender Biology.net' (http://www.genderbiology.net/genderbiologynet/web_sites/)—to name just two of many. Such 'mainstreaming' has been good news for the health of all of us, as many demands of the early movement—the agency of patients in their own health care, and an acknowledgement that the relationship between patient and

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provider makes a difference in the treatment outcome—have become 'best practices' in contemporary health care.

Despite—or perhaps because of—its success, however, the practice of women's health has become a jumble of biomedical expectations[1], reproductive health politics, and surveillance of conditions more common in women (e.g., Rosenfeld, 2001; for further discussion on this point see: Clarke & Olesen, 1999). At the same time, feminist theory, which as part of second wave feminism once undergirded and guided the women's health movement, has, with some notable exceptions, turned away from the biological body to adopt a more discursive approach. To some extent, these developments have left postmodernist feminist theory unaligned with current women's health practice. The result has been a divergence of what we might call 'women's heath qua movement' and 'women's health qua practice.'

The aim of this paper is to explore how to align poststructuralist concerns with the practice of women's health—i.e., how to reunite theory and practice—so as to reinvigorate women's health clinics as spaces for active theoretical engagement. This goal is in keeping with the politics of women's health, which, even in its early days, served as a space for ontological and epistemological inquiry. Indeed, as Tuana (2006) points out, one of the most important functions of the women's health movement has been to lay ignorance bare. We believe that bringing a poststructuralist perspective to bear on concrete issues of women's health, in turn, will open up a space in which to grapple with some of the current problems of the health care system in general and the health of women in particular.

Problematic

Contemporary practice of women's health care stumbles over two key modernist assumptions:

(1) The binary divisions and separability not only of illness and wellness, but of related body structures, female/male, nature/nurture, sex/gender, and patient/physician; and
(2) The notion of an autonomous, self-owned body.

With regard to the first, many current women's health practices still operate within a context of a healthy/sick binary, making a person univocally 'better', or bringing them closer to a universalized notion of 'normal'. Such practices are politically troubling, given that one of the most important contributions of the theoretical feminist agenda has been to challenge both the primacy of the universal, white, able-bodied, masculine subject, and the unexamined normative codes that underlie it (Shildrick, 1997).

Through a sustained critique of the supposed neutrality of traditional health care, feminist studies have shown how a network of hierarchical binaries around gender, race, and class inflect the distinction between health and illness. In order to move forward, practice must attend to each in their specificities (Clarke & Olesen, 1999). In addition, we must not only challenge the normative assumptions embedded in traditional biomedicine, but also find ways to accommodate a bioscience that is growing increasingly technologized, which is generating ever-expanding possibilities, leading to unpredictable data sets, and throwing up unfamiliar problems and dilemmas. It is increasingly clear as well that the classically modernist model of the body—as a well-defined machine comprising distinct systems—is being overtaken, even in the most scientific contexts, by the realisation that all corporeality is constantly changing and ultimately uncontainable. Morphology is not an unchanging given, but a process without end.

Uncovering (hierarchical and conflated) normative assumptions, recognizing the disruptive morphological impact of new technologies, and attending to the specificities of particular contextual practices all serve to destabilize the 'neat' suite of binaries on which modernist practice has rested for so long.

Just as serious an impediment to a progressive women's health is the second problem: the assumption endemic to current Western biomedicine, including women's health, that the health care consumer is a free, rational, self-determining subject—with unexamined and unchallenged agency through, and property rights over, her own body. Without taking anything away from the importance of acknowledging authentic agency, it can nevertheless be seriously problematic to view all biomedical interventions into the body—e.g., in assisted reproductive technologies, gastric bypass, cosmetic surgery, etc.—as unexamined choices made by the rational subject about her *self-owned* body. As we will show (below) in concrete cases, such an assumption can 'disappear' political influences and pressures of power, deny (or exculpate) care-givers from appropriate responsibility, and paint as 'beneficial to women' treatments that may literally cause unwarranted and unjustifiable suffering.

By setting aside the theoretical assumption of an unproblematically self-owned body, a space is opened up to consider the effect of interventions and modifications from different perspectives. Attention can be given to how the procedure acts on the person through a full consideration of context, rather than presuming that engagement with biomedical interventions can be decided solely on the basis of their accord with claims to individual agency. Such a contextual view of health, moreover, could give women's health the tools to interrogate the real dilemmas of technologies that invade a woman's body in ways that, in the limit, can in fact usurp the notion of autonomy. Such an approach could in turn offer new grounds for considering the effects and bioethical implications of such technologies as assisted reproductive technologies, transplantation, and body modification.[2]

The goal of our project is not simply to critique these traditionalist assumptions, but to urge an uncovering of the places in which the application of unexamined normativities, simplifications, and idealizations obscures the very real complexities, impasses, and misunderstandings that characterize decision-making and treatment in health matters and thus, the shortcomings of rule bound action. The result will have application both in the realm of the everyday and in the face of life and death decisions. More pragmatically, we argue that replacing these modernist conventions with a theory-practice alignment that takes account of contingency, situated lives, and the messiness of the material world is a practical way to deal with concrete contemporary conditions.

More theoretically, our contentions are two.

First, we argue that postmodernist thought can provide a ground from which to adopt such an uncovering viewpoint, allowing more adequate action in the face of an ever-changing body that cannot be restored to any single, unchanging normative position. Whether subsumed under the term 'postconventional'[3] or named as poststructuralist, deconstructive, or postmodernist, this body of thought troubles and disrupts reformist goals by insisting that knowledge is always fragmented and dispersed in a series of

[1] Here, we wish to differentiate between the current practice and the movement/theorizing of women's health.

[2] Susan Sherwin (1992) expands on the relevance of feminist ethics to health care ethics, in general, in her book, *No Longer Patient: Feminist Ethics and Health Care.*

[3] The term 'postconventional' cannot be defined adequately in a few points, and its use here signals just some of its facets that might support a radical rethinking of the developments that impact on the care of the body.