"These Things Don't Happen to People Like you": The Embodied Experience at the Doctor's office

James Honke

MSc. Political Theory
Email: jameshonke@protonmail.com

Abstract

This paper explores the theoretical implications of embodiment in interactions with medical professionals in hospitals, doctors offices etc. It explores the emotional reactions that can be experienced during these interactions, isolating three main emotional 'themes' – vulnerability, shame and discipline – which arose from participant submissions. These are theorised using Agamben's concept of 'bare life', Mbembé's *necropolitics*, and Foucault's disciplinary theories, to explore how these emotional themes are engendered in patients. The paper argues that the hierarchies inherent to our current experience of medical institutions leads to power relations that are ripe for abuse, and leans on a religious lexicon of 'sin' and 'redemption' to explore the effect of these power relations on the relationships between medical professionals and patients. The paper incorporates evidence from the aforementioned transcribed personal accounts including an auto-ethnographic account from the author in order to illuminate, and provide support for, the theoretical argument.

Keywords

Healthcare, Power, Necropolitics, Bare life, Discipline

Introduction

"So you've had a panic attack, then?", the doctor said confidently. Having recently moved to the Netherlands, I was meeting this doctor for the first time; I had not yet sat down and was still removing my coat. What followed was a description of my symptoms (promptly ignored) and a discussion of my medical history (assertively disputed). And then the immortal words: "You're too young for things like that." I immediately became aware of my body and physical appearance. My youth and apparent health had robbed me of a more thorough examination; instead, I had been given a brief once-over and was relying on a doctor's assumptions about the odds. This was not the first time such assumptions had been made, and the previous time had left me fearing for my life.

This is not an uncommon experience. Medical examination is time-consuming and expensive, and doctors are under increasing pressure to cut costs (American Hospital Association, 2024). As such, doctors, under pressure to make diagnoses with little time or resources for longer evaluations, have to rely on assumptions and probabilities when deciding treatment for patients, and the obvious source of such assumptions is the patient's body and its gender presentation, age, ethnicity, size, and ability (Nuila, 2023). This leads to different outcomes based on

various identity markers[1], and changes the embodied experience of medical care. This is what unites the accounts in this essay - they all relate how the medical profession interacts with the body, and how the body changes the trajectory of diagnosis and treatment (despite an absence of medical justification). This essay aims to normatively theorise the emotionality of this interaction, i.e., what it feels like to be a patient and have one's body become subject to the "clinical gaze" (Foucault, 1973, cited by Singer et al., 2020, p. 89). In essence: how might we understand the emotional experience of patients in a medical institution?

I have structured the argument under three emotional 'themes' that I noted in the submissions: vulnerability, shame, and discipline, and have supported these with ethnographic accounts from myself and others that are taken from submissions. The accounts were often dense with emotion - complementary and conflicting - but these categories serve for the purpose of analysis. I have often allowed the submissions to 'take the lead', as I aim for the emotionality to be expressed directly in the words of the people who experienced it. This means that the muscle of this argument - whilst theoretical and based upon concepts such as Agamben's 'bare life' and Mbembé's 'necropolitics' - is hung upon a skeleton of empirical reality that can structure it.

This is not an attempt at recrimination, nor an attempt to discredit medical professionals and the important work that they do. Doctors, nurses etc. perform essential (often life-saving) work under increasingly difficult conditions and deserve praise. This is especially true given that we live in the aftershocks of the Coronavirus pandemic in which medical professionals daily risked their own lives for their patients. This was nothing short of heroic. I also specifically do not want to contribute to the trend of anti-intellectualism that has become inextricably linked with the rise of far-right populists across European and North American democracies (Merkley, 2020). Instead, this paper exists to critique the current power relationship afforded by the clinical gaze; as a necessarily limited study, I am only seeking to contribute in a small way to wider literature exploring the different and distinct experiences of healthcare (e.g. Casanova-Perez et al., 2021).

Ethics

Finally, we must note some ethical concerns given the private nature of the accounts included within. The participants sent me their accounts orally and these were transcribed digitally to be used in the paper. I used all the accounts I received, and since these were to serve the theoretical argument I have only included excerpts throughout. These excerpts were lightly edited for clarity, as I wished for the emotional experiences to be explored in the words of the participants themselves. Participants were also given the opportunity to feedback on the paper throughout the writing process in order for them to contribute new insights or for them to change elements that they felt didn't reflect their experience.

Most participants were happy to have their accounts published under their first names. Those who weren't sure or wished to be pseudonymised have been pseudonymised, and these accounts have been marked with an asterisk. These participants have been pseudonymised under names that fit their nationality, ethnicity and gender. The original audio files and transcripts have been securely stored either under the first names given in the paper or

1 For examples, see: MACPAC, 2023; Macapagal et al., 2016; Teunissen et al., 2016; Phelan et al., 2015.

under the pseudonyms used in the paper. No other personal data has been stored, and I have only mentioned the age of participants when they deemed it relevant to their account. Otherwise, I have used descriptive terms to indicate the ages of a participant - 'younger' to indicate 35 and below, 'middle-aged' to indicate 36 to 60, and 'older' to indicate 61 and above. These categories are not perfect, but are used to broadly indicate how the participant would have appeared to a doctor at the time of their account.

Vulnerability and Loss of Personhood

The first emotional theme to explore is a sense of acute vulnerability. Garrau and Laborde termed this "problematic vulnerability", which they distinguished from "fundamental vulnerability" (2015, p. 13-15). Fundamental vulnerability is the vulnerability that we all share as human beings as we remain dependent on each other within society. This becomes problematic vulnerability when it becomes capable of being abused i.e., whether it makes one vulnerable to being dominated.

One way this is evident is when the medical staff decide diagnoses or treatments without the patient's meaningful input. Medical professionals are experts, and this expertise can be understood through the framework of "biopower", as the "knowledge of the body translates into power over the body" (Singer et al., 2020, p. 89) that can leave the patient vulnerable to domination. In such a case, one is lowered to 'bare life' and ceases to be an autonomous human being (Agamben & Heller-Roazen, 1998, p. 6), becoming instead a kind of "damaged life, stripped of its political significance" (Ziarek, 2008, p. 90). One becomes something like an infant; stripped of personhood and subject to the authority of medical experts who are sovereign within the smaller domain of the medical institution. The patients within exist in a state of exception by virtue of the subject matter, as they are only there due to a discrepancy between their body's behaviour and its baseline function. As such, patients are usually expecting to cede their autonomy to some degree, as long as they are treated with respect and dignity (Joffe et al., 2003, p. 106). However, this can quickly be eroded by medical professionals who fail to treat patients as sentient human beings but rather as 'cases' to be 'solved'.

By way of example, after one serious medical incident, I had my blood tested to the point that my sleep was disrupted and my arms were heavily bruised. Only after I demanded an explanation was this stopped, and it was never explained to me why this had begun in the first place. I felt as if I had ceased to be a person with a social world, and had instead become the biological equivalent of a broken-down car and thus deserved no explanation; I had become 'bare life'. When a doctor did come to explain other aspects of my care, it didn't feel as if it was for my understanding but more so they might tick a box marked 'consent'. I did not feel that I was being treated as a human being in need of care but as a 'problem' – a patient rather than a person.

Consent and Autonomy

This vulnerability is particularly acute when it arrives at the intersection of disability, as disabled people have an even more difficult time being seen as autonomous; what some have coined the 'Does He Take Sugar?' effect (Rogers & Marsden, 2013, p. 48). This is the tendency of able-bodied people to talk past disabled people to care figures "regardless of whether that person can speak for him- or herself". Disabled people are also "inevitably

dependent" (Kittay, 2015, p. 55),[2] and thus more 'fundamentally' vulnerable as a result of the interaction between their impairment and social structures. In a more inclusive society this would not be a problem (indeed, the social category of 'disability' might not need exist), but in an ableist society and coupled with the attitude described, this leaves disabled people more exposed to 'problematic' vulnerability. Zak, a younger disabled man, related his experience in the UK during a clinical trial:

> ... I had to stay over the night, and I don't know if you remember the last time you were in hospital [but] they're... kind of on with the observations they do. And I think if you work in hospital it becomes very routine and what that tends to mean is you get a lot of stuff done to you, which seemingly for me… it's like elderly people with dementia, they tend to kind of treat you like a passive object, so they'll try and take your blood pressure without actually saying "oh would you mind" [...] [they'll] just grab your arm and then kind of assume that you have no ability to be an active part in whatever they're doing...

Zak's mention of dementia patients is illustrative, as disabled people (Adams & Erevelles, 2017) and dementia patients (Burke, 2019)[3] have both been discussed in the context of 'bare life'. The ethical philosopher Peter Singer, for example, argues that when judging personhood, the mere experience of "pleasure and pain" is not enough; Singer calls these "merely conscious beings" (idem, p. 85). Instead, we must take into account "rationality and self-consciousness" (2011, p. 74) which he takes in a Lockean conception to mean that a being is "aware of itself as a distinct entity, with a past and a future" (idem., p. 76). Singer has used this to argue that "killing a chimpanzee is, other things being equal, worse than the killing of a human being who, because of a profound intellectual disability, is not and never can be a person" (idem., p. 101), and to argue for the "nonvoluntary euthanasia" of "severely disabled infants[4] and people who through accident, illness or old age have permanently lost the capacity to understand" (idem., p. 158). Singer goes on to say that "killing a disabled infant is not morally equivalent to killing a person. Very often it is not wrong at all" (idem., p. 167).[5] In this way, it seems that Singer takes the lives of those with dementia or intellectual disabilities to be 'bare life' (Burke, 2019, p. 201) as we have described it – life that is alive but not worthy of social relevance. Singer's philosophy has had an outsized impact in medicine and has birthed "institutional… and medical practices" (idem., p. 204): Zak related in a different conversation that he had been told by medical professionals that it would have been 'kinder to have aborted' him. Taken in this light, Zak's account is unfortunately both disappointing and unsurprising.

This disempowerment is not unique to disability. Laura relates her experience in Germany of trying to get a particular type of birth control when she was 17 accompanied by her parent:

2 This need not be a bad thing – in this same text, Kittay convincingly argues that we are all dependent to some degree, and should seek "managed dependence" (idem., p. 58). A longer discussion of this is outside the scope of this essay, but in any case this is open to abuse as both Kittay (ibid.) and Garrau and Laborde (2015) acknowledge.

3 Burke goes on to argue that we need to move beyond this framing for understanding dementia (2019, pp. 203-204). While I am inclined to agree, this discussion is outside the scope of this essay, which seeks to explore the relationship between doctors and patients based on how dementia patients are understood in the present.

4 It should be noted that in this section, he uses the example of a father who "killed his twelve-year-old disabled daughter" with "exhaust fumes" (idem., p. 159), so it seems that this extends beyond infancy.

5 Needless to say, disability studies scholars take a dim view of this (e.g., Johnson, 2003).

> ….that lady, she was a bit older, and she seemed, first of all, very put off by me wanting non-hormonal birth control, she was like [...] she finds it wrong to place an IUD in girls who have not yet been pregnant […] so, yeah, she was kind of already very against some sort of device, and she really wanted to put me on the pill. And I was like, no, but, you know, I've looked this up, I know what the risks are, and I know of the painful insertion process, all of that [...] I come here informed. Now, I was 17 years old, so, of course, I couldn't stand up for myself that well...

The doctor talks past her due to a combination of her age and gender presentation. Laura lacked the 'physical capital' (Kukkonen et al., 2021) that would embody the portrayal of expertise or 'wisdom' that is valued in a doctor's office; things traditionally associated with age (Gordon & Jordan, 2017, p. 1) and male-gendered presentation (Embacher et al., 2018, pp. 12-14). As such, the perception of Laura's body led her to be treated as uninformed, meaning the doctor talked past her to her parent (seen as more credible due to age) much in the same way as Zak experienced. Indeed, the doctor looks to her parent to be 'responsible' for her:

> *...she talked, not really to me, but to my mother. And also, she very much used this, I, as a mother, would not allow my kid to do that, and, you know, kind of tried to push my mom's buttons there, by, you know, emphasizing the pain of it so much, and that she would never do that. So, she kind of used her medical authority [...] and, like, kind of played the 'fellow mom' card, and I was not really asked. Like, I was very much talked over in that conversation…*

Zak and Laura are both treated as 'bare life'. They are stripped of meaning and autonomous power, becoming wards of either the medical staff or – in Laura's case – their parent. Rather than being seen as human beings with social meaning, they are treated as either objects to be manhandled (as per Zak) or as something to be cared for, as one might an infant (as per Laura). In either case, they feel deeply disempowered as they are treated according to the whims of others, as caregivers are the ones who are considered to be capable of giving consent or dictating the processes of care. They are deemed incapable of managing their own health *tout court* (rather than having this stripped away from them by 'poor choices' as we shall discuss later) and so are dictated to, and acted upon, from the first instance.

Physical Vulnerability

Vulnerability can also be experienced as a lack of physical capability to act. Zak relates this in terms of disability:

> … [disability] often demands a kind of sacrifice of the body, a feeling of submitting yourself to a higher authority that'll speak about you as if you're not there, and treat your body as a mechanic treats a car [...] I'm kind of at the mercy of others to hold my personhood and autonomy to the degree of importance that they deserve - and if they violate that, there's not a whole lot I can do to protect myself in the moment…

Zak's disability means that his physical vulnerability is particularly acute. Since Zak's disability affects his physical strength, he physically cannot resist the actions of nurses or doctors. This is not necessarily the only experience of disability, but those with physical impairments that lead to wheelchair use or similar may recognise this account, as

the ability to resist or simply leave the situation is reliant on others. This is not exclusive to disabled people. Eliza (a physically diminutive younger woman) related her experience in the USA with an older, bigger, male gynaecologist:

> ...when it came time to examine me, he said the words, "That's a good girl," about five times with his hand fully up my vagina. [...] And my experiences with all the other gynaecologists I've seen in my life have been very different because they've all been with female gynaecologists...

This is similar to Zak's experience, as Eliza is physically incapable of acting to prevent what is happening. She is reduced to bare life but what remains are her sexual characteristics, leaving her exposed to "sexual violation" (Ziarek, 2008, p. 93). She is stripped of her personhood by her acute physical vulnerability (laid down with her genitals exposed), and is then perceived through this as a 'defenceless woman' subject to the male gynaecologist's sovereign power; she is little more than an object to be toyed with. They are both reliant on medical professionals for reasons related to their fundamental vulnerabilities in ways that leave them exposed to problematic vulnerability. Eliza is a cis-woman and needs gynaecological care, while Zak's congenital disability means that he needs hospital care related to the specifics of his condition. In either case, this makes them dependent, and yet their bodies are also acutely physically vulnerable due to their inability to physically assert themselves. This physical vulnerability in each experience leads them being stripped of their personhood in a physical, tangible fashion.

Mortality

The last type of vulnerability is a vulnerability to death. In this way, medical care staff are the expression of necropolitics (Mbembé, 2003), as they get to decide who lives and who dies. This is different from how the violent organs of state that we traditionally associate with necropolitics (the military or police) make choices, since hospitals do not consciously decide that certain types of people should be killed or not. However, it still represents a kind of *deathworld* as medical staff are the ones who choose how and when care is administered and therefore who gets to live or die. Jenkins et al. (2023, p. 4) describe the way that patients enter a place "somewhere between life and death" as decisions are made. In the case they describe, it is the perception of the person's body - "degrading flesh, swollen limbs, and purple fingers and toes" - on which the nursing staff make their final decision (idem., p. 2). Stan* (an older man) relates a similar experience in the UK, but in an alternative direction:

> …"my left lower leg, my calf is a little bit swollen. It hurts when I walk, you know. It's just come on all of a sudden."
> So he prods around my left knee and he says, "Well, I think I know what the problem is, you know. I think it's osteoarthritis in your left knee."
> I said, "Yeah, but hang on a minute. Even if it is osteoarthritis in my left knee, Doc, it's not going to cause a shooting sensation like a red-hot poker going down the back of my calf, is it?"
> "Oh, yes, it's very possible."
> I said, "Well, it may well be possible, but I'm not really very happy with that. Can't you send me for a scan?" [...] And then they examine the leg and they find out I've got an effing blood clot behind my left knee, which I've had then for about two months. I've been walking around with this [blood clot], which

> meant that I possibly could have passed out and died at any time during that two-month period. But the doctor thought it was osteoarthritis…

The doctor made a judgement about Stan*'s body based on his age and condition and attempted to deny care. It was only when Stan* pushed to receive further examinations that he received them, and even then only after a significant delay. In this, he entered a kind of *deathworld* on the threshold between living and potential immediate death as he awaited his obstructed care. As he noted, in the interim he was entirely reliant on chance for his survival - one piece of bad luck and the blood clot could have moved, killing him. Charlotte* (a younger woman) had a similar experience after she went to the doctor's office in France coughing up blood:

> And then she went, "you've just got a cold". And I was proud of myself for doing this. I stood up for myself and I was like, "I'm not usually someone who would come to the doctors with just a cold... I'm here because I was coughing up blood this morning and I had blood in my phlegm". And she was like, "you do not have to come to the doctors if you've got blood in your phlegm. You should just go home and get better…" [...] I have always been under the impression that if you're coughing up blood, you should go to the doctors…

Charlotte is immediately dismissed, despite the fact that her symptom – coughing up blood – is fairly serious (NHS, 2024) and, as such, is a common trope in media to indicate that a character is gravely ill and likely to die (Weaving, 2020). The doctor, by withholding care without explanation, exposes Charlotte to experience of the *deathworld*, as she is left in a limbo state of ill-health. One is left feeling immensely vulnerable, as the *necropolitical* reality – that the sovereign doctor is the one with the power over your life and death – is laid bare. This kind of vulnerability to mortality is, in my own experience, horrifying. During a period in the USA, I was previously misdiagnosed and denied care after a mini-stroke, since I was told that I was 'too young' for such a thing to happen. After a different doctor's intervention I was returned to hospital for treatment, but the limbo period where one lingers in the *deathworld* exposes one to profound, frightening vulnerability; the medical professional holds the keys to either life or death, and you feel powerless to nudge the needle in either direction. Some ethicists have argued that this process of "*letting die* is not the same as *making die*" (Rabinow & Rose, 2006, p. 211[6]. In the cases described by Jenkins et al. as well as Stan*, it is clear that choosing to withhold or withdraw care is as much an ethical choice as any other; in any case, for the patient on the other side, it is just as terrifying.

Shame

Another emotion that appeared multiple times through the submissions was shame. This is related to our final case discipline, but it is also quite distinct, as shame can be imparted without expecting behavioural change. Doctors are susceptible to being influenced by the same ableist societal conceptions of an "imagined, idealized body" (Taussig, 2020, p. 12). Indeed, Foucault argues that medical science "embrace[s] a knowledge of healthy [hu]man… a definition of the model [hu]man" (2012, p. 50). When people are deemed to have 'erred', they are shamed. Bates and LaBrecque (2020, p. 6) distinguish between reintegrative and stigmatic shaming: the first is

6 Peter Singer also makes a similar argument (2011, p. 183).

intended to reassert norms and change behaviour, whilst the latter reinforces a power dynamic by "degrad[ing] and isolat[ing]". Reintegrative shaming is disciplinary (see below), whilst stigmatic shaming is the assertion of a power hierarchy through identification with the group (idem., p. 7) i.e., the 'good' as opposed to the 'sinner'. It is this that is expressed in the accounts. For example, Noah (a younger man) related his experience with a French doctor:

> I had gone to the doctor for a routine check-up and he [...] made multiple (at least three) comments on my stretch marks, which just felt weird more than anything [...] it was very odd to me to have someone like a doctor directly say "You have a lot of stretch marks. Why do you think?" as though I was going to give a response other than "because I'm fat". [I was] definitely ashamed. [...] Weight comments are nothing new for me... but this felt so much more focused on my appearance in a way I hadn't really experienced before in a medical setting.

The doctor, by noting how Noah's body differed from his vision of the 'ideal', makes Noah aware of his body and invites him to compare his "actual self" with his "ideal self" and note the "discrepancy between the two" (Miceli & Castelfranchi, 208, p. 723). There is no reasonable medical explanation for this highlighting, either, as 'stretch marks' represent no threat to a person's health; indeed, they are purely aesthetic. This highlighting was also not intended to change behaviour or encourage a healthier lifestyle since there was no offer of advice or treatment for the stretch marks. Instead, it must be concluded that these comments were meant to allude to Noah's weight. However, again, this is distinct from the 'Discipline' that we see later in this paper, since there was no offer of dietary advice, nor any explanation of how this might be harming Noah's health. Indeed, Noah's health is not a factor in this discussion. Instead, Noah's weight is referred to only in oblique, aesthetic terms (i.e., through the stretch marks), so it seems that Noah's weight is taken as a marker of his "lack of self-respect" (Vandebroeck, 2017, p. 89) and therefore Noah is subjected to "body shame" (Schlüter et al., 2023, p. 33).

This can also come from the medical professional's own beliefs about the world and how people should behave within it. In Eliza's case from earlier, she relates how the same gynaecologist had treated discussions of her sex life:

> He asked me, "Am I married?" and I said no. Then he asked me if I had a boyfriend and I said no. And then he asked me, "Why am I on birth control? Who else would I be having sex with?" […] And I just felt extremely uncomfortable: "What the fuck are you doing? Why do you feel the need to ask me that question if you're in this profession?"

This interaction results from Eliza's perceived gender and the discrepancy between the doctor's seeming ideal, traditional sexual behaviour for women and Eliza's 'actual' behaviour. This is not related to any medical reasoning – Eliza was not there related to any sexually transmitted infection – nor was there any medical advice here offered for STI avoidance or safer sex practices; instead, the discrepancy is highlighted in a way that seems designed induce shame, leaving Eliza feeling uncomfortable and exposed.

Serena (a middle-aged woman) combines both the gendered experience and the experience of being a bigger person in the UK:

> I took my 15-year-old stepdaughter to an appointment [...] As I walked into the room with my three stepchildren, my son, and [...] not having lost my baby weight, the doctor [...] looked me up and down, looked at the baby in the car seat and looked at my stepchildren and then asked me if this was a production line. [...] The whole experience left me feeling quite deflated, embarrassed and it certainly didn't help with me having a negative view about the way I looked. After having had a baby relatively recently, it does shake your body confidence quite a lot [...] It really made me feel quite small.

The doctor is comparing his perception of Serena to the 'ideal' body (since he appears to assume that she is pregnant again based purely on her shape), his ideal vision of a mother, and his notions of the ideal family. This is particularly shaming since Serena was not the intended patient and thus did not seek medical advice around weight loss or family planning. The doctor constructs where Serena has erred: she has erred as a patient (by failing to meet the conception of the 'ideal body') and as a woman (by having too many children and by not conforming to beauty standards). He then engages in stigmatic shaming, leaving her feeling "small".

Discipline

The final feeling that was described was that of discipline. Like with shame, this involves the highlighting of a discrepancy between the ideal and the actual self, but the medical professional's intervention is instead geared at encouraging 'healthy' behaviour. This has a regulating effect on patients (Singer et al., 2020, p. 89) through "reintegrative shame" (Bates & LaBrecque, 2020, p. 6). This results in a 'chastening' feeling; a 'sin' is established and a 'penance' meted out. The penance is undertaken after the appointment through self-surveillance (Vaz & Bruno, 2002, p. 274), where the clinical gaze is self-imposed. We might link this to Foucault's concept of the Panopticon (Duncan, 1994), which posited that since individuals in a disciplinary society are unaware of when they are being surveilled or not, they tend towards measures of self-discipline. Since participants could not know when they would next visit a medical institution, they took steps to behave in ways that could avoid the chastening feeling in the future. Anne Marie's (a younger woman) account from the USA is a perfect example of this disciplinary power:

> … the doctor weighed me and he was like "Oh my God you're 120 you've gained 20 pounds" and I was like "I don't think I've gained 20 pounds" because I usually I fluctuate anywhere between like 105 and 115, and he's like "No I weighed you last time and it's 20 pounds that you've gained, you know you should probably watch out because if you gain any more it'll start showing". It took me aback. [...] So I think it did scare me in a sense. [...] I was really dedicated to working out every day. [...] I woke up at 5 – 5.30 [am] and then worked out and then took a shower and went to work and I did that even on the weekends even after I'd been drinking the night before [...] it was pretty religious.

The disciplinary power of the doctor elicited a strong response – a sense that she had 'sinned' in her dietary behaviour and needed to be corrected. Again, this cannot be linked to medical reasoning: the doctor in this instance

is quite clearly referring to her aesthetically and not to the impact that her perceived weight could have on her health. This 'sin' resulted in a penance and a self-surveilled fitness regime. It is this religious lexicon that helps us understand why the doctor seemed uninterested in Anne Marie's baseline weight fluctuations since gaining any weight at all was evidence of 'sin' that needed rectifying. As in church, the size of the sin is only relevant to the size of the penance: it is the existence of sin that needs discipline. Anne Marie had failed as a "patient-in-waiting" (Shilling, 2016, p. 46) and had not prioritised "*wanting* to be thin" (Vandebroeck, 2017, p. 124, original emphasis), thus requiring disciplinary correction.

We can see this again when Charlotte* went to a French doctor about a skin condition and asked if it was related to a different hormonal condition that she had:

> …she made me weigh myself. And I was, at that point, really not feeling very good about my mental health... [so I thought] I'm not going to look at the weight. And she was like, "you have to look at the weight because it will never get better if you can't confront it" [...] she just started being like, the problem isn't [the hormonal condition]. The problem is that you're morbidly obese... obviously I was definitely overweight, but I don't think I was obese [...] I've always been overweight. So [...] I knew that already, you know? [...] She said, "you need to stop eating so much fat and so much meat". And I was like, "I am a vegetarian. I don't eat meat". And she was like, "That's the problem. You eat too much pasta, you eat too much cheese." I did eat pasta and cheese, but I said to her [...] my roommate says "I'm the healthiest person she's ever met… I eat so many vegetables" [...] She was just like, "You have to eat only vegetables… I don't believe you. You have to just start eating only vegetables." Like I was crying at this point as well, and I was like, I can't believe a doctor is telling me I have to eat only vegetables because no human should eat only vegetables…

Charlotte* was also deemed to have sinned due to her weight. Rather than her weight being a mix of factors inside and outside of her control, including genetics (Hebebrand & Hinney, 2009, pp. 89-90) – which is especially relevant since Charlotte*'s hormonal condition is known to cause weight gain[7] – her weight is reduced to an embodied representation of her perceived lack of "individual control" (Vandebroeck, 2017, pp. 124-125), which must be corrected. Indeed, the penance began during the appointment with the 'punishment' of being forced to "confront" her weight as part of the corrective process in a way that can only be described as humiliating. The doctor makes it clear that she does not believe Charlotte*'s claims about her health; her weight has made her an untrustworthy source of information who must be punished in the way that one might punish a deceitful infant. A behaviour change was also mandated – a strict vegetable-only diet. This also bears similarity to a punishment, as a vegetable-only diet cannot be construed as genuine, healthy nutritional advice since it lacks basic nutritional content; even the strictest plant-based diets contain other elements, e.g. nuts, grains or seeds, to complete them. Instead, this diet seems designed to *morally* absolve Charlotte* since it would mean that she was doing everything possible to cease being overweight; if she remained overweight after this, it could be considered to no longer be her fault. Even if the doctor is using 'morbidly obese' in the medical sense, there is no way that this can be

7 This is the 'other condition' that is referred to (and dismissed by the doctor) in the text. I have obscured it to maintain Charlotte*'s privacy since the condition itself is not substantively relevant; what is relevant is the response (dismissal) and the feelings that this elicits.

understood as a genuine medical solution to a medical problem, particularly given that this 'advice' was given unrelated to the condition for which Charlotte* was seeking help. She is instead left weeping and humiliated.

Conclusion

This essay has theorised the embodied experience of the interaction between medical professional and patient under three broad themes: vulnerability, shame, and discipline. These accounts are distinct, and even within them are further articulations i.e. within vulnerability, it is possible to understand at least three distinct forms: autonomy, physicality, and mortality. These sub-themes are all united by their shared emotionality, but are theorised in distinct ways.

One way to understand the lack of autonomy felt in a medical setting can be through a kind of Bourdieau-n 'physical capital' (Kukonnen, 2021), whereby patients are ignored due to their lack of perceived wisdom or knowledge about their own bodies. Agamben's concept of 'bare life' (Agamben & Heller-Roazen, 1998) is the other part of understanding the lack of autonomy that is felt in a hospital, as the 'clinical gaze' (Foucault, 1973, cited by Singer et al., 2020) reduces people to their biological essence, to bodies that can be manipulated in anyway way to 'fix' them. Between these two facets, patients are often treated as lacking the autonomy necessary to guide their own treatment. 'Bare life' is also helpful to understanding the ways that people become physically vulnerable too. As people with 'fundamental vulnerability' (Garrau & Laborde, 2015) are exposed to medical situations, this can rapidly turn into a 'problematic vulnerability' when combined with a medical system that is predisposed towards treating patients as 'bare life'. This can lead to the kind of situations described by Zak and Eliza, as patient's bodies are treated as somehow being distinct from the person inhabiting them. Finally, we can understand the vulnerability to death - mortality - through Mbembé's *necropolitics* (2003), as patients' lack of autonomy and physical vulnerability collide to push them into a terrifying *deathworld*.

The other emotional themes - shame and discipline - each have their own theoretical groundings. In terms of shame, we lean on the 'ideal body' as it is explored by Taussig (2020) and Foucault (2012) as well as the reintegrative and stigmatic shaming of Bates and LaBrecque (2020). In this way, doctors can enforce a kind of orthodoxy on patients without necessarily disciplining the patient. Instead, the doctor can induce deep feelings of "body shame" (Schlüter et al., 2023, p. 33) related to either aesthetics or behaviour. This has no medical reasoning, but is related to the doctor's expectations of how an 'ideal' person looks and behaves. In any case, the patient leaves feeling suitably shamed. Discipline, by contrast, enforces similar mechanisms but to the end of changing the patient along biopolitical lines by encouraging them to self-surveil. We might draw on religious practice to explain this, as the body is measured against an 'ideal', deviance is attributed as 'sin', and then a penance is applied. Both cases behaved in a way aligned with Foucault's 'panopticon' (Duncan, 1994), as since they didn't know when they would next be surveilled, they felt compelled to act in self-disciplining ways or were even encouraged directly to do so.

In conclusion, this paper acts as a small, critical contribution on the behalf of patients towards the growing understanding of embodiment in medical practice. Whilst existing research has explored the utility of embodiment in the training of doctors (Kelly et al., 2019) or in their practice (Kelly et al., 2020; Loftus, 2015; Leder, 2003), and has explored the ways that the practice of medical professionals can be embodied from the perspective of the

doctor or nurse (Rudebeck, 2009), the embodied emotional experience of patients has mostly been viewed through the prism of illness e.g. with cancer (Waskul & van der Riet, 2011) or with a broken leg (Mazis, 2001). I hope that this research can be a small contribution in the direction of a normative, critical approach to existing medical practices, and can spur further research that seeks to understand what it means to be a 'patient'. Given the export of Western medical norms internationally (Macleod & Lewis, 2022), it would also be important to explore whether these experiences of power and subjectivity are comparable elsewhere in the world, and thus whether the same theoretical accounts can be applied to experiences other than those Euro-Atlantic ones explored here. As I noted in the introduction, it would also be very important to explore this embodied experience and its emotionality for BIPOC communities, as this represents an obvious limitation of this paper as well as an avenue for further research. Finally, I hope that this paper can help to further the discussion as to how the experience of medical institutions feels for patients so that we might begin to find solutions that reduce the immense vulnerability, shame and chastening discipline that have become routine for some people in these interactions. Instead of 'non-persons', we should look to build medical institutions that treat patients as autonomous individuals in need of help; people to be treated with kindness, care and solidarity, rather than broken objects in need of fixing.

Conflict of Interests

The author declares no conflicts of interest

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Bibliography

Access in Brief: Health Care Experiences and Satisfaction by Race and Ethnicity (Issue Brief). (2023). MACPAC.

Adams, D., & Erevelles, N. (2017). Unexpected spaces of confinement: Aversive technologies, intellectual disability, and "bare life". *Punishment & Society*, *19*(3), 348–365. https://doi.org/10.1177/1462474517705147

Agamben, G., & Heller-Roazen, D. (1998). *Homo sacer: Sovereign power and bare life*. Stanford Univ. Press.

Bates, R. A., & LaBrecque, B. (2020). The Sociology of Shaming. *The Journal of Public and Professional Sociology*, *12*(1). https://doi.org/10.62915/2154-8935.1162

Burke, L. (2019). Dementia and the Paradigm of the Camp: Thinking Beyond Giorgio Agamben's Concept of "Bare Life". *Journal of Bioethical Inquiry*, *16*(2), 195–205. https://doi.org/10.1007/s11673-019-09913-5

Casanova-Perez, R., Apodaca, C., Bascom, E., Mohanraj, D., Lane, C., Vidyarthi, D., Beneteau, E., Sabin, J., Pratt, W., Weibel, N., & Hartzler, A. L. (2022). Broken down by bias: Healthcare biases experienced by BIPOC and LGBTQ+ patients. *AMIA Annual Symposium Proceedings*, *2021*, 275–284.

Coughing up blood. (2017, October 18). NHS. https://www.nhs.uk/symptoms/coughing-up-blood/

Duncan, M. C. (1994). The Politics of Women's Body Images and Practices: Foucault, The Panopticon and Shape Magazine. *Journal of Sport and Social Issues*, *18*(1), 48–65. https://doi.org/10.1177/019372394018001004

Embacher, K., McGloin, R., & Richards, K. (2018). When Women Give Health Advice Online, Do We Listen? The Effect of Source Sex on Credibility and Likelihood to Use Online Health Advice. *Western Journal of Communication*, *82*(4), 439–456. https://doi.org/10.1080/10570314.2017.1367028

Foucault, M. (2012). *The Birth of the Clinic* (3rd ed). Taylor and Francis.

Garrau, M., & Laborde, C. (2015). Relational Equality, Non-Domination, and Vulnerability. In C. Fourie, F. Schuppert, & I. Wallimann-Helmer (Eds.), *Social Equality: On What It Means to be Equals* (p. 0). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199331109.003.0003

Gordon, J. K., & Jordan, L. M. (2017). Older is wiser? It depends who you ask… and how you ask. *Aging, Neuropsychology, and Cognition*, *24*(1), 94–114. https://doi.org/10.1080/13825585.2016.1171292

Hebebrand, J., & Hinney, A. (2009). Environmental and Genetic Risk Factors in Obesity. *Child and Adolescent Psychiatric Clinics of North America*, *18*(1), 83–94. https://doi.org/10.1016/j.chc.2008.07.006

Hospitals Face Financial Pressures as Costs of Caring Continue to Surge | AHA News. (2024, October 5). American Hospital Association. https://www.aha.org/news/perspective/2024-05-10-hospitals-face-financial-pressures-costs-caring-continue-surge

Jenkins, D., Chechel, L., & Jenkins, B. (2023). Nursing in deathworlds: Necropolitics of the life, dying and death of an unhoused person in the United States healthcare industrial complex. *Nursing Philosophy*, *24*(4), e12458. https://doi.org/10.1111/nup.12458

Joffe, S., Manocchia, M., Weeks, J. C., & Cleary, P. D. (2003). What do patients value in their hospital care? An empirical perspective on autonomy centred bioethics. *Journal of Medical Ethics*, *29*(2), 103–108. https://doi.org/10.1136/jme.29.2.103

Johnson, H. M. (2003, February 16). *Unspeakable Conversations* [News Article]. The New York Times. https://www.nytimes.com/2003/02/16/magazine/unspeakable-conversations.html

Kabir, R., & Zaidi, S. T. (2022). Implicit Bias Against BIPOC Patients in Clinical Settings: A Qualitative Review. *Spectra Undergraduate Research Journal*, *2*(1). https://doi.org/10.9741/2766-7227.1014

Kelly, M., Ellaway, R., Scherpbier, A., King, N., & Dornan, T. (2019). Body pedagogics: Embodied learning for the health professions. *Medical Education*, *53*(10), 967–977. https://doi.org/10.1111/medu.13916

Kelly, M., Svrcek, C., King, N., Scherpbier, A., & Dornan, T. (2020). Embodying empathy: A phenomenological study of physician touch. *Medical Education*, *54*(5), 400–407. https://doi.org/10.1111/medu.14040

Kukkonen, I. (2021). Physical Appearance as a Form of Capital: Key Problems and Tensions. In O. Sarpila, I. Kukkonen, T. Pajunen, & E. Åberg (Eds.), *Appearance as Capital* (pp. 23–37). Emerald Publishing Limited. https://doi.org/10.1108/978-1-80043-708-120210002

Leder, D. (2003). Medicine and Paradigms of Embodiment. In A. Blaikie, M. Hepworth, & M. Holmes (Eds.), *The Body: Critical Concepts in Sociology*. Psychology Press.

Loftus, S. (2015). Embodiment in the Practice and Education of Health Professionals. In B. Green & N. Hopwood (Eds.), *The Body in Professional Practice, Learning and Education: Body/Practice* (pp. 139–156). Springer International Publishing. https://doi.org/10.1007/978-3-319-00140-1_9

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in Healthcare Access, Use, and Experiences Within a Community Sample of Racially Diverse Lesbian, Gay, Bisexual, Transgender, and Questioning Emerging Adults. *LGBT Health*, *3*(6), 434–442. https://doi.org/10.1089/lgbt.2015.0124

Macleod, R., & Lewis, M. J. (2022). *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*. Routledge.

Mazis, G. A. (2001). Emotion and Embodiment within the Medical World. In *Handbook of Phenomenology and Medicine* (Vol. 68, pp. 197–214). https://link.springer.com/chapter/10.1007/978-94-010-0536-4_10

Mbembe, A. (2003). Necropolitics. *Public Culture*, *15*(1), 11–40. https://doi.org/10.1215/08992363-15-1-11

Merkley, E. (2020). Anti-Intellectualism, Populism, and Motivated Resistance to Expert Consensus. *Public Opinion Quarterly*, *84*(1), 24–48. https://doi.org/10.1093/poq/nfz053

Miceli, M., & Castelfranchi, C. (2018). Reconsidering the differences between shame and guilt. *Europe's Journal of Psychology*, *14*(3), 710–733. https://doi.org/10.5964/ejop.v14i3.1564

Nuila, R. (2023, March 9). The Assumptions Doctors Make. *The New Yorker*. https://www.newyorker.com/science/annals-of-medicine/the-assumptions-doctors-make

Phelan, S., Burgess, D., Yeazel, M., Hellerstedt, W., Griffin, J., & van Ryn, M. (2015). Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obesity Reviews*, *16*(4), 319–326. https://doi.org/10.1111/obr.12266

Rabinow, P., & Rose, N. (2006). Biopower Today. *BioSocieties*, *1*(2), 195–217. https://doi.org/10.1017/S1745855206040014

Rogers, Y., & Marsden, G. (2013). Does he take sugar? | ACM Interactions. *ACM Interactions*, *XX.4 July / August 2013*, 48.

Rudebeck, C. E. (2009). The doctor, the patient and the body. *Scandinavian Journal of Primary Health Care*, *18*(1), 4–8. https://doi.org/10.1080/02813430050202479

Schlüter, C., Kraag, G., & Schmidt, J. (2023). Body Shaming: An Exploratory Study on its Definition and Classification. *International Journal of Bullying Prevention*, *5*(1), 26–37. https://doi.org/10.1007/s42380-021-00109-3

Singer, M., Baer, H. A., Long, D., & Pavlotski, A. (2020). *Introducing medical anthropology: A discipline in action* (Third Edition). Rowman & Littlefield.

Singer, P. (2011). *Practical ethics* (3rd ed). Cambridge University Press.

Taussig, R. (2020). *Sitting Pretty: The View from My Ordinary Resilient Disabled Body*. HarperCollins Publishers.

Teunissen, T. A. M., Rotink, M. E., & Lagro-Janssen, A. L. M. (2016). Gender differences in quality of care experiences during hospital stay: A contribution to patient-centered healthcare for both men and women. *Patient Education and Counseling*, *99*(4), 631–637. https://doi.org/10.1016/j.pec.2015.10.033

Vandebroeck, D. (2017). The Perceptible Body. In *Distinctions in the flesh: Social class and the embodiment of inequality* (1 Edition). Routledge, Taylor & Francis group.

Vaz, P., & Bruno, F. (2002). Types of Self-Surveillance: From abnormality to individuals 'at risk'. *Surveillance & Society*, *1*(3), 272–291. https://doi.org/10.24908/ss.v1i3.3341

Waskul, D. D., & van der Riet, P. (2002). The Abject Embodiment of Cancer Patients: Dignity, Selfhood, and the Grotesque Body. *Symbolic Interaction*, *25*(4), 487–513. https://doi.org/10.1525/si.2002.25.4.487

Weaving, S. (2020, May 7). *Friday essay: Coughs on film and the fine but deadly art of foreshadowing*. The Conversation. http://theconversation.com/friday-essay-coughs-on-film-and-the-fine-but-deadly-art-of-foreshadowing-135697

Ziarek, E. P. (2008). Bare Life on Strike: Notes on the Biopolitics of Race and Gender. *South Atlantic Quarterly*, *107*(1), 89–105. https://doi.org/10.1215/00382876-2007-057