

# Culture, Embodiment, and the Senses

Thursday, 29 September 2005

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## Reading

- Jerome Bylebyl, “The Manifest and the Hidden in the Renaissance Clinic,” in *Medicine and the Five Senses*, pp. 40-60.
  - Richard Palmer, “In Bad Odour: Smell and Its Significance in Medicine from Antiquity to the Seventeenth Century,” in *Medicine and the Five Senses*, pp. 61-68.
  - Roy Porter, “The Rise of Physical Examination,” in *Medicine and the Five Senses*, pp. 179-197.
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Aside: Complementary and alternative medicines are globalizing (e.g. acupuncture, reiki, ayurveda). Certain types of knowledge are being commodified and marketed.

**Galen** was a *rationalist*, starting with abstract principles and from there understanding society. **Hippocrates** was an *empiricist*, examining material evidence first and *then* deriving abstract principles from the data.

DeMonte (who was the earliest physician whose interactions with patients were recorded) was a Galenist – **humoral theory** with universal concepts of the humors, e.g. there were 7 humors by which you understood the body’s pathways – the emphasis was on *analysis* and not just rote memorization. He **combined teaching with bedside consultation**.

We are exploring the senses from the perspective of embodiment and seeing how the emphasis on certain sensory modes influence methodology, how the body is seen and sensed.

**The method of clinical diagnosis is influenced by styles of thinking and communication**, e.g. verbal history in lieu of touch used to diagnose the patient. Details such as these illuminate the doctor/patient and doctor/doctor relations.

**Hospital discourse** used senses to assess condition. **Bedside consultation** was more of a mortality/morbidity conference. Doctors disputed but didn’t want to step on each other’s toes. This is evidence of the **power and politics in medical history**, with which we see similarities today (e.g. professional relationships).

- *What types of touch are socially acceptable?*
- *How do styles of touch and presentations of the body vary across class?*

**Porter** explores why the physical exam had such a minimal role in England.

☞ For one, doctors didn’t have any **objective tools**. (Recall Kuriyama’s point that the West wanted to quantify the pulse so we didn’t have to trust the subjective senses. Here is the Western tendency to want to find root causes, not trusting sensory data. This **rationalist tradition** was revived in during the Renaissance and Enlightenment.

☞ **stylized act** between doctor and patient – social meanings attached to social positions

☞ philosophical/abstract/rational vs. empirical, professional physician role vs. surgeon

- *What is smell?*

Smell had a **tangibility** to it – it was able to affect the person (e.g. the scents of perfumes had bodily effect). It could also be **nutritive** or indicative of **disease**.

It could also affect the body's spirits. There were **animal, vital, and natural spirits** that operated the body and were ontological entities. Animal spirits were located in the brain, vital in the heart – related to Kuriyama's analysis of the Western emphasis on the **seat of governance**. Also applicable is the concept of *pneuma* and how it transitioned to the concept of spirit.

- *How does the perception of smell change a society? Consider sanitation, segregation, and theories of disciplined bodies by Foucault...*

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## MICHEL FOUCAULT

Foucault theorized about how modern European society organized itself – effectively, he developed a **theory of the state**.

- ∞ the state was organized by attending to health, hygiene, disease, the body
- ∞ contagion was cast out or confined (e.g. asylums confined the morally indigent, and idleness was confined in the thought that it was therapeutic for the patient)

- *What practices encourage organization vis-a-vis our own bodies?*

The State was built up with an interest in **security**, e.g. it would classify each house inquiring who is sick where and would also categorize a *system of disease*.

Attention to the body shifted as we came under **disciplinary regimes**. Bodily practices encouraged at these sites were really *embodied* by those individual involved. For example, schools, tests, and the compartmentalization of time all are forms of **exercising power over bodies**.

**External forms of discipline were eventually internalized.** We went from casting off and confinement (external) to self-discipline, self-regulation through things like the Family or religious institutions.

**Regimes of truth** – our sense of self is influenced by institutions with which we are interacting and involved. We internalize ways of thinking about how to manage our bodies.

- *How do we resist?*
- *Is everything patterned after an institution?*
- *Would resistance change the fundamental structure of power?*

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The **social status** of the patient influenced what type of treatment he/she received.

Institutions were developing at this time. Knowledge production was at work at any given moment, e.g. through doctor/patient relations and clinical diagnosis.

*How do notions of prudery change over time?*

**Social distance** (between socioeconomic classes) created a “two-way invisibility” and gave the upper class the freedom to be less prudish.

During the 19<sup>th</sup> century, there was an emphasis on female modesty, virginity, and adherence to **sexual mores**. In the colonies, **sexuality was employed strategically** through capitalism and regimes of slavery. At the same time, there was the rising Victorian ideal of purity and modesty which was concurrent with the rise of **miscegenation** fears.

Social aim: **control over female sexuality** (particularly upper class women)

There was an increase of mixed race people in the colonies and this was disconcerting in the home country since it compromised the notion of the family.

- *How do we display/treat the body? Consider the symbolic value of the family...*
- *How is it that we read the **body as a system of signs**?*

Physicians perform diagnoses according to discernible *symptoms* – they identify the damaged *function*, and address the *underlying problem*.

Different parts of the bodily discourse are communicated verbally and through the observations of the clinicians...

- *How did the physicians vary in their opinions over different points?*

We want to concentrate on the **status of touch** in a given society.

- *How is touch regulated differently in different settings?*