S/A 4071: Social/Cultural Aspects of Health and Illness:
Class 4: The Rise of Surveillance Medicine:

* Today we introduce the postmodern perspective on health & illness

* Armstrong's paper is deeply rooted in the work of Michel Foucault

* I will proceed as follows: (1) Introduce postmodernism
(2) Introduce Foucault on surveillance
(3) Discuss Armstrong

(1) Postmodern thought:

-Exemplified in work of M. Foucault, J. Derrida, & J.F. Lyotard
-Radical skepticism: challenges taken for granted, global, all encompassing viewpoints as
-Questions possibility of knowledge: considers what is taken as "knowledge" to be an aspect of power/coercion
-Interdisciplinary focus: interest in alternative discourses/meanings
-Rejection of traditional, linear, rational academic discourse; favor provocative literary forms. Notorious for jargon/playing with words
-Linguistic emphasis: "everything as a text" to be deconstructed
-Comfort with relativism: objectivity impossible
-Cut and paste character: takes ideas from many perspectives and creates a "collage" - not always consistent, but not seen as problem
-Most find things they like/they don't: PM always on verge of collapse
-P.M. Rosneau: skeptical vs. affirmative postmodernists
-P.M. Rosneau: Important postmodern themes:

- privileging the text (vs. the author) and elevating the reader
- the death of the subject (i.e. the individual as a concrete reference point)
- rejection of conventional history, linear time, & a predictable

geography of space
- theory & truth are not neutral: must be abandoned to relativism
- attempts at representing reality must be rejected
- objective knowledge is impossible, as are methods attempting it
- political agnosticism

* Overall there is a tension between skeptical intellectual consistency and affirmative relevance for social science

(2) Foucault: The Means of Correct Training:

* 17th century: strict discipline used to "train" (i.e. make) individuals. They become both objects and instruments of the exercise of power.

* This gradually invaded mechanisms/procedures of the state

* Three key elements: (1) Hierarchical observation
(2) Normalizing judgement
(3) The Examination

Hierarchical Observation:

* Discipline needs a mechanism that coerces by means of observation (e.g. military camps, city planning, architecture).

* Need to build in calculated openings/transparencies to better observe and control individuals (e.g. hospitals, residential schools).

* Worked to objectify/partition individuals through observation, recording and training

* Perfect apparatus: a single gaze could see everything constantly (e.g.

Bentham's Panopticon)

* Hierarchized, continuous surveillance made power an integrated system

* Discipline makes possible a relational power that is self-sustaining

* Irony: a power that seems less corporal but is more subtly physical

Normalizing Judgement:

* Penal mechanisms lie at the heart of all disciplinary systems

* These establish penalties over areas the laws leave empty (e.g. lateness, impoliteness, inattention)

* Accompanied by subtle punishments (e.g. minor deprivations)

* Subjects may be caught in a punishable, punishing universality

* Key here is non-observance: not measuring up to norm:

    (1) refers individual actions to a whole/average/rule
    (2) differentiates individuals from this 'minimal threshold'
    (3) measures/quantifies individuals in value on this basis
    (4) introduces the constraint of conformity
    (5) defines external limit of 'abnormal'

* Essentially, such observational practices *normalize*. Secrete a "penalty of the norm" irreducible to law

* The power of the norm appears through the disciplines: it is a principle of coercion in many areas (e.g. education, medicine, industry)

* It homogenizes previous marks of distinction and difference into a new hierarchy based on normalization.

The Examination:

* Examination combines observing hierarchy and normalizing judgement

* Examination:

  - a normalizing gaze
  - surveillance enabling qualification, classification & punishment
  - combines ceremony of power / form of an experiment
  - objectifies its subjects
  - enacts power/knowledge relations (e.g. schools)

* Examination involves invisible exercise of power/ compulsory visibility of subjects: maintains subjugation through this focus/emphasis

* Examination introduces individuality into documentation:

  - situates individuals in a mass of documents that capture/fix them
  - enables comparisons/ categorization/ fixing norms

* Examination/documentation opened up 2 possibilities:

  (1) Constituting/maintaining the individual
  (2) Constituting a comparative system

* Individualistic conceptions of scientific knowledge and clinical sciences rooted in this examination/documentation

* Examination/documentation makes each individual a “case” to be trained or corrected, classified, normalized, excluded, etc.

* Detailed documentation = a means of control/ method of domination

* This signals the appearance of a new mode of power: creating individuality as a “case”: a fabricated individual

* Ultimately, through hierarchical observation, normalizing judgement and examination, domains of objects and rituals of truth are produced.

* We must be wary of these.

(3) D. Armstrong and Foucault’s Sociology of Health

* Foucault’s work emphasizes how the historical development of capitalist/bureaucratic societies involves the need of administrators to generate, monitor, evaluate and use information as the basis of planning.

* The modern sciences/social sciences arose in turn, the power/ knowledge generated aiding in the “disciplinary” management of free labor in a more efficient manner than coercion

* Foucault suggests that we “internalize” the power/knowledge claims of helpers and healers as subjective realities/identities - operating like subjugation through remote control

* Armstrong discusses Foucault’s ideas in terms of the rise of “surveillance medicine”

* Medicine historically evolved through various incarnations:

(1) *Library medicine* (i.e. emphasized classical learning)

(2) *Bedside medicine:* During this time doctors were dependent on patronage of the patient. Disease happened to the whole person. Key question: “What’s the matter with you?” There was practical management of symptoms & a two dimensional classification of symptoms: symptoms = the illness).

(3) *Hospital medicine*: The patient became dependent on the new, professional doctors in urban hospitals. Disease became a pathology of a particular organ. Key question: “Where does it hurt?” (related to clinical examination, post- mortems & hospitalization: 3 dimensional model: symptom, sign & mapping of underlying pathology in “neutral” space of hospital)
- Primary, secondary & tertiary spatialization related (i.e. 3 dimensions of symptom, sign & illness, location of lesion in relation to body, & removal of patient to hospital). Increasing technology pushing patient as a person into background

(4) *Laboratory medicine*: Both patient & doctor are displaced by scientific tests: disease a biochemical process, the domain of scientists & lab technicians. Key phrase: “Let’s wait & see what the tests say.”

(5) *Surveillance Medicine*: based on the surveillance of normal populations, remapping the spaces of illness and moving beyond the body. Characteristics:

* Problematization of the Normal:

- Surveillance medicine targets everyone/dissolves distinct clinical categories of healthy & ill by making normality problematic
- Began with worries children wouldn’t develop properly without careful medical observation & inspection practices (physically & mentally). Normality, as a result, became a matter of degree

rather than distinct (e.g. height & growth charts)
- Socio-medical surveys of population followed (illness widely distributed rather than either/or binary opposite to health)
- Most are normal in a sense but nobody is truly healthy

* Dissemination of Intervention:

- Problematization of the normal resulted in health care intervention couldn't remain reactive (e.g. hospital patient who came in sick), but had to become proactive & deal with wider population
- Introduction of community health care / population surveillance (e.g. Pioneer Health Centre based on continuous observation: only 7% found "truly healthy")
- Helped justify further surveillance such as screening programs & school "health education" encouraging population to engage in healthy behavior/ monitor itself/be examined periodically)
- Health promotion tactics of pathologization & vigilance: all are at risk/all can become healthier with monitoring &encouragement

* Spatialization of Risk Factors:

- The extension of surveillance has changed relationship between symptom, sign & illness: new emphasis on "risk factors" for possible future illness (symptom & sign merely signify more risks).
- Move beyond the body to any state/event from which risk of illness may be calculated - things like "lifestyle." Infinite chain of risks/predictive factors
- More emphasis on "semi-pathological pre-illness at-risk state"
- The new space of illness is the community/ grid of interactions (focus on attitudes, beliefs, cognitions & behaviors, limits to self-efficacy & lifestyle)

- New temporal focus on “chronic illness”: searching for temporal regularities, offering anticipatory care, & attempting to transform the future by changing the health attitudes/behaviors of the present
- Temporal axis added in surveillance medicine where “illness becomes a point of perpetual becoming”

* Reconfiguration of Identity:

  -Surveillance medicine removed health identity from the body alone into an ever risky world & future:

    -self& community blurred
    -temporal uncertainty about future health generalized
    -produces a new temporalized risk identity in individuals, where problems are administered by professional groups on the basis of their alleged claim to scientific “knowledge”