Health Promotion and Moral Self-Management in Everyday Life

Abstract

This paper argues that health promotion discourse operates as a ‘dispensary’ for moral prescriptions and that, as such, it is a resource for the construction of both ethical subjects and ethical objects of ingestion. The medical and the moral are collapsed - by health promotion images and information - into an elaborate yet naive network of self-surveillance in which virtuous action is based on simple rules of conduct for behavior in everyday life. Health promotion discourse embodies the expectation that rational and virtuous citizens will manage their lives by drawing on the behavioral imperatives associated with a healthy lifestyle. Lifestyle implies moral or ethical self management since the world of health promotion discourse is a Manichean world of good and bad behaviors and good and bad objects of consumption. In health promotion discourse, behavior and things are classified as either salutogenic or pathogenic. The ethical subject or the well behaved body chooses health but those who do not, expose themselves to the charge of laxity in relation to self-management and are likely to be stigmatized as a drag on the resources of the community.
Introduction

Biomedicine separated the person from the disease and, therefore, from culpability with respect to its causation. This is not to suggest that disease has never been a site for moralising. On the contrary, as a recent volume by Brandt and Rozin (1997) suggests, disease and morality, regardless of the nature of the medical system, are invariably imbricated. Yet, with the erosion of the doctrine of specific aetiology, the huge expansion of chronic disease problems in late capitalist societies and the rise of health promotion, it has become commonplace to conceive of disease as consequent upon the action, behaviours and even the locations of people. The emergence of biopsychosocial medicine which propounds the view that prevention (and promotion) is better than cure consecrates an ideology of personal attribution with respect to responsibility for illness. Hence the contemporary debate about whether or not to treat people who smoke or consume too much alcohol is directly related to the contemporary shift from a focus on disease to a focus on health. If biomedicine was primarily pathogenic, biopsychosocial medicine is primarily salutogenic and health promotion is its 'primary' form of intervention.

This focus - which De Swaan (1990) describes as the ‘management of normality’ - proliferates discourses of blame and culpability and opens a new chapter in the moralisation of bodies, behaviour and lifestyle: ‘As more and more of life’s aspects, from diet, through exercise to mental attitude’, writes Allan Radley (1994: 199) ‘become linked with the onset of disease, so the medical view attaches moral judgements to activities.’ Health Promotion is very much implicated in the moralisation of subjects, their behaviours and their relationships to objects of consumption. It ‘dispenses’ the moral ‘prescriptions’ (for good behaviour) that arise out the clinical and research practices of the medical community. It is in the front-line in the war against risk and unhealthy behaviour, which has become the battle before the battle against disease.

In this paper, I want to argue that health promotion discourse is best understood in terms of the moral self-management of lifestyle and behaviour. The subject which uses the moral prescriptions of health promotion to manage and regulate her life becomes the ethical subject. Medicine has been slow to make health and salubrity (rather than disease and illness) its focus but the economic crisis in welfare and health care in the 1970’s was a significant spur to this re-orientation. Discourses of self-care and self-management have proliferated ever since and moral action has become embedded in the rhetoric of the ‘new public health’. The passive body of biomedicine has been replaced by the reflexive, active body of health maintenance and promotion. The first section, examines the context in which health promotion prospers. The second - drawing heavily on the later work of the late Michel Foucault - examines the construction of the ethical subject in health promotion discourse. The primary analytical tension within the essay is between the assumption of a unitary subject in health promotion discourse and the assumption of the de-centred subject in Foucault’s work. The essay does not seek to resolve the tension but to use it to trace the ways in which the moral and medical combine to produce the well managed ethical subject. The third examines the moral careers of objects of ingestion and notes the value of material cultural studies in the examination of the management of well being in everyday life. The argument suggests that medicalisation - as a social project of
biopsychosocial medicine - proceeds by way of promotional texts and activities which construct both ethical subjects and ethical objects. It then introduces them to one another, in the hope of creating lasting partnerships in the struggle for health. This is essentially an encounter between idealised images and information about good (or bad) subjects and good (or bad) objects. Health promotion invites (it is nothing if not polite) real subjects to place themselves in this universe of moral signs and to act in it in a manner which will ensure that they make minimum demands upon the resources of the health services. The most pressing question for contemporary medicine is how to stop the healthy citizen from becoming a patient. Health promotion is the ‘institution’ charged with finding a solution to this problem and, in this respect, it has set itself up as a dispensary of moral prescriptions. The well managed body applies these moral prescriptions to itself.

**Contextualising the ethical subject of health care**

The (economic) context of the rise of health promotion is the late capitalist image and information economies. The notion of self-responsibility for health and health maintenance as the duty of the self-respecting citizen is consonant with the dramatic growth in the fitness, slimming and cosmetic industries. This consonance works itself out in the ‘free’ social space which has come to be known as lifestyle. In this arena health and fitness circulate as beliefs and practices that bring together the moral and the market; producing a moralised market in which the rowing machine and the static bicycle are technologies for the creation of ethical or well managed subjects. ‘The fit body holds a signal position’, writes Barry Glassner (1989: 183) ‘as a locus for billions of dollars of commercial exchange and a site for moral action.’ Relations of power pass through images and information which become (raw) materials for bodily projects and reflexive strategies of self-care. The individual is expected to become entrepreneurial in relation to her own body and to apply a semi-skilled medical gaze to her own actions and activities. Health promotion informs this gaze and acts as a set of repertoires for the medicalisation of self-management.

Though it may (and does) stigmatise certain groups, the biomedical gaze protects, to some extent, against a discourse of individual blame for the causation of disease - a theme central in the Parsonian concept of the sick role. The ‘old’ public health, likewise offered some immunity from responsibility since it assumed that control of infectious diseases - the major killers of the 19th century - depended upon environmental interventions such as the improvement of systems of sanitation. But as one moves from the ‘sanitary idea’ to health promotion one problematises lifestyle and inaugurates a politics of health behaviour as moral action. If one does not look after oneself, one gets what one deserves. Disease is transformed - all too easily -into dessert, into justice, into an outcome predicated upon ones degree of will power and self-mastery. It becomes common to regard it as a consequence of characterological defect or carelessness or some other flaw or lack in the make-up of the individual. The biopsychosocial gaze (which combines medicine and public health) moralises the relationship between the individual subject and her body and health promotion is particularly comfortable in the context of the Neo-Liberal state which is happy to commend the moral dimensions of individual self-care.
Health - which during the period of the hegemony of biomedicine and the social democratic welfare state was regarded primarily as the responsibility of institutional medicine - is now re-allocated into the arena of personal responsibility creating a situation in which self-care becomes an individualised ethical project. Consequently, many critiques of Health Promotion have been levelled at the victim blaming kernel within its discourse (For a summary; see Nettleton and Bunton, 1995: 44-47). The world conjured up by the utterances of health promotion discourse is one in which medicalisation and moralisation collapse into one another. The postmodern world is one in which ‘everything is normal and at the same time profoundly abnormal’ (Armstrong, 1995: 40). Health promotion discourse constructs the world as a place full of risks in which everyone is constantly ‘at risk’. What Giddens (1991) calls ‘ontological security’ is profoundly problematic in the ‘risk society’ (Beck, 1992). The medicalisation of everyday life is predicated on the discursive construction of events, things and behaviours as risks or potential risks. Beck believes that the proliferation of risk is one of the defining features of the contemporary world. Mary Douglas (1986: 59) has argued that risks ‘clamour for attention; probable dangers crowd from all sides, in every mouthful and at every step.’ Medicine and health promotion posit new risk factors almost on a daily basis. The problem for individuals and the network of expertise dedicated to the enhancement of health is how to avoid the dangers and pitfalls embedded and embodied in the ‘semi-pathological pre-illness at risk state’ (Armstrong, 1995: 401). The trick is to manage ones lifestyle in the pursuit of the avoidance of risk. Lifestyle becomes a ‘project’ of moral self-management.

Fortunately, medicine and health promotion can provide some answers; a map through the minefield of life, a guide to appropriate management techniques. If, for example - as some evidence suggests - that the use of aluminium cooking utensils is correlated with Alzheimers disease, then the risk can be cancelled by using cooking utensils that are made from other materials. If fatty foods are risk factors for heart disease then dietary change is the solution. The discourse of health promotion embodies both the utterance of the nature of the risk and the (usually behavioural) ‘prescription’ for its elimination. It is the bearer of both bad and glad tidings. Every risk is calculable and every illness, preventable.

To posit risk as the external, objective and pervasive feature of being in the contemporary world is - at the same time - to posit anxiety as the paradigmatic psychological condition. Indeed the ‘Age of Anxiety’ has become a common description of the period in which we live. Health promotion is both embedded in and contributes to the the existential aura - not to mention the hype - in which the body, lifestyle and social relations are problematised. The themes of risk and (ontological) anxiety are played out in the medium and the message of health promotion in a manner that mimics the highly privatised world of promotional culture.

Both health promotion discourse and commercial marketing directed at body care rely on appeals to anxiety around death and decay to motivate self management and promote the consumption of commodities marketed to fend off ageing and ill health. Each seeks to
construct the ideal type of the controlled body which moves between the indulgence of desire and the constraints of asceticism. (Lupton, 1995: 130).

Contemporary ontological insecurities which are sustained by the risk / anxiety couplet are clearly related to the rise of consumerism and the omnipresence of promotional media. Promotional culture (in which health promotion is thoroughly imbricated) has problematised the body in two ways. Firstly, it has emphasised the body’s potential as a source of embarrassment, grotesqueness and disease: Acne, hair in inappropriate places, body odour, halitosis, bits that bulge and so on are just a few of the minor pathologies which prevent one from making friends and going places. Secondly, on the positive side, promotional culture constructs the body as a malleable canvas of sensual potentialities and as a potential resource for gratification, social advancement, and well being. Every body, no matter how exquisite or imperfect can be enhanced, recreated, rejuvenated.

The message is clear. If its potential for offensiveness and disease is to be kept in check and if it is to succeed in the fashion walkway of everyday life, then the body requires constant vigilance and attention. The solution to the problematised body with its stigmas, blemishes, imperfections and exotic potentialities lie in the myriad products and services lying in wait in the market place. The trades which service the surface of the body offer transformation and metamorphosis to those willing to manage their presentational selves. The market place constructs itself as the friend of the sub-perfect soma (everyone) and offers the means to obtain the ever shifting corporeal ideal. Health promotion sits inside promotional culture in both its mode of communication and its propensity to problematise and offer solutions at the same time. A recent Scottish public health campaign problematises idleness as a route to illness and then offers exercise - specifically walking - as the solution. A sporting icon - Gavin Hastings - is used to get the message across. In the commercial sphere, Linford Christie and John Barnes (more sporting icons - who function as role-models and 'coaches') link sporting excellence with a drink which contains chemical properties consonant with the needs of excessive physical expenditure. The commercial effort promotes a product while the public effort promotes an activity. Both, however, promote self-management and the technologies and techniques - be they activities or products - that are appropriate to it.

Such promotional efforts invite us to consider strategies of self-management, to reflect on the relationship between our well being and what we consume and how we behave. They provide us with the words that we can use to watch and improve ourselves and the technologies we can use to make adjustments to our bodies and ourselves. Nick rose (1990: 10) suggests that these words and technologies are the raw materials of self-care and self-regulation and describes them as: ‘the ways in which we are enabled, by means of the languages, criteria and techniques offered to us, to act upon our bodies, souls, thoughts and conducts in order to achieve happiness, wisdom, health and fulfilment.’ If these are the criteria of a politics of health behaviour as moral action then they are dependent upon individual practices of self-care, upon what Foucault (1990a) calls ‘ethics’, that is, the practical activities of day to day living which entail ‘how one should concern oneself with oneself in everyday life’ (Barker, 1998: 71).
Care of self and self mastery: Health promotion and the ethical subject.

The path towards ethical self management is one which calls upon medical knowledge for guidance and mediation. Conduct - shall we say moral conduct - seeks a legitimate “regime of truth” to provide a code and a set of behaviours which are useful to the artful management of ones existence. Health promotion provides a ‘regimen’ or a mode of management of existence. It is striking that the scope of this regimen is not very different from the one that Michel Foucault (1990b: 101) describes as paradigmatic of ancient prescriptions for conduct. He refers to Book V1 of Hypocrates ‘Epidemics’ in which the conceptual map of regimen includes, exercise, food, drink, sleep and sexual relations. Regimen is, in short, daily itinerary or daily habits. Today we would probably invoke the term lifestyle. Foucault argues that the health maintenance strategies of the Ancients is, in essence ‘an art of living’ indeed ‘a whole manner forming oneself as a subject who had a proper, necessary and sufficient concern for his body.’ (1990b: 108).

Health promotion can be analysed as a set of prescriptive texts which constitute a practical philosophy for the management and regulation of the body and the production of ethical subjectivity. It proposes “an art of living” which is predicated upon a concern for the body. Its key concern is the conduct of life, the 'appropriate' routes to ‘well being’ and ‘self mastery’ as the objectives and outcomes of adherence to the regimes and rules of conduct of life laid out in the texts and utterances of promotional discourse. Health promotion as a range of educational statements and utterances about proper behaviour is a discourse of moral management (Lupton, 1995) with an investment in the production of self regulated bodies and populations.

In his three volumes on the History of sexuality, Foucault examines a plethora of classical texts which he describes as ‘prescriptive texts’ or ‘prescriptive discourses’ (1990b: 249). These are:

texts which, no matter what their form - dialogues, treatises, collections of precepts, letters - sought primarily to propose..... rules of behaviour. Such texts acted as “operators” enabling individuals to question their own conduct in order to build their own personalities - the very stuff of character-making or ethopoetics. (Merquior, 1985: 126)

It is fairly evident that health promotion texts embody a prescriptive role with respect to conduct in contemporary societies - the very stuff of ethopoetics. Indeed the rules and codes are established in a moral-semantic form as a course of action, behaviours or choices that are either good for one or not. One should not loose sight of the derivative form of these prescriptions. They are derived from the scientific endeavours of medicine, its archive of ‘truths’. Health promotion in the information society is the handmaiden of laboratory medicine; its dispensary, dispensing not tablets and medications but words of wisdom - medicine reduced to aphorisms of conduct. Health promotion is biomedicine and public health in practical concert - the biopsychosocial model in practice. A practice in which courses of treatment are replaced by courses of self-management.
What constitutes ‘the good life’ is increasingly understood in terms of health and self-care. Medicalisation constructs an ideal salutogenic world of good behaviour, good things and even therapeutic places like ‘healthy cities’. Medical knowledge (cast as information) forms the foundation for the good life and is manifest in the form of exhortations and prescriptions to give up smoking, take up exercise, drink in moderation, eat healthy foods (defined by the latest nutritional wisdom) and to practice safe sex. Medical research - filtered through the popular organs of culture and the promotional media - promotes a way of life which applauds and condones certain behaviour and condemns others. Virtue and vice are the province of medicine and its promotional efforts (whether these are formally sponsored by it or not).

Virtue has become associated with exercise and moderation with respect to food and alcohol consumption. In traditional societies, religion provided the framework for moral education and (moral social control) denouncing, for example, sloth and gluttony as ‘deadly sins’. In contemporary secular societies medicine is the primary discursive source of moral discipline and control, condemning indulgence and idleness as (not sinful) but deadly, risky, detrimental to our well being and ontological security. The role and scope of medical social control in modernity is analogous to that of the church in medieval times (Zola, 1972-3). One might push this thesis much further by suggesting that in matters moral, secularisation and medicalisation are all but synonymous. As Turner (1996: 203) argues ‘medicine has replaced religion as the social guardian of morality.’

Health promotion as the moralisation of choice and behaviour extends secularisation through a popularisation and even, democratisation of medicine. It makes the complexities of medical science visible and available as simple commandments of self-management. One is reminded of the classical writer invoked by Foucault. His advice to the citizens of Rome would not look out of place in a contemporary health education publication:

It is advisable, or rather, necessary for everyone to learn, among the subjects that are taught, not only the other sciences but also medicine and to hear the precepts of this art, so that we may often be our own accomplished counsellors in matters useful to health; for there is almost no moment of the night or day when we have no need of medicine. Thus whether we are walking or sitting, whether we are oiling our body or taking a bath, whether we are eating, drinking - in a word, whatever we may do, during the whole course of life and in the midst of lives diverse occupations, we have need of advice for an employment of this life that is worthwhile and free of inconvenience. Now it is tiresome and impossible always to consult a physician concerning all of these details. (Foucault, 1990b: 100)

This ancient text might be taken as a manifesto for health promotion. It links everyday life and mundane behaviour with medical imperatives. Medicine is reduced to a set of practical prescriptions and defined in terms of the techniques that it offers in the care and cultivation of embodied self. It is construed as a set of applied knowledges and conducts; as a proper basis for self-management just as contemporary health promotion discourses offer themselves to the public in a similar vein. The passage invokes self-governance as a
practical moral imperative while health promotion encourages care of the self as a particular kind of ultra-modern subjectivity:

public health and health promotion discourses and practices privilege a certain type of subject, a subject who is self-regulated, health conscious, middle class, rational, civilised. They also privilege a body that is contained, under the control of the will. (Lupton, 1995: 131).

One could argue, extrapolating from Foucault (1990b: 13) that health promotion texts function as devices that people use to observe and monitor their own conduct, that is, as benchmarks in the reflexive process of self-judgement. They constitute expert advice on how to live, how to conduct and cultivate oneself, how to use medical knowledge in the construction of the ethical self. The possibility to normalise and moralise oneself is held out in checking (say) what one eats against the recommendations for a healthy diet. Giles Deleuze (1992:7) argues that, ‘the socio-technological study of the mechanics of control, grasped at their inception would have to .... describe what is already in the process of substitution for the disciplinary sites of enclosure, whose crisis is everywhere proclaimed.’ Perhaps one can suggest that the moral architecture of the panopticon and the disciplinary society is in the process of being replaced by the pervasive presence of medico-moral information in which codes for the exemplary life are a more efficacious means of social control than the disciplinary sites of enclosure. This contention makes even more sense in the context of Allan Peterson’s (1997) contention that the Neo-Liberal state - principally through its health promotion activities - mobilises its ‘subjects’ in the battle against disease. It re-skills them in matters of medical action and places them in the front line in the management and elimination of risk. Neo-liberalism embodies both a dispersal of medical power and an expansion of medical control. It, ‘privatises health by distributing responsibility for managing risk throughout the social body while at the same time creating new possibilities for intervention into private lives.’ (Peterson, 1997: 194)

Foucault’s concept of surveillance in the three volume 'History of Sexuality' detaches itself from regulation through the process of being made visible and focuses on discourse itself, particularly the moral constituents of discourse as the rules people adopt in order to construct themselves as subjects. In panoptic forms of regulation, the body is docile, but in regimes of ‘the care of self’ (Foucault, 1990b) one is active in relation to discourse, choosing a path towards ethical self management.

In an essay entitled ‘Ethic of the Care of the Self as a Practice of Freedom’ (1987) Foucault turns the notion of self-surveillance into the performance of being in control. The gaze - a concept which does not appear in the three volumes on sexuality - is transformed into the self-conscious visibility of the performing self. Foucault is only interested in the ocular to the extent that the care of the self involves responding to being visible, that is, involves ‘a certain manner of being visible to others.’ (1987:117).

In the ‘Use of Pleasure’, in discussing sexuality and the processes by which it becomes a domain of moral experience, Foucault (1990a:27-8) focuses upon the rules or rules of action / conduct which are embedded in discourse. In the formation of the ethical subject,
one establishes a relation to the rules of conduct - which refer to a specific moral field of action - by virtue of subjectivation, that is the obligation to put the rules into practice. The ethical discourse, through the rules of conduct or ‘interpretative repertoires’ constructs the ethical subject. Such discourses with respect to the care of the self are likely to arise out of concerns surrounding health and well being. Indeed, as Lupton (1995: 155) suggests; ‘Public health and health promotion have provided a set of central interpretative repertoires for individuals to draw upon in their ceaseless working to construct subjectivity.’

One performs ethical work upon oneself in the name of customs, rules, moral discourses. Two things are happening at the same time. Firstly, ones conduct is brought ‘into compliance with a given rule’ and secondly, one is transforming ‘oneself into the ethical subject of ones behaviour’ (Foucault, 1990a: 27). In other words the project of ethical subjectivity demands conformity to rules of conduct and reflexivity. Foucault writes (1992: 29) that ‘every morality .... comprises two elements: codes of behaviour and forms of subjectivation.’ Health promotion - as a discourse of self management - assumes and affirms these two elements and thus is readily understood as a species of moral surveillance.

Contemporary health knowledges form themselves, more and more, into rules of conduct and interpretive repertoires for living, into do’s and don’ts, into, shall we say, moral imperatives. They are easily reducible to watch-words and beatitudes. Health promotion professes these watch-words as codes for living but also offers strategies for their subjectivation. Discourses about smoking tell us not only to give it up but how to do it. The discipline of health promotion provides what might be called manuals (like car manuals or even management texts) of “practices of the self”. The encouragement to abnegation with respect to tobacco is formed by its persistently reiterated linkage to disease, death, anti-social behaviour and failure with respect to self-mastery. And the techniques of abnegation and self-mastery are laid out in the manuals in which one is encouraged to critically interrogate ones actual behaviour against the codes of an ethical ideal.

The discourses of health promotion are always narratives of transformation and self-regulation and are based on the assumption of the flexible self. One is encouraged to make a transformation with oneself as the object of change and, more often than not, some ascetic practice dominates the mode of transformation. The telos inscribed in the process of embarking on the journey of self-transformation is the realisation of the ethical self, the achievement of self-mastery, the sublime moment of success when the addiction is brought under control, the target weight achieved, the finishing line of the marathon crossed. The reward for success is the personal and public recognition of ones moral status or moral rehabilitation. The purified body wears a badge of self mastery, where the badge is the body itself, transformed, re-ordered, pristine, ethical: One might even say well managed or successful.

Health norms in contemporary society - as they are manifest in health promotion - form a new regime of self-surveillance based on the medical management of behaviour and
lifestyle. They construct the ethical self-regulated subject as the embodiment of self-mastery and offer the deviant subject strategies and repertoires for moral transformation. Foucault describes the transformation and normalisation of subjectivity as:

a process in which the individual delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept that he will follow and decides on a certain mode of being that will serve as a moral goal. And this requires him to act upon himself, to monitor, test, improve and transform himself. (1990a: 29).

Disease is a failure of health maintenance, a manifestation of an improper relationship to ones body and to what ones body does. Self as ‘will to health’ is problematised by the appearance of disease since disease is a sign of weakness, of lack of management, of self-neglect, of a person in moral debt. The right to appeal to the public purse for resources to tackle the invaded body becomes more dependent on normative (as opposed to clinical) assessment, since one has failed, palpably, to put into practice the moral prescriptions of health promotion. The ontological trauma of disease is the pay back for a bad diet, too many hours spent slumped on the couch watching the television, the long years consuming coffin nails, those lost weekends in the arms of the demon drink, that quick fuck without the condom. Each activity carried a highly publicised risk, a health warning. Those who have ignored the dangers and set aside them imperative to manage risk, get what they deserve.

Health and Resource Management: Salutogenic objects of consumption or the social life of healthy things

The previous section dealt with the medicalisation and moralisation of behaviour and lifestyle at the level of the ethical subject. It addressed the processes by which everyday life is constructed as an ethical project of the care of the self (Foucault, 1990b) in which prescriptive promotional texts of medical origin play an important ‘dispensary’ role. The ethical or well managed subject is constituted in terms of a range of ‘healthy behaviours’ or a regime in which moderation, but most of all self-mastery and self-control is the key moral theme. The disciplined body is fit, lean, shapely, well turned out, devoid of poisons, and, therefore, symbolic of healthy ingestive practices and a programme of physical activity. The body as a product of voluntarism (cut into shape by the will of the subject) is a sign of moral order.

Yet the moralising, colonising influence of biopsychosocial medicine does not stop here. The empire of its medical gaze appears to be limitless. Not only does biopsychosocial medicine articulate the polarisation of human behaviour into actions that are salutogenic (good) and pathogenic (bad), it also medicalises and therefore moralises material objects of consumption, particularly those that are ingested or incorporated into the body. Thus moral capital is variously ascribed to the symbolic markers of lifestyle and consumption (Bourdieu, 1984): Fruit is good; chips are bad. The external resources for self management are encapsulated in a moral glossary.
In the context of consumer capitalism where pathologies of consumption are commonplace and objects of consumption are examined for their health protecting properties, one can argue that a sociology of health and illness needs to embrace a sociology of the social life of things, specifically, the external resources for the accomplishment of a well managed body. It needs the analytical sophistication of material cultural studies to contribute to the analysis of objects of ingestion.

Certain material objects, specifically those objects that are consumed in the name of health (Glassner, 1992) are subject to intense forms of discursive construction in which they take on medico-moral significations. Such things become invested with 'psychic qualities'. They become socialised, humanised, enlivened by the meanings that we invest in them (Appadurai, 1986; Csikszentmihalyi and Rochberg Halton, 1981). Making things meaningful in terms of human health has been a particularly pervasive pre-occupation in the latter half of the 20th century. Healthism - a concept which describes the contemporary infatuation with projects devoted to the management of embodied self - demands that objects - particularly objects of ingestion - be known in their nature as either for or against the body. Medical research is at the heart of this process of the epistemological and moral construction of the things we eat and drink. As they become accountable to the tribunal of medical and nutritional science, items of food (especially for the purposes of health promotion) are classified into those which are good for us (salutogens) and those which are bad for us (pathogens). This bifurcation into the medicinal and the poisonous is often taken up in popular and promotional culture such that shifting narratives of meaning are attached to food items.

Promotional activities construct objects by investing them with ‘psychic’ significance such that they come to denote or have connotations which are either helpful or detrimental to well being. Health care expertise, through a range of promotional activities is instrumental in imbuing things with social life, investing them with moral character such that they become - as Roland Barthes (1979) argued - complex systems of communication. Brown bread contains fibre. Fibre protects against gastric problems and illnesses such as bowel cancer and diverticulitis. Ergo - relative to its white counterpart - brown bread has heroic status; it is a trooper in the battle against disease, a salutogen of the first order. The scientific valorisation of fibre by the medical community in the last two decades has been a vital moment in its commercial exploitation. The presence of dietary fibre in the nutritional make-up of a product is regularly used as a means to market it. Such a strategy draws on the ethical character of the food objects that contain it and this ethical character has been shaped by the informative narratives of health promotion discourse.

Objects of ingestion are continuously transformed or transvalued (at the level of signification) into goods which protect or have healing properties or those which are harmful or can do harm if consumed in immoderate quantities. Focus on the risky nature of food consumption and the centrality of consumption to social and economic order has provided the context for the proliferation of ingestive / oral pathologies (Falk,1994). Ideas about what constitutes ‘self-abuse’ focus on consumption and its denunciation. Onanism - once regarded as one of the most loathsome forms of self-abuse - has lost its
place in the hierarchy of self-abusive practices and is now conceived as a pathology only by a small religious minority. Onanism was a 'sickness' of a productivist culture. In consumer culture moral panics are much more likely to erupt around substance abuse where the substance can be alcohol, drugs or food. Self-abuse (despite the emic moment in Bulimic practice) is no longer related to the (unproductive) emissions of the body but to forms of chaotic ingestion - the mis-management of resources. This is not simply a question of overconsumption. Anorexia Nervosa, for example, is a pathology of underconsumption. Objects of consumption / ingestion acquire meaning in consumer cultures with only minimal reference to their origins in labour and production. They acquire ontological status and become potentially troublesome by virtue of being objects of consumption which are incorporated into the body. With the defeat of scarcity in the occident, affluence is transformed into an arena of medical risk and fear of hunger is replaced by fear of fat. Food becomes problematised, not for want of it, but because of the potential abuses related to its proliferation and abundance. The science of the medical aspects of nutrition - in this context - extends itself into prescriptive discourses of healthy eating in which food becomes good or bad and consumption of food, alcohol and tobacco, are articulated with the construction of self identity. Food choice offers opportunities for both self-control and self-indulgence and is central to the construction of the civilised or ethical body (Lupton, 1996). Food items themselves become subject to intense debates in which their moral constitution is at stake.

Incorporation constitutes risk. It breaks down the boundaries between the internal and the external. Where there is moral doubt about food, there is anxiety, fear and consternation. Medico-nutritional science through its promotional dispensary, mediates this psycho-drama by placing itself in a prescriptive role in relation to existential dilemmas about incorporation, mapping out the consequences of dietary choice in terms of its effects upon the body. The narrative status of objects of ingestion become important reflexive resources for body projects and everyday regimes of self-management. The meanings of objects of ingestion have become extraordinarily precarious and their symbolic relation to the body can shift dramatically. This suggests that food items have moral careers. The egg - its place and role in the eating habits of the British in recent decades - is a case in point.

In the last two to three decades the egg has been transformed from the good egg to the bad egg. Science contaminated the egg with cholesterol and then revelations about shoddy and inhumane methods of production in the early 1980’s exposed the potentially poisonous core of the inner egg. The salmonella panic exposed toxins beneath the shell and question marks over its fitness for incorporation transformed it from a symbol of natural goodness and fresh arcadian nurturance into a potential threat to the body. In the late 1960’s the promotional efforts of the Egg Marketing Board encouraged the population to ‘go to work on an egg’. The egg was hailed as the centrepiece of the most important meal of the day, a vital source of energy and protein, indeed a necessity in the task of sustaining the population through a hard days labour. The egg was articulated with the work ethic and its moral status was grounded in its role as a key player in the constitution of the healthy, vigorous, labouring body. In the early 1970’s the Marketing
board tried to extend the value of the egg beyond its narrow but important status as a nutritional curtain raiser to the day. The egg was promoted as a staple. Its ‘versatility’ was emphasised. It could be boiled, fried, scrambled, poached, coddled and, more importantly, it could be at the heart of a whole host of recipes, meals, concoctions, from snacks to the main meal of the day. A larder or fridge without eggs was incomplete. The egg was ambitious, on a career path to the status of cultural superfood.

Yet, by the end of the 1980’s, the egg had lost its halo, had become the bad fruit of the animal world. This moral decline had its origins in the exposure of the cruelty and restrictions of battery farming in which profit is everything and welfare nothing. Unless an egg is ‘free range’ it is tainted with original sin. In the annals of healthy eating discourse, the egg is not yet taboo but it invokes a lexicon of moderation and discretion. It embodies too many dangers and risks to be eaten ubiquitously. It invokes caution. The egg has become a potential threat to, rather than a champion of public health. It has been transformed from a salutogen to a potential pathogen, from a friend to the body to a dubious acquaintance.

The radical moral transformation of the egg is part of a wider narrative in which dairy products have been transformed from purity to danger, from being healthy foods which protect the body from illness into foods from which we need protection. In the 1930’s the British population was encouraged to consume dairy products on the grounds that they were fresh and ‘flesh and bone forming’. By the 1970’s, nutritional orthodoxy had come full circle. Dairy products were associated with ‘saturated fats’ and ‘cholesterol’, with clogged arteries and coronary heart disease. These were ominous signs; signals of damage and death. As Le Fanu (1991: 1990) argues: ‘This imagery of fat on the plate entering the blood to be laid down on the arteries was immensely potent.’

The meaning of the egg, in particular, and dairy products in general have been discursively repositioned in such a way that they have, in the course of a few decades, become their own semiotic alterity. The same science which once constructed dairy foods as good for us, now constructs them as the central enemy of the heart. The protective constituents of the 1930’s ideal dietary regime have become, in recent years, agents of the grim reaper. The Health Education Board for Scotland (HEBS) (1995: 2) advises the nation with the worst mortality rate for Coronary Heart Disease in the world to: ‘Eat more high fibre foods such as bread, fruit and vegetables’ and to ‘cut down on fat, especially the saturated fat found in meat, milk, and dairy products, pies, pastries, cakes and biscuits.’ This is the reverse of the advice given by Scotlands most celebrated nutritionist - John Boyd Orr - who argued, during the Great Depression, for a diet to form flesh and bone, thus constituting a nutritional orthodoxy which only began to break down in the 1970’s. Today, dairy products and fat constitute risk and danger and the egg is thoroughly implicated in this threat to physical integrity: ‘When you use fat’, HEBS advises (1995: 2) ‘use as little as possible and choose oils and spreads high in polyunsaturates.’

Danger becomes part of the psychic structure of foods - like the egg - which contain saturated fat. Prescriptive healthy eating texts construct the psychic and semiotic
character of foods and food groups and direct the public towards a relationship with them which turns on the moral responsibility of the individual to choose life and health, to reflexively engage with the public information which characterises food items as salutogenic or pathogenic. The meaning of the food item is determined by its ‘objective’ nutritional properties which are then translated into moral properties. Saturated fat, for example, is an objective property of the egg which is, simultaneously, indexical of its dubious moral character. Medical and nutritional science establishes the relationship between food and bodies (for better or worse) and public health agencies are called upon to inform upon the food items and expose their nature as either things that possess goodness or the potential to poison and become a risk to the flesh. Healthy eating discourse proposes the unity of the ethical subject and the ethical object of ingestion.

The so called ‘objective properties’ are of course ‘regimes of truth’ about food items, the outcomes of discursive practices which fill the food-things with qualities and character. If through the nomenclature of medicine the food-thing acquires the ‘material’ and moral form which establish it as a particular type of system of communication, the contribution of the promotional process - which transfers the discursive game from laboratory to community - is to give the food-thing, soul - to spread the news about its moral character and to encourage a proper relationship to it.

Finally, there is the metaphysical moment of metamorphosis in which the moral character of the food-thing escapes its object status (in the process of mastication and digestion) and becomes integrated into the character of the subject who ingests it. One can detect the righteousness in the words spoken by this dietary neophyte, quoted in a healthy eating pamphlet: ‘I only eat a bowl of cereal instead of any type of fry-up. Now I always eat brown bread instead of white and a meal is followed by fruit and not a desert.’ (HEBS, 1995: 7). The pathogens have been discarded in favour of salutogens. The risks and dangers embodied in the fry-up, white bread and deserts have been abrogated. The words are a narrative of purification in which the speaker charts the path from impurity to ethical conduct and points - along the way - to the binary of good and bad that underpins knowledge about food.

The process may not be so metaphysical or mysterious if we begin from the consuming self, who ‘cultivates’ objects in order to ‘cultivate’ self (Csikszentmihalyi and Rochberg-Halton, 1981: Leach, 1995). In this view, the consumption of healthy (ethical) objects is an investment in a way of life and in an embodied performance which is part of the ongoing process of identity construction. One consumes the good-food-thing - body and soul - as part of an ontological, aesthetic and ethical project which is anchored in the moral value of health. The healthy thing - incorporated into the body - becomes a prosthesis, an extension of the self; an extension and validation of the healthy self. ‘The prosthesis ...... figuratively and literally’ writes Leach (1995: 17) ‘extends the self’ and the soul of the object becomes an image of the self. Consumption is performative and narcissistic in so far as we consume what we want to be but to choose health and healthy objects of ingestion is to extend the self in a rational and ethical manner. The healthy choice is the rational choice and the ethical object of ingestion compliments and extends the ethical self. The lesson for the moral management of everyday life can be reduced to
vigilance. The character of the resources available for health work are unstable. Those resources which may once have been of profit to the project of health do not necessarily retain such a positive status. The well managed body adopts a flexible relationship to the market of objects that can and might be mobilised in the quest to maximise health outcomes.

**Concluding remarks**

The passive, asocial body of biomedicine is not dead or anachronistic. It comes alive after the onset of disease as an object to be worked upon by medical expertise. Yet it may have come into being in this form as a result of mis-management. The opportunities to ‘choose’ health may have been squandered by improper or unhealthy lifestyle decisions. In so far as health promotion constructs a Manichean world of good and bad actions and resources, then, when one presents oneself to the health care system in a state of disrepair and makes a claim upon its resources one is subject to judgement and examination which is both clinical and moral. What is at stake is a judgement about ones capacity to manage ones health. Whilst this was certainly the case - in much more covert form - under the hegemony of (heroic) biomedicine the proliferation of health promotion discourses and its institutionalisation as a set of codes and prescriptions for living severely undermines the assumption that one is not responsible for ones illness. Those who become damaged and diseased are those who refused to conform to the 'moral prescriptions' of healthy self mangement.

In the image and information economies of late capitalism the rules of self-care and health maintenance are made completely transparent (dispensed) by the apparatuses of health promotion. Lifestyle can be managed to avoid risk and (salutogenic) resource and activities can be selected instead of their damaging, pathogenic counterparts. One can be safe in ones own hands if one follows the rules of conduct and mobilises the appropriate moral prescriptions. Like good and evil in pre-secular, pre-modern societies, the therapeutic and the anti-therapeutic are omnipresent, manifest and easily identifiable in actions and in objects of material culture. Health promotion builds itself on the ‘obvious objectivity’ of good and bad, subject and object and underpins the transparency of its world with the assumption of the givenness of a rational unitary subject who can be ethical by acts of informed will. These assumptions are normative and utopian. They mobilise the medical in pursuit of the ethical in a way that positions power productively and fairly unambiguously, on the terrain of everyday actions and behaviours and their relations with mundane objects of material culture. Even if one resists the rules and moral prescriptions of health promotion, one cannot help but engage with them: Indeed, they engage with us as the normative codes which underpin the ‘proper’ management of bodily practices.
References