Volume 22 Issue 45
Originally issued as G9

Global Journal of human-social science: G
Linguistics & Education
Volume 22 Issue 9 Version 1.0 Year 2022
Type: Double Blind Peer Reviewed International Research Journal
Publisher: Global Journals
Online ISSN: 2249-460X & Print ISSN: 0975-587X

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GJHSS-G Classification: *DDC Code: 362.1089 LCC Code: RA563.M56*



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Body, Health and Society: Socioanthropological Considerations

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I. Introduction

In a classic text titled "Health and Society", author Donnangelo (1976) brings up a basic premise: in the relations that medicine keeps with the economic, political and ideological structure of societies where capitalist production predominate, medical practice ends up participating in the reproduction and maintenance of such structures by means of the upkeep of labour force and, further, of the participation in the control of social antagonisms.

This is to say that medicine, in such contexts, articulates beyond technique with other social practices, establishing itself as an important discursive field, in the organisation of norms and interdictions.

By means of different perspectives, several authors have analysed this aspect, among them Foucault (1976; 2006), Adam and Herzlich (2001), Fabiola Rohden, (2001), Camargo Júnior (2003), authors who studied the history of medicine in addition to the normative and moral interventions beyond technique that are at the service of the social configuration, of the division of roles that are to be maintained among individuals.

In this relationship between medicine and society, Donnangelo (1976) highlights the discriminatory class character that is manifested in the manipulation of medical resources.

Minayo (2001) analyses this aspect, underlining that to study the health field is to study social inequalities, being, therefore, necessary to mobilise the notion of social class in the perception of this field's complexity. Such inequalities refer to the population's differentiated access to health services, and, further, to the professionals' very hierarchisation, inside which the hegemony of medical knowledge and its articulation with power is revealed. A hegemony that results, additionally, in the asymmetrical and power relations between doctors and the patients given assistance (Lima, 2018).

According to Minayo (2001) one needs to resort to class sociology, not only in the study of health, but also in the study of any other wider theme of culture.

Sarti and Melucci (1998), in a text discussing the importance of the social sciences for the health field, refer to other social cleavages, beyond class, which restrict the access by individuals to health, such as, specially, gender, race, ethnic background, religion, as well as cultural particularities.

Donnangelo (1976) highlights the social class aspect in the differentiation of medical practice. For the author, this differentiated relation, given by class, gains specificity in capitalist societies.

In such societies, the extension of medical practice by means of the quantitative widening of services and the increasing incorporation of populations into medical care is related, the author states, to the continuation of capitalist accumulation processes. This means seeking to provide health care to the worker only as it meets immediate economic goals, which do not involve the growing incorporation into medical care of social groups marginalised from the production process, Donnangelo (1976) ponders.

The extension of medical practice, presently, in Western societies, implies the extension of medicine's normativity. As Adam and Herzlich (2001) elaborate, contemporary problems are increasingly considered under the light of medical rationality, which grounds the normatisations. Thus, problems such as drugs, alcoholism, child abuse, among others, are medicalised more and more. In such medicalised societies, as defined by a few authors, among them Breton (2003; 2006) and Camargo Júnior (2003), fiscalist and normative arguments are increasingly deployed in the comprehension and definition of social problems.

For Jane Russo (2006), in its preventive version, medicine exhorts people to live a prescribed and balanced life; a healthy life - according to moral concepts around the issue, the author stresses.

Conceptions that prescribe an action on our bodies. For Donnangelo (1976), this body, sociologically speaking, is not limited to the physiological anatomical aspects, being, above all, an agent of work.

To be ill in such societies, Adam and Herzlich (2001) argue, is to be absent from work. In a study made about representations of health and of the sick

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person, the authors detect an association, in the popular classes, between illness and the incapacity for work. Especially for this population, work is a central category, concretely and symbolically speaking, once it allows for the legitimate access to social space by means of the construction of a working person's identity, chiefly among men, according to an ideal imaginary within such families, Sarti (1996); Adam and Herzlich (2001) highlight in different studies centred on such populations.

It is thus that, on this work (biological and social) body, medical and biomedical practices are operated.

Medical attention on the body, the biological organism, is grounded on the separation between body and spirit; on the divide between Man and his body. The Cartesian dualism that founds this distinction answers for the conception of the body in modernity, which is continued up to contemporaneity, ponders Breton (2006), in a sociological study about the issue.

This separation is supported by the notion of a split person, separated from her own body, which is conceived only in its biological dimension. In this perspective, Morin (2000) states that the fragmented conception of the world tries to reduce complex phenomena down to simplifying explanations, instead of conceiving them as multidimensional.

Differently from such conceptions, in the human sciences, the body is constituted as a human reality by the meaning that collectivity attributes to it, not having a character that is objective or prior to the meaning itself, Sarti (2001) highlights in a study about pain and suffering.

In face of it, the human sciences develop a critique of biomedicine's naturalised body, especially gender studies, which have problematised the social construction of women's and men's bodies. Within this scope, Thomas Laqueur (2001) retraces the historical process of the invention by medicine of the two sexes, with implications to the consolidation of a model and of a moral for women and the family, by means of the disciplinary control of the female body and its sexuality.

The split body and the individual are notions that go together in modern western culture. As developed by Durkheim ([1912] 1989), in the text "Elementary Forms of Religious Life", the body is an individuation factor.

The notion of a "self" in the relation of the individual with society is recent in the history of the Western world. This is a historically built social category (the notion of the individual) in the context of the search for freedom and autonomy, which is counterposed to submission to the collectivity. As Dumont (1983) develops, the individual is constituted by a value, the triumph of individualism.

In this conception separating body and person in contemporary Western societies, the corresponding model of health and illness is ontological. As Laplantine (2001) clarifies, this model takes illness as an autonomous entity. For Sarti (2010), in a text discussing the traffic of knowledge in the health field, this implies another diverse conception of that which had already split human beings between body and person, autonomising the body into the biological body, in a matter unveiled by experimentation. And all this together with the increasingly more advanced technological resources that end up instrumentalising the body even further, in a process of maximum medicalisation, Breton (2003) writes in "Farewell to the Body".

The critique to this intended objectivism of the biological sciences' has been elaborated by Canguilhem (2006) and Foucault, focussing on the historical process of this knowledge construction and of medical practice.

This critique, under different perspectives, is well-established in the social sciences. In this field of knowledge, human beings are deemed social beings, who are born, grow up, fall ill and die, Sarti (2001) stresses, in relations that are established by society, by culture and by the times in which individuals find themselves.

Birth, pain, suffering, illness, are manifested in the biological body and are lived grounded on the way in which society, culture, defines such experiences. This meaning is socially elaborated. The biological body is thus socially translated, from the instant the individual is born. As Sarti (2001) develops, every human fact is a social language. The apparent naturalness yields from the fact that we assimilate it through habit, unthinkingly, as Mauss (1973) clarifies in a text related to bodily techniques.

The social sciences, in particular, seek the deconstruction, in social studies, of the "naturality" of the relations there established by individuals.

In such relations, the social is defined by constantly made and remade rules, which implement the dynamics of power relations.

The social analysis of the health field operates the apprehension of power relations. In such relations, some practices, defined as medical-scientific, are legitimated to the detriment of other that are demoted, as Laplantine (2001) and Breton (2006) elaborate.

In anyway, these are discourses and practices that coexist, even though, in this clash, the medical discourse is hegemonic and dominant in Western societies. They are, as Laplantine (2001) develops, models for illness and health, valid for the practices articulated to them, according to a specific rationality. But the ill person holds his or her own interpretation models of the health-illness process, rooted in the sociocultural contexts one is inscribed in. In this sense, all knowledge is relative and liable to mutation, such as scientific knowledge, highlighted by Foucault in "The Birth of the Clinic".

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In the examination of different cultures, not only what is considered an illness or not, such as the importance attributed to specific parts of the body, is diverse. Adam and Herzlich (2001) reveal that in some cultures, for instance, intestinal worms attacked by Western medicine are not considered malefic, but are considered part of the digestive system. In another example, the authors reveal that, while in Western societies the brain and heart are given much importance, in Japan, the stomach is the central organ, the one that merits the most attention.

So it is the belonging to a culture, the authors highlight, that will furnish individuals with the limits within which the interpretations regarding bodily phenomena operate. This perspective relativises the biomedical interpretation model for the health and illness process, whose emphasis is placed on the universal and objective, anatomophysiological character. At the same time, it widens the understanding of this process that is not restricted to the biological, necessarily demanding the articulation with the sociocultural, economic and political aspects manifested there.

This is a comprehension of the specific meanings that the biological phenomena take up in a given culture and society, in view of the fact that the records of normality and of abnormality are determined grounded on socially valid values. As debated by Canguilhem (2006), there is nothing in the biological that defines the exact exit point or moment for normality, other than a value. It is the subject's experience, in his or her relation with the environment, that informs the doctor about the state of health and illness in which the individual is to be found.

Man is a relational and symbolic being. For biomedicine, the sick person is circumscribed within a set of organs and systems. The human sciences resite humans to the body, learning the meanings of experiences lived and expressed differently according to gender, social class, ethnicity, religion, among them other social determinants.

As pointed out by Adam and Herzlich (2001), health professionals recognise the existence of different interpretations of the health-illness process. But these are seen as a simple translation of a fixed, objective reality. Differently from this conception, the human sciences conceive health and illness as social realities, historically constituted. Culture is not just a way of representing health and illness; it is the very constitution that models it, furnishing its meanings, its outlines, the resources deployed, also regarding the support obtained, i.e., the social networks (friends, neighbours, relatives etc.) which individuals rely on in order to speak of their illness, diffusing the meanings shared there and, thus, becoming someone able to get help.

The reference to class is specifically important in this issue. As Adam and Herzlich (2001) demonstrate, it is chiefly the upper classes who most resort to a doctor in situations of preventive care. The reasons for that revolve around the language common to both parties, the shared meanings in the explanation of the illness, also given by the proximity regarding formal education.

II. Final Remarks

In the terms that establish the relations between health, body, culture and society, in the context of Western contemporary societies, Adam and Herzlich (2001) show, in a study about the representations of health and illness, how individuals, as they speak about health and illness, do not refer to the body, but, instead, speak of the relation that they establish with the social. Illness, from this perspective, implies a conflicting relation with the social. To speak of health and illness is to speak of the relation that the individual establishes with society's social order, within which he or she find themselves.

The present text sought to reflect about the articulation between the dimensions of the body, health, the individual and society, understanding that it is necessary to consider the diversities and inequalities rendered evident by social markers, among them class, gender, ethnicity/race and place of abode, which allow for the understanding of discourses about and representations of care, being ill or being healthy, as well as for the comprehension of the constraints and (im)possibility of access to health services, inside the space and time where individuals are situated in different ways.

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