GENDER
OPEN
REPOSITORIUM

Missing Connections: Medical Sociology and Feminism

Annandale, Ellen

2009

https://doi.org/10.25595/3161

Veröffentlichungsversion / published version
Zeitschriftenartikel / journal article

Empfohlene Zitierung / Suggested Citation:

Annandale, Ellen: *Missing Connections: Medical Sociology and Feminism*, in: Femina politica : Zeitschrift für feministische Politik-Wissenschaft, Jg. 18 (2009) Nr: 1, 24–34. DOI: https://doi.org/10.25595/3161.

GenderOpen – Repositorium für die Geschlechterforschung: www.genderopen.de

FREIE
UNIVERSITÄT
BERLIN

HUMBOLDT-UNIVERSITÄT ZU BERLIN

Vinz, Dagmar/**Dören**, Martina, 2007: "Diversity Policies and Practices: A New Perspective for Health Care." Journal of Public Health. 15. Jg. H. 3, 369-376.

Vlassoff, Carol/**Moreno**, Claudia Garcia, 2002: "Placing Gender at the Centre of Health Programming: Challenges and Limitations." Social Science & Medicine. 54. Jg., 1713-1723.

Weber, Monika, 2008: „Gender Mainstreaming in Gesundheitspolitik und -versorgung." Bundesgesundheitsblatt – Gesundheitsforschung – Gesundheitsschutz. 51. Jg. H. 1, 70-80.

Webber, Douglas, 1988: „Krankheit, Geld und Politik: Zur Geschichte der Gesundheitsreform in Deutschland." Leviathan. 16. Jg. H. 2, 158-203.

Webber, Douglas, 1989: „Zur Geschichte der Gesundheitsreform in Deutschland, Teil II: Norbert Blüms Gesundheitsreform und die Lobby." Leviathan. 17. Jg. H. 2, 262-300.

WHO Euro, 2001: Mainstreaming Gender Equity in Health, Madrid Statement. Kopenhagen.

WHO, 2002: Integrating Gender Perspectives in the Work of WHO. Genf.

WHO, 2007: "Strategy for Implementing Gender Analysis and Action into the Work of WHO. WHO Regional Office for Europe." Internet: http://www.euro.who.int/eprise/main/WHO/Progs/HSM/Conference/Documents/20080620_34 (07.02.09).

Woodward, Allison E., 2008: "Too Late for Gender Mainstreaming? Taking Stock in Brussels." Journal of European Social Policy. 18. Jg., 289-302.

Wrede, Sirpa, 2008: "Educating Generalist: Flexibility, Identity and Auxiliary Nursing in Finland." In: Kuhlmann, Ellen/Saks, Mike (Hg.): Rethinking Professional Governance: International Directions in Healthcare. Bristol, 127-140.

Zweiwochendienst, 2009: Frauen, Gesundheit & Politik, Supplement zur Ausgabe 263, 12. Februar 2009

Missing Connections: Medical Sociology and Feminism[1]

ELLEN ANNANDALE

We only need to cast our minds back to the 1970s to find a strong connection between medical sociology and feminism. Health and illness was of vital concern to feminists and medical sociology, then in its ascendancy as a new sub-disciplinary field, drew on feminist insight. They shared a common disciplinary project which was to distinguish the biological from the social – in feminist terms, sex and gender – and claim the social as their own. Today – 30 or so years on – the connections between feminism and medical sociology are at best peripheral and, at worst, totally absent. It is difficult to find much, if any, direct reference to health in sociological accounts of gender and social change in the western world. In a raft of otherwise excellent books published over the last decade by feminist sociologists, education, work, the family, sexuality, identity and political representation all figure highly, but health fails to get

more than a passing mention – if that (see Aapola et al. 2005; Charles 2002; Delamont 2003; Hughes 2002; Marshall 1994; Pilcher 1999; Walby 1997).
Within theoretical writing the absence is even more marked (see Evans 2003). It may seem inappropriate to say that health is missing in feminist writing when there has been an explosion of work in areas such as the body, genetics and new reproductive technologies, but more often than not, attention stops either at the body's surface or probes the body's interior in a highly reductive manner (see Birke 1999; Klein 1996). Prominent feminists like Butler, Haraway, and Grosz have no interest in health and illness (see Kuhlmann/Babitsch 2002; Shildrick/Price 1998). This is light years away from the 1970s and early 1980s when feminist sociology effectively developed *through* an interest in health and health care.
But what of the other side of the coin? There is no shortage of research and publications on gender and health within the social sciences. The problem is that gender is everywhere and nowhere. Although it would be imprudent to stretch the point too far, "gender" has become somewhat taken-for-granted. So much so that we rarely seem to reflect critically upon what concepts like gender, patriarchy – even feminism itself – mean for us anymore. When medical sociologists use the term "gender" in reference to women's health it typically connotes potential or actual disadvantage – the same often now applies to the growing body of men's health research – but the reasons *why and how* this disadvantage comes about are often murky. All too often research focuses only on a cluster of proximate causes, be they quantitatively or qualitatively defined, and the relationship between gender and health loses its structural moorings. Without these moorings we are left with similarities and differences in women's and men's health status and similarities and differences in their experience of health and illness for which we have no real explanation beyond a generalised sense that they are related to women's and men's positioning within society.
What has conventionally been thought of as "biological sex" and "social gender" become less fixed and more fluid, the traditional distinctions between male and female experience are breaking down and being reconfigured in new, more complex and highly problematic ways with significant implications for patterns of health and illness and for the qualitative health experience of individuals. To fully understand these changes medical sociology and feminism need to be brought closer together.

Thinking about sex and gender

The story of how and why medical sociology and feminism came together, how they parted, and how they might be brought back together can be told through changing conceptualizations of the relationship between sex and gender. As far back as the seventeenth century women writers were acutely aware that mind/body dualism had enabled men to define themselves as rational agents and to equate women with a defective biology that excluded them from agency. It therefore made perfect sense centuries on for feminists to challenge this biological determinism with a new dua-

lism of their own: the distinction between sex and gender. This distinction enabled the argument that women's oppression is *socially caused*, rather than *biologically given*. The conceptual distinction between sex and gender, the biological and the social which took off in the 1970s, has proven unshakeable (see Annandale 2009). Even those who appeal for an appreciation of the interdependence of sex and gender in the production of health and illness persist in using the terms and, in effect, try to parcel out when sex (biology) is most important, when (social gender) is most important and when they are equally important (see Krieger 2003). Effectively, researchers are calling for greater precision in the use of these concepts, rather than a fundamental questioning of them.

The sex/gender distinction is as equally well embedded in the wider consciousness of society as it is in social scientific thought. This means that it is an object of enquiry as well as a conceptual tool. It is the lens through which debates on women's oppression and liberation have been refracted for many years – and increasingly the focus for understanding men's health in gendered terms. In this respect it is important to appreciate that the meanings attributed to "sex", to "gender" and to their inter-relationship have varied over time. I suggest that they are tied to particular configurations of patriarchal capitalism (Figure 1).

Figure 1: Patriarchy, capitalism and feminist conceptualisations of sex and gender

Operation of patriarchy	Operation of capitalism	Feminist approach	Relationship between sex/gender
"old single system"	binary difference fixed	–	Sex = gender
↓	↓ binary differences relatively fixed	2nd wave "social difference approach", (differences-between)	↓ sex ≠ gender
"new single system"	↓ sex and gender more fluid	↓ 3rd wave "diversities approach", (differences within)	↓ sex *and* gender (multiple forms)

Patriarchy has traditionally operated by conflating sex and gender – that is, sex = gender – through what I will term the "*old single system*" of patriarchal capitalism. Within industrial capitalism, production and consumption were predicated on a relatively fixed binary difference between men and women; that is, male "biological sex" maps onto male "social gender" and female "biological sex" onto female "social gender". This "old single system" benefits patriarchy insofar as it is male sex and its associated social gender that enjoys the benefits of political and economic primacy. Gender follows directly on from sex and woman's inferiority is a natural product of her (inferior) biological make-up. The heyday of this "old single system" in the West was probably the 1950s when production and consumption depended on a relatively fixed binary difference between men and women. Men were the producers, women the consumers. Products and services were targeted to a segmented

gender market, but it was women who were incited to do the purchasing and servicing for the household (see Firat 1994; Lowe 1995).
Slicing through the tight connection between sex and gender – that is, arguing that sex ≠ gender – provided what I will loosely call "second wave" feminisms of roughly the 1970s onwards with the conceptual wherewithal to challenge the "old single system" of patriarchal capitalism. It enabled the argument that women's relatively poor health is the result of social (or gender) oppression, not biological inferiority. The sex/gender distinction was truly a conceptual treasure trove for sociological research on health and health care, spawning influential work in areas such as reproduction and childbirth and gender equalities in health.

Problems with the sex/gender distinction

Notwithstanding the wealth of groundbreaking insights that emerged, two inter-related problems followed in the wake of the "second wave" distinction between sex and gender. First (sex) biology came either to matter too much (for example in radical feminist influenced work on reproduction) or not to matter much at all (for example in liberal feminist inspired work on health status) and the interplay between the biological and the social was neglected. The second and related problem was a tendency to draw a firm divide between male and female experience, be this on biological or on social terms. While on the face of it, (social) gender is treated as a variable against sex (which is more fixed), in reality gender effortlessly maps back onto a binary biological difference. Researchers still read gender through sex (or biology) as assumptions typically are made about which social/cultural/political/economic factors are relevant for male experience of health and which are relevant for female experience of health – often in advance of empirical research. Health and illness are irrevocably drawn towards opposition as part of this process. An unfortunate consequence of the binary logic that flows from the sex/gender distinction is that positively valued health is typically attached to men, and negatively valued illness to women. The ironic consequence is that feminism can end up entrenching women's ill-health, effectively colluding with patriarchy by not letting them be well. And, of course, as a corollary, construed as well by comparison, men in general cannot be ill (see Annandale/Clark 1996).
These difficulties of second wave feminism reflect a more fundamental underlying problem: that of trying to treat gender as variable, when sex (male/female biological difference) is construed as fixed and dichotomous. This may suggest that "social gender" can only fulfil its initial feminist promise and be truly variable when it is no longer necessarily associated with either men or women, that is, when it is no longer tightly bound to the sex (biology) dichotomy. Or, we might say that fulfilling the "gender" promise requires feminists to mount a two-headed attack whereby *both* (biological) sex *and* (social) gender are seen as malleable and carrying multiple meanings? It could be argued that patriarchy loses its moorings when diversity – for

instance, differences within women's and within men's experience – replaces binary differences between them.
Operating as a *critique* of second wave feminism this kind of approach – typically identified, of course, with "third wave" or postmodern feminism of the mid-1980s onwards – disrupts the conceptual straight-jacket of the second wave "*difference*" approach since, when sex and gender *both* become more fluid, men can no longer be so readily identified with positive health and women with negative health. Rather, the experience of health and illness can more appropriately be seen to cross-cut gender in complex ways. Insofar as the process of individualization which many sociologists argue characterises contemporary social life generally and the experience of health and illness specifically (see Beck/Beck-Gernsheim 2002) resonates with the postmodern feminist vision of both sex and gender as multiple and malleable entities it could be said to appropriately to reflect the contemporary social world in which men and women live out their lives.

The "new single system" of patriarchal capitalism

Not only traditional gender roles (the "social"), but also distinctions between sexed (or "biological") bodies are diminishing through what Hennessy (2000) dubs the continual tooling and retooling of the desirous subject. It has been argued that capitalism shapes biology in its own image (see Dickens 2000). It also shapes the way we think about the relationship between the biological and the social, sex and gender. Social scientists, as well as some biologists, including feminist biologists such as Birke (1999), have recently drawn our attention to openness as a counter to biological determinism. It is pointed out that as self-actualising agents bodies have agency in relation to their environment as they constantly interact to change, both inside and out. And, as Martin (1999) and others have shown, within society at large people are moving away from a fixed mechanical view towards a conceptualisation of the body as fluid, flexible, and ever-changing.
As discussed earlier, during the "old single system" of industrial capitalism, sex (as biology) and (social) gender were seen as dimorphic with biological sex determining social gender. Typically men earned the family wage, while women, when not drawn into the work force as a reserve army of labour, worked unpaid in the home. But this dichotomy does not make sense for late capitalism which relies heavily upon fluid and malleable identities formed equally, if not more, in the sphere of consumption as the sphere of production. The social body is being reformed as the once steadfast roles of male breadwinner, female homemaker and all that accompanied them in attitudinal and behavioural terms are being torn apart by far-reaching changes in employment, education, family and household structure, leisure and consumption, although of course this varies enormously by factors such as "race", social class and age.
The opening up of the *biological body,* as described by social and natural scientists, and the opening up of the *social body* in the manner just described, means that sex

(biology) is no longer so directly tied to gender in the traditional manner of the "old single system" of patriarchal capitalism. The mapping of what has traditionally been thought of as male sex onto male gender, and female sex onto female gender, has begun to give way to a more flexible, or open, system. This is not to say that (biological) sex and (social) gender are no longer connected – as mentioned earlier, it is still not possible to think about one without the other – but rather that they are being drawn into a new, more complex, shifting and arguably more pernicious relationship. A new sex/gender tapestry is being woven, a "new single system" wherein (biological) sex and (social) gender depend on each other for understanding just as much as before, but where the meaning of biological sex and the meaning and enactment of social gender, as well as the connections between them, are far more fluid (see Annandale 2003, 2009).

The "new single system of patriarchal capitalism profits from the new markets that an increasingly "diversified" gender economy operates. The self-culture of late modern capitalism is an extremely fertile ground for the commodification of sex and gender (and the body) *as* malleable entities. Indeed, sex/gender isomorphism has been readily seized upon, indeed advanced by, the marketing industry. Lury (2002) argues that features which might once have been considered natural such as one's sex or "race" have acquired the "mutability of culture". A good illustration of this is the Benetton clothing company which makes diversity its brand-identity.

Destabilised sex/gender identities have become an indispensable condition for the cross-marketing of products and lifestyles that were previously more or less confined to either men or to women, such as cigarette smoking and cosmetic surgery, with dubious or nebulous benefits to health and well-being. Marketing and the media position women (and increasingly men) in diverse and contradictory ways. In the case of alcohol, for example, British women have been problematised as "ladettes" and sexual aggressors who are losing their femininity and also viewed as liberated women living in an increasingly gender-neutral world (see Benson 2000; Marsh 2004). Media and corporate representations of the "ladette" are of a young woman who only *appears* to have it all. Here the vicissitudes of the 'new single system' of patriarchal capitalism are transferred to individual consumers who are positioned as inherently unstable themselves. The young female drinker is volatile and unreliable and, lest she forgets, needs to be constantly reminded of this (see Day et al. 2004). More widely, drinking is positioned as a male undertaking that women take on at their peril. If they do so, they risk subverting natural female virtues such as modesty and their looks. So, as the *Observer* newspaper put it in 1999: "if she (any woman) drinks like a man she may start to look like one" (quoted in Day et al. 2004, 174).

A no-win situation then: women are in dire straights whatever their circumstances. The clear message is that liberation has let them down and in the process generated a lucrative market of unstable identities and individual women who need to be shown the light. My argument is that this fluidity of identities is actively fostered through the "new single system" of patriarchal capitalism.

The impact on morbidity and mortality

Discussion of the remaking of sex/gender within feminism typically has been concerned with the body's *surface*. Yet the changes associated with this protean "economy of differences" (Ebert 1991) of the "new single system" of patriarchal capitalism, self-evidently extend *beneath* the surface. They reach deeply into the interiors of the body and change traditional health profiles. As health problems that were once largely the province of men begin to increasingly affect women (for example, lung cancer), and vice versa (for example, melanoma), the materiality of the body is modified and takes on characteristics more typical of the so-called "opposite" sex – the damaged lung, skin lesions and so on.

At t he population level, traditional patterns of male/female morbidity and mortality appear to be shifting in the west. For example, the widening gender mortality gap favouring women which characterised the period from around 1870 to the early 1970s has been closing in many nations (Table 1).

Table 1: Life Expectancy in the United Kingdom

	1969 (peak)	1971	1981	1991	2001	2007	Overall "gain"
Males	68.5	69.1	70.8	73.2	75.7	77.5	9.0
Females	74.8	75.3	76.8	78.7	80.4	81.5	6.7
Gap	6.3	6.2	6.0	5.5	4.7	4.0	

Source: Office of National Statistics (ONS) 2007, derived from data for Figure 7.1: Expectation of life at birth by sex, UK.

The above table shows improvements in life-expectancy for both men and women, but a gradual chipping away of the female mortality advantage, as reflected in the reducing gap. In fact, the main contribution to longevity for both men and women comes from accelerated improvement at older ages, and it is here that men have faired especially well in recent years (see Annandale 2009). This trend is mirrored in many other countries such as Australia, Sweden, Germany, France and the USA.

Somewhat ironically, then the "old single system" of patriarchal capitalism may have conferred a mortality advantage to women. Binary difference may have kept them away from the dangers to life and limb that cut male lives short. As differences between men and women attenuate and inequality is reconfigured women appear to be "losing out" and men "gaining". Interestingly, very little popular attention has been given to men's improvement at older ages. Ironically, the tendency of the UK men's health lobby to draw attention the historically invisible character of men's ill-health may unwittingly have contributed to this.

Lung cancer

Male rates still higher. But since mid-1970s, rising rates for women, declining rates for men in many western countries (see Griffiths/Brock 2003).

In 1950, lung cancer accounted for 3% all female cancer deaths in USA, by 2000 it accounted for 25%; overtaken breast cancer (see US Surgeon General 2001).

Opinion that women are "in the throes of an epidemic of tobacco-related disease" which is yet to reach its peak (US Surgeon General 2001).

Heart Disease

Coronary heart disease (CHD) is major cause of death of women and men across the globe, concern that CHD is perceived incorrectly to be a "male disease"; UK women amongst highest rates in world (British Heart Foundation 2003)

The major contributors to changing patterns of morbidity and mortality are heart disease and cancer. There is ongoing debate over whether women and men have a different biological vulnerability to heart disease and cancer, but it is generally recognised that social factors are very important (see Payne 2001). There is a lag effect whereby health behaviours linked to cancer and coronary heart disease such as cigarette smoking, alcohol consumption and diet initiated 20 or so years ago show up in later statistics. The commonsensical explanation for changes in mortality in the west is, as explained earlier, a social one: that men and women are becoming "more similar" in their health behaviours and particularly that women are "paying the price for liberation". It is common to hear that young women are setting off an illness time-bomb that will go off in 20 or so years' time as they "become more like men" (Brettingham 2005).

As was discussed earlier in respect of media representations, explanations are typically couched in attitudes and beliefs such as heightened health consciousness amongst men and the taking up of damaging health behaviours, notably cigarette smoking – which is generally considered a major cause of women's declining mortality advantage – by women. This explanation is mirrored within the medical and social sciences, where the "state of the art" view is also that change is afoot and "any remaining health differences between men and women may disappear" (Bartley 2004, 139/40; see also Vallin et al. 2001). Researchers now point out that the so-called "gender paradox" whereby women live longer, but are apparently sicker than men throughout their live, has been a product of blinkered thinking, a product of research designs which set out to *find* male/female differences (see McDonough/Walters 2001).

There is nothing intrinsically wrong with these summaries. Rather, the difficulty is that we seem to have a problem in search of a theory. Without this we can end unwittingly lapse into accepting popular representations of change (such as those already discussed) rather than providing a critical commentary on them. With their vision of both sex *and* gender as multiple and malleable entities, many "third wave"

or post-modern feminisms tilt precariously in this direction. They come painfully close to endorsing the flourishing academic and more popular "new feminist" literature of authors like Coward (2000), Wolf (1994) and Roiphe (1993) who claim that feminism's very success means that it is no longer needed. As Skeggs (1997) and Whelehan (2000) aptly remark, this "new feminism" offers a markedly individualistic kind of radicalism, one that feeds easily into the rhetoric of individualism where the way forward for women is lifestyle choice and self-determination largely unfettered by the erstwhile constraints of sex and gender.

I suggest that we take the "new single system" of patriarchal capitalism as the *object* of our study; this approach provides us with the conceptual wherewithal to interpret the new biological embedding of experience reflected in changing patterns of morbidity and mortality and the experience of illness as direct and visible representations of how, to paraphrase Rosemary Hennessy (1993) (who gives no attention to health and illness), the common experience of health-related oppression is produced differently, and experienced differently, through systematically driven processes of sex/gender fragmentation. Heart disease is a good concluding illustration of this. Although deaths from heart disease are falling for both men and women in many western countries, heart disease is the leading cause of premature death for both men and women in the UK, typically occurring some seven to ten years later in women than in men, and the number of people living with cardiac morbidity is increasing. But it is only recently that popular opinion has begun to shift away from heart disease as a "male disease" (see British Heart Foundation 2003).

Conclusion

If I can then return to my starting theme: the missing connections between medical sociology and feminism. Back in the mid-1980s, Lewin and Olesen (1985, 19) felt confident in claiming that more than any other domain of life, "health embodies almost all the crucial elements necessary to achieve an understanding of ... society itself". As they continue, "health permits the revelation of most of the elements of western cultures which bear most directly on the construction of gender and its consequences for women, men, and the larger social order" (ibid.). While other domains – such as religion or the law – provide insights, Lewin and Olesen make clear that none take us as far as health does, precisely because health is so all encompassing. Many feminists seem to have forgotten this and pushed health and illness out of view. Medical sociologists in their turn seem perplexed by the increasingly complex social relations of gender in the west, and unable to fully account for health-related change, in good part – I would argue – because they have lost their original anchor in feminist thought. They often work with vague derivatives of feminist theory, failing to appreciate the significant differences between them, and the implications of this for their research. I therefore argue that there is a need to bring feminist theory and gender-related research on health and illness within medical sociology much

closer together than they are at present. Contemporary health-related changes are highly complex and reach deeply into the interiors of the body. They are part of what Teresa Ebert (1991) – writing outside of the domain of health – refers to as "an economy of differences". What we know as social (gender) and (biological) sex are drawn into a new symphysis within the "new single system" of patriarchal capitalism Within his "new single system" the common experience of health-related oppression is produced differently, and experienced differently, through systematically driven processes of sex/gender fragmentation.

Annotation

1 This paper was originally delivered as a plenary address to the British Sociological Association Medical Sociology Group Conference in September 2005. It has been revised and more recent statistics on health status are included.

References

Aapola, Sinikka/**Gonick**, Marnina/Harris, Anita, 2005: Young Femininity. Girlhood, Power, and Change. Houndmills, Basingstoke.

Annandale, Ellen, 2009: Women's Health and Social Change. London.

Annandale, Ellen, 2003: "Gender and Health. Does Biology Matter?" In: Williams, Simon/Bendelow, Gillian/Birke, Linda (eds.): Debating Biology. Sociological Perspectives on Health, Medicine and Society. London, 85-95.

Annandale, Ellen/**Clark**, Judith, 1996: "What is Gender? Feminist Theory and the Sociology of Human Reproduction". Sociology of Health & Illness. Vol. 18 No. 1, 17-44.

Bartley, Mel, 2004: Health Inequality. Cambridge.

Beck, Ulrich/**Beck-Gernsheim**, Elisabeth, 2002: Individualization. London.

Benson, Richard, 2000: "Hip Tipples". Guardian, 12.05.2000.

Birke, Lynda, 1999: Feminism and the Biological Body. Edinburgh.

Brettingham, Madeleine, 2005: "Men's Life Expectancy is Catching up with Women's". British Medical Journal. Vol. 331, 656.

British Heart Foundation, 2003: Take Note of Your Heart. A Review of Women and Heart Disease in the UK. London.

Charles, Nickie, 2002: Gender in Modern Britain. Oxford.

Coward, Rosalind, 1999: Sacred Cows. London.

Day, Katy/**Gough**, Brendan/**McFadden**, Majella, 2004: "'Warning! Alcohol Can Seriously Damage Your Health'. A Discourse Analysis of Recent British Newspaper Coverage of Women and Drinking". Feminist Media Studies. Vol. 4 No. 2, 166-183.

Delamont, Sara, 2003: Feminist Sociology. London.

Dickens, Peter, 2000: Social Darwinism. Buckingham.

Ebert, Teresa L., 1991: "Writing in the Political. Resistance (Post)Modernism". Legal Studies Forum. Vol. 15 No. 4, 291-303.

Evans, Mary, 2003: Gender and Social Theory. Buckingham.

Firat, A. Fuat, 1994: "Gender and Consumption. Transcending the Feminine?" In: Costa, Janeen Arnold (ed.): Gender Issues and Consumer Behaviour. London, 205-227.

Griffiths, Clare/**Brock**, Anita, 2003: "Twentieth Century Mortality Trends in England and Wales". Health Statistics Quarterly. Vol. 18 No. 2, 5-17.

Hennessy, Rosemary, 2000: Profit and Pleasure. London.

Hennessy, Rosemary, 1993: Materialist Feminism and the Politics of Discourse. London.

Hughes, Christina, 2002: Women's Contemporary Lives. London.

Klein, Renate, 1996: "(Dead) Bodies Floating in Cyberspace. Post-Modernism and the Dismemberment of Women". In: Bell, Diane/Klein, Renate (eds.): Radically Speaking. Feminism Reclaimed. London, 346-358.

Krieger, Nancy, 2003: "Gender, Sexes, and Health. What Are the Connections – and Why Does it Matter?" International Journal of Epidemiology. Vol. 32 No. 4, 652-657.

Kuhlmann, Ellen/**Babitsch**, Birgit, 2002: "Bodies, Health, Gender – Bridging Feminist Theories and Women's Health". Women's Studies International Forum. Vol. 25 No. 4, 433-442.

Lewin, Ellen/**Olesen**, Virginia, 1985: Women, Health, and Healing. London.

Lowe, Donald, 1995: The Body in Late-Capitalist USA. London.

Lury, Celia, 2002: "From Diversity to Heterogeneity. A Feminist Analysis of the Making of Kinds". Economy and Society. Vol. 31 No. 4, 588-605.

Marsh, Beezy, 2004: "The Ladette Takeover". Daily Mail, 19.01.2004.

Marshall, Barbara, 1994: Engendering Modernity. Feminism, Social Theory and Social Change. Cambridge.

Martin, Emily, 1999: "The Woman in the Flexible Body". In: Clarke, Adele/Olesen, Virginia (eds.): Revisioning Women, Health, and Healing. London, 97-115.

McDonough, Peggy/**Walters**, Vivienne, 2001: "Gender and Health. Reassessing Patterns and Explanations". Social Science & Medicine. Vol. 52 No. 4, 547-559.

Office of National Statistics (ONS), 2007: Social Trends 37. London.

Payne, Sarah, 2001: "'Smoke Like a Man, Die Like a Man?' A Review of the Relationship between Gender, Sex and Lung Cancer". Social Science & Medicine. Vol. 53 No. 8, 1067-1080.

Pilcher, Jane, 1999: Women in Contemporary Britain. London.

Roiphe, Katie, 1993: The Morning After. Boston.

Shildrick, Margrit/**Price**, Janet, 1998: "Vital Signs. Texts, Bodies and Biomedicine". In: Shildrick, Margrit/Price, Janet (eds.): Vital Signs. Feminist Reconfigurations of the Bio/logical Body. Edinburgh, 1-17.

Skeggs, Beverly, 1997: Formations of Class and Gender. London.

US Surgeon General, 2001: Women and Smoking. Rockville.

Vallin, Jacques/Meslé, France/Valkonen, Tapani, 2001: Trends in Mortality and Differential Mortality. Strasbourg.

Walby, Sylvia, 1997: Gender Transformations. London.

Whelehan, Imelda, 2000: Overloaded. London.

Wolf, Naomi, 1994: Fire with Fire. London.