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Adam Buczkowski holds a PhD in sociology. He works at the Institute of Philosophy and Sociology at the Maria Grzegorzewska Academy of Special Education. His research interests focus on the body, sexuality and gender in the context of the sociology of knowledge.
e-mail: buczkowski@aps.edu.pl

Adam Buczkowski

Gender as a historical category: Relations between the medical conception of the body and the notion of gender

As it is today, the concept of gender is defined as "a culturally-shaped group of attributes and behaviours given to the female or the male" (Humm, 1989, p. 84). Importantly, culture is understood here in very broad terms, including also political institutions and legal norms. It cannot remain unnoticed that scholarly discourse includes a relatively limited number of works approaching the concept of gender from the perspective of the sociology of knowledge. Focusing on the dynamics of change in the approach to, and definition of, the category of gender in relation to changes in other spheres of social life, this article presents the concept of gender in the context of medical conceptions of the body (medical discourse of the body) dominating in particular historical periods and changes in the definition of sexuality (cultural discourse of sexuality).

The present discussion assumes that relations between gender, the body and sexuality are essentially inextricable. Indeed, it appears that in most cultures these concepts are closely interrelated and inseparable within knowledge systems and systems of ethical meanings (and institutionalisation of behaviours) to which they give rise. This relationship is sometimes covert, i.e. inaccessible to immediate experience of an individual living in a particular socio-cultural period. It follows that gender can be approached as a historical category whose understanding and experience is subject to the process of change over time. Another assumption made here is that of a discursive nature of the experience of the body

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and sexuality by an individual. In each case, the body and sexuality, as well as the impulses they generate, require an interpretation in order to identify the attendant social/biological/cultural norm or its absence.

In the context of these assumptions, the conceptualisation of the category of gender (as it is today) is based on at least three discourses presented below. At this point, however, it is worth stressing the functions of discourse and noting the fact that it certainly does not have to translate into actual behaviours of individuals. First of all, discourse is a category socialising individuals with the existing world, particularly in the process of socialisation and acculturation of new generations. It also has a control function, as it indicates norms and their transgressions, sometimes perceived as breaking cultural taboos. In addition, discourse provides arguments supporting a social world order and restores it in liminal situations involving a temporary break-up of cultural order, particularly in the context of behaviours stemming from other symbolic orders (other discourses). What needs to be noted is that the discourses of gender, the body and sexuality are upheld by the systems of relatively coherent philosophical and medical knowledge, and that – as observed by Pierre Bourdieu in his *Masculine Domination* – the body plays a fundamental role in ordering the social world (Bourdieu, 2002).

All discourses presented below function in today's social and cultural sphere and are upheld by different social institutions. It could even be said that there is a certain "rivalry" between them over defining the "truth" of gender, with each of them offering a different discursive pattern allowing individuals to understand their own bodies, sex and sexuality.

Gender as inequality

In Western culture, the oldest discourse defining gender is one created within the tradition of classical antiquity and Christianity. As it is today, it certainly assumes the form conservative outlooks of different intensity. The assumptions of this discourse have been supported by religious, philosophical and medical arguments.

Religious arguments concerning the position of women in Catholic theology and the Catholic Church have already been discussed in the literature of the subject; arguments supporting their inferior position are analysed by Uta Ranke-Heinemann (1990) and other authors. This section focuses on medical arguments concerning differences in the body and sexuality which substantiate the inferior position of women and form a "scientific", hence relatively value-independent, system of interpretation.

The system of interpreting the world according to which the female gender was defined as inferior (i.e. a type of being characterised by a lower level of perfection and proximity to God) was based on defining human body as part of the cosmic and cultural order. The antique and medieval definition of gender was related to the conception of the body and sexuality dominating at the time. On the basis of Aristotelian philosophical thought, developed in medicine by Hippocrates (ca 460–375 BC) and Galen (130–200 AD), it was assumed that the male and female body were not substantially different. The difference between them did not consist in anatomy, as interpreted today, but in the composition of elementary substances known as humours, which had an impact on the anatomic characteristics of males and females. Regardless of sex, then, the human body consisted of four such fluids: blood (moist and warm), phlegm (cold and moist), yellow bile, or choler, (warm and dry) and black bile, or melancholy (dry and cold), associated with the elements of air, water, fire and earth, respectively. The relationship between humours was hierarchical, with the categories of warmth and dryness ranked higher than those of wetness and cold. Bourdieu observes that this structural order of reality (supported by empirical observations) was the heritage of the early stages of interpreting the world and represented probably one of the oldest attempts to conceptualise human natural environment (Bourdieu, 2002). The objects which are warm and dry (e.g. the sun) were associated with masculinity, while those moist and cold – with femininity. As can be seen, the medical discourse of the period did not define sex in terms of a distinctive male and female anatomy, but in terms of a different inborn composition of humours in the one-sex body (Laqueur, 1990).

Differences between the male and female body are easily noticed by way of simple observation, particularly with regard to female breasts and vagina and the male penis. According to the medical knowledge of the period, breasts were responsible for accumulating heat in the female body, whose composition of humours did not provide it with enough warmth. The difference between the penis and uterus, in turn, was one of location rather than kind: they were regarded as the same organ that in the case of males was contained in the scrotum, while in the case of females it was within the body. The factor behind the difference of sexual roles and the according shape and form of the male and female genitals was heat. Medical texts did not feature different names for female reproductive and sexual organs. While the ovaries were known as female testicles, such terms as the clitoris and the labia did not exist at all. In other words, the female body was a different version of the male one (Laqueur, 1990).

Neither was there any difference of substance between blood, semen, milk and other male or female bodily fluids. The male body was warmer as it lost less blood, and it was for this reason that it was unable to produce milk. On the other hand, the female body was colder as a result of loss of blood through menstruation. The ontic status of women was lower on account of less heat in their bodies.

Aristotle characterised sex differences in the animal world as follows:

> (…) it is clear that an animal is not male or female in virtue of an isolated part or an isolated faculty. Clearly, then the distinction of sex is a first principle; at any rate, when that which distinguishes male and female suffers change, many other changes accompany it, as would be the case if a first principle is changed. (Aristotle, 2015, Book 1.2)

In the world of medicine which forbade the examination of internal bodily organs, this vision of the body survived practically unaltered for entire centuries. Indeed, the concept of the one-sex body persisted until the mid-eighteenth century.

Under the circumstances, the question of the "real" sex was quite irrelevant. According to the general conviction there was only one model, perfectly embodied in the male, with its less developed version being that of the female. Although admittedly there were a number of gender roles defined by the intensity of particular humours, they were all performed by the one-sex body that differed depending on humoral temperaments. Anatomical differences were regarded as a secondary feature arising from the distinct inborn composition of the four elementary substances.

Biological differences between the male and the female were in fact regarded as a reflection of the absolute truth, God, who designed different roles for each gender. Gender did not result from differences attributed to sex, as can be seen from the example of slaves, who had no social rights and consequently were considered to be sexless (Laqueur, 1990). Likewise, in the case of individuals characterised by sexual ambiguity, i.e. hermaphrodites, the question was not to determine their "real" sex, but to establish the actual functions undertaken by their bodies. On reaching adulthood, hermaphrodites were observed in order to assign them to a particular sex on the basis of these functions (Foucault, 2001).

It was assumed that sex change in adults was theoretically possible, and rare cases of such miraculous metamorphoses were sometimes confirmed in medical writings. Importantly, the change in question was only possible from the female to the male and not vice versa, the argument being that nature, as God's creation, "always tends towards what is

the most perfect" and thus cannot degenerate, or "make imperfect what was perfect". Passage from one sex to the other involved the rites of receiving a male name and male clothing (Jo-Bonnet, 1995).

The concept of the one-sex body expressed the conviction that man – perceived as the male – is the measure of being, as he was created "in the image of God". The female, in terms of gender as it is today, did not have the status of an ontically distinct category of being, since differences between the male and the female were ones of degree rather than kind.

Sexuality, or, to be more precise, the adopted sexual behaviours, were considered in relation to the conception of the body and its significance. The approach to this domain was guided by two intellectual traditions. Firstly, the antique understanding of sexuality as an area of self-control and sovereignty of the self over inner drives (Foucault, 1985). Secondly, the tradition shaped by the Christian vision of the world in general, and – as observed by Peter Brown (1988) – by St Paul's First Letter to the Corinthians in particular. The letter includes references to two different ways of approaching sexuality: "It is good for a man not to touch a woman. Nevertheless, to avoid fornication, let every man have his own wife, and let every woman have her own husband" (1 Cor. 7:1–2).[1]

The dichotomy observed by St Paul resulted in the emergence in Christian theology of tension between two different dimensions of sexuality. One of them consisted in homosocial feelings involving the taming and denial of sexuality, which was directed towards God and fulfilled first and foremost in the world of consecrated life, the male and female monastic orders. In the secular world, it took the form of "manly love", which was rather popular in the period. The other dimension of sexuality was fulfilled in marital love (Tin, 2012).

Fundamental differences between the medieval and modern understanding of sexuality stem from the discrepancy of perception of the roles attributed to each sex and to their bodily differences. Ruth Marzo Karras (2005) stresses that while all extra-marital sexual behaviours were considered sinful, those undertaken by women were particularly condemned since they contradicted their passive nature. Sexual activity within marriage was not a private decision of the male and the female involved, but a requirement of the institution, which, as such, had an impact on the preservation of social order and social reproduction. In other words, married couples had an obligation to engage in procreative activity.

[1] English translation of the quotation from St Paul: *King James's Bible*, retrieved 20 August 2017 from https://www.kingjamesbibleonline.org/1-Corinthians-Chapter-7/ (translator's note).

The roles of sexual partners were different and strictly specified: "Medieval people, for the most part, understood sex acts as something that someone did to someone else", which found its linguistic expression in the use of transitive rather than intransitive verbs to describe sexual intercourse (Karras, 2005, p. 3). While the man was supposed to be the active partner, the role of the woman was passive, as dictated by their respective composition of humours and the attendant humoral temperaments. Sexual behaviours did not reflect sexual identity but involved fulfilling the role of the male or the female as designed by God and nature. Non-normative sexual behaviours were considered unnatural and condemned.

As can be seen from the above account, the discourse of inequality defined gender as a function of the adopted social roles whose contents stemmed from the cosmic/divine order. The body on the one hand, and male and female sexual behaviours on the other, reflected the existing ontic order, with medicine and philosophy providing scientific evidence in support of this knowledge.

Gender as difference

Change in the approach to, and definition of, gender resulted from a number of factors. One of those more important seems to be change in the medical knowledge of the female body stemming from breaking the cultural and religious taboo of performing autopsies. Consequently, a breakthrough in medicine observed from the mid-seventeenth century involved its evolution from speculative to empirical science. Although the long-established tradition of the inferior social position of women (which had lasted for over a millennium) continued, it came to be supported by different argumentation. New scientific evidence led to approaching the female gender in terms of difference rather than inequality.

The discovery of the two-sex body, with the woman's body essentially different than the man's, was one of the principal achievements of "new medicine". Having determined human reproductive functions, medics attempted to attribute the existence of the uterus as a biological organ to motherhood as a social role of women. This approach to physiological functions of the female body led to associating women's social roles with their distinct anatomical characteristics.

Scientists began to focus on constructing the anatomical model of an ideal male and female. Drawings published in medical writings not only illustrated differences between their bodies, but also reflected the ideas of gender promoted at the time. Indeed, in the belief

that they represented the ideal type of woman, anatomists often selected female models who had given birth. As a result, anatomical drawings of the period feature female skeletons with an excessively broad pelvis (Laqueur, 1990).

Medical science adopted the assumption that sex differences were not limited to reproductive organs but extended to the entire body. This line of reasoning stemmed from the investigation of the skeleton. As observed by some medics, it was different in females: it was weaker, had narrower shoulders and a broad pelvis facilitating carrying the foetus.

> The first part of the body to become sexualised was the skeleton. If sex differences could be found in 'the hardest part of the body', it would be likely that sex penetrated 'every muscle, vein, and organ attached to and moulded by the skeleton'. (Schiebinger, 1989, p. 191)

The former conception attributing differences between the male and the female to differing degrees of their bodily heat proved utterly insufficient. Towards the end of the eighteenth century anatomists produced drawings indicating that the male/female distinction was more than skin-deep and that sex differences could be found not only in the skeleton. Their illustrations reflected the dominant vision of gender, which focused on selected parts of the body that were culturally significant.

By the late nineteenth century the male/female distinction had been discovered not only in the bones, but also in other parts of the body, including the brain, as well as in hair, blood components and cells (Oudshoorn, 1996). The newly discovered sex differences in humans came to be transposed to other sciences, such as botany, where, by way of analogy, they led to accepting the concept of the male and female inflorescence.

Traditional interest of the earlier periods in the uterus as the most distinctive female organ had resulted in its identification as the essence of femininity. In the mid-nineteenth century, following a series of research and discoveries, medical science attributed this role to the ovaries, regarded as autonomous control centres of reproduction in the female body. This shift of the idea of femininity from the social role to the anatomical organ provided a new basis for defining sex differences.

The discovery of the role and importance of the ovaries resulted in the growing popularity of their surgical removal in certain cases of "behavioural pathologies" attributed to their malfunction (e.g. hysteria, excessive sexual desires, intense menstruation pains). The number of such operations increased, particularly after the introduction of aseptic techniques:

> Removing healthy ovaries in the hope of curing so-called failures of femininity went a long way toward producing the data from which the organ's functions could be understood. (Laqueur, 1990, p. 176)

This medical procedure, also known as "female castration", resulted in stopping menstruation and brought changes in secondary sexual characteristics (voice pitch, body hair). In other words, ovariotomy made women become more "masculine" (analogically to castrated males, who became more "feminine"), which provided secondary confirmation that the ovaries were the essence of femininity.

Medical discovery of biological distinctness of women led to approaching the female body as essentially different from the male one, still regarded as the norm and point of reference. The focus on the reproductive system as the source of women's "otherness" naturalised their place in society: they were no longer defined as subordinated to men on account of their social roles. Rather, they came to be viewed as fundamentally different from men in biological terms and thus completely incomparable, which is why they undertook entirely different social roles. Hence, the "natural" order was that the woman focused on private life, where she played the role of the mother and nurturer of the family, while the man was active in the public sphere.

In this context, a new approach to the sphere of sexuality involved the emergence of psychiatric discourse, which later evolved into sexological discourse. Psychiatry and sexology were particularly interested in behaviours which were the source of social concern, such as masturbation and sodomy, defined as "homosexuality". The rationalisation of sexuality involved identifying other perversions, including women's hysteria and excessive sexual behaviours in married couples (Foucault, 1978). From the second half of the nineteenth century sexuality came to be regarded as a sphere of human psychology, which resulted in its autonomy from the body. All behaviours, images, associations, dreams and thoughts that so far had not been part of sexual discourse acquired sexual significance. The result of this approach to sexuality involved the emergence of the category of of sexual orientation, regarded as an expression of "sexual nature" of the individual. Women's sexual nature was determined by their social roles, which in turn reflected predispositions of the female body, with the uterus and ovaries as autonomous control centres of femininity. The woman was still perceived as passive and masochistic, particularly in the framework of the newly emerged psychoanalysis.

One of the most important social consequences of this approach to female distinctness was the emergence of women's group identity. The development of feminist movement reflected changes in the medical definition of the body and sexuality, particularly with regard to women, and their impact on socio-cultural developments. The first wave of feminism faced an important task of developing interpretative categories indicating an equal position of women in society. One which proved a difficult problem was the category of gender roles and their attribution. They had long been perceived as historically fixed and unchangeable and their cultural context remained unnoticed until the publication of studies conducted by Margaret Mead in the late 1920s and early 1930s (Mead, 1928, 1930, 1935).

The surge of the second wave of feminism, amplified by cultural changes of the 1970s, and the use of the category of gender in Robert Stiller's *Sex and Gender* (1968), involved a change of paradigm in social sciences. Most importantly, the modern understanding of gender came to consider the cultural context – defining the roles and functions of each gender and naturalising them within the framework of functional discourses – and the context of socialisation with its social mechanisms of generating and reproduction of masculinity and femininity. This formed the basis for the study of the contents of socialisation discourse and for their conscious remodelling – both with regard to family structure and relations (e.g. Chodorow, 1978), and the message conveyed in the educational process (e.g. Buczkowski, 1997) – in order to achieve equal position of men and women. As can be seen in different streams of feminist thought, the feminist movement deeply explored and strongly supported the development of women's group identity (Tong, 1998). On the other hand, attempts to study and develop men's group identity based on gender distinction did not receive much social response (e.g. Kimmel, 1996).

With the concept of gender at their disposal, sociology and other social sciences developed a clear focus on the study and identification of gender differences. At the same time, they marginalised similarities between and differences within the genders themselves (e.g. class, racial, ethnic and sexual differences). In addition, the identification of such gender phenomena as cross-dressing (transvestitism) and transsexualism (transgender), as well as the disinclination of some women to identify with feminist postulates, further undermined the idea of stressing the collective otherness of women. These problems were coupled with cultural changes related mainly to the rise of individualist culture, involving also changes in the medical approach to the body.

Gender as choice and dispersion

Today's medicine increasingly more often points out the need to approach the body of an individual as a distinct biological organism rather than a member of a particular age, sex or ethnic category. Both theoretical works and medical practice come to address the issue of the individual course of the disease, individual reactions to medication and individual prospects of treatment. Therapies designed for a particular category of patients sometimes fail to produce the expected medical results and often involve complications, which so far have been tolerated as side effects. Consequently, the new medical approach to the body known as personalised medicine aims to tailor therapies to fit individual needs of patients (Bodiroga-Vukobrat, Rukavina, Pavelic, & Sander, 2016).

The principles of personalised medicine are applied, for example, in antibiograms (compiled in order to determine the effectiveness of particular antibiotics), and in oncological treatment, where diagnosing the type of genetic mutation makes it possible to adjust treatment as required. Also, identification of the genetically conditioned ability of a particular patient to metabolise particular drugs (e.g. antiaggregants) ensures their adequate dosing and effective concentration.

Medical practice increasingly more often stresses the social and cultural dimension of patients. One example of these changes involves patients' rights in contact with medical personnel. In a number of countries, including Poland, the right to privacy of the body and individual autonomy is a legally binding norm. Likewise, legal regulations include provisions stressing the clarity of information provided to the patient as an essential element of doctor–patient communication.

The current change in the medical conception of the body coincides with social and cultural changes. It has been about two decades since social sciences diagnosed individualism as a new way of perception and interpretation of the world (Bauman, 1993). Individualist perspective is noticeable with regard to the body, which becomes the locus of personal awareness and the attendant sense of control. Bodily smell, look and behaviour increasingly more often come to be the basis of shaping personal identity. The discourses of "cosmetising", plastic surgery, women's diet and fitness, men's sport and bodybuilding provide an essential point of departure for constructing personal identity of the individual regardless of sex, although it is worth stressing that bodily discourses still tend to focus on women.

Individualist discourse emerged as a result of considerable social and cultural changes. The growth of privacy of the body as a value, which is at the core of individualist culture, stemmed from improvements in hygiene and sanitation and from the atomisation of social life in the urban environment. This fostered a different approach to the body, pertaining not only to individual self-perception, but also to the feel of the body, its comparison with other bodies, and the attendant dissemination of practices of body care.

In cultural perspective, human body slowly ceases to be regarded as natural and comes to be perceived as an individual project, a plastic substance shaped according to the wishes of the individual, or even according to the current fashion. In this project, the naturalness of the body is in fact simulated rather than real. According to some authors (e.g. Melosik, 1996), the body has become the core of modern human identity.

The role of corporeality in constructing identity is particularly apparent in the case of women's identity (Kaschak, 1992; Wolf, 1991). Since the body is a fundamental category of assessing their social functioning – an idea supported by discourses of visuality, which are particularly exploited by consumerist market economy – the construction and self-evaluation of women's identity adopts the perspective of the "indeterminate observer", one that is formed by cultural rules of patriarchy. According to Ellyn Kaschak, the result is that the body becomes the core of women's identity. Daily gazing into the mirror is a symbol of women's identification with their reflected image, of constructing and sustaining their bodily identity. A woman whose appearance is distinctly at odds with culturally determined expectations is often perceived as a person suffering from depression or personal problems. By creating an interrelation between the body and identity, consumerist culture moulds women into a group of consumers who are the most interested in cosmetics and beauty products. The message is that using them improves their quality of life:

> Unloved in the human world, the woman is pampered in the world of beauty cremes and fragrances: cosmetics are soft, gentle, plastic, delicate and sometimes sexy. They can 'take proper care of her' and provide her with a sense of comfort. A magical transformation of the face by means of using mascara is also a promise of transformation of life and identity (How can I be depressed if I'm so beautiful?). (Melosik, 1996, p. 116)

The phenomenon of individualisation is also apparent in the domain of sexuality. Some authors assessing change in the experience of sexuality write about "plastic sexuality" (Giddens, 1992) and a related "striptease culture" (McNair, 2002). Individualised sexuality is

characterised by an approach to sexual activity which is different than in previous historical periods. Today, it is increasingly more often seen as a form of both behaviour and social relation unencumbered by the approaches involving the categories of sin, deviation or paraphilia, or by group sexual identity (Buczkowski, 2016).

Individualised sexuality developed, among other reasons, as a result of scientific discoveries, particularly in medicine. The introduction of the contraceptive pill in the 1960s separated sex from procreation. The fashion discourse of the 1930s and 1940s increasingly revealed the body, and the sexual revolution of the 1960s and 1970s resulted in a breakup between sexuality and marriage. With the risk of unwanted pregnancy reduced, the idea of "free love" stimulated interest in the individual experience of sexuality.

The growing interest in sexuality was underpinned by the results of studies conducted in the 1950s and 1960s by such sexologists as Alfred C. Kinsey (Kinsey, Pomeroy, & Martin, 1948; Kinsey, 1965), William H. Masters and Virginia C. Johnson (1966), who popularised new, individualist concepts, including that of sexual orientation of the individual. At the micro-level of the individual, sexology puts increasingly more stress on health aspects of sexual behaviours and their impact on emotional ties with the partner.

Sexology made its contribution to the modern perception of sexual behaviours as an individual project of gathering and intensification of bodily experiences. Satisfaction of sexual desires and fantasies became a value in itself and a criterion of assessing not only younger but also older people. Sometimes individualised sexuality is radically at odds with sexological knowledge, as is the case of judgment on BDSM practices, rated as non-normative and rather risky. The pursuit of new and more intense sexual experiences has been reflected in the proliferation of pornographic discourse, one involving presentation of countless scenarios of practically any form of sexual behaviours stimulating sexual fantasies (and recommended by some sexologists as a stimulus for engaging in one's own sexual experiments). Knowledge about sexual behaviours increasingly more often becomes not so much an adaptation of the popular version of sexological knowledge, as an autonomous system of individualised non-specialist knowledge disseminated over the Internet. It is often regarded as a more reliable source of information than sex guides, particularly in the case of young people beginning their sexual activity.

Such phenomena as the above mentioned cross-dressing (transvestitism) and transsexualism, or the newly emerged phenomenon of asexuality (agender?), indicate the weakening of a direct link between gender and sexuality. Gender comes to appear as a form of individual

choice, and its previous conceptualisation as a cultural construct becomes a limitation to the actualisation of individual autonomy. This understanding of gender is also supported by certain theoretical concepts, including Judith Butler's idea of gender performativity (1990), according to which there is no direct link between sex and gender, as sex is in fact the effect of performative acts confirming the existence of the assumed cultural difference. The overall result of these processes may involve a gradual dispersion of the category of gender.

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This article underlines the significance of the so-far rarely explored interaction between the medical and scientific conceptions of the body and sexuality on the one hand, and the perception of the category of gender dominating in a particular historical period on the other. Modern culture has at least three principal discourses of gender at its disposal. The first and oldest of them is the discourse in which gender was conceptualised as an ontic difference. This approach to the difference between the man and the woman was supported by the concept of the one-sex body, holding that the female was an imperfect version of the male. In this discourse, the forms of sexual activity depended on the social roles, which in turn were dictated by the inborn composition of bodily humours.

The second discourse perceives gender in terms of difference. As in the first case, the difference was established by way of comparison with the existing model – the male body. This approach was supported by medical science, which – having discovered the distinct anatomy of the female body, particularly in the sphere of the reproductive potential – began to disseminate the concept of the two-sex body. As a result, women's body came to be perceived as biologically different. This, in turn, gave rise to the concept of gender in which femininity was related to anatomical features, originally the uterus, later the ovaries, and finally (with the development of endocrinology) – the level of female hormones. Likewise, difference emerged as the core paradigm in sciences exploring sexuality: psychiatry (with the use of psychoanalysis) and sexology. In the social context, the discourse of difference led to the emergence of women's group identity. In this line of reasoning, the development of feminist movements can be traced to the medical conception of the two-sex body. Today this discourse is among the most popular ones in scientific and popular scientific literature.

Finally, the latest discourse, in which gender becomes a domain of individual choice and transgression, is connected with the new concept of personalised medicine, stressing bodily features of the individual in relation to medical practices. Currently the least widespread, this discourse is still in an early stage of its development.

To conclude, it is worth noting that the relation between the medical conception of the human body and the corresponding category of gender is probably not one of direct causality. This, however, does not change the fact that medical approach to the body is an element of interpretive knowledge systems which provide arguments supporting the conception of gender dominating in particular historical periods.

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Gender as a historical category: Relations between the medical conception of the body and the notion of gender

The article offers a discussion of the relation between gender and the medical conception of the body in the context of historical changes. The oldest European conception of gender was linked to ontic inequality, which corresponded to the concept of the one-sex body in medicine. From the eighteenth century, the medical conception of the body began to change, and the idea of the two-sex body gained popularity: the female body came to be perceived as different. This change was accompanied by a social and cultural shift leading to the emergence of women's group identity. The latest medical idea is personalised medicine, and the body is an element of the culture of individualisation. Judging by the recent changes in the medical conception of the body, we are probably witnessing a change in the idea of gender involving its dispersion.

Keywords:
gender, body, history of medicine

Płeć kulturowa jako kategoria historyczna. Relacje między medyczną koncepcją ciała a pojęciem płci kulturowej

Artykuł dotyczy relacji pomiędzy pojęciem płci kulturowej a medyczną koncepcją ciała w kontekście zmian historycznych. Najstarsza w kulturze europejskiej koncepcja płci kulturowej wiązana była z nierównością ontyczną, co odpowiadało jednopłciowej koncepcji ciała w medycynie. Zmiana zaczęła następować od osiemnastego wieku, gdy w medycynie zaczęła się rozpowszechniać koncepcja ciała dwupłciowego, w którym kobiece ciało było traktowane jako inne. Tej zmianie towarzyszyły szerokie zmian społeczne oraz w konsekwencji powstanie grupowej tożsamości kobiet. Najnowsze koncepcje medycyny personalizowanej wskazują na indywidualizację ciała. Towarzyszy temu zmiana kulturowa polegająca na coraz wyraźniejszym akcentowaniu indywidualności ciała. Przyjmując za punkty wyjścia zmiany

pojmowania ciała w medycynie, prawdopodobnie jesteśmy świadkami zmiany pojęcia płci kulturowej – jej rozproszenia.

Słowa kluczowe:
płeć kulturowa, ciało, medycyna

Note:
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