Disturbing notions of chronic illness and individual responsibility: towards a genealogy of morals[1]

Rose Galvin
Woolgoolga, NSW, Australia

ABSTRACT   This article seeks to demonstrate that chronic illness is increasingly being viewed as culpability in the face of known risks, an instance of moral failure that requires the intervention of a range of political technologies. I argue that, in many western nations, it is becoming less acceptable to enter and remain in a physically incapacitated state: it clashes too uncomfortably with the image of the 'good citizen' as someone who actively participates in social and economic life, makes rational choices and is independent, self-reliant and responsible. By engaging in a genealogical analysis of chronic illness and individual responsibility, exploring how they are placed within the framework of contemporary 'risk-society', employing the insights derived from recent governmentality studies and developing a case study based on the current Australian experience with health promotion and welfare reform, I investigate the ways in which the concepts of health and illness are currently being deployed as tools of 'government'.

KEYWORDS   *chronic illness; genealogy; moral responsibility; neoliberal governance; risk*

ADDRESS   Rose Galvin; PO Box 568, Woolgoolga, NSW, 2456, Australia. [rose@midcoast.com.au]

Introduction

When Samuel Butler (1872), in his novel, *Erewhon*, created a land in which the ill and infirm were considered to be morally reprehensible and were punished for their misdeeds, it is unlikely he would have believed that, more than a century later, Erewhon would be drawn upon as a metaphor to defend the current thrust towards individual responsibility for health and illness that is sweeping most western nations. Yet, in 1991, when George Bush sought re-election as American president, one of his favoured health reform platforms was based on the notion of Erewhon and, as such, was

built on the stark imagery of the denigration and punishment of those who fail to stay well (Quillen, 1991: 7). Similarly, a health food chain in the USA has also succumbed to the seductive moral metaphor of Erewhon in naming its stores. Ted McKasky (1998), the chain's manager, wrote: 'Erewhon is taken from the Utopian novel of the same name written by Samuel Butler in the 1800s about a land where people are held responsible for their own health. Today, this seems more appropriate than ever.'

The idea that health and illness are matters of personal responsibility is not a new one. Its roots are deeply embedded in traditional notions of illness and sin. However, I will argue that it has taken on a more subtle yet more powerful form within contemporary liberal democracies which has resulted in a culture of victim blaming that is becoming increasingly difficult to contest. This has ramifications for the chronically ill, not only with respect to how they view themselves and are perceived by others, but also in relation to how they are expected to interact with government, expert knowledges and the market place. I argue that, within advanced liberal societies, it is becoming less acceptable to enter and remain in a physically incapacitated state: it clashes too uncomfortably with the image of the 'good citizen' as someone who actively participates in social and economic life, makes rational choices and is independent, self-reliant and responsible. Chronic illness is increasingly viewed as culpability in the face of known risks, an instance of moral failure that requires the intervention of a range of political technologies.

It is important to recognize that the arguments that will be developed here rest on a strong tradition of social inquiry, informed by the disciplines of sociology, social and behavioural psychology, nursing and the history of medicine, which has contributed to our current understanding of illness as a matter of individual responsibility. It will not be possible within the scope of this article to do justice to the history of this discourse. However, I will begin with a brief outline of the relevant literature to furnish some of the historical background, empirical support and theoretical grounding for my claim that those who are chronically ill are considered to be failing in a moral sense.

The main thrust of this article, however, will be based on the belief that a Foucauldian approach to this well-tilled ground will offer us new tools for its cultivation, the sowing of fresh insights and a harvest which offers its bounty, not in the search for universal solutions or utopian ideals, but rather in the acknowledgement that the potential for resistance is enmeshed in our relationships with power and is not something that can be prescribed from within the constraints of meta-theory. In broaching the topic in this way I am indebted to the work of those such as Bunton (1997), Nettleton (1997) and Petersen (1997) who have certainly laid the groundwork for my arguments. However, I will be adding to their broader Foucauldian analyses by adopting a more specific governmentality approach. This should illuminate more clearly the kinds of mechanisms, strategies and tactics

which transform mentalities of rule into particular forms of moral prescription and individual self-management, unearth via genealogy the evolution and historical contingency of the concept of chronic illness and point the way to alternative modes of thinking and acting which can be developed to challenge the subjugation which accompanies long-term illness and incapacity.

From demons to self-discipline

It can be demonstrated that, although they have exhibited a variety of forms, moral theories of illness have always held a firm place in traditional belief systems, across cultures and over time. These theories have either been based on the notion of 'spirit aggression' which stems from the belief that illness results from the punishment of supernatural beings (Murdock, 1980: 20), or 'behavioural culpability' which is based on 'the belief that people can choose to avoid illness by engaging in healthy thoughts and behaviours' (Galvin, 2000: 12). Up until recently, beliefs based on theories of spirit aggression were by far the more popular of the two, but I will argue that, although a strong body of contemporary research has revealed that they are still surprisingly prevalent (Kroll and Bachrach, 1986; Landrine and Klonoff, 1994), it is the transformation of the notion of behavioural culpability into our current obsession with health and fitness, and the accompanying belief that both are a matter of individual choice, which now predominates and results in a new culture of victim blaming.

Foucault warns the genealogist against the search for origins as this would rest on an erroneous belief in essentialism: he encourages rather a recognition of 'accident and succession' (1977: 142). In keeping with this fundamental principle of genealogy, I accept that the contemporary emphasis on individual responsibility for health, which is commonly argued to have originated with the Lalonde Report in Canada in 1974, was prefaced by a series of not always connected, yet mutually reinforcing, events, such as the rise of the science of epidemiology, its link with what Rose refers to as the 'psychologisation of the mundane' (1999: 244), and the transition from the 'welfare state' to neoliberal rationalities of government in the West. However, while the Lalonde Report should not be mistaken as an origin as such, it is an incisive point of entry into the analysis of contemporary forms of behavioural culpability.

The delivery of the Lalonde Report marked the birth of the term 'health promotion'. This concept of promoting health behaviours was developed by Lalonde to form part of a multi-dimensional approach to public health which had a strong focus on social and environmental factors. Yet it has since been cited predominantly in isolation from its intended social framework, particularly in countries outside of Canada, and used to defend an ever-increasing focus on individual responsibility (Falk Raphael, 1999;

Minkler, 1999). A deeper analysis of health promotion and its development as a political technology will be addressed later in this article, but the intention here is briefly to outline the debate which has arisen from the contemporary rearticulation of the belief that individuals can control their own health.

Knowles (1977) threw down the gauntlet which sparked this debate in his article 'The responsibility of the individual'. He claimed that the escalating health care bill in the USA was the result of individual behavioural mismanagement. The arguments launched by Knowles were heavily backed by the statistics developed within the fields of epidemiology and behavioural research and, thus, rested on a claim to scientific neutrality, but his agenda was distinctly moral. He refers to the exercise of healthy behaviours as 'a moral responsibility' and decries the 'cost of sloth, gluttony, alcoholic intemperance, reckless driving, sexual frenzy and smoking' (1977: 75).

> I believe the idea of a 'right' to health (guaranteed by the government) should be replaced by the idea of an individual moral obligation to preserve one's health – a public duty if you will. (Knowles, 1977: 73)

Crawford responded to Knowles and the more general arguments supporting his view in 'You are dangerous to your health: The ideology and politics of victim blaming' (1977), and in 'Sickness as sin: A health ideology for the 1970s' (1978). He argues that the attitudes expressed by Knowles and others have resulted in a 'victim blaming ideology' which places ill people in an untenable position (1977: 668) and he mocks the major attitude informing the individual responsibility thesis when he writes: 'why waste money, after all, on people whose lifestyle contravenes good therapeutic results, or, as one commentator put it, on a "system which taxes the virtuous to send the improvident to hospital?"' (1977: 669).

To demonstrate the prevalence of this point of view Crawford (1977) quotes from a range of doctors and health officials:

> For once we cannot blame the environment as much as we have to blame ourselves. The problem now is the inability of man to take care of himself. (Ernst Wynder MD, quoted in Crawford, 1977: 664)

> many of our most difficult contemporary health problems, such as cancer, heart disease and accidental injury, have a built-in behavioural component . . . . *If they are to be solved at all*, we must change our style of living. (Robert Whalen, Commisioner of the New York Department of Health, quoted in Crawford, 1977: 671, emphasis added)

> health is a *duty* . . . one has an obligation to preserve one's own good health. The theory of a right to health flies in the face of good sense, serves to undermine personal responsibility, and in addition, places obligation where it cannot help but be unfulfillable. (Kass, quoted in Crawford, 1977: 669, emphasis added)

These stringently individualistic attitudes are reflected in the health policy that originated in both the USA and the UK during the same period. In 1979 the Surgeon General's Report, *Healthy People*, was released, declaring that 'perhaps as much as half of US mortality in 1976 was due to unhealthy behaviour or lifestyle' (US Department of Health, Education and Welfare, 1979: 9). The focus on individual responsibility has been so extreme in the health promotion programmes that were developed during the following decade that even the former director of the Office of Health Promotion, Lawrence Green, was critical:

> We Americans allowed our health promotion terrain to be restricted to lifestyle determinants of health, but we also allowed lifestyle to be interpreted too narrowly as pertaining primarily if not exclusively to the behavior of those whose health is in question. (Green, quoted in McLeroy et al., 1988: 360)

The most recent US government health initiative, *Healthy People 2010*, proudly states that it is pursuing the same vision outlined in the original Surgeon General's Report in 1979 (US Department of Health and Human Services, 2000: 1) and, although it emphasizes a community approach, by merely declaring that a healthy community and a healthy nation relies on the health of each of its citizens, it retains its individualistic stance (US Department of Health and Human Services, 2000: 3).

The British government also chose to draw the message of behavioural reform from the wider platform of the Lalonde Report and, in 1975, in response to the warning it received from the International Monetary Fund to cut back on public expenditure, the House of Commons expenditure committee began an investigation into the potential savings that a preventative medicine approach might bring. When the report was published in 1977 its primary conclusion was

> that substantial human and financial resources would be saved if greater emphasis were to be placed on preventio n. This is not just a theoretical conclusion; it is literally a matter of life and death. Our recommendations cover organisation, training, advertising, finance, and *last but not least, self-help*. (Mitchell, 1982: 169, emphasis added).

The Department of Health and Social Security's own publication, *Prevention and health: Everybody's business*, published at around the same time reinforced the Government's message: the social model of health was no longer viable. *Saving lives: Our healthier nation*, the White Paper released in July 1999, reinforces the ever-increasing focus on individual behaviour and Mayor comments that it places 'more emphasis on improving individual responsibility for health than has traditionally been expected from the Labour party' (1999: 73).

Leichter argues that 'health promotion has achieved the status of a moral imperative' (1997: 361). No one disputes the fact that the lessons which stem from health promotion programmes can be beneficial to people's

health and well-being. Rather, what is in contention here is the attitude which is rooted in a twist in the logic of the responsibility thesis which includes the premise, sometimes hidden, often blatant, that, if a person *does* become ill, it is necessarily the result of faulty behaviour. This extrapolation of the notion of individual responsibility from one of care to one of culpability has developed in response to what has been portrayed as a rising incidence of chronic illness and this has resulted in a social milieu in which chronic illness is being seen as a particularly damning example of behavioural culpability (Caplan, 1993; Brandt, 1997). Consequently, it is now the experience of many people that 'impotence in the face of illness has become an unbearable, indeed almost scandalous, failure' (Herzlich and Pierret, 1987: 134).

Radley argues that the health consciousness that stems from the idea of individual responsibility has resulted in the necessity to engage in 'manœuvres to reassert continually [one's] moral credentials in order to counter the ever-present threat of stigma' (1999: 168), a battle which is sadly being lost by those who cannot stay well in a world where '[h]ealth, in itself, is often interpreted as a sign of good moral character and individual worth, [and] disease is . . . equated with moral failure' (Caplan, 1993: 234). This 'secular moral code' (Katz, 1997: 301) is based on a transition from the perspective of health as a *right* to one which views it as a *duty* (Knowles, 1977; Rabinow, 1991; Brandt, 1997; Osborne, 1997) or as Greco (1993) terms it 'a duty to be well'. For the chronically ill these attitudes are devastating and are usually internalized to form a sense of guilt and self-recrimination (Abrams and Finesinger, 1953; Marantz, 1990; Brownwell, 1991; Finerman and Bennett, 1995; Lowenberg, 1995).

Much can be done by arguing for a recognition of the social and environmental causes of illness (Herzlich, 1973; Gerhardt, 1989; Waitzkin, 1991; Donahue and McGuire, 1995; Brandt, 1997) and by launching a challenge to the dualistic manner in which we frame the debate (Tesh, 1988). However, what I will be focusing on here is the possibility of an alternative mode of resistance inspired by the insights gained from a genealogical analysis. It is my belief that, by revealing the historical contingency of the convergence of contemporary notions of chronic illness and individual responsibility, it will be possible to challenge them at all possible levels, from the personal to the political.

The construction of chronic illness and the deployment of health

There is a notion of chronic illness that exists today which seems grounded in common sense. We believe that chronic illnesses were relatively rare before the advent of modern medicine and the associated improvements in sanitation and hygiene because people either died from their serious illnesses or did not live long enough to contract the illnesses which have

become common during the 20th century. This belief is evident in the 1979 Surgeon General's Report *Healthy people* in its claim that 'the proportion of deaths from major chronic diseases has increased more than 250 percent since the beginning of the 20th century' (US Department of Health, Education and Welfare, 1979: 2). Closely associated with this view is the notion that chronic illnesses are a consequence of an affluent lifestyle. This kind of logic begins with locating illness in a particular historical context, but it ends with the concepts of 'lifestyle', 'behaviour' and 'choice' which place the responsibility for illness squarely on the shoulders of the individual. I argue that this reading of chronic illness has been constructed within a diffuse network of power relations fundamental to contemporary neoliberal governance and, as such, is based on certain ways of 'knowing' that obscure other readings.

By subjecting chronic illness to a genealogical analysis it will be possible to unearth the assumptions which have led to its contemporary definition, to demonstrate that what now appears as self-evident and outside of ideology is in fact a historically contingent construction which serves particular purposes and that, therefore, other ways of viewing it are and always were possible. Foucault created a series of invaluable intellectual tools, modes of critical analysis, which have made it possible to deconstruct the supposedly self-evident nature of the concepts which structure our lives and to understand them in their social, political and historical contexts. His method of genealogy or 'history of the present' operates by problematizing certain taken-for-granted notions and tracing their paths from relevant points in history to illuminate how they have become what they are and to question how they might have been different.

By applying this kind of analysis to the notions of chronic illness and individual responsibility, by attempting to unseat their taken-for-granted nature and to question the ways in which they fit into a larger structure of power which influences the ways in which people act and define themselves, I argue that it is possible to move beyond the traditional critiques of victim blaming which attempt to challenge contemporary power structures while remaining trapped within their language and assumptions. In her incisive problematization of health promotion, Tesh has already challenged the failings of its critics by demonstrating that they retain the dualisms which frame the oppositions of individual/social, objective/subjective and fact/value, forming as they do an integral part of an unacknowledged political ideology, and she expresses a 'plea to get politics out of hiding' in the attempt to create an egalitarian health system (1988: 177).

My task is similarly to disturb the notions of illness causation and chronicity that we all take for granted, but my focus is slightly different. What concerns me most about the ramifications of contemporary notions of individual responsibility is that people who suffer from the misfortune of illness tend to be blamed for their malady and thus are faced with the added burden of moral reproach. Therefore, the underlying aim of the

genealogical analysis proposed here is to challenge the damning imputations that are ascribed to chronic illness by understanding how they function within contemporary logics of power and, by working in consonance with the Foucauldian revelation that power and resistance are mutually reinforcing, to develop alternative readings which hold the potential to liberate the chronically ill from their prejudicial definitions.

Genealogy as metaphor was originally developed by Nietzsche in his *Genealogy of morals* (1956) as an approach to the understanding of cultural history, and was later adapted by Foucault as a methodology. I argue that it is the moral dimension of the genealogical method which provides the key to slicing through the layers which flesh out our taken-for-granted notions so as to reach the core wherein the traces of truth and the production of 'truths' remain firm and recognizable. Foucault (1991) acknowledged that one of his prime interests in studying the prison was to 're-activat[e] the project of a "genealogy of morals" '. He argued that, in his analyses of madness, sexuality and the prison, he was not looking at *what* they constituted but rather '*how* these divisions are operated'.

> It is a question of analysing a 'regime of practices' – practices being understood here as places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect. To analyse 'regimes of practices' means to analyse programmes of conduct which have both prescriptive effects regarding what is to be done (effect of 'jurisdiction'), and codifying effects regarding what is to be known (effects of 'veridiction'). (Foucault, 1991: 75)

Chronic illness is embedded in such a 'regime of practices' and I argue that, while chronic physical maladies have always existed in one form or another, chronic illness as we have come to think of it is a relatively recent construction which is embedded in this very intersection of what can be 'known' and what should be done.

Chronic illness was first referred to in the *Index medicus* in Britain in 1947 (Armstrong, 1990) and in the National Commission on Chronic Illness in the United States in 1949 (Sidel, 1997). It was the perpetual collection of statistical data which led to its birth as a concept. Prior to this there may well have been a medical understanding of 'chronicity' as long-term infirmity, but the incidence of chronic illness had never been measured and it had not been focused upon as an issue of knowledge or government. It was the creation of the sociomedical survey which brought chronic illness to the attention of researchers; when the question: 'Are you ill?' was first asked of an entire population (Armstrong, 1990). It then became apparent that there was a great deal of illness in the community, and, from that moment onwards, chronic illness became a political entity, one which 'both derives from and justifies surveillance over time' (Armstrong, 1983: 87). Therefore, claims such as the one made by the US Department of Health, Education and Welfare that 'the proportion of deaths from major chronic

diseases has increased more than 250 percent since the beginning of the 20th century' (1979: 2) must be viewed with suspicion in light of the fact that there were no measures for chronic illness until halfway through the century.

The surveillance of 'bodies' – the body of the population and the individual body – has its origins in 18th-century Europe when the upsurge in population, the organization of a labour force, the birth of the human sciences and the beliefs inherent in political liberalism, all in their varied yet connected ways, gave shape to the concept of the 'population', its dominion, its welfare and its measurement (Pasquino, 1991; Rabinow, 1991). The health of the population became of prime importance for it was a measure of economic productivity, military strength and personal happiness. Foucault (1980a) referred to this phenomenon – the growth of the mechanisms of power in relation to the ability to observe, measure and, subsequently, to 'know' the details of a population – as 'bio-power', and it is this understanding of the connection between power and the body which paves the way for an analysis of the ways in which health and illness have been conceptualized in our society.

When the government of health was in its infancy in the 18th and 19th centuries it focused on creating more salubrious living conditions and on lifting the poor from their ill-health and 'degeneracy'. The technologies of surveillance of the health of the population were panoptic in nature and health was 'policed' by way of a proposed set of guidelines for living, a kind of hygienist moral code devised by experts and administered largely by the middle class. Over time, however, the emphasis gradually shifted from direct forms of surveillance and intervention to technologies which would encourage individuals to police themselves. Chief among the technologies which allowed for the surveillance of the population 'at a distance' was the science of statistics – originally referred to as the 'moral science' (Hacking, 1991: 182) – which provided the human sciences with a means for classifying the population in an infinite number of ways. The ability to quantify the human condition not only contributed to the growth of knowledge and opened a window into the private lives of individuals, it also 'created a great bureaucratic machinery' which still forms the central locus of power in the modern liberal democratic state (Hacking, 1991: 181).

Indeed, statistics have become the basis for defining the concept of 'risk' in accordance with the view that chronic illness is a matter of individual responsibility and choice. Ruhl has argued that 'risk is fundamentally a way of making the implicit moral content of "neutral statistics" explicit' (1999: 99). Current health promotion perspectives are grounded in the belief that all people are at risk of becoming ill according to how they choose to think and behave. Within this structure of thought, the chronically ill are seen as those who have failed in the face of 'known' risk by making unwise or even culpable choices.

> 50% of disability and death in the United States is lifestyle related. (McCaughrin, 1984: 105)

> There is evidence that approximately one third of cancers and one quarter of cardiovascular diseases are attributable to remediable aspects of the affluent diet. (Nutbeam, 1993: 107)

> Dietary factors contribute to the causation of about 35% of all cancers, thus edging slightly ahead of smoking. (Hetzel and McMichael, 1989: 104)

The number of epidemiological studies which provide statistical evidence to support the links between behaviour and chronic illness continues to multiply and the message they bring is clear: we only have ourselves to blame if we 'succumb' to illness.

Illness in general, and chronic illness in particular, could not have be redefined in contemporary terms if it was not in the context of some kind of 'norm'. In the case of illness, this standard or norm is 'health' and I contend that 'health' as we currently understand it has become an extremely potent tool of government and that it is within this formulation of norms and deviations that the moral foundation of the notion of individual responsibility for illness lies.

> Moral concepts define the processes and end points that are desirable, a definition that science cannot provide. *Norms* thus result from the interplay between existing behavior and practices and moral conceptions as embodied in formal and informal societal reactions to ongoing behavior. (Mechanic, 1997: 80–1, emphasis added)

When health – the norm – becomes connected to good behaviour, and illness – the deviation – to bad, what results is a behavioural code which can be used to great effect in defining and influencing the conduct of human populations (Harris, 1994).

Foucault (1978) in *The history of sexuality*, wrote of the 'deployment of sexuality' to highlight its utilization as a tool for controlling human behaviour. I contend that 'health' is also being deployed as a concept which 'exists to proliferate, innovate, annex, create, and penetrate bodies in a detailed way' and to 'control populations in a comprehensive way' (Foucault, 1978: 107). Health was once viewed as merely the absence of illness. Now, Leichter argues, 'it symbolises a secular state of grace. As such, good health constitutes affirmation of the life lived virtuously' (1997: 359). It is no longer the absence of something bad, it is a positive entity all of its own, a state to be actively pursued.

> Good health has become more than a means to personal goals such as greater attractiveness and increased longevity. It symbolises self-control, hard work, ambition, and success in life. Inherent in this symbolism is the concept that the individual controls behaviour, which in turn controls health. (Brownwell, 1991: 303)

The healthy person is, in effect, symbolic of the ideal neoliberal citizen, autonomous, active and responsible and the person who deviates from this ideal state is, at best, lacking in value and, at worst, morally culpable.

Responsibility, risk and the shaping of chronic illness

With the collapse or, at the very least, shrinking of the welfare state and the emergence of neoliberalism and economic rationalism as guiding principles of government in contemporary western culture, the concepts of social engineering and tutelage have been swept aside by the belief that individuals should be empowered to take control of their lives outside of the patronage of a large, complex and benevolent state apparatus. At the heart of this shift in political posture is the neoliberal resurrection of the classical liberal concept of 'negative liberty' which seeks to minimize the intervention of political administration in the lives of citizens and, in the current context, casts them as 'consumers' and 'enterprising' individuals who make 'choices' and who, consequently, are responsible for the outcomes of these choices. As a result, circumstances which were once viewed as either resulting from the failure of the modern state or simply a matter of social responsibility, such as sickness, poverty, unemployment, homelessness, racism and exposure to crime, are now being redefined as matters of individual responsibility.

From within the social sciences a discourse has emerged concerning the justice of claiming that individuals are responsible for their illnesses, and numerous social science journals have been publishing articles which support the opposing positions. For those who support it, the term 'individual responsibility' represents personal empowerment and a solution to the escalation of health care costs, yet for those who object to it, individual responsibility and 'victim blaming' are interchangeable concepts. The latter argue that the focus on individual responsibility ignores the social origins of illness (Herzlich, 1973; Gerhardt, 1989; Waitzkin, 1991; Donahue and McGuire, 1995; Brandt, 1997), stresses affluence instead of poverty as the cause of illness (Crawford, 1977; Minkler, 1999), reduces rather than enhances personal freedom (Bell, 1996), relies on the analysis of single factors rather than taking into account the complexities of chronic illness (Wallack and Winkleby, 1987), more severely disadvantages women due to their greater surveillance within the medical system (Davies, 1984), negates the value of health as a 'right' (Lowenberg, 1995), is used as a justification for cost-cutting in health care (Calnan, 1987; Keigher, 1996), and often leads to activities and treatments which can result in iatrogenesis (Alonzo, 1993).

All of these arguments raise very important concerns, but it is necessary to expand this critical framework so as to make room for an analysis of the fundamental issues which have structured the possibility for this recent, if not unfamiliar, descent into victim blaming. There is a new world order in existence which operates on very different logics and utilizes vastly divergent

strategies to those that defined the welfare state, and, if social justice is to remain an objective of critical theory, it must be sought in ways that respect and accommodate the rationalities and technologies of rule that constitute the government of neoliberal society. A Foucauldian analysis opens the way for such an understanding. By constructing a history of the present it becomes possible to understand the current evolution of the concepts of individual responsibility and chronic illness and to question the ways in which they fit into a larger structure which celebrates freedom, personal choice, empowerment and the taming, or even eradication, of 'risk' and misfortune.

The current emphasis on individual responsibility and how it affects the way we view chronic illness and other forms of misfortune in our society thus forms part of a larger system of polity. This is the system that Foucault redefined when he coined the neologism, 'governmentality'.

> Governmentality studies attempt to make sense of the development and operation of the ways in which populations are rendered thinkable and measurable for the purposes of government. They focus on the 'mentalities' of rule, understood as the self-scrutinising intellectual linkages forged between abstract political rationalities and the strategies and technologies through which they are implemented. (Stenson, 1998: 333)

Rose defines political rationalities as 'a kind of intellectual machinery or apparatus for rendering reality thinkable in such a way that it is amenable to political programming' (1996a: 42). The political rationality which frames our modes of thought and conduct and our relationship with power in the late modern world is neoliberalism, and it is by developing an understanding of the basic tenets of this mentality of rule and how it is applied to the political and personal lives of individuals that it will be possible to locate chronic illness and its connection to the notions of responsibility and risk in its current context.

Neoliberalism has emerged over the past two decades from a union of classical liberal thought and a new set of ideals which are relevant to an increasingly individuated society based on autonomy, choice and economic primacy (Barry et al., 1996: 10). I argue that the notion of individual responsibility is a fundamental element of neoliberalism and, as such, is a constituent part of this all-embracing rationality of government. Ericson et al. (2000) argue that a belief in the notion individual responsibility is one of five basic characteristics of neoliberalism, alongside minimal government, market fundamentalism, risk management and the inevitability of inequality due to choice. They argue that 'individual responsibility for risk does not occur spontaneously but must be actively governed. Indeed, the active management of responsible choice in risk taking is at the core of neo-liberal governance' (2000: 553).

The idea that individuals bear responsibility for their actions and circumstances is firmly embedded in the classical liberal principle which limits

freedom only if it encroaches on the freedom of others. Ruhl expresses it thus:

> The model liberal citizen has free reign over purely self-regarding actions, but exercises self-control over actions that may affect others. The ideal liberal citizen thus possesses remarkable qualities of self-discipline and in responsible form refrains from activities which impart a burden on others. If his actions do result in a burden being placed on society as a whole, he alone is responsible for resolving that burden. (1999: 109)

This kind of rationale also connects with another basic liberal tenet, the belief that rights cannot exist without accompanying responsibilities (Giddens, 1998). Consider, for example, the growing belief that people do not deserve the right to medical care if they are thought not to have behaved responsibly in attempting to maintain their state of health (Morrein, 1995; Cheek and Willis, 1998). Furthermore, it is also becoming more popular to argue that people should not have a right to medical care if they have not acted responsibly by taking out private health insurance (Stone, 1989).

Chronic illness in its present conceptual form has been shaped by the rationality of neoliberalism, specifically in its interaction with the notions of individual responsibility and personal choice. Indeed, there are many that argue that the 'ideology of individual responsibility' is directly responsible for our current culture of victim blaming in relation to illness (Crawford, 1977: 678; Wright, 1993: 3; Donahue and McGuire, 1995: 47). Personal choice may appear to the uninitiated as antithetical to social regulation and the constraints of power, but one of the many legacies left to us by Foucault is the understanding that we are governed by our choices and that freedom is one of the 'objectives and instruments of modern mentalities of government' (Rose, 1992: 147). The birth of the concept of 'lifestyle' in recent times exemplifies the change in tack from traditional roles and responsibilities to a life mapped out by multiple sites of identity formation based on choice. The belief that we can freely select our ways of living is fundamental to the claim that illness results from behaviours associated with faulty lifestyle 'choices'. It is in this way that chronic illness becomes defined as an instance of personal moral failure in contemporary times, for if we can *choose* to be healthy by acting in accordance with the lessons given us by epidemiology and behavioural research, then surely we are culpable if we do become ill.

This production of choices for which we bear responsibility is fuelled by the knowledge which emerges from the social sciences and is defined largely in relation to the concept of 'risk'. Risk is emblematic of the perfect neoliberal device because it incorporates both measurement and management strategies and rests on the precepts of statistics, science and economics. Indeed, the evolution of the notion of risk is indicative of the particular pathway that has been followed in the transition from welfarism to neoliberalism. In the same way that responsibility has been relocated

from a social to an individual locus, risk has been redefined as an internal rather than external factor. Ogden contends that:

> risk is no longer external to the self in the form of viruses and pollution as in biomedical models, nor a product of interactions between the individual and their environment as in the biopsychosocial model . . . . In the late 20th century the individual has become at risk from his or herself. (1995: 412–13)

Risk has become simultaneously a source of personal power and a tool for blaming those who fail in the face of choice. O'Malley argues that, while the welfare state was, in effect, a 'no-risk' society where sickness, crime, unemployment and poverty were thought of as failures of the system that required redress, risk is these days celebrated as 'a source or condition of opportunity, an avenue for enterprise and the creation of wealth, and thus an unavoidable and invaluable part of a progressive environment' (1996: 204). The attempted removal or amelioration of risk attributed to the 'safety net' of welfarism is recast as the cause of the problem rather than the solution. Risk is looked upon as a force which can generate desirable action in the face of challenge and the removal of risk is believed to be a source of disempowerment which only discourages the exercise of neo-liberal virtue.

The real power of risk in relation to defining illness as a matter of personal responsibility is that its applications are infinite. Risks are conceivably everywhere and our growing knowledge of the statistical correlations between illness and various behaviours results in a seemingly endless chain of possibilities for intervention. What we eat, how we move, where we work, whether our relatives suffer from health problems to which we may also be predisposed and even how we think are sites of possible risk. Consequently, when illness does occur there is usually a plethora of explanations available which rest on the premise that, if we had behaved differently, we could have avoided becoming sick. Yet, the management of risk has come to mean more than simply attempting to avoid dangerous behaviours by, for example, giving up smoking or moderating the intake of alcohol, salt or fat, it involves active self-management, the adoption of new behaviours thought to promote health and fitness.

Therefore, people are blamed if they become ill and cannot demonstrate that, not only did they avoid risky behaviours and situations, but they also did everything in their power to be healthy so as to overcome the risks intrinsic to lack of action. A particularly striking example of this is related by Marantz (1990), a medical practitioner who was able to view 'from the inside' the reactions of the medical profession to his friend's heart attack. Marantz's friend did not demonstrate any of the standard risk factors that have become associated with the incidence of myocardial infarction. He ate well, was not overweight, did not have high blood pressure and did not exhibit Type A personality characteristics. Yet,

rather than accept that this man's condition was a matter of misfortune or unknown cause, the medical staff decided that he must be lazy and inactive as this was the only other risk category available to define him and he was referred to as a 'couch potato' who basically deserved what he got (Marantz, 1990: 1186).

Yet, as Marantz points out, 'we are not really sure what causes cardiovascular disease – or any chronic disease. A risk factor is not an absolute cause. In the strictest sense, there are *no* single causes in cardiovascular disease' (1990: 1187, emphasis in original). O'Connor and Parker also argue that epidemiological research is weakened by its tendency to simplify the notion of illness causation by splitting up behaviours and focusing on single factors (1995: 65) and Finerman and Bennett in their treatise on guilt, blame and shame in illness point to the maxim that every researcher is warned to keep in mind, that correlation does not imply causation (1995: 1). Still, even if Marantz's friend could have been shown to suffer from hypertension, would this have been a more valid indicator of his potential to have a heart attack than his less than athletic exercise regime?

Dr John Knowles in his seminal article purported that 'high blood pressure is the primary cause of 60,000 deaths a year and is a significant causative factor in the more than 1,500,000 heart attacks and strokes suffered annually by Americans' (1977: 69). This argument is still quoted by those who support the case for personal responsibility, yet Knowles cites no studies to confirm it and, I would argue that there is much evidence to refute it. For example, Marantz demonstrates that '[m]ost patients with coronary disease do not have hypertension, and most hypertensives do not develop coronary disease' (1990: 1187). Alexander argues that blood pressure is so variable that it cannot be unitized in meaningful correlations with illness (1988: 564). And Lowenberg states that cardiovascular disease has been demonstrated to be due more to genetic factors than either diet or exercise (1995: 322).

Still, the notion of risk with all its defects is becoming ever more powerful as an instrument of government. Along with responsibility and choice it has become integral to the rationalities which frame what can be known and what can be done within contemporary liberal democracies. It is a concept which encourages us to seek expert advice through professional consultations, self-help books, the electronic media and gymnasiums; it fosters an increasingly intimate connection between health and the market place; and it is becoming more visible in the language of government programmes. The result is that people who become ill and cannot recover are perceived in increasingly negative terms. Brandt puts it in a nutshell when he states that illness has become defined 'as a failure to take appropriate precautions against publicly specified risks, a failure of individual control, a lack of self-discipline, an intrinsic moral failing' (1997: 64).

Political technologies and the disciplining of chronic illness

The rationalities which frame neoliberal thought exist not only as an intellectual backdrop to current 'regimes of practices', they are transformed by way of expert knowledges, market forces, political programming and personal 'choice' into processes which define, monitor and guide human conduct. The link that is evident between scientific knowledge and our perceptions of responsible behaviour, illness prevention and personal choice is not serendipitous. In fact, expert knowledges do not function as separate entities from the rationalities and technologies of rule, or even in parallel to them. Rather, they form the intellectual machinery which, first, continually questions and redefines the political rationalities which specify what can be 'known', and, second, translates this knowledge into practice by way of the various technologies of government. The development of knowledge which interacts with the political rationalities of the day was the subject of the last section. It is the transformation of this knowledge into practice via political technologies that will be focused upon here.

Rose defines political technologies as the 'practices and techniques, through which the self-governing capabilities of individuals can be brought into alignment with political objectives' (1992: 147). These technologies can be roughly divided into two relatively distinctive yet integrated systems of practice. The first, and most obvious of these, are the 'disciplinary' technologies, those which engage in the surveillance, evaluation and discipline of the population through the generation of government programmes and the construction of further knowledge. The second, which are the more subtle and perhaps even more significant of the two, are the micro-political practices which act directly on people's lives by way of their choices and desires, those which Foucault (1988a) named the 'technologies of the self'.

It will be the purpose of the remainder of this article to explore each of these levels of technology in relation to how they implant the rationalities of risk, responsibility and choice into the everyday lives of people and how they facilitate the view that illness is a form of personal moral failure. An Australian case study was chosen to highlight the political technologies of 'health promotion' and 'welfare reform' as they exemplify the general trends which are influencing the incorporation of the rationality of individual responsibility into political programmes which directly affect the status and treatment of the chronically ill in contemporary western society. An exploration of the language and objectives that frame health and welfare policy in Australia will demonstrate how tightly interwoven are the rationalities of neoliberalism and the mechanisms by which they are transformed into practice.

The political technologies of health promotion and welfare reform

The notion of 'health promotion' first entered the language of Australian public health policy in 1978 when the Australian government commissioned

a study by the University of Sydney to 'examine the potential of health promotion, disease prevention, health education and self-care in Australia' (Australian Department of Health, 1979: 1). The report that ensued was heavily influenced by the individual responsibility thesis put forth by the Lalonde Report and made frequent reference to the more scathing comments so often quoted from Knowles' (1977) inaugural article. Since its inception, the health promotion campaign has achieved its aim of channelling the rationalities of risk, responsibility and choice into the lives of Australian citizens by way of an intricate network of health education and screening programmes.

The concept of health education, like all government strategies, has reflected the dominant rationalities of the day, such that it has been transformed since the 1970s from a form of social engineering and tutelage consonant with welfarism, to a mechanism which is based on voluntary participation and active self-management (O'Connor and Parker, 1995: 45–6). The budding language of neoliberalism is evident in the following:

> In order to procure behaviour change, the giving of information is followed if possible by *involving people* in experiences which will lead them into different attitudes and behaviour. Those who are to benefit from health education service – the target group – become *partners* rather than *passive recipients* in what is being done to make them healthier. (Australian Department of Health, 1979: 14–15, emphasis added)

Through health education, based on prescriptions drawn from epidemio-logical research, the subject of health promotion is inducted into the world of 'risk', where behaviours, attitudes and lifestyles become a source of concern and the focus of constant self-surveillance (Lupton, 1995).

Screening has also become a technology which embodies the principles of risk management. Once people have become aware of the dangers related, not only to their behaviours, but to their age-group, gender and genetic make-up, they are encouraged to undergo regular check-ups in case they are developing illnesses of which they are not yet aware. After it was introduced in the 1950s in response to the growing surveillance of chronic illness (Armstrong, 1983), screening developed into a range of highly technical procedures primarily concerned with the early detection of cancer and birth defects (Ruhl, 1999). Recently in the USA, however, screening techniques have been used to deny employment and increase the premiums for medical insurance when they reveal that a person may have a 'high risk' of contracting certain illnesses (Stone, 1989; Novas and Rose, 2000).

However, unlike health education which locates at-risk groups according to the vastly generalized population data of epidemiology, screening pro-cedures bring risk technology directly to the body of the individual and are becoming an increasingly overt presence in our lives. Consider, for example, the mass screening programmes that are occurring, not only in doctors' surgeries, but also in shopping centres, car parks and on street

corners to test cholesterol levels and blood pressure. Health education introduces an awareness in people who *may* be at risk of contracting certain illnesses, but screening takes this one very large step further, and, by probing individual bodies, points the finger *directly* at people who are at risk of illness and who, as a consequence, are 'required' to change their ways (Weir, 1996).

This increase in the number of points at which the risk of illness can be detected and averted serves to magnify the sense of responsibility that people feel when they do 'succumb' to illness. Moreover, when viewed through the lens of risk management, chronic illnesses seem not only symbolic of the failure to stay well, they are also risk factors in themselves.

> [O]ne illness becomes the risk factor for another. Symptom, sign, investigation and disease thereby become conflated into an infinite chain of risks. A headache may be a risk factor for high blood pressure (hypertension), but high blood pressure is simply a risk factor for another illness (stroke). And whereas symptoms, signs and diseases were located in the body, the risk factor encompasses any state or event from which a probability of illness can be calculated. (Armstrong, 1995: 401)

For the chronically ill this can lead to a feeling of loss of control, but when viewed in relation to the rationality of individual responsibility it can appear that those who do not regain their health are behaving more and more culpably as the risk factors multiply and prevail.

The same language which defines the subject of health promotion, the 'autonomous' and 'enterprising' individual who makes 'rational choices' concerning his or her health, also defines the subject of welfare reform. The political technology of 'welfare reform' is integral to the relationship between individual responsibility and illness as people who are chronically ill are often unable to work or, even if they can, may still be in need of certain forms of social support due to their limitations. Moreover, while the subject of health promotion is presumably representative of each and every citizen, the actual subject of welfare reform belongs to a sub-culture whose members, due to circumstances which have led to their reliance on certain forms of social support, are often seen as diametrically opposed to the abstract subject of neoliberalism due to their failure to be seen as 'independent', 'hard-working', 'autonomous' and 'self-reliant'.

To merge the actual subject of chronic illness and welfare support with the abstract neoliberal subject, the exemplar of responsible behaviour and rational choice, the Australian government has developed a two-pronged approach to welfare reform, first, targeting 'people with disabilities', and, second, by focusing on the larger demographic of 'welfare recipients'. Both of these strategies are centred around the principles of 'mutual obligation' and 'participation', concepts which exemplify the removal of the 'passive safety net' of former welfare programmes.

In a recent address to the Australian Council of Social Services (ACOSS),

the current Prime Minister of Australia, John Howard, spoke at length about these two principles and 'emphasised the importance of people helping themselves' (Australian Department of Family and Community Services (FACS), 1999: 43). He concluded by saying: 'I believe that by working together that each and every Australian, irrespective of whether they are the bravest and brightest in the land or the most disadvantaged, can be *empowered* to reach their maximum potential' (quoted in FACS, 1999: 44, emphasis added). 'Empowerment' has become a key term in translating the rationality of individual responsibility into practice as it refers to the role that experts will play in assisting the subjects of welfare reform to become fully fledged neoliberal citizens.[2]

In this way the 'disadvantaged individual' becomes seen as one 'whose self-responsibility and self-fulfilling aspirations have been deformed by the dependency culture, whose efforts at self-advancement have been frustrated for so long that they suffer from "learned helplessness", whose self esteem has been destroyed' (Rose, 1996a: 60). To remedy the situation, this damaged individual must be transformed through the process of empowerment to become the epitome of the neoliberal, self-actualizing subject. The Australian Department of Family and Community Services (FACS) (1988) describes the creation of this very neoliberal subject when they stress that people with disabilities should be encouraged to 'take *responsibility*' for developing 'choices', 'goals' and 'lifestyles' and increasing their 'self-reliance', 'competence', 'confidence' and 'self-worth' aided by 'the freedom to choose' and the 'positive consumer outcomes' facilitated by government programmes (emphasis added).

More recently, Australian Department of Family and Community Services (FACS) (2000) has commissioned a study into welfare reform, *Participation support for a more equitable society*, which aims to remove the dependency of the ill and the unemployed once and for all. Like the push towards health promotion, welfare reform is argued for principally on the basis of cost-containment, and this is reflected in the newspaper articles by Horin (1999) 'The burden of disability'; Duffy (2000) 'Weeding out the welfare poison'; and Gray (2000) 'Push to toughen rules on welfare'. FACS (2000) frames the solution in terms of 'self-reliance' and 'capacity-building', suggesting that, when people are 'empowered' to make 'choices' so that they can 'help themselves and contribute to society through increased social and economic participation in a framework of Mutual Obligation' (2000: 2), they will overcome the 'risks of 'social disadvantage' and 'poor health' that serve to entrap them in a cycle of poverty and dependency. In her landmark speech on welfare reform in 1999, Senator Jocelyn Newman, Minister for Family and Community Services, argues that the solution lies in turning the passive safety net which has become 'a trap for welfare dependency' into a 'springboard to economic security and independence'.

The way that this 'springboard' will function is made clear in the

hypothetical case studies which FACS (2000) has created to show how the new system of 'participation support' will operate. In one of these we are introduced to Hans, aged 50, who, after working for 35 years as a store-man, was retrenched due to his health problems of lower back pain, mature onset diabetes and high blood pressure. Under the new system, instead of being given a Disability Support Pension, Hans was warned that he was 'at risk of long-term unemployment' and advised to use part of his retrench-ment pay-out to fund a retraining programme in computers (2000: 19). Nine months after he lost his old job, Hans had completely turned his life around due to his state-aided 'empowerment'. He had joined a walking group, gone on a diet and, with the aid of a back brace, had mastered his pain and was managing to work part time (2000: 20). Hans exemplifies the dream of welfare reform, the dream that people can *choose* to overcome their disadvantages, and, if they work hard and act responsibly, regain their health and their independence.

In the same way that Australian health policy has been heavily influenced by the health promotion programmes developed in Canada, Britain and the United States, the strategies which guide the Australian approach to welfare reform are representative of an international trend. In June 1998 at the Meeting of the Employment, Labour and Social Affairs Committee on Social Policy, it was agreed that an emphasis on welfare reform in OECD nations was vital to reduce the burden of welfare dependency (OECD Ministerial Communiqué: 4, cited in Australian Department of Family and Community Services (FACS), 2001). The British Prime Minister, Tony Blair, signalled the end of what he refers to as the 'something-for-nothing welfare state' when he proposed cuts of £1.2 billion a year from the dis-ability benefits programme (Lyall, 1999b: 3). Blair stated that welfare dependency had 'drifted out of control' and was scathing in his attack on the tendency for people to use incapacity and disability benefits 'as an excuse to never seek work again' (Lyall, 1999a: 10).

King and Wickham-Jones (1999) argue that Tony Blair has modelled much of his welfare reform policies on the hard-hitting strategies of the United States. Beginning with *The Personal Responsibility and Work Opportunity Reconciliation Act* in 1996, the then American President, Bill Clinton proposed to 'end welfare as we know it' by insisting that all people receiving welfare assistance be made to work for it by engaging in Work-fare programmes, similar to Australia's Work-for-the-Dole and Partici-pation Support schemes. This welfare reform initiative and those that have followed have been based on Clinton's promise of 'honoring a moral obligation to help poor people help themselves' (Kern, 1998: 427). As Clinton (1999) remarked in an address delivered towards the end of his presidency: 'It doesn't make sense for people to be denied the dignity of work and for the taxpayers to pay the bills.' It is also evident that President Bush, the newly elected American president, although he speaks in terms of a caring welfare policy, maintains the same approach as Clinton when

he remarks that 'personal responsibility is the new frontier of social reform' (Segar, 2000: 17).

Health promotion and welfare reform are disciplinary technologies which serve to reify the notions of individual responsibility and personal choice within a distinctly moral framework. Health promotion redefines health as a 'duty' rather than a 'right' and classifies those who become ill as behaviourally culpable. Welfare reform also reframes illness and disadvantage as matters of choice and suggests that the exercise of certain neoliberal virtues, such as autonomy, self-reliance and enterprise, will resolve them. In both cases, experts, such as medical professionals, educators and counsellors, become intermediaries in the process of government 'at a distance' so that, although the administration of government still involves the disciplinary strategies of surveillance and instruction, the behaviours and attitudes which are advocated become increasingly contiguous with the choices and aspirations of the free liberal citizen.

'Lifestyle correctness' and the micro-political technologies of health

Most people are barely aware of the intricacies of health policy and welfare reform and their lives seem far removed from the mechanisms of public administration. Yet, one does not have to look far to recognize that the 'health conscious' neoliberal subject is more than merely an abstract entity. The pursuit of health abounds in a kind of consumerist frenzy designed to avert the ever-present spectres of illness and ageing. Health food shops and gymnasiums seem to be sprouting from every street corner, joggers pound the pavements with their designer running shoes in ever-increasing numbers, public libraries and book shops burst at the seams with new self-help titles which promise eternal health and happiness to those who are willing to 'take control' of their lives, and the contents of shopping trolleys spell out the notion of risk-management in such products as sun-screen, dental floss and foods approved by the Heart Foundation.

It is this infiltration of the notions of choice and responsibility into the everyday lives of people which most deeply affects the perception that the chronically ill are blameworthy. Foucault (1988a) refers to these methods of self-regulation as 'technologies of the self' and argues that the government of individuals resides at the point of contact between the disciplinary technologies and the modes by which individuals act upon themselves (Burchell, 1993: 268). The micro-political technologies of health are those actions, objects, attitudes and processes through which people define and achieve their state of 'being', be it well or ill, with regard to certain norms, values and goals. The technologies of self-regulation which structure the health and fitness movement exist in a moralist form which Leichter refers to as 'the lifestyle correctness movement' within which the 'zealots of wellness have created an atmosphere that . . . is often self-righteous,

punitive, exclusionary, imperious, evangelical, and elitist in tone' (1997: 360–1).

This contemporary manifestation of moral theories of illness, known variously as 'healthism' and 'health consciousness', affects the neoliberal subject in different ways according to their health status. Those who are not sick face a seemingly endless number of choices with regard to how they can improve their health and reach the state of well-being and virtue consistent with the behaviourally correct lifestyle. Barsky (1988) refers to this group as the 'worried well', a term which is representative of the constant state of tension that exists between choice and possibility in the new 'risk society'. The search for optimum health has become a kind of pilgrimage, a journey which it is believed will result in the virtuous being rewarded and the guilty having to suffer. Consequently, those who are not well are seen, by themselves and others, as failing in the quest for health. Yet they are also offered many 'solutions' in accordance with the 'marketization' of health if they are 'enterprising' and 'responsible' enough to take advantage of them.

This sphere of consumption brings individuals into contact with expert knowledges and political rationalities in increasingly indirect ways. For example, nutritional knowledge in combination with epidemiological findings is accessible through health food outlets and even supermarkets.[3] The mechanics of physical fitness and how aerobic function and muscular action affect health and illness is transformed into the machinery of the gymnasium. The research conducted by the social sciences and health sciences is transformed into 'consumer friendly' formats in books, radio and television programmes, newspaper and magazine articles, audio and video tapes and computer software. 'Experts' of a different kind emerge – naturopaths, homeopaths, spiritual healers, acupuncturists, herbalists, etc. – who deliver new knowledge and lifestyle choices conducive to health. Rose writes that, in a governmental sense,

> [i]n the new domain of consumption, individuals will *want* to be healthy, experts will instruct them on how to be so, and entrepreneurs will exploit and enhance this market for health. Health will be ensured through a combination of the market, expertise and a regulated autonomy. (1992: 155, emphasis in original)

The problems that the 'commodification of health' present for the chronically ill are manifold. It has been recognized that it is the middle class who have the education and the financial resources to take most advantage of what the 'health market' offers (Bunton, 1997). However, people who are chronically ill are often reduced to poverty due to losing their income earning potential, and, even those who have good incomes can find them greatly depleted by the expense involved in doggedly pursuing one possibility after another in the attempt to regain their health. As Parsons (1951) noted, the 'sick role' is only legitimately offered to those who seek every possible means of recovery and, in the contemporary context, this

can create a costly, confusing and never-ending search for the 'right' consumer devices.

Of all the micro-political technologies of health, the self-help book market is perhaps the most striking in its omnipresence. A visit to my local library, a relatively small regional centre, revealed a section that holds over a thousand books devoted to the maintenance, optimization, and recovery of health. These books are written by authors ranging from epidemiologists, psychologists, doctors and other health professionals, through alternative therapists and new age healers, to people who share their own health problems and how they overcame them. Yet, although they hark from such different levels of expertise, they all bear the same message, that you can control your health by changing your behaviour and attitudes. Consider, for example, the following excerpts, three of which come from medical doctors:

> Most of the diseases we get are really failures of our 'doctor within'. (Fox and Fox, 1989: 1)

> . . . complete well-being is within the reach of all of us . . . good health is the natural condition of mankind [*sic*]. We imperil that health when we neglect the mutually dependent needs of mind and body . . . (Griggs, 1989: 7–8)

> Remember this: there is no reason to get colds. People who take care of themselves naturally choosing a positive mental outlook, proper diet and exercise are virtually cold-free (or free from practically any disease for that matter). (Dorobiala, 1988: iii)

> I hope to encourage the sick to acknowledge their own responsibility to heal. (Meink, 1995: ix)

> The first secret we want to reveal about perfect health is that you have to choose it. You can only be as healthy as you think it is possible to be. (Chopra, 1990: 5)

The above quotations from health literature reflect the powerful technology of 'self-help' and how effective it is in translating the rationalities of responsibility and choice into everyday life.

While most of the activity associated with fitness culture transpires in the isolated lives of individuals, there *is* an institution which has become the meeting place of the proselytized. In many ways the Church has been replaced by the gymnasium as the edifice which represents the kind of moral perfection that individuals are encouraged to aspire to in contemporary times. The healthy person must not only be free from illness, he or she must look 'fit' and be strong. The belief that physical perfection is a moral imperative is reminiscent of the attitudes of Bernarr McFadden, the driving force behind the health and fitness movement in America in the early 1920s. He expressed his belief that 'the man who is looking for health but does not want muscles, will search in vain' and 'it lies with you, whether you shall be a strong, virile animal . . . or a miserable crawling worm' (quoted

in Brownwell, 1991: 304). The motto of his magazine, *Physical Culture*, was 'weakness is a crime', a moral sentiment reminiscent of *Erewhon*.

Conclusions

The sentiments which are disseminated by way of the micro-political and disciplinary technologies discussed in this article may not all be as overtly denigrating as those expressed by Bernarr McFadden, but they do have a certain uniformity that nevertheless builds a shared platform which rests on many of the values that are central to neoliberal governance. These technologies allow for the knowledge that is aligned with political rationalities to become enmeshed in everyday practices and ultimately taken for granted as emanating from common sense, and it is in this way that 'health' and 'illness' become tools of government. What was once part of a system of control based on a belief in divine retribution is now embedded in a network of power relations which is integral to the notions of freedom and choice. Yet, those who are exiled to the edges of full neoliberal citizenship because they are unable to maintain their health and fitness are not likely to feel any less damned than those whose illnesses were believed to be the result of sin.

I believe that being able to locate victim blaming practices in their contemporary context opens the way for resistance to occur because it allows for the raising of voices which were formerly silenced, the subaltern voices which speak from the knowledges which Foucault refers to as 'subjugated' (1980b [1976]: 82). These are forms of knowledge or experience 'that have been disqualified as inadequate to their task, or insufficiently elaborated: naive knowledges, located down in the hierarchy, beneath the required level of cognition or scientificity'. They include the low-ranking knowledge of the psychiatric patient, the ill person, the delinquent. 'Popular knowledge' is not shared by all people, 'but it is, on the contrary, a particular, local, regional knowledge, the differential knowledge incapable of unanimity' (1980b [1976]: 82). I believe that genealogy, by revealing the gap which exists between the knowledges which inform neoliberal mechanisms of government and the actual lived experience of the chronically ill, forms a domain within which the potential for resistance resides.

Along with popular knowledge, there are the 'buried knowledges of erudition' (1980b [1976]: 82), the slices of history that were formerly concealed by 'the apparent coherence of human scientific knowledge' (Simons, 1995: 90), and together they are capable of performing 'an insurrection of subjugated knowledges' (Foucault, 1980b [1976]: 81). By bringing to light both the parts of our history that were formerly untold and the voices of those who have been silenced, genealogy unseats what we have come to think of as historical and scientific truths and makes other readings possible. I argue that the new way of thinking inspired by the genealogical analysis discussed in this article can lend strength to the understanding, contrary to

scientific belief, that illness results from misfortune and should not be considered synonymous with personal moral failing. To learn that the knowledge that defines us has been constructed for a particular purpose removes the personal element from the experience of marginalization and carves a space where subjectivity can be defined outside of hierarchical dualisms. 'Our relationship with ourselves will change when powers that have worked secretly are revealed. They can never have the same kind of force, even if they continue to influence us' (Ransom, 1997: 58).

'Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it' (Foucault, 1978: 100–1). It is this potential for the human sciences not only to create knowledge that supports the dominant rationality, but also to challenge it at its very roots, that opens the way for new modes of thinking which may very well begin in the halls of higher learning, but they must end, as Foucault (1988b) warns us, in the localized struggles of those who require liberation. Genealogy, by revealing the 'faults, fractures and fissures' in history, 'open[s] up the space of freedom' (Foucault, 1988c: 37). For the chronically ill this means the possibility of weaving into the resistance they engage in, either in formalized self-help groups or in their own personal reinscription, the knowledge that they can reject the pejorative identities foisted upon them by current neoliberal rationalities. By developing the insights gained from a genealogy of chronic illness and individual responsibility we can, in Foucault's words, 'separate out from the contingency that has made us what we are, the possibility of no longer being, doing, or thinking what we are, do, or think' (1984: 46).

Notes

1. This article draws from and incorporates parts of my honours thesis which bears the same title.

2. Rose (1996b) argues that:

   > *Empowerment*, then, is a matter of experts teaching, coaxing, requiring their clients to conduct themselves within particular cultural communities of ethics and lifestyle, according to certain specified arts of active *personal responsibility*. Empowerment, with all its emphasis on strengthening the capacity of the individual to play the role of actor in his or her own life, has come to encompass a range of interventions to transmit, under tutelage, certain professionally ratified mental, ethical and practical techniques for *active self-management*. (1996b: 349, emphasis added)

3. See Clasmann (2000) 'Food, food, functional food', for a discussion on how health promotion is affecting the way supermarket food is being marketed: 'So far, the foods come in three categories; bone support, digestion and cardiovascular' (2000: 9).

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Author biography

ROSE GALVIN completed her BA (hons) in politics, philosophy and sociology at Murdoch University in Australia last year. She is now undertaking doctoral studies in the School of Social Inquiry, Murdoch University. Her current research focuses on chronic illness, disability and the development of a new methodology which will attempt to bring a more grounded approach to governmentality studies.