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Discuss and critique how the body may be problematic and how nurses may accommodate and respond to these issues.

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Abstract

This essay will explore the view that the body becomes problematic in nursing due to the dominance of the biomedical model and its representations of the body. This model effectively renders much of the work that nurses do with the body invisible. The characteristics of the biomedical model and its representations of the body will be described. The central role of the body in nursing will be established and a contemporary concept of gender discussed. I will then briefly describe the historical construction of nursing and medicine that I believe has produced the gendered and hierarchical workplace that presently exists. Cartesian dualism and the development of a dominant discourse that defines the body scientifically will be examined in greater detail. My personal experiences both as a nurse in a neonatal intensive care unit and an experience as a patient in a neurosurgical unit will be examined in the light of these issues.

The biomedical model of medicine is characterised by an institutionalised, scientific, and technologically directed approach and is derived from the positivistic philosophy of Descartes (Turner 1987: 214). The body is represented as a machine and disease is seen as a mechanical problem (Parker 1997:11). The biomedical model is also focused on cure, not care and seeks to control 'dysfunctions of the body-physical by controlling the cellular molecular level' (Watson 1999:132). While this paradigm has had success and 'led to diagnostic and therapeutic advances of stunning effectiveness' (Cassell 1992:237) it has ignored the personalised and subjective experience of embodiment.

I write from a perspective that supports the view that the body is central to nursing (Parker, 1997: 11, Fassett & Gallagher, 1998: 15, Holmes, 1994: 111) and is more than just flesh and blood, being produced as much through historical and cultural processes as biological processes (Parker, 1997: 21, Fassett & Gallagher 1998: 14, Grosz, 1994: 20, Turner, 1992: 47). I also support 'the perspective that considers gender to be one of the most important means by which the world is structured. This gendered structure grants men and women unequal opportunities, unequal access to resources and different social statuses' (Harrington and Kunkel, 1996: 8).

Connell (1987: 139) argues that 'collectivities, institutions and historical processes' are also gendered, and this understanding can be applied to the construction of nursing and medicine. The institutionalisation of women's role as caregivers can be traced to the rise of Christianity and its appropriation of Greek philosophical ideals regarding 'the superiority of the spirit over the inferiority of the body' (Colliere 1984: 99). By the 13 th Century hospital orders had developed, with nuns providing patient care, while at the same time women's knowledge of healing outside of

the church was declared pagan' (Colliere 1984: 99). A gendered hierarchy that allowed women to nurse under the control of men and punished women who chose to preserve their own knowledge was clearly visible. Punishment extended to death in the witch-hunts of 14th to 18th Centuries (Colliere 1984: 99). This gendered hierarchy continued into modernity.

Colliere maintains that a moral and a technical perspective determined the modern training of the nurse and care of the body became so overwhelmed by procedures and treatments that it became invisible within a task oriented environment. (Colliere 1984:102-103). Caring for the body subsequently became part of a moral identity rather than work (Reverby, 1987: 5). This perspective influenced my experience as a nurse training in the 1970's. Following medical orders and collecting data for doctors were visible and important parts of my work. Care of the body was assigned the title of 'basic nursing care' and the term basic was seen to mean 'simple' rather than 'essential' or 'fundamental' (Lawler 1991: 31). Caring for the body therefore became part of my feminine identity, shaping the stereotypes of 'ministering angel' and 'Doctors handmaiden' (Bridges 1989: 851-2) rather than being central to my work as a nurse. These stereotypes also supported the existing gendered division of labour.

While historically the church had defined the body, and nurses owed their allegiance and devotion to God, in modernity science and the biomedical model define the body, and nurses owe their allegiance and devotion to the Doctor. While women are no longer burnt as witches 'medical knowledge is legitimated as superior to subjective observation, intuition and the skilled practical knowledge acquired over time by the nurse' (Street, 1992:157). Nursing, and care of the body, have over time become strongly associated with femininity, while science, and medicine, have been constructed using masculine images (Lumb, Strube 1992: 87, Emden 1995:31). Wilshire (1989: 94-95) points out that culturally we extol things perceived of as male and degrade those things perceived of as female, and supports Connell's (1987: 139) view that it is not only individuals that are gendered. The historical construction of nursing has produced a gendered hierarchy that functions regardless of the gender of individual nurses and doctors and values medical and scientific knowledge at the expense of all other forms of knowledge.

"This prevailing attitude affected my experience as a nurse on a daily basis. Perhaps its biggest effect was that I internalised these attitudes and thought of my colleagues and myself as 'just' nurses. I was taught to believe that part of the role of a good nurse was obedience and subservience to medical staff and to their assessment of any situation. At the same time close contact with patients meant I was aware of an expanding knowledge base being developed from my practice. This was often at odds with the bio-medical model and its understandings of the body and was difficult to verbalise. Any knowledge gained through the practice of nursing was gendered knowledge and could therefore be legitimately devalued as 'feminine'." (Carr 2000)

Western philosophical thought is characterised by dichotomous thinking and leads to hierarchies that assign advantage to one of the polarised terms (Grosz 1994: 3). The mind/body separation of Cartesian dualism is an example of this type of thinking and has been a powerful influence on perceptions of the body. Holmes (1994: 105) states Cartesian dualism has 'delineated the realm of scientific enquiry, and of rationalist understanding, as being concerned with the physical and not the spiritual or psychological aspects of persons'. This has meant that the body has increasingly become a thing to be studied and the experience of embodiment is ignored (Madjar 1997:55).

As a nurse I often felt as if I was working in two worlds, the patient's and the Doctor's. As Lawler states (1991: 34) 'one cannot simply nurse the body in the bed' and I found it was impossible to focus only on the medically defined problem and provide effective care. How a person defined their illness and their body could not be ignored. Their lived, embodied experiences of health could not be ignored. But they were! While the concept of embodiment was not recognised I, and other nurses, were daily working with its reality. The body I worked with was not the one in textbooks, neatly divided into body and mind. Body and mind were inextricably linked. Scheper-Hughes and Lock (1987: 10, 30) point out that even when we begin to question the notions of Cartesian dualism we are often left without a vocabulary to voice our concerns.

Martin (in Turner 1992: 51) points out while we are able to acknowledge that the language used by medicine in previous centuries is a 'symbolic representation of social ideas', modern language is seen to be an accurate description of the natural world. Language is, however, recognized to have the power to shape our understandings of the world and to inform practice (Bruni 1995: 173, Turner 1992: 52) and this extends to our understanding of the body and our role as nurses in caring for bodies (Parker 1997: 11). Foucault (in Turner 1992:52-54) argued that understandings are created by the dominant epistemology of any given time. This ability to create reality is also linked to power (Turner 1992: 52-54) and Glass (1998: 122) reminds us with Delacour's words, 'nursing has been constructed by powerful discourses including those of medicine and gender, in which our society's dominant ideologies are enshrined'.

In what way does this make the body problematic in nursing? The body in modernity has been created by the dominant scientific discourse of modern medicine (Parker 1997: 24, Foucault in Fassett and Gallagher 1998:14) and as Silverman (in Fassett & Gallagher 1998: 22) describes it 'discursive bodies lean upon and mould real bodies' Until recently alternative ways of describing or knowing the body had been silenced or marginalised (Gray & Pratt: 173,) and I believe that nursing is one of these alternative ways of knowing the body. However it may be that the invisibility of care of the body, and of nursing, in the dominant scientific discourse has been a double-edged sword. While it has meant that our work has been unacknowledged and assigned little value it may have also created a space for this different way of knowing the body to grow and develop unimpeded. Since Merleau-Ponty in 1962 (Turner 1992: 43) nurses have been writing of their knowledge of the body and embodiment and the recent proliferation of papers dealing with these issues could be seen to support this view. The challenge I see, as a nurse, is to take this conceptual and subjective view of the body and build its legitimacy in both the professional and public spheres.

My experience is that this way of knowing the body is sometimes accepted and respected but on an informal basis only. 'As a neonatal intensive care nurse there were huge amounts of observations to be recorded every hour. Many of these could be recorded without ever paying any attention to the baby; it was possible to simply look at the appropriate machines. As I gained experience I learnt that while all the observations could appear normal sometimes a baby just did not look right. Over time I learnt to trust this assessment and I saw other nurses doing the same. Although there was no way to adequately express my concerns, due to their experiential and subjective nature, I learnt that if I reported my concerns to an experienced doctor they were acted on. Just as my experience informed me, the doctor's experience was that this was valuable information. This was never recorded anywhere, only what was found was recorded' (Carr 2000)

The biomedical model of the body may dominate health care at the moment but this dominance is not total and nurses can choose to resist this dominance. I believe that as language constitutes knowledge and is linked to power nurses could use language to promote their knowledge of the body. If we can develop a discourse that adequately describes not only what we do, but also why we do it, we could challenge this dominance and allow a different model of the body to emerge.

The difficulty of working as care givers in an environment focused on cure also makes the body problematic in nursing. Parker (1997: 16, 22) sees cure and care as 'conflicting temporalities, one directed to the present time, the other towards the future. They can also be understood as competing ideologies of health care.' I have already established that medicine and nursing are gendered and cure and care are similarly gendered. This gendering leads to care of the body being invisible and devalued in a system that is focused on cure. In such a system the experience of embodiment and even the body as a whole can become lost. Cassell (1992: 237) tells us how the trend towards molecularisation in modern medicine has created a situation where pain is no longer understood in terms of human suffering but as the biology of nerve transmission. The embodied experience of pain is of no interest. For nurses, focused on care, the experience of pain is what matters. How an individual manages pain, what it means to them and how it affects their life are what matters. If these two ways of understanding the experience of pain were equally valued I believe the patient would be well served, but as Cassell points out 'medical science and disease theory naturally deal with clinical events by reaching for molecular explanations even when they provide no insight into the clinical situation'.

I will end this discussion by recounting a personal experience illustrating the importance of the work of nurses in caring for the body.

'After an operation to have a meningioma removed a nurse with warm towels came to wash me. I was tired, scared, and unable to speak, although the words were in my head. For the first time in hospital the whole of me was noticed, not just my tumour. Although I.V. lines, cannulas, drains, catheters and other pieces of plastic and steel had to be negotiated I was central to this experience. Warm towels helped me feel what was different about my body, helped me to find my body again. I stopped being scared because of warm towels'. (Carr 2000)

A sponge is the most basic of nursing tasks, and yet in terms of my embodied experience of illness and hospitalisation it was significant. While this sponge was significant to me, the biomedical model would not have even noted its occurrence.

This paper demonstrates the ways the biomedical model, and its representations of the body, have created a situation where much of the work nurses do, and knowledge gained through this work, is made invisible or worthless. I have established the centrality of the body to nursing and the important role that gender has played in the construction of nursing. The way in which Cartesian dualism has restricted modern understandings of the body has been noted. The discourse of the biomedical model and its role in maintaining the dominance of this perspective has been explored. I have discussed the possibility of resistance through the use of another discourse that recognises the experience of embodiment, and knowledge gained through working with embodied beings. The conflict between cure and care is also recognised. I have used my experiences as a nurse throughout this paper and have recalled one experience as a patient. While the dominant bio-medical model

presently ignores the experience of embodiment I believe, like Cassell, (1992: 241) 'We are of a piece. Persons can accomplish nothing, see, hear and touch nothing, know nothing and think nothing in which their bodies do not take part'.

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