

Medicalized bodies

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Introduction

If someone is in pain, it is not simply a matter of biology. For a start, the presence of pain has to be recognized and therefore experienced. This experience constitutes a moment in which the biological, the emotional and the social collapse into one another. 'Pain', therefore, 'needs to be reclaimed from exclusive biomedical jurisdiction and relocated at the juncture between biology and culture' (Bendelow and Williams 1995: 159). Such a claim could also be made about the body itself. It too needs to be rescued from one-sided biomedical explanations. For biomedicine, the body is defined in purely biological terms. It is pre-social and has no history. It is an essence, a timeless, material thing. It has no cultural meaning and cannot think, feel or relate to others. Such a body is 'typically assumed to be a fixed, material entity subject to the empirical rules of biological science, existing prior to the mutability and flux of cultural change and diversity and characterized by unchangeable inner necessities' (Csordas 1994: 6). Indeed, as Shildrick (1997: 214–15) argues, for biomedicine 'the body is scarcely considered at all but is taken simply as the gross material basis of health care practices'.

The biomedical body owes its birthright to Cartesian philosophy (Seymour 1998). In this guise, it is simply a child of nature. However, sociology confounds this possibility by suggesting that nature and society are not mutually exclusive categories. Categorical distinctions, in a world where all kinds of boundaries seem to be collapsing, are not popular today. Sociology is alive to this, but medicine is not.

Consequently, the bodies that people the sociological imagination are a reflection of the fragmentation of contemporary life and thought and the medical body is differentiated only on the grounds of sex.

There are significant differences between sociological bodies and the medical body. The first thing to note is that the former is plural and the latter singular (at best twofold if one distinguishes between the sexes). The body in sociology is highly contested. By contrast, in medicine it has an objective, scientific, universal, indeed 'real' status. For medicine, the reality of the body is a practical necessity. Sociology, on the other hand, can deal with all sorts of bodies, largely because it relates to them primarily as either the source or the outcome of meaning (Lloyd 1999). In the past 15 years or so, sociological bodies have proliferated. They have been defined by their 'docility' (Foucault 1977), their 'performativity' (Butler 1993) and their 'lived' carnality (Merleau-Ponty 1962; Crossley 1995; Nettleton and Watson 1998); and embodiment has been explored in terms of its government (Turner 1996), its 'physical capital' (Bourdieu 1984), its 'effervescence' (Mellor and Shilling 1997) and the impact on it of the 'civilizing process' (Elias 1978).

The influence of constructionism and postmodernism in sociology is strong whereas in medical science it is nebulous. Contemporary sociological ideas are often wrapped up in a world of ambivalence, deregulation, insecurity and uncertainty (Bauman 1991). Medicine, on the other hand, cannot survive as an effective practice without assuming that the body that it seeks to mend is a secure and orderly thing that is obedient to the laws of anatomy and physiology. One could not, for example, expect the average surgeon to pay much attention to the claim that '[a] body analysed for humours contains humours; a body analysed for organs and tissues is constituted by organs and tissues; a body analysed for psychosocial functioning is a psychosocial object' (Armstrong 1994: 25). Medical practice is a servant of positivism and common sense. Our hypothetical surgeon would be unlikely to give up the 'universal truth' of the body for Armstrong's suggestion that it might contain many contradictory truths. As a practitioner, he or she would also be bound to overlook the fact that the body is a source of desire, pleasure and passion. Whereas contemporary social thought may be keen to take note of and even focus on these unruly elements of embodied life, medicine ignores them.

Despite the general stability of the medical conception of the body, I want to argue in this chapter that it is undergoing some significant changes, not so much in content but by the way it is becoming contextualized. These changes can be summed up by two propositions. First, the medical body is changing from a passive to an active entity. Given that ordinary people – rather than medical experts – are now expected to be responsible for their own well-being, the healthy body has been redefined as flexible in character (Martin 1994). It can be mobilized, by lay people, as a resource in their biographical projects of self-identity (Giddens 1991). Second, as medicine begins to prioritize

health maintenance as opposed to the elimination of disease, the body is being rethought in terms of its relationship to both lifestyle and the environment (Bunton *et al.* 1995). In other words, biomedicine has come to recognize that the body exists in a psychosocial context that is relevant to its health and well-being. These propositions can, in turn, be located analytically in the process by which medicine is being transformed from a biomedical to a biopsychosocial practice (Armstrong 1987, 1993; Cooper *et al.* 1996). It is in the lap of this transition – to a 'regime of total health' (Armstrong 1993; Nettleton 1995: 227) – that we must place ourselves if we are to understand the changing nature of the medical body.

From the biomedical to the biopsychosocial body

The dominant representation of the body in modernity has been provided by biomedical discourse. In the nineteenth century, biomedicine became a science of universal bodily processes. However, it now seems to be in crisis. Alternative, particularly more holistic, conceptions of embodiment are challenging its monopoly over the 'truth' about bodily existence. Biomedicine has come under fire from epidemiologists, social scientists, feminists, gay and disabled people, animal rights activists, alternative therapists, theologians and – most tellingly – lay persons (Gabe *et al.* 1994). In an attempt to incorporate these critiques and to respond to changes in the nature of disease, medicine seems to be repositioning itself as a biopsychosocial practice. Health maintenance, rather than disease and its elimination, is slowly becoming the focus for medical organization and intervention.

In the twentieth century medicine dominated our conception of the body. Anything that could be shown to be a concern for the body – including the big themes of life and death – was articulated in a language that if not medical per se, more often than not could be traced to it. Modern cosmopolitan medicine or biomedicine dominated the moral, political and social terrain with respect to health, illness and the body. Biomedicine can be defined as follows:

[It] is reductionist in form, seeking explanations of dysfunctions in invariant biological structures and processes: it privileges such explanations at the expense of social, cultural and biographical explanations. In its clinical mode, this dominant model of medical reasoning implies that diseases exist as distinct entities; that these entities are revealed through the inspection of 'signs' and 'symptoms'; that the individual patient is more or less a passive site of disease manifestation; that diseases are to be understood as categorical departures from normality.

(Atkinson 1988: 180)

At its simplest, the concept of biomedicine refers to modern scientific medicine. As a body of knowledge about the body (and to a lesser extent the mind) it is based on the principles of scientific observation applied principally to corpses. Through this work, it has produced and draws on the disciplines of anatomy, physiology and pathology. Biomedicine seeks knowledge of the human body in order to repair it when it goes wrong. As Engel (1977: 131) put it, biomedicine regards the 'body as a machine and . . . the doctor's task as the repair of the machine'. It is concerned, therefore, with producing a map or a picture of the normal body in order to identify and eliminate abnormality or disease. According to Foucault (1976b: 35), medicine becomes biomedicine when its scientific endeavours focus on charting the contours of normality – that is, when it becomes concerned with 'a regular functioning of the organism' and seeks to identify 'where it had deviated, what it was disturbed by and how it could be brought back into working order'.

As biomedicine established itself in the nineteenth century, health became defined increasingly against a standard of normality and in terms of the absence of disease or infirmity. Pathogenesis – the search for the origins of disease – became the cornerstone of medicine. In contrast to older forms of humoral medicine in which the balance, vigour and health of the person were paramount, biomedical practice focused on the impersonal search for the 'lesion' (Armstrong 1987).

The power of biomedicine rests in its monopolistic right to 'produce' the body by naming its parts (anatomy), its functions (physiology) and – most importantly – its lesions (pathology). This focus on abnormality and its elimination meant that the 'person' – or what Jewson (1976) called the 'sick man' – disappeared from biomedical language and practice. The sick person became reduced to and understood in terms of the disease that she or he suffered from, and biomedicine engaged not with people, but with damaged tissues and diagnostic labels.

As the 'sick man' disappeared, so too did 'bedside medicine' (Jewson 1976). The intimacy of the patients' 'natural' environment was replaced by the hospital, which became the primary site of medical practice. Before the rise of the hospital as *the* therapeutic space, a great deal of attention was paid to patients' distinctive accounts of their conditions. A vast range of biographical detail was considered important to a full and proper understanding of patients' medical condition, and the home (or bedside) was regarded as the appropriate place for medical work.

Modern 'hospital medicine' put an end to personalized, patient-centred practice and secured a change from a conception of disease as a disturbance in the balance of life to one that focused on it as a localized pathology. Patients became 'cases' who were not unique. They were defined (by diagnosis) as belonging to a specific category of disease derived from the general body of abstract clinical knowledge. Patients' stories about their lives became much less important than the objective signs of disease that the physicians would read from their patients' disturbed bodies. Of what relevance are patients' narratives

when disease 'is regarded as the consequence of certain malfunctions of the human body conceptualized as a biochemical machine' (Turner 1995: 9)?

By the 1870s biomedicine had developed a sophisticated scientific conception of causality which became known as the 'doctrine of specific aetiology' (Scambler 1991: 19). This doctrine locates disease in the pathology of human tissues. It assumes 'that all human dysfunctions might eventually be traced to... specific causal mechanisms within the organism' (Turner 1995: 9). This is a uni-causal model in which a specific disease is associated with a single cause and a specific germ or microbe is regarded as the causal agent. Such a notion of causality helps to sustain a conception of the body as a pre-social, natural, passive entity.

Biopsychosocial medicine proposes a holistic practice and a multi-causal model. It developed out of the limitations of biomedicine, some of which have just been identified. The Achilles' heel of biomedicine is that it reduces human life to biological life and so privileges biological 'explanations at the expense of social, cultural and biographical' ones (Atkinson 1988: 180). As René Dubos (1960: 77) put it, biomedicine has the 'tendency to study man as a non-thinking, non-feeling animal'. It is a victim of its Cartesian origins. In other words, the central limitation of biomedicine is biological reductionism. For biopsychosocial medicine people are more than bodies. Human existence is, simultaneously, biological, psychological and social. A healthy life suggests not only a healthy body, but also a healthy mind and a safe environment. Health therefore becomes a concept that embraces all the dimensions of human existence (Hughes 1996). This argument suggests that health and illness – indeed, existence itself – can be explained (and experienced, perhaps simultaneously) on three levels – the somatic, the psychic and the social. Healthcare practice must, therefore, be dedicated to intervention at whatever levels are appropriate to the enhancement of the well-being of the patient. Biopsychosocial medicine is described as holistic because it does not reduce health to its biological dimensions. It is concerned with 'total health' (Nettleton 1995).

As biomedicine begins to conceive of health in holistic terms rather than as the absence of corporeal infirmity, it must, of necessity, expand its knowledge base beyond the traditional biomedical sciences. Healthcare professionals now meet the disciplines of psychology and sociology in their education and training, and these subjects, in theory, provide the platform for overcoming biological reductionism. As medicine expands what it means by a healthy life, it demands a much expanded epistemology. Not only the body, but also its behaviours and the spaces in which it moves, become medicalized. The biopsychosocial model envisages multiple, even unlimited, sites for intervention and surveillance. The expanded concept of health knowledge, which supersedes its reductionist and mechanical counterpart, implies a body that is active in the production of its own well-being.

It has become increasingly difficult to sustain the notion that the body is a machine and that its health is solely dependent on its repair. The mechanical metaphor ignores the thinking, feeling and social aspects of healthy human existence (Mishler *et al.* 1981), and biomedicine feels compelled to embrace these social and emotional dimensions of health. In so doing, the passive body of biomedicine is slowly replaced by the active body of biopsychosocial medicine.

The vigilant body of biopsychosocial medicine

The shift from biomedicine to biopsychosocial medicine is partly a consequence of the incredulity and scepticism that surround science and professional expertise in contemporary times. By focusing on health maintenance as opposed to the identification and elimination of disease, the role of healthcare expertise can be recast as advisory. As people are expected to take responsibility for their own health and to practise healthy behaviour, everyday life becomes regarded as an arena of risk and preventive action (Giddens 1991; Williams and Calnan 1996). This shift has prompted scholars such as Meg Stacey (1994: 89) to comment that lay people 'are as much producers as consumers of health care'. Indeed, they can be regarded as 'medical auxiliaries' involved 'in the division of medical work' (Pinell 1996). The vigilant lay body, which practises self-care through self-surveillance (Foucault 1990), is at the heart of contemporary healthcare practice.

Buried in the notion of the vigilant lay body is a concession to a multi-dimensional view of the causes of health and disease. Germs make us ill, but so too do stress, unhealthy activities, poverty, unemployment and so on. Not only do we need to guard against invasive microbes, we must also organize our lives to maximize our immunity against a risk-laden social world. The doctrine of specific aetiology is far too unilateral to account for contemporary patterns of morbidity and mortality. In what has been called the 'epidemiological clinic' of late modernity (Bunton and Burrows 1995), the socio-moral question about how we maintain our bodies has become more important than the technical question about eliminating disease after it has become established in the human body. The range of causal possibilities for both health and illness has consequently proliferated. As the social world becomes constituted as a massive space for preventive action in which risk is all around us, then the uni-causal doctrine that underpinned biomedicine seems less convincing.

This transformation in medical practice is also linked to significant changes in the pattern of disease. Biomedicine was at its height during the last part of the nineteenth century and the early part of the twentieth century, when infectious diseases were the major killers in western societies (McKeown 1976). Today, in countries such as Britain, death from infectious disease is relatively rare. The major killers are

cancer, heart disease, stroke and accidents. There has been, therefore, a massive change in the epidemiological map. Indeed, Anselm Strauss *et al.* (1985) have argued that we have entered a 'new biological era'. As the pattern of disease has shifted from the acute and the infectious to the chronic and limiting, the pathogenic and curative emphasis of biomedicine has become increasingly untenable. The pattern of contemporary disease encourages the search for salutogens – the things, behaviours and spaces that contribute to well-being. The discourse of health maintenance raises questions about how we behave, the kinds of things that we consume, the risks we are prepared to take or avoid and the 'therapeutic' status of the social spaces in which bodies work, rest and play. The problem of heart disease, for example, has been recast as a lifestyle problem. Biomedical solutions are a last resort when strategies of health maintenance fail.

As health maintenance – as opposed to curative – strategies emerge as the priority in contemporary patterns of health care, then responsibility for health shifts from the professional to the lay person and the relationship between these two parties in the medical encounter becomes less entrenched and polarized. Biomedicine deskilled ordinary people by expecting them to be passive in relation to their health and differential in their relationships with health professionals. The idea of 'doctor knows best' was a recipe for professional paternalism. The patient was expected to play the infant role and the professional to act out the adult one. One was expected to put one's body in the hands of expertise (Parsons 1951). Biomedicine absolved the lay person from responsibility for illness. The contemporary climate, which valorizes the vigilant lay body, is less forgiving.

At the beginning of the twenty-first century, authority – be it medical, parental or political – can no longer command unequivocal respect or compliance. The 1960s put an end to that. Authority was there to serve and be questioned, not to follow blindly. Lay people and patients began to ask questions, to expect service and to recognize the validity of their own perspectives. There can be no doubt that this apparent democratization of the relationship between professional and patient suited western governments intent on reducing public expenditure and squeezing the welfare state. The ideas of self-care and health maintenance as the responsibility of the lay person rather than the professional became, in the 1980s, important ideological tools in the privatization of healthcare activities. Illich (1977: 6) identifies this shift as a sociological landmark: 'The age of disabling professions... when people had "problems", experts had "solutions" and scientists measured imponderables such as "abilities" and "needs". This age is now at an end.' In the post-professional age the state – no longer the 'nanny' of old – expects its 'active citizens' to take responsibility for their own bodies. The lay person has been transformed into the rational consumer and medicine has been subjected to political, social, cultural and economic forces that have driven it further into the logic of commercialism. In Britain, the *Patient's Charter* (Department of Health

1991) is the manifesto of this transformation from the passive to the consuming body. As consumers, patients can no longer be objectified as compliant bodies. Lay power proletarianizes professionalism and transforms its actions into goods and services. Consumerism undermines medical dominance and demands partnership rather than paternalism from professionals (Klein 1989). Health professionals can no longer expect to work with and on docile bodies. The patient has become a person and this new status opens up the psychosocial dimensions of health, illness and the body to new forms of social control and medical surveillance (Peterson and Bunton 1997).

Biomedicine has long been regarded by sociologists as an institution of social control (Zola 1972). Feminist scholars have been particularly productive in charting the story of medical control over women's lives and bodies (for example, see Martin 1989). Despite its claim to scientific neutrality, modern medicine has been involved in the disciplining and surveillance of populations (Foucault 1976b). It is an important player in the production of social order. Medicine is deeply involved in the regulation of people and the government of bodies (Turner 1992, 1996). By drawing lifestyle and environment into the domain of health, biopsychosocial medicine extends and deepens these possibilities. In the contemporary, secular, deregulated world, a good deal of the policing of human behaviour – which is traditionally invested in the powers of religion and law – is carried out in the name of health. The contemporary physician is as likely to 'dispense' 'healthy' information or 'prescribe' behavioural change as he or she is to treat one's condition or offer the instant solution of 'magic bullets'. Biopsychosocial medicine, therefore, involves the medicalization of lifestyle, consumption and social space and it does so through its various manifestos for healthy living (Bunton *et al.* 1995). Eating, drinking, sleeping, leisure activities, sexual behaviour, cities and communities have all come under the jurisdiction of medical regulation. The good life has become the healthy life and each and every one of us is expected to integrate the codes, conducts and prescriptions of such a life into our daily activities. As medicine extends its gaze beyond the body, its power disperses throughout the social body. Medical knowledge, often in the form of behavioural prescriptions, challenges the population to be healthy, to adopt healthy behaviours and to choose healthy places to live and work. Biopsychosocial medicine, with its exhortations to choose health and actively practise self-care, is well suited to the information society (Lyon 1994), in which technologies of communication provide populations with advice about how to live and how to avoid risk.

Yet, just as everyday behaviour, or embodied activity, has become a target for healthcare intervention, so too have the spaces in which bodies move. There has been a significant expansion in the geography of healthcare activity. Nettleton (1995: 248) notes some of the ways in which biopsychosocial medicine transcends the geographical limitations of biomedicine:

First, it involved a new way of organizing health care that related to community. Functioning beyond the walls of the hospital, it acted as a coordinating centre for those who sought out and monitored disease. Second, the medical gaze was diverted from the interior of the physical body to the spaces between bodies. Pathology was not localized and static but found to travel throughout the social body and so there was a need to focus on contacts, relationships and home visits. . . . Third, as surveillance extended throughout the community the emphasis began to shift from those who were ill to those who were potentially ill.

The community has become a therapeutic site in which relationships and space are targets for healthcare intervention. The logic extends to the environment, particularly urban space, which is manifest in the concept of the 'healthy city' (Ashton and Seymour 1988). This massive relocation of healthcare activity has been neatly summed up as a 'shift from bodies in hospitals to people in communities' (Nettleton and Burrows 1994: 3). The phrase suggests the (potential) omnipresence of therapeutic sites and possibilities. It also suggests a much extended conception of the subject of healthcare expertise and a reworking of the definition of health as the relationship between the body and the social world. The biopsychosocial body is locked into a 'systems theory' of health in which the body, the mind and social location are interacting subsystems in the complex web that makes up the multiple determinants of health.

Public health, health promotion and the disciplined body

If biomedicine was concerned, primarily, with the medicalization of the body, then biopsychosocial medicine – in the name of the health of the body – extends the process of medicalization into lifestyle and social organization. The 'new public health', and health promotion in particular, is the key mediator in this process of bodily regulation (Lupton 1995). In practice, health promotion tends to focus on transformations of lifestyle rather than changes in social structure. Health promotion preaches the precepts of a proper, medically informed relationship to one's body.

In a partial sense, health promotion embodies a promise of release from medicine. Regimes of health maintenance imply the possibility of independence from medical expertise through the hard work of self-mastery and bodily regulation. If one is, for example, willing to transform the rhythms of leisure and the patterns of consumption, then freedom from heart disease and circulatory problems is – more or less – promoted as the outcome. The encouragement to exercise, for example, envisages a profound transformation of leisure – from relaxation to working out, from rest to activity. Glassner (1989: 187) writes:

At the postmodern health club – filled with glimmering machines which disaffirm their modernism by being labour-making devices – leisure is work, impulses are harnessed into repetitions per minute, and the conscience, now of the body as much as it is of the soul, is only as strong as its owner's heart and as firm as her thighs.

It costs a lot to join the postmodern health club but one is paying for more than firm thighs. One is paying for a 'good' body. In contemporary consumer culture, to look good is to feel good is to be good. The outer body, when healthy and beautiful, confirms the positive moral disposition of the inner self (Featherstone 1991a). One is paying – if one can afford to do so – for access to facilities that are essential to success. Contemporary projects of self-identity are based on the moralization, aestheticization and medicalization of self through body work. Health promotion discourse is tuned into this project and it enables medicine to engage productively with aesthetic and ethical trends in contemporary culture. The ethical self (of both health promotion and contemporary culture) appears in a particular shape – in fact, 'in shape'. The embodiment of the ethical self is toned, ordered and visible as a 'good' body, and the good body is indicative of the subjection of self to regimes of discipline. The firmness of one's body is a testimony to oneself as an ethical subject. The firm body sends a clear message: its 'owner' is one who applies the codes and commandments of contemporary medical wisdom to him or herself. To practise healthy behaviour is to improve one's 'physical capital' (Bourdieu 1984) and, therefore, enhance one's social and moral worth.

The path to ethical self-regulation is one that is signposted by health promotion discourse which translates and simplifies medical wisdom into dicta of conduct. These provide a code and a set of behaviours that are useful for the management of one's daily existence. They promote a 'regimen' of mundane healthy activities. It is striking that the scope and nature of this regimen is not that different from the one that Foucault (1986: 101) describes as a model of ancient prescriptions for conduct. He refers to Book VI of Hippocrates' *Epidemics*, in which a conceptual map of regimen exhorts people to take care in relation to exercise, food, drink, sleep and sexual behaviour. Regimen refers to the management of everyday conduct or daily habits. Today we would probably invoke the concept of lifestyle. Foucault argues that the health maintenance strategies of the ancients are 'an art of living' – indeed, 'a whole manner of forming oneself as a subject who had a proper, necessary and sufficient concern for one's body' (1986: 108).

Health promotion offers prescriptions for behaviour. It comprises a set of prescriptive texts that constitute a practical philosophy for the 'civilized' government of the body and the construction of ethical subjectivity. It is concerned, primarily, with the conduct of life, with 'well-being' and with 'self-mastery'. Health promotion as a set of educational statements and images is a discourse of moral regulation (Lupton

1995), with an investment in the production of self-regulated bodies and populations. Thus, the prescriptions for behaviour embedded in health promotion texts are both medical and moral. Once again we can draw a parallel with Foucault's work on conduct in the classical age. In *The History of Sexuality* he examines a number of classical texts which he describes as 'prescriptive texts' or 'prescriptive discourses' (1986: 249). These are:

texts which no matter what their form – dialogues, treatises, collections of precepts, letters – sought primarily to propose rules of . . . behaviour. Such texts acted as *operators* enabling individuals to question their own conduct in order to build their own personalities – the very stuff of character making.

(Merquior 1985: 126; our italics)

Contemporary health promotion texts embody this prescriptive role with respect to conduct and its link to 'character'. The rules and codes are established in moral-semantic form as behaviours and actions (and even places) that are good for you or bad for you. Given that these prescriptions are derived from the scientific discoveries of medicine, health promotion might be described as its moral dispensary. It does not, however, dispense tablets or medications but rather words to live by. It is medicine reduced to aphorisms of conduct that encourage people to develop a *proper* relationship to their bodies. Health promotion is based on the assumption of the informed lay person who is active in the production of the healthy self.

The promotion of knowledge about health is not intended to be didactic, but it does tend to be presented as interpretive repertoires for living which are based on rules of conduct. The health promotion messages are 'dos and don'ts' – if not commandments, then moral imperatives that trade on aesthetic outcomes. They often have a sound-bite form and can easily be reduced to watchwords and beatitudes. They are also practical guides. For example, health promotion discourses about smoking tell us not only to give it up but how to do it. The disciplines and skills of abnegation are presented in the form of manuals (like car manuals) from which one can learn how to put into practice the doctrine of self-care. One is expected to quit the weed because its use is linked to disease, death, antisocial behaviour and moral failure and one is given instructions on the techniques for overcoming the irrational cravings of the body. The wayward body has to be brought to heel because the price for failing to do so is so high. One is encouraged to critically interrogate one's actual behaviour against the codes of an ethical ideal.

The efforts of health promotion are, therefore, invariably narratives of transformation through self-regulation. One is encouraged to make a transformation with oneself as the object of change and, more often than not, some ascetic practice dominates the mode of transformation. The not-so-perfect body is expected to make a journey of

self-transformation that terminates in the ethical self, in self-mastery. This is symbolized in practice by the sublime moment of success when the addiction is brought under control, the target weight achieved, the finishing line of the marathon crossed. The reward for success is the personal and public recognition of one's moral status or moral rehabilitation. The badge of self-mastery is the purified, transformed, disciplined, orderly, ethical body. The health norms of contemporary society are manifest in health promotion. As such, they form a new regime of self-surveillance based on the medicalization of lifestyle and behaviour. They construct the ethical, self-regulated subject as the embodiment of self-mastery and offer the deviant body strategies and repertoires for aesthetic and moral transformation. These processes imply a change in the meaning of disease.

Disease – in at least some of its manifestations – can now be regarded as a failure of health maintenance, a sign of an improper relationship to one's body and to what one does with it. The self is problematized by the appearance of disease because it is a sign of weakness, of lack of control, of self-neglect, of a person in moral debt. The right to appeal to the public purse, to the acute health services, for resources to tackle the invaded body, is becoming more dependent on normative – as opposed to clinical – assessment. One has failed to put into practice the moral prescriptions of health promotion, so why should the community take responsibility for that failure. The trauma of disease can therefore be interpreted as a payback for a bad diet, for too many hours spent slumped on the couch glued to the TV, for the long years consuming coffin nails, for those lost weekends in the arms of demon drink, for that quick fuck without a condom. Each activity carried a highly publicized risk, a health warning. Those who have ignored the dangers get what they deserve.

In the image and information economies of late capitalism, the rules of self-care and health maintenance are made as transparent as possible. They are dispensed, in people-friendly form, by the apparatuses of health promotion. In theory, therefore, lifestyle can be managed to avoid risk. Healthy activities and objects can be selected in preference to their pathogenic, dangerous counterparts. One can be safe in one's own hands, providing one follows the rules of conduct and mobilizes the appropriate moral prescriptions. Like good and evil, in pre-secular, pre-modern societies, the therapeutic and the anti-therapeutic are omnipresent, manifest and easily identifiable in actions and in objects of material culture. Health promotion structures its messages on the distinction between good and bad and assumes a rational, unitary subject who can be ethical by acts of informed will (Lupton 1995). These assumptions are normative and utopian. They mobilize the medical in pursuit of the ethical and aesthetic, in a way that positions power productively and fairly unambiguously on the terrain of everyday actions and behaviours. Even if one resists the rules and moral prescriptions of health promotion, one cannot help but engage with them. Indeed, they engage with us as the

normative, narrative codes that underpin proper bodily practices. As such, they are thoroughly implicated in the construction of self-identity (Giddens 1991) and the body projects that are testimony to the 'unfinished' nature of embodiment in the contemporary world (Shilling 1993).

Breasts and testicles: the medicalization of lay tactility and the dispersal of medical power

The touch of the health professional is supposed to be informed by 'affective neutrality' or emotional distance. In the vast majority of cases it probably is. The health professional has access to the most intimate parts of the body. This privilege is predicated on the application of a special type of touch, one in which emotional distance defuses the ambiguities and tensions of physical proximity. During the process of professional socialization the health professional learns to objectify the patient. This probably helps the professional to internalize the unwritten rules of physical engagement, so that in the actual medical encounter the definition of touch brooks no dubiety. However, one can argue that this specialist form of tactility is beginning to be dispersed throughout the lay population and is most manifest in the growth of self-examination as a legitimate form of lay health work.

The jury is out with regard to the clinical effectiveness of self-examination of breasts and testicles (Austoker and Evans 1992). However, the consensus is that it cannot do any harm and may well, in some cases, reduce the time between onset and diagnosis of cancer in these sites. Information about self-examination is readily available in clinics and hospitals in the standard 'how to' format. What this information does not say, however, is that the practice of self-examination turns the lay person into an auxiliary diagnostician. There is implied in this process a reorganization of embodiment, or at least a reorganization of how we are expected to know and touch our bodies. Although we can and do experience our bodies as objects (Leder 1990), particularly when ill or damaged, the frame of reference through which our bodies are known to us, or *lived*, is usually personal and subjective. The idea of self-examination implies, however, that we must apply a clinical and professional frame of reference to ourselves and thus experience our carnality as a sort of fleshy otherness. In touching our own breasts or testicles we are expected to forgo the onanistic and pleasurable element associated with these erogenous zones and adopt a medical form of tactility in which we exteriorize ourselves. In these acts of vigilance, in which our health is, quite literally, in our own hands, we are expected to turn the medical gaze on ourselves. This is a classic example of self-surveillance (Foucault 1980) – the moment in which social control becomes self-control: 'Just a gaze. An inspecting

gaze, a gaze which each individual under its weight will end by exteriorizing to the point that he is his own overseer, each individual thus exercising this surveillance over and against himself' (Foucault 1980: 155).

In the contemporary world the logic of medicalization extends into the private world of self-reflection, encouraging new forms of body work in which medical skills are applied by lay persons to themselves. Through its ever-growing imperative to inform, medical discourse empowers us to inspect ourselves and provides us with the tools – once jealously held only by the state registered – of bodily vigilance and self-examination.

Bodily manifestations usually considered innocuous by lay people have to be dramatized in order to give them another meaning ie: possible signals of an early cancer. This dramatization takes place within the dynamics of medicalization. Its aim is to turn everyone into a sentry, a potential patient looking after his own body and ready to consult his practitioner as soon as he picks up on a suspicious signal. The explicit objective is, through adequate education, to medicalize the way that each person looks at his own body.

(Pinell 1996: 13)

The informed patient or potential patient knows how to read his or her body as a medical text, to screen him or herself by self-examination and to conclude – should bodily norms seem distorted – with a preliminary and provisional diagnosis. Self-examination or learning to relate to one's body as a medical text – that is, as an object of para-professional self-scrutiny – is a significant aspect of the medicalization of everyday life that arises as medicine disperses its knowledge throughout the social body.

The notion of a vigilant, active, lay body that mobilizes medical information and advice – be it around issues of health maintenance or self-examination – in the name of health work has significant implications for the nature of medical power. The re-ordering and transformation of medical power has a strong affinity with Jean Baudrillard's (1988a: 107) description of the new form of American power:

... America is no longer the monopolistic centre of world power. This is not because it has lost its power, but simply because there is no centre anymore. It has ... become the orbit of an imaginary power to which everyone now refers. From the point of view of competition, hegemony and imperialism, it has lost its ground, but from the exponential point of view it has gained some: take the unintelligible rise of the dollar for example which bears no relation to any economic supremacy ... or even – and why not – the world wide success of *Dallas*. America has retained power, both political and cultural, but it is now power as a special effect.

The idea of power diversified and without a centre seems to fit contemporary medicine and is consistent with the idea that medical work has become displaced and diversified, a matter as much for lay vigilance as the application of expertise. In the form of TV programmes and Coca-Cola, America is everywhere, colonizing every reach of the globe with the typical symbols of its consumer culture. Likewise, medicine is omnipresent in the form of information that we use to guide us through the risks, pitfalls and problems of life. It is the source of the good life, the means to longevity, health and fitness (Glassner 1992), be it 'natural' or cosmetic (K. Davis 1995). It is our companion in decisions that need to be taken about eating, sleeping, drinking and sexual relations, and it informs how we run and plan our cities and communities (Bunton *et al.* 1995). As health work has become 'decentred', then 'power relations are rendered invisible, and are dispersed, being voluntarily perpetuated by subjects upon themselves' (Lupton 1994: 32).

Conclusion

In the 'regime of total health' (Armstrong 1987) the subject of healthcare activity is massively expanded. Even though the body is the focus of all this activity the psychosocial dimensions of health and illness are considered to be integral to the regime. The embrace of biomedicine and public health gives birth to biopsychosocial medicine. This is a model of medicine in which health is conceived in terms of the interaction between biological, psychological and social systems. It becomes difficult to distinguish between the clinical and the social because the world is divided into actions, things and spaces that are either 'good for you' or 'bad for you'. As the social forces that act on the body and embodied behaviour itself are recognized as belonging to the 'regime of total health', new forms of therapeutic space and action can be continuously invented. Nothing, in theory, falls outside the orbit of healthcare work because the healthy subject is ecologically situated. If the problems and patterns of living are implicated in the causation of disease and the maintenance of health, then the clinic is compelled to escape the confines of its specialist space and subject (the body) and spread its gaze over the complex canvas of everyday life. Every behaviour, thing and space is scrutinized for its salutary potential, and for the support that it can offer to the body in its battle to survive. Furthermore, the agency of the body is valorized because health is transformed into an individual responsibility. The old passive body of biomedicine is dead and buried.

Understood as a biological object, the medical body has remained, in some ways, stable and predictable. For example, Laqueur (1990) has argued that since the latter part of the eighteenth century, medical science has maintained the view that the sexes are opposite. It is only

recently that challenges to this hegemonic perspective have been mounted. Feminists such as Elizabeth Grosz (1994) have suggested that the classification of bodies by 'opposed sex' misrepresents the character of embodied difference. Sex is unstable, indeterminate, relational, caught up in and produced out of relations of power. Even biology itself is generating new ways of thinking about the body and, indeed, life itself. Molecular biology, biotechnology and the Human Genome Project are beginning to spell out a 'radical revision of the very notion of corporeality' (Rose 1998: 161). One wonders what medical practice will look like after the new biology has given it a thorough theoretical make-over. If social constructionist arguments also have an influence on it, it may be difficult to recognize.

Further reading

For an interesting discussion of the biomedical body Leder's edited collection *The Body in Medical Thought and Practice* (1992) is useful. The sociology of the body – and its debates and theoretical richness – has, of late, become more integrated into the sociology of health and illness. *Regulating Bodies: Essays in Medical Sociology* (1992) by Bryan Turner is an early and valuable example of this symbiosis. Deborah Lupton in *Medicine as Culture: Illness, Disease and the Body in Western Societies* (1994) uses a constructionist account to both analyse and critique the medical body, whereas Sarah Nettleton in *The Sociology of Health and Illness* (1995) and Bryan Turner in the second edition of *Medical Power and Social Knowledge* (1995) have both produced textbooks in which the sociology of the body plays a significant role in delineating the scope of sociological debate about medicine, health and illness. Wendy Seymour's essay on rehabilitation, *Remaking the Body* (1998), is well grounded in a phenomenological sociology of the body. In her recent work on immunology – *Flexible Bodies* (1994) – the feminist scholar Emily Martin provides a fascinating analysis of the links between broad social transformations and lay accounts of the importance of 'agile' immune systems. There is, of course, a well established literature in which medical control over women's bodies is a central theme. It seems almost offensive to single out and recommend a text from this rich tradition, but one cannot go wrong, as a point of departure, with Emily Martin's *The Woman in the Body* (1989). With respect to the male body, Sabo and Gordon's edited volume, *Men's Health and Illness: Gender, Power and the Body* (1995), provides an interesting introduction to embodied masculinities. The 'new public health' and health promotion signal the arrival of the healthy body as a product of the active and vigilant lay subject. Of the literature in this field two books stand out: Deborah Lupton's Foucauldian volume *The Imperative of Health: Public Health and the Regulated Body* (1995) and the collection edited by Bunton, Nettleton and Burrows entitled

The Sociology of Health Promotion (1995). For those who wish to learn more about the application of constructionist theory to the medical body, then Foucault, *Health and Medicine* (1997) edited by Peterson and Bunton and Nick Fox's rather more esoteric work *Postmodernism, Sociology and Health* (1993) will both repay scholarly attention.

C H A P T E R 2

Disabled bodies

KEVIN PATERSON AND BILL HUGHES

Introduction

This chapter considers bodies that have often had a liminal or token presence in sociological discourse. We will call them 'disabled bodies'. It should be noted at the outset, however, that the two words that form the couplet are uneasy bedfellows because disability, as we will see, has more to do with social exclusion and oppression than with corporeal status. By and large, sociology has accepted the hegemonic notion of the 'disabled body' as 'deficit' and 'invalidity'. Disability is perceived as pre-social and hence as best understood by the disciplines of medicine and psychology (Oliver 1990; Barton 1996; Barnes *et al.* 1999). Sociology has failed to redeem itself even where it might be expected to do so. Disability studies treats both the sociology of medicine and the sociology of the body with some suspicion. Medical sociologists have insisted on conflating analysis of the disabled body and the sick body (Barnes and Mercer 1996; Shakespeare and Watson 1997). For their part, sociologists of the body have been keen to rethink female, black and gay bodies, but have largely ignored the corporeality of disabled people (L. Davis 1995; Abberley 1997; Paterson and Hughes 1999). It has been left to disabled activists and their allies to provide a critical, radical and structural analysis of disability (see Barton and Oliver 1997).

For (bio)medicine, disability is reduced to physicality but in disability studies the body has been displaced as the central focus of analysis. However, as we will see in the first and final sections of this chapter, in disability studies the body is now returning from exile and it is