
The government and ethics of health promotion: the importance of Michel Foucault

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Abstract

A debate about the ethics of health promotion recently appeared in this journal. While the papers involved provided a number of new insights into this area, they appeared to stop short of many possibilities. In particular, the dismissal of the relevance of the work of Foucault in this area prevented another line of inquiry opening up. This paper provides a fuller explication of Foucault's relevance to ethics and health promotion. It draws attention to the way health promotion produces subjects, especially choosing subjects. Using nutrition promotion as an example, it highlights the way that various positions in health promotion—which on the surface appear to be at odds with each other—can in fact be seen to be part of the same project: that of producing self-regulating subjects. The paper concludes by stressing that health promotion provides an ethics, in a Foucauldian sense, by producing the means by which subjects assess their own desires, attitudes and conducts in relation to those set out by health promotion expertise.

Introduction

In a recent edition of this journal, two papers provided a commentary and a critique of normative analyses and the ethics of health promotion. In the first paper, Duncan and Cribb (1996) compare what

they see as two contrasting normative idioms in the ethical evaluation of a programme designed to assist professionals 'help people change'. The second paper by Whitelaw and Whitelaw (1996) praises the earlier authors for opening up a debate about ethics and health promotion, but also take them to task for, *inter alia*, using Foucault in a normative analysis. A major problem raised by Whitelaw and Whitelaw is Duncan and Cribb's narrow characterization of Foucault's work. In fact, Whitelaw and Whitelaw question the trend of using individual philosophers in social analysis, preferring instead the use of *ideas* which have been developed out of philosophical schools of thought. In regard to ethics and health promotion, Whitelaw and Whitelaw believe that a pragmatic approach—built from ideas around social constructivism—allows for the transcendence of ontological assumptions of human interaction, like ethics.

The present paper seeks to contribute to the earlier debate started by these authors. It is not, however, the intention to systematically challenge or support the arguments already made. Instead, it uses these arguments as a point of engagement and a point of departure to develop another understanding of the ethics and health promotion. This understanding takes issue with the very foundation of health promotion, known here as the 'subject of choice'. This choosing subject is at the centre of much of the debate about the ethical evaluation of health promotion. Duncan and Cribb's paper illustrates this perfectly when they ask what is the ethical basis of forms of health promotion which help people chose or change? A larger debate which has mainly been ignored concerns the sovereignty of the choosing subject. While this point

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was raised by Whitelaw and Whitelaw (1996) they were unable to do it justice because they focused on the problematic appropriation of Foucault's work rather than its use in the area of ethics.

Where Foucault fits in

In order to examine the importance of Foucault to this area let us first examine the points made by the earlier authors. The first is the use in Duncan and Cribb's paper of Foucault's work in a normative analysis. There are major problems with this. As Whitelaw and Whitelaw explain, Foucault was not a nihilist. But neither was he an ideologue. In fact, Foucault's work is famous for failing to posit ideas about what 'should be' (see, e.g. Fraser, 1989, p. 56). So the use of Foucault to develop normative analyses is highly contentious. It is true that Foucault's involvement in a variety of political movements allows us to appreciate his personal commitment to social change in some areas. However, looking for this commitment in his work can be an exasperating task. This is because Foucault is much more interested in examining who we are rather than what we should be. As will be seen later, this underpins almost all of his work to do with the subject. The second point which should not go unchallenged is Whitelaw and Whitelaw's objections to the use of individual philosophers. Ideas are, of course, important. However, these are often best understood and applied through an appreciation of the way individual philosophers developed them. This is not to argue for snobishness or slavish devotion, only consistency and sympathy with the aims of the philosophers and social commentators from whom ideas may have originated or been developed. As we shall see, this is especially important for the work of Foucault which, while ranging over a number of areas, has an internal consistency around notions of subjectivity.

Foucault's subject

It is productive to return to Foucault's early work in order to find out what initial problems engaged

him and how they endured in his writing. Although Foucault (1990a, p. 258) admits that there were changes in the trajectory of his project, fundamentally his concern is with the fabrication of the modern subject: Who are we today?

Towards the end of *The Order of Things*, Foucault (1982a, p. 318) suggests that the modern subject may be considered as an 'empirico-transcendental doublet'. As Foucault's later work shows us this 'doublet' is the product of a relationship between two human experiences. The first is concerned with our interactions with the world and the problems that apparently confront us; the second is the way we spiritually discipline ourselves. This spiritual discipline, or *ascesis*, is not 'theological' but instead refers to the means by which individuals are required to construct themselves as subjects with a 'correct' concern for the 'proper' way of behaving. Foucault sees the 'empirico-transcendental doublet' as both the target and the effect of the human sciences; the subject/object of human inquiry. The human sciences are understood to be biology, medicine, economics, psychology, sociology, philosophy, etc.

Now there is an important point to be made here. While Foucault was in no doubt that the modern subject was a fabrication made available by the human sciences, he did not believe that there was a 'real' subject lurking beneath. In other words, for Foucault, knowledge in the human sciences is not a pale reflection of what knowledge of man is 'really' (this is, of course, why the concept of ideology was so foreign to Foucault). It is true that in *The Order of Things* Foucault is critical of modern philosophical efforts to forge an understanding of an entity, man, that is both the source of the world and an object of the world (Gutting, 1994, p. 12). For Foucault, however, there is no extra-discursive point outside of the human sciences from where we can seek empirical facts or epistemological truths which constitute what we 'really' are. So, as we know, Foucault was not a humanist. But neither was he an anti-humanist. He did not believe the subject to be absent, dead, or an ideological fiction, as is the case in some structural and post-structural accounts

(Williamson, 1989, p. 34).¹ He was, as Dreyfus and Rabinow put it, 'beyond structuralism and hermeneutics'. Foucault was in no doubt that humanity existed. It was for him a hallmark of modernity. But it was a fabrication, a construction. How is the subject of humanity fabricated? In a late essay, Foucault tells us that the modern subject is produced from two techniques or technologies: technologies of power and technologies of the self (Foucault, 1988, p. 18). Technologies of power are best explained in his work on power/knowledge relationships and one of the most famous metaphors from this aspect of Foucault's work is the *panopticon*. Technologies of power—where power is defined by Foucault as directing the conduct of others (Foucault, 1989, p. 11)—operate through processes like surveillance and normalization in which individuals are made objects of control who are submitted to certain ends or objectives.

Foucault's project on the history of sexuality (especially Foucault, 1990b, 1992) provides an understanding of the technologies of the self. This work and Foucault's reflections on it (Foucault, 1986a) provides an overview of the ways in which—through self-discipline or *ascesis*—we develop a sense of self, or as Foucault put it, a *rapport de soi* or 'ethics' (Foucault, 1986a, p. 342). Foucault's ethics differ from more conventional understandings in that they are individualized forms of self-regulation—rather like a popular understanding of a 'work ethic'. Foucault's ethics are concerned with the relationships we have with ourselves, and he is interested in the Christian practices of penance, confession and self-examination which he sees as forerunners to current practices of self-regulation. In summary we can say that Foucault is concerned with the ways in which people's experiences are controlled by others and the ways in which individuals control themselves.

Foucault brings these two concepts together in his study on government where he examines the organizing technologies of the modern state (Foucault, 1991). For Foucault, the art of government is the establishment of a continuity between a government by the state and the discipline of the self: a politico-moral foundation for control. The

notion of 'government' here has little to do with dominant sovereign power or democratic party politics, but is concerned instead with the range of practices: 'tactics, strategies, techniques, programmes, dreams and aspirations of those authorities who shaped beliefs and control of the population' (Nettleton, 1991, p. 99). It is the beauty and subtlety of this form of government that impresses Foucault since it is not necessarily oppressive action to which individuals are required to submit. On the contrary, it governs through development of expert knowledge—or 'control at a distance'—which flourished after the Enlightenment, through the expansion of a complex set of discourses and practices in the human sciences and what it means to be human (Van Krieken, 1996). Central to this knowledge of humanity was the understanding of choice, autonomy and reason. In order to historically situate this concept of humanity, Foucault discusses Enlightenment in relation to Kant. In the next section this aspect of Foucault's work is summarized.

The importance of Kant for Foucault—the choosing subject

Foucault sees in the 'Aufklärung' in general, and Kant in particular, an emergence of a philosophy 'problematizing one's own discursive present-ness' (Foucault, 1986b). In other words, he sees Kant asking the question that Foucault himself is interested in, i.e. who are we today? Kant attempted to resolve this question through his explanation of the existence of a subject in which one's experiences of the world (the phenomenal) had to be filtered through pure reason (the noumenal). In other words, for Kant, what was given by the world to our senses had to be shaped by the eternal and unalterable laws of reason. Kant's struggle between empiricism and rationalism creates a dialectic in which reason achieves the rank of pure intellect. In this way, Kantian philosophy elevates pure reason, or 'good', as the universal form of humanity (Greenfield, 1984). Moreover, for Kant, moral law—a universal law of reason—is imposed by a person's will on him or herself. This belief directly

follows from Kant's thesis of the 'autonomy of the will' as the fundamental principle of morality (Kemp, 1968, p. 93). Thus central to Kantian philosophy is the notion of freedom and autonomy. But, as Hunter explains (Hunter, 1994, p. 51), this is not *any* kind of freedom or autonomy; only that exercised self-reflectively against moral judgement. And from where does moral judgement arise? Moral judgement in Kantian philosophy arises out of a rational knowledge of moral principles. Hunter continues, 'For Kant, we might say, the subject is founded in the subject—in the moral laws of its own constitution' (Hunter, 1994, p. 52). In other words the autonomy and choice of the 'choosing' subject are always mortgaged to the moral principles that the subject has *rationally* set for itself. We are, therefore, left with a moral autonomy in which self-enacted principles are always registered in accordance with the subject's rational knowledge (Cooke, 1992), especially knowledge of what is 'right', 'proper' and 'good'. On a Foucauldian reading, however, moral problems—how should one behave? what should be one's concerns?—emanate from the technologies of power through a normalization and categorization of experiences by expertise. As well, through practices inculcated by a heritage of Christian pedagogy (technologies of the self), individuals seek to be 'good' self-reflecting, self-regulating subjects. The result is the 'empirico-transcendental doublet'. What we see then is the 'forging of alignments between the personal projects of citizens and images of the social order' (Miller and Rose, 1988, p. 172), in which individuals *actively* and *productively* seek out the 'correct' course of action which will *positively* fulfil their ethical concerns.

The important point to make is that Foucault's work on the historical specificity of the modern subject forces us to consider autonomy and choice in ways that are almost counter-intuitive since they are taken for granted in everyday life. Indeed, political structures that provide autonomy and choice in the form of democracy are especially valued in Western cultures. After Foucault, however, we can see that having choices, making

choices and being able to make the *right* choice—always against an index of morality—are things which arise from a particular understanding of freedom which, itself, was central to the arrival of a particular figure of modern man. It should not surprise us then that the notion of choice has been important to the human sciences and we can especially see this in the practices of health promotion. In other words, *pace* Foucault, we can see health promotion as a form of government which is *productive* in the sense that it *produces* modern subjects: it defines empirically what it *is* to be healthy (in ever expanding ways) and it 'supervises' the proper routes to health through a discipline which establishes for us a *rapport de soi*, or 'ethics'. From a Foucauldian point of view, health promotion is fundamentally 'ethical' because it provides us with an *ascesis*—a course of action for moral training. Even 'critical' approaches in health promotion—which are often scathing about so-called individualistic, behaviour-oriented programmes—are, on closer inspection, imbued with an *ascesis* of their own. The next section focuses on the area of nutrition promotion as an example of the construction of 'ethics' within different forms of health promotion.

Nutrition promotion and principled positions

A recently published book about current nutrition discourse in Western cultures describes 'good nutrition', where views about food and health are promulgated by experts such as doctors, scientists and nutritionists (Crotty, 1995). Crotty sees this as a form of social control which is not necessarily a conspiratorial state of affairs, but more to do with control 'exercised by any social institution which attempts to ensure that people follow the rules it sees as acceptable' (Crotty, 1995, p. 65). Crotty points out that current nutrition strategies engender a form of control which is scientific—where a population is encouraged to adopt specific concerns based upon assumptions that it is a 'sick population' and, as such, everyone is in need of dietary reform. These assumptions are based on

dietary surveys which indicate that the population is not following dietary recommendations. Diagnosed as 'sick' and 'non-compliant', the population is subjected to rational, scientific, dietary modifications through mass education strategies. Crotty's argument, which is supported by others (see, e.g. McKie *et al.*, 1993), is that the scientific and authoritarian rules which underpin many modern public health nutrition programmes are symptomatic of a dominant medical culture, which as well as being moralistic, sexist and class prejudiced, is highly fallible to boot. For example, current theories which encourage the reduction of fat in the population's diet are based on studies which exclude women, the elderly and children. As a consequence, the health problems of middle-aged men have been used as models for health problems affecting the population as a whole. Current nutrition promotion is also criticized because it 'lacks a social perspective and compassion' (Crotty, 1995, p. 1) in that it fails to take into consideration the everyday realities of life which are believed to inform food decision making for most people.

In arriving at the moralistic attitudes of today's nutrition reformers, a number of authors (Aronson, 1982; Levenstein, 1988; Crotty, 1995; Santich, 1995) have tracked modern nutritional science back to 19th century welfare crusades in Australia, America and Britain. At that time, middle class concerns about the degenerate nature of the poorer classes saw philanthropic groups, many of whom were affiliated with the church, endeavouring to educate the working classes about food and health. According to some commentators, good nutrition and scientific eating were arguments used against the demands by workers for higher wages.² Early nutrition reformers were often openly critical of the wastefulness of the working classes, and were thus able to secure government funding for research, thereby making nutrition a concern for the state (Aronson, 1982).

These critical accounts of the development of nutrition are quite different from a number of others. Clements (1986), for example, describes historical events in nutrition as a series of unfolding discoveries. Firstly, there was the scientific discov-

ery of nutritional elements in the laboratory, and, secondly, there was the discovery of poor eating habits and malnutrition in children in the poorer classes of rural and urban England. Nutrition history continues with an application of the scientific discoveries to the sociological ones, so that, by the beginning of the 20th century a country like Britain was 'leading the world in the practice of preventative medicine' through the work of 'a long line of humanitarians [who] led to many legislative reforms designed to improve health and living conditions' (Clements, 1986, p. 19). In a country like Australia, these humanitarian efforts were realized in, for example, the establishment of baby health clinics, where scientific discoveries about infant feeding were turned into recommendations for parents to follow.

It is the present day manifestation of this model—where scientific knowledge is translated into appropriate behaviours for individuals to follow—that has been criticized as a medical, or disease-related, model. The scientific approach, some say, should be made more relevant to the everyday concerns that people have about food and eating in order to make it 'a more humane and effective approach' (Crotty, 1995, p. 110). This transformation could be achieved by 'active participation' at the level of the community. Community involvement, or 'bottom up' approaches, facilitate social action, which will help ensure that nutrition promotion programmes remain more relevant to the people for whom they are intended to be of benefit. As part of this process, the use of 'reflection in action' is recommended (Crotty, 1995, p. 107), where health professionals and community members focus on a problem and develop an understanding of the problem to help them decide upon an appropriate approach. By encouraging communication and reflexivity, links are strengthened between experts and the non-experts through a mutual understanding of each others' concerns.

Let us now look more closely at the different models of nutrition promotion—the medical model and the social model—which have been described, remembering that the debate around these models

is not confined to nutrition. On the one hand, we have what might be called the medical model—reflecting the position of medical science—which some have seen as a liberalist. For example, Tesh (1988, p. 154) describes the way that the science-based approach to health promotion is individualistic. Tesh believes that, far from being ‘objective’ and ‘scientific’, this approach is ideological in that it promotes individual rights and individual choices on the basis of scientific fact. Accordingly, ‘Unhealthy behaviours result from individual choice, the ideology implies, so the way to change such behaviour is to show people the error of their ways and urge them to act differently’ (Tesh, 1988, pp. 161–162).

On the other hand, there is what may be called a social model. This is the view taken by the so-called ‘new’ public health which believes in action at the level of ‘community’. The principles of the ‘new’ public health’s version of health promotion have been documented by two writers in the field, and are summarized here as (1) actively involving the population in the setting of everyday life; (2) directing itself towards action on the cause of ill-health; (3) using many different approaches including education and information, community development and organization, health advocacy and legislation; (4) actively engaging public participation; and (5) enlisting the help of health professionals—especially those in ‘primary health care’—who have an important role to play in nurturing health promotion and enabling it to take place (Ashton and Seymour, 1990, p. 25). In taking to task the dominant Western model of health care, Ashton and Seymour believe that ‘there is a real conflict between the clinical model based on individual transactions and the public health model based on a social contract with the entire community’ (Ashton and Seymour, 1990, p. 37).

What concerns us here, however, is not the *differences* between the so-called ‘individualistic transactions’ and the ‘social contract’, so much as their *similarities*. To be sure, unlike the individualistic approach, the ‘new’ public health emphasizes the environment in which people live and the effect of this on health. Just as the ‘old’ public health

improved the health of populations through improvements to the environment, e.g. water supplies, sanitation, air quality, etc., so the ‘new’ public health examines what it sees as factors external to and not immediately under the control of communities. For food and nutrition, this translates to issues around the availability and cost: nutritious foods have indeed been shown to be less available and more expensive for some poorer members of the Australian population (Santich, 1992). However, in terms of directing people’s conduct—what we might call the relationship of each model with individuals or communities—there is a striking similarity in what each side is striving for.

With the scientific model, individuals are required to make informed choices about their eating habits after having learned and considered the scientific facts about food and health. The scientific information is designed to raise the consciousness of individuals in relation to those factors in food that affect their health. In other words, what is needed for this approach to be successful is a self-reflective, self-regulating individual with the correct concern for themselves. For the ‘new’ public health too, the requirement is for a self-reflective individual, but one who, in this case, actively participates in the community in order to identify problems and reflect on the consequences for themselves and for others.

There are of course differences in the ways that medical and social models operate in order to make either individuals or communities aware of the problems they face. Thus while the scientific model relies on rational decision making by the individual, the ‘new’ public health favours ‘community development’, as Ashton and Seymour note above. Community development is a process by which ‘equity’, ‘empowerment’, ‘collective action’ and ‘community building’ are all encouraged (Petersen, 1994). As we have heard, health professions play a vital role in fostering community development. They do this by acting as enablers, catalysts, coordinators, teachers of problem-solving skills, small group facilitators and advocates for members of the community. Often the first step in

community development is critical consciousness raising, whereby people come to see their problems rooted in social, political and economic structures which constrain their lives and that of the community (Wass, 1994, p. 132). The outcome of this critical reflection is someone who can become a member of a 'competent community', defined as a community which is able to recognize and address its problems (Minkler, 1991, p. 268).

In both cases, then, there is a need for the development of a self-reflective, self-problematizing subject—or collective subject—which is indispensable to the solution of the problem. Of course, individuals or communities are not left to themselves in this process. Consciousness raising is developed after the involvement of expertise through which the individual is the subject of 'material practices and technologies of reflection and introspection' (Barker, 1994, p. 196).

Coming back to nutrition promotion, we can now look more carefully at what currently *are* nutrition promotion practices and what some feel *should be*. Within most current nutrition promotion programmes good eating habits are encouraged when individuals have been exposed to or have participated in campaigns in which nutrition experts focus public attention on the role of food and nutrition in bodily processes. The emphasis is on the development of chronic diseases, such as heart disease, cancer, diabetes, etc. In the case of what *should be* 'compassionate' nutrition promotion, we can see that this requires active participation of a group of individuals who, by means of self-reflection over everyday life matters, understand the problems and evaluate their solutions. Importantly, the involvement of the expert is no less crucial here since, as we have heard, the community should be helped and guided in its decision making. This help and guidance is important. For example, it would be almost unthinkable—and for some, unethical—for nutrition and other health professionals to support and advocate for more American-owned hamburger fast food outlets, even if this were the community's expressed wish. The community's wish in this case would be challenged, presumably on the basis that it

lacked a critical and informed understanding of the promotion and advertising of foods with dubious nutritional value by powerful capitalist interests. For the new public health to be successful, then, there is a requirement for a 'collective' subject, with the capacity to make informed and proper choices about itself: a competent community. We can see, therefore, a striking similarity between these two positions. In each, the subject or the collective subject (the community) is required to be self-reflexive and self-regulating in order to make 'proper' and informed decisions. The judgement as to what is proper is dependent upon the principled positions of the various streams of health 'promotionisms'. Each will have very good reasons about why their version is most proper or ethical, as Duncan and Cribb and Whitelaw and Whitelaw have demonstrated.

What is important to us here, however, is to see the various health 'promotionisms' as examples of what Foucault called 'pastoral power' which is salvation oriented (Foucault, 1982b, p. 215). In this context, salvation has little to do with life hereafter, but is more concerned with health, happiness and wellbeing in the present. Health promotion is a perfectly good example of this form of salvation in which the government of choice plays a central role. Hunter shows how this government developed out of the overlapping of two historically autonomous technologies of human existence: 'the pastoral guidance of Christian souls and the governmental training of national citizens' (Hunter, 1994, p. 31). On the one hand, there was the administrative state with a concern for its own survival and prosperity through the expert management of the population. On the other hand, there were concerns, ethics and practices of the Christian church which had, throughout the 16th and 17th centuries, sought to 'Christianize' lay populations in Europe in order to concern them with their own spiritual being. This religious education was achieved by the pedagogical techniques and practices of Christianity through which individuals could 'master the arts of self-problematization and self-concern, and in so doing acquire the means of relating to themselves as the reflective subjects of their

thoughts and actions' (Hunter, 1994, p. 37). In this way, the newly emerging governmental state appropriated Christian practices as a means of moral training of individuals.

What we have, then, is the historical construction of Foucault's 'empirico-transcendental doublet', and we can see how this examination of the subject assists us to overcome the apparent contradictions we encountered earlier in the 'individual' and 'community' approaches to nutrition promotion. By fostering the means by which individuals become self-reflective, as either individual agents of scientific contemplation or by becoming members of 'competent communities', both sides of the nutrition promotion spectrum are part of a 'hybrid' which is both governmental and ethical. We recognize this subject as one who is, as Hunter terms it, 'the reflective agent of all social conducts and capacities' (1994, p. 32). The concerns which health promoters raise for consideration—be they medical or social concerns—require individuals to reflect on their own capacity for engagement. Thus we no longer need state bureaucracies to personally inspect our daily habits. On the contrary, as health becomes a personal and social responsibility through the duty to be well, individuals and communities watch over their own, and each other's, habits. As Foucault puts it, this is a superb formula since 'power is exercised continuously and for what turns out to be a minimal cost' (Foucault, 1980, p. 155). Discourses on health promotion—like those on other aspects of human improvement—govern at a distance by ensuring that subjects are bound into the language of expertise at the very moment they are assured of their freedom and autonomy (Rose, 1990, p. 203). Health promotion—whether it be individually or socially oriented—provides for us an ethics; a means by which we can assess our own desires, attitudes and conducts in relation to those set out by expertise. As such, health promotion is one of a panoply of techniques of government which, according to Foucault, makes us what we are today.

Conclusion

This paper has attempted to advance the points about the ethics of health promotion that have been made by earlier authors. It has also tried to put into context some of the tensions which traverse the field of health promotion. These tensions arise out of the principled positions which, among other things, try to argue points around how the subject, or subjects, should choose or be guided in choice. Left totally unproblematized, however, is the nature of the choosing subject itself, which, as has been argued here, is always mortgaged to the moral principles that are set by politics, reason and expertise. Some authors have been quick to point out that morality is embedded in the medical model of health promotion. As we have seen, however, the social model of health promotion also contains its own objectives which encourage communities to do the 'right' thing and behave in a 'proper' way. On a Foucauldian reading, both models therefore practice a form of power which is aimed at directing the conduct of others. The fact that this form of power can be found within what are believed to be the benign practices of the social health model supports Foucault's assertion that power is transforming and positive; it is 'a productive network that runs through the whole social body, much more than a negative instance whose function is to repress' (Foucault, 1980, p. 119). In their own ways, both models of health promotion provide ways in which individuals and communities can gain ethical fulfilment. Foucault's work, then, provides us with a useful understanding of how the government and ethics of health promotion seeks to be transformative. Whether this transformation is achieved by so-called 'bottom-up' or 'top-down' approaches is not relevant to Foucault's notion of ethics. As a practice of government, health promotion (in its various guises) establishes that which should be aspired to, and the technologies of the self encouraged by health promotion provide for individuals the ethics which they seek in order to understand themselves as 'good', moral and ethical individuals.

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Notes

1. Foucault makes this point clear in earlier work where he says (Foucault, 1979, p. 29): 'It would be wrong to say that the soul is an illusion, or an ideological effect. On the contrary, it exist, it has a reality, it is produced permanently around, on, within the body by the functioning of power...This is the historical reality of this soul, which, unlike the soul represented by Christian theology, is not born in sin and subject to punishment, but is born rather out of methods of punishment, supervision and constraint.'
2. Interestingly, nutrition was also referred to in the case for better conditions for workers. For example, in his work, *Capital (Volume 1)*, Marx (1977, p. 612 [orig. 1894]) explicitly draws on the research of early nutritionists to justify the need for men and women to have more food. Moreover, Todd (1998) shows how scientific calculations of diet and nutrition were used in arguments in 1906 by trade unionists in Australia to establish, for the first time, a basic wage for unskilled labourers.

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