Disciplining the feminine, the home, and nature in three Australian public health histories

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Abstract

Within environmental studies, nature typically is conceived as an object out there, a pre-existing reality that we can discover and know. Poststructural theorising about the production of knowledge as contingent and textual has had very limited exposure in environmental studies, but its insights challenge the notion that nature is *a priori* and knowable. It is the purpose of this paper to examine poststructural concerns about the body, biopolitics, and governmentality by focusing on the constitution of three categories of meaning – namely the feminine, the home, and nature – in three Australian public health histories. The paper asserts that many communication devices – metaphor, metonymy, statement, text, and discourse – serve to conflate and reify these categories in highly problematic ways. Poststructural analysis may provide analytical avenues out of a morass of stereotyping generalisations about nature.

Introduction

This paper is a patchwork quilt. It is about ecology as *oikos*, the home. It is about language, meaning, and discourses that naturalise and reify certain forms of knowledge and marginalise others. It is also about poststructural and specifically Foucauldian conceptions of pastoral care of populations and resources, dealing with these issues by asking how the feminine, the home, and nature are constituted in three texts that deal with public health in Australia.

It is only very recently that relations among the feminine, the home, and nature have been discussed in environmental studies. The use of poststructural methods to analyse texts, discourses, and social practices

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in environmental studies is even more limited. Thus, this paper attempts to show how such methods may be used to study how nature is given meaning. This project therefore is committed to suggesting that scholars and activists rethink how nature is construed in environmental studies.

Bennett and Chaloupka (1993) assert that nature has become the focus of 'a profuse and polyglot discourse' (p. vii). Nature is the other to the human and the cultural. Nature is a text that is typically reified as feminine, and as manageable or as needing to be domesticated, like the private sphere – the home. This association among the feminine, the home, and nature is often treated using somatic metaphors. So, in important ways, this paper is about bodies; corporeal and textual bodies; bodies devised through the linguistics tools of communication; humanity, home, and nature as body. The constitution of these modern bodies is part of the constitution of a series of discourses about population, economy, polity, society, science, and religion, colonial imperialism, nationalism, and especially about public health. All such fields of knowledge and social practice also imply management.

Discourses about health have proliferated in the last 100 years. Such discourses are centrally concerned with creating healthy human bodies by also creating healthy environments, cities, neighbourhoods, homes, and families. Ideas about the nature of the healthy feminine body and about healthy nature converge around the body of the home. Yet, so often the discourses with which we surround ourselves and the modes of communication by which we interact are concerned to interrogate why healthy bodies are so elusive, and how we can get well. When our physical bodies or our domestic spheres are unbalanced, we are less able to cope. As the body of the earth becomes increasingly degraded and dysfunctional, we also feel the effects of this illness through higher incidence of disease and stress, or through the ravages of maldistribution and 'under-development' (McMichael, 1993). So, this paper is about a kind of ecology, a Foucauldian biopolitics of the feminine, the home, and nature, using public health as a focus for analysis.

These issues of body are issues of governmentality. Foucault (1978) defines governmentality as characterised by three things. First, it is the 'ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power' (p. 102). Foucault argues that its target is population, its form of knowledge is political economy, and its techniques are the apparatuses of security. This description implicates the military, the bureaucracy, the police, and the discursive instruments of social distinction such as class, race, and gender. Second, governmentality is a tendency for bureaucratic technologies and knowledges to become pre-eminent over long periods. Finally, it is the out-

come of a process whereby the exercise of justice was changed into the deployment of administration from around the sixteenth century. In the West, a particular range of ethical prescriptions about the body, the home, and nature have been developed, normalised, and even reified through ethical practices (Stratford, 1994). Together with these discourses have come practices of governmentality – technologies of surveillance and of discipline – by which the body, the home, and nature have been constituted and widely communicated as normal or otherwise. De Lauretis (1987) argues that – like other cultural categories such as class, race, or nature – gender is representational; it is a construction that is given effect through textual and social practices. Many of the leading masculine figures of the poststructural have presumed a genderless or masculine body in their analyses of various problems. Poststructural feminist scholarship recognises that gender, like other cultural categories such as class or race, constitutes a multiplicity of meanings. Poststructural feminist analyses of the nexus between gender and nature have been crucial in breaking the reified connection that even poststructural masculine scholars have made.[1]

Representation thus forms another thread in this patchwork quilt. Metaphor and metonymy are particularly powerful tools of communication for constructing and naturalising meaning. For example, in Western cultural contexts, nature typically is gendered female – Mother Earth, Mother Country, Dame Nature. Pronouns referring to nature and to many objects tend also to be feminine. These are metaphorical and metonymical devices that collapse the feminine into nature, nature into the feminine, essentialising both. Since language often obfuscates as much as it clarifies, it is important to analyse textual material with scepticism – to ask what is being said. This question is posed in relation to the three texts on Australian public health analysed here. What is being said about the feminine, the home, and nature, with what effects?

Public health histories, bodies, and nature

In *The Archaeology of Knowledge* (1972), Foucault challenges the influence of the author, the commentary, theory, and knowledge. Who speaks for whom, with what authority, and presuming what truths? Using which strategies? What rules govern the production and distribution of statements? How do certain statements come to form discourses and to give effect to the constitution of particular social practices and institutions? How do different discourses and social practices coexist? Succeed one another? How are particular statements hidden from history? Foucault's genealogy (1975, 1976, and others) theorises about meaning, surveillance, discipline, and power. What are the power effects of discourses and social practices? How does our gazing at ourselves

differ from how we gaze at others? What technologies of discipline are deployed in various social practices and through various discourses to constitute us, and have us constitute ourselves, as social beings?

Archaeology and genealogy thus are useful in analysing how nature comes to be imbued with meaning and communicated as feminised, domesticated, and unchanging to wide audiences. These theories expand the meanings of the symbol environment. They open out spaces in which to analyse gendered bodies and domestic spaces in ways that do not essentialise either as universal and immutable, and they empower subaltern peoples, many of whom operate in degraded environments.

Discourses and actions produce and sanction different kinds of knowledges for different contexts. Histories are very different when told from different perspectives (see, for example, Reekie, 1994). Public health histories by Cumpston (1978), Crichton (1990), and Nutbeam et al. (1993) are examined here, although the figures of the authors are deliberately deflected. In Foucauldian terms, we cannot know the author of a text except as a function of criticism. Hence, the relationship between the commentator in the present and the historical 'subject' is necessarily intertextual. Who the authors 'are' is a question inappropriate to the method being employed.

In these histories, all of which are aimed at generalist audiences, public health is constituted as a set of discourses, social practices, and institutions converging around bodies. Yet, nature as a body in which we are well and ill comes to stand as mere background, rather than as a central element in the constitution of health and sickness. This background is constructed differently in different models of health: the medical model views nature as mechanistic, while the public and community models constitute it in terms of organismic and holistic metaphors.

The text by Cumpston was published in 1978. On the frontispiece, the authority of the commentator is invoked, conveying his clear discipline as a successful and productive member of the structures and functions of bureaucracy.

The reader is shown the body and life of the author in shorthand. No space exists to challenge his function as an accurate commentator on Australian health, to ask if such a history would be different if written from a different position in the same time, to ask what Cumpston might possibly have hidden or marginalised from his analysis.

The construction of the author-function as legitimate(d) continues in the introduction by Professor Michael Roe (1978). In a sixteen-page treatise on Cumpston, Roe contextualises the establishment, background, and significance of the federal department of health, founded in 1921. Roe establishes certain orthodoxies about the 'author' he is introducing. After marking Cumpston 'a pioneer resident and community leader . . . a public servant of the highest rank, and an historian of

> This was a period of most exciting and stimulating discoveries which opened almost limitless fields of new activities in medical science, and banished for ever the ignorance and superstition which had persisted from almost the beginnings of recorded history. But, as Tennyson wrote, 'Knowledge comes but wisdom lingers' and it was not until the second period – the twentieth century – that the knowledge newly acquired was fully applied... It is reasonably true to say that before 1850 the true cause of every disease and of every epidemic was quite unknown . . . Effluvia, miasma (Greek – meaning pollution) were the words most commonly used in explaining epidemics: the word 'malaria' means nothing else than 'bad air' (1978, p. 1).

In the opening passage, marking the period to 1900 as one of scientific progress, there is a distinction made between knowledge and wisdom. The latter is privileged as more valuable, more permanent; it was the era in which Cumpston worked. The terms superstition and ignorance are also conflated. Such a convergence is unreasonable. Medical knowledge held by subaltern groups, and by women especially, has been relegated to the inferiorised realm of superstition. Holistic treatments based on homoeopathy and naturopathy, and linked more closely to nature than was clinical medicine, have also been marginalised.

Cumpston suggests that pursuing the 'true cause' of disease was essential to the foundational wisdom of modern medicine. Clearly, diseases arise because of particular events or entities. We may now know that tuberculosis is caused by a specific bacillus, that AIDS is the blow out of a viral infection, or that cholera bacillus resides in faecal matter. What Cumpston leaves unsaid, however, is that certain conceptions and representations of disease remain whether the cause of the disorder is known or not. Tuberculosis also continues to be associated with images of poverty and dirtiness, AIDS (in the West at least) with moral and sexual deviance, and cholera with under-development and an inability to care for oneself and one's economic well being.

Cumpston argues that views about miasma were widely held until the mid 1890s, particularly in relation to diseases that could be read for visible symptoms transmitted from person to person. The means of transmission remained mysterious until the findings of Darwin, Pasteur, and Lister were sanctioned; miasmatic theory was the dominant, but not exclusive, model for understanding disease transmission. In contrast, there was considerable speculation that unseen entities would cause illness, a reasonable assumption given the use of technologies – such as microscopy – allowing hidden things to become apparent to the scientific gaze.

Cumpston marginalises environmental symptoms such as odour and ooze from the diagnosis of disease. Yet, these kinds of signifiers still tell much about the presence of disease and disorder. Malaria does mean 'bad air', and understandably so, in the nineteenth century context of mias-

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considerable achievement' (p. ix), Roe argues that Cumpston's work is also a pioneering document, presenting a 'comprehensive story' of a 'neglected history'. Roe establishes the importance of such history by citing its broad base in bipartisan colonial and federal concerns about plague and quarantine (the control of which, he notes, is reified in s.51 of the Constitution of the Commonwealth of Australia). He establishes the chronology of progress, using the passage of time as a disciplining tool by which to measure success. Roe notes that debates exist about the interpretation of the history of health in Australia, noting that the unifying agenda across the political spectrum was that 'individual needs and the national good' (p. xv) were served. Having established the emergence of health and the 'prehistory' of the department, Roe constitutes Cumpston as a biographical entity, tracing his life and works, his militant progressivism, his ideological agenda and achievements, and liaison with other prominent colleagues. In all, Roe manages to invoke the rarefaction of the author-function, the commentary, the discipline of public health history, and the academic/professional club.

Cumpston's own work focuses on the period from 1850 to 1945, after which he retired. Of the period from 1850 to 1900, Cumpston records the following:

matic theory. It is now known that malaria is carried by a living vector, yet that vector is nevertheless carried on the air; bad air remains an appropriate metaphor. The point is that so-called superstitious and non-scientific explanations for health and disease – explanations such as odour and ooze – actually provide other, illegitimate(d) kinds of knowledge.

So how did Darwin, Pasteur, and Lister and the discourses and social practices produced by and about them contribute to the constitution of public health in Australia?

> It was Darwin who from 1858 onwards freed the human race from the centuries-old fetters of tradition and superstition. It was impossible, after his unanswerable exposition of the universal struggle for existence in nature, for any man apathetically, with whatever sublime resignation, to accept disease or epidemics as manifestations of the Divine will . . . By 1877 [Pasteur] . . . had, through a brilliant series of experiments, identified the micro-organism which caused anthrax in animals and in man, and, going much further had shown that it could be isolated, grown on artificial media under controlled conditions, and its behaviour studied . . . While Pasteur was thus scientifically proving that disease was a natural process, one living organism maintaining its existence at the expense of another, Lister in Scotland was proving that [wound sepsis] . . . was due to infection from outside, because the instruments used, the hands of the surgeon, and the dressing applied were not clean: that dirt, not visible dirt, but germ-containing material, was present (Cumpston, 1978, pp. 3-6).

In discussing the effects of Darwin, Pasteur, and Lister on conceptions of health and disease, other normative understandings of history and progress become clear. Cumpston writes of Darwin as saving humanity from tradition and superstition, ignoring in this analysis the immense and totalising effects that scientific and medical traditions have had on bodies and populations. He again disregards alternative knowledges, and he constitutes a divinity exogenous to nature.

Divinity may or may not exist, and it may or may not be in nature, which also may or may not exist; this is not the point. Rather we must ask what are the effects of Cumpston's locating spiritual will externally to things corporeal? Cumpston leaves from his history the multiple effects of these medical and scientific advances on the practices and institutions of subalterns. For instance, in the home, the cleaning, dietary, clothing, sexual, reproductive, and child-rearing regimens of Australian women were to change dramatically as a result of these discoveries. Feminised practices made significant contributions to the initial health of new generations and the maintenance of the health of existing populations, yet no comment about these issues is made by Cumpston until a later discussion on the falling birth rate in the years to 1945. Even then, the debate perpetuates normative understandings of the position of women, at a time when alternative discourses did exist, especially from the era of first wave feminism.

Slowly Taking Control? Australian Governments and Health Care Provision 1788-1988, written in 1990 by Crichton, is another history of public health in Australia from 1788 to 1988. It is a text about 'negotiated compromise' and political practice (p. 1). Crichton argues that the major transitions in health have been threefold. From a nineteenth century combination of class-based philanthropy and medical entrepreneurial activity there was a change to an early twentieth century concern with placing bureaucratic limitations on the power and practice of medicine. Finally, there has been a partial transition from this bureaucratised medical model of health to one based on instrumental concerns with finding a balance between the public and private. This last phase has seen the rise of community health models oriented to more radical variants of structural and social reform, and of other liberal models constructing health as an individual responsibility. Thus, Crichton understands history to be progressive. Medical care and health are conceived as moving from one state to another more bureaucratically and socially advanced, albeit with problems about balancing community participation, medical autonomy, and state accountability.

Definitions of health have changed from an instrumental concern with helping populations to achieve their full potential (disciplining and normalising bodies for economic and social production and reproduction?) to a holistic concern with individuals' lifestyles (with the normalisation of whole bodies and whole lives?). Health is no longer the absence of sickness; it is a state of being that encompasses social, emotional, psychological, spiritual, and physical well-being. The whole body and subject are now the objects of surveillance, and well-being itself is a normalised entity that can be read on the body and in the actions of people (see also Baum, 1990).

Definitions of health also have become part of a post-colonial world; Crichton notes that it is the responsibility of the World Health Organisation to set international standards of health. However, these standards and the practices needed to achieve them marginalise important differences among peoples. In the process, a whole new set of colonising actions can be sanctioned in the medical, political, aid, and social welfare communities. Certain cultural practices of body-care may be anathema (clitoridectomy, infibulation, or the slaughter of endangered species for 'remedies' and aphrodisiacs come to mind). Other practices and 'pre-scientific' medical knowledges are at risk of being lost or insensitively appropriated because of some of the functions of modern international medical discourses and practices.

Slowly Taking Control? is based around changes in the federal political leadership. There are distinct differences between Liberal focus on the market, the issue of supply and the autonomy of medical professionals, and Labor concerns with national health systems, the issue of demand,

community representation, and accountability among medical professionals. The text focuses on power: economy, time, inter- and intra-sectoral conflicts and compromises, federal-state relations, and the tensions among health professionals, bureaucrats, and the community. It traces 'power shifts' among groups (p. 180), examining different configurations of pressure, interest, challenging, repressed, and dominant groups. It asks, 'What effect are these shifts of power likely to have?' (Crichton, 1990, p. 194). It also asserts a heterogeneity of health objectives, outcomes, processes, and structures in the Australian health care system.

The link between health and environment is explicit. Crichton notes that environmental health has emerged in discourses and social practices about Australian health mainly during the Labor years, with concerns about environment being linked to those about health education and public health programs and policies. Labor's stated aims include:

> A philosophy of health education which examines not only what the individual can do to prevent illness but also the need to control the promotion of hazardous products and other environmental/cultural factors which can militate against the best intentions of health education campaigns (Crichton, p. 161),

and

> A properly conceived and executed public health program to ensure that Australians are getting the best possible protection through health research in unmasking toxic, carcinogenic, teratogenic and mutagenic health risks associated with drugs, pesticides, chemicals and environmental pollution (p. 161).

This rhetoric of environmental concern is intriguing. There are indeed distinct links in the late twentieth century between the green movement and certain models of community health (Gunnell, 1994). Environmental health is often marginalised from consideration when large amounts of money are at stake. As both McEachern (1994) and Peace (1994) note in relation to the rhetoric of environmental damage control and environmental resource management, developers, bureaucrats, and politicians are able to adopt the language of oppositional groups and normalise the discursive constitution of what are protest documents and actions. Once marginal discourses are incorporated into mainstream agenda, their disruptive effects are jeopardised.

Goals and Targets for Australia's Health in the Year 2000 and Beyond (1993), commissioned by the Commonwealth Department of Health, Housing, and Community Services, was written by a team of researchers headed by Donald Nutbeam. The document complies with many of the discursive rules proposed by Foucault (1972). From the outset, it establishes as legitimate the long arm of pastoral and policing concerns of the bureaucracy. The report relies on ideas of what a population's health is and should be. The report focuses on physical,

psychological, bureaucratic, and educational elements of health and illness, and then on particular disease groups such as cardiovascular disease, cancer, injury, communicable diseases, AIDS, sexually transmitted diseases, obstetric care, asthma, diabetes mellitis, mental health disorders, physical and developmental disabilities, oral health, diet and nutrition, physical activity, high blood cholesterol and pressure, substance abuse, sexuality, contraception and infertility, sun protection, safety behaviours, immunisation, and health education.

The report rarefies the commentary and the discipline of health by deploying particular discursive strategies that invoke the authority of other organisations. It appeals to internationally accepted definitions and standards of health, again colonising and normalising often disparate national and regional approaches to health. It notes the existence and efficacy of the National Better Health Program, the National Health Strategy, and the instrumentalities constituted to oversee their success. It accepts problematic understandings of health as a commodity that can be accessed with 'good management practice . . . strategic planning . . . equity and efficiency . . . resource allocation' (Nutbeam et al., 1993, p. 5), all of which sound remarkably like the rhetoric adopted in mainstream environmental resource management to discipline and normalise nature. Health goals and targets are defined using a comprehensive understanding among health professionals and bureaucrats of the combination of trends (of bodies, populations, disorders, diseases, medical advances); of assessments of these trends; and of research and development (of drugs, treatments, diagnostic procedures, environmental controls, technologies). Again, the deployment of rhetorical devices of communication serves to maintain a government of bodies and the sites through which these operate.

There is a further proliferation of statements about institutional arrangements, projects, programs, and strategies noted in the Nutbeam report. These texts include the World Health Organisation's (1981) *Global Strategy for Health for All by the Year 2000*, and its Ottawa Charter (1986) for health promotion. There is the Australian Better Health Commission's (1985) *Advancing Australia's Health*, and its (1986) *Looking Forward to Better Health* in three volumes. There is the Health Targets and Implementation Committee, the Australian Health Ministers' Conference and its (1988) report on *Health for All Australians*. There is the Australian Health Ministers' Advisory Council (AHMAC); National Health Advancement Program; National Campaign on Alcohol and Drug Abuse; National HIV/AIDS Strategy; Women and Health Sub-Committee of AHMAC; the National Health and Medical Research Council (NHMRC) and sub-committees such as Environmental Health Committee; the Healthy Cities and Better Cities projects; the Australian Education Council; Worksafe Australia; the Public

Health Education and Research Program; state and federal ministries; local government health initiatives; non-government and community organisations oriented to health; peak consumer bodies; and pressure and interest groups. All these 'advances' in health provisions for the Australian population remain, at some level, intimately concerned with notions of governmentality, surveillance, and how we constitute ourselves and each other as healthy or sick, normal(ised) or marginal(ised).

Theorising poststructural bodies: A discursive conclusion

In Foucauldian terms, power may be positive and exercised in a range of contexts by a range of subjects on themselves and others. Health is about power over bodies, populations, communities, and environments. Bureaucratised health provision is a particular form of administration serving to contain definitions of health and illness, and to constitute normal and deviant bodies. Through the deployment of rhetoric, it can influence how certain areas of health research are funded, how much power is exercised by specific groups, how much credence is given to particular discourses. In the light of the foregoing critiques, how can bodies, the feminine, home, and nature be theorised as subjects rather than as mere objects?

In the Preface to *The Birth of the Clinic* (1973), Foucault writes, 'This book is about space, about language, and about death; it is about the act of seeing, the gaze' (p. ix). He traces the emergence of discourses and social practices that constituted modern clinical medicine from the end of the eighteenth century, arguing that approaches to the study of humanity, to the technologies allowing such study, and to the moral and ethical exhortations that justified it have changed. In turn, there has been a shift in knowledge about the visible and the invisible, about what could be seen and what could be said (Riley, 1987). It became possible to look inside the body, label its workings and its disorders, and constitute new meanings of health and illness. These activities were used with social practices that policed and disciplined individual bodies and groups for the health of larger configurations of society, and for the manipulation of social and natural sites.

The new medicine was a mechanistic and instrumental approach to the physical that was also to have wide-ranging implications for nature (Merchant, 1990; Worster, 1987). In some respects, it was this new ability to gaze at components of the world that were previously hidden that prompted the emergence of medical health and later of public health and environmental health. Foucault (1973) is concerned to point out the relationship between the signified and the signifier – the

concept and form – of health and illness. He argues that the new gaze of clinical medicine redefined how health and illness came to be spoken about and written, how they were represented in the symbolic order and came to be accepted as real and natural.

Thus, the body became a map to be read for the marks and traces of disease. It was a terrain where health and disease became moral outcomes of individual and collective thoughts and actions. Among others, Foucault, Donzelot (1980), and Finch (1993) argue that the family was constituted as a natural locus of life and of disease: a site where moral actions may determine the penetration of disease onto and into bodies. The home and nature have become targets for the gaze of pastoral and police concerns. Along with the emergence of the medical expert in the late eighteenth and nineteenth centuries came other panoptic professions: health, shop, and factory inspectors; central and local government officials; statisticians; quarantine officers; abattoir supervisors; architects trained in the principles of healthy housing; advisers and philanthropists to the community.

In these professions, and in the discourses and social practices that have constituted them, there were and continue to be particular assumptions about what it is to be healthy: a healthy body, family unit, home, workplace, community, society, nation, environment. Turner (1992) argues that ideas about the body are constituted in discourses and social practices, and the body itself becomes a text for the production of our subjectivities. Thus, Turner suggests that Foucault's later ideas about biopolitics necessitate an expanded understanding of *text* in relation to the body to incorporate lived experiences. Turner notes in passing how the 'green movement' reflects current biopolitical concerns in a somatic society, particularly with the regulation of numbers of bodies, spaces between bodies, and spaces between bodies and nature.

Although his analysis is generally sensitive to issues of gender, at this point Turner does not make it explicit that spaces, like bodies, are gendered. It seems important that he should have done so. Spaces such as the home are corporeal and constructed (Routt 1986; Rybczynski 1988). The home, typically, is construed as a feminised and domesticated site where regulatory regimes and practices are enacted in ways quite differently from those in masculine and public sites. The essentialising politics behind such stereotypes is defied by gay and lesbian, SNAG and SNAW, communal and alternative households, and by new eco-communities. The allocation of spaces within the home is also gendered (Johnson, 1993); orthodox feminine terrains are focused on production: the kitchen, the laundry, the nursery, the bedroom. Masculine spaces are normatively constructed to emphasise rationality and action: the den, the garden, the garage. Space and action are regulated and deployed through discourses and practices from planning, architec-

ture, and building, and have become naturalised and reified in social practices of urban design and lifestyle.

Moreover, these gendered spaces and the symbolic order to which they are linked are related to notions of healthy homes. Some of the most unhealthy and dangerous locations in the domestic sphere are those very spaces which are constituted as feminine. In the last 100 years, and with the advent of standards of cleanliness far beyond those prescribed earlier, kitchens and laundries have been centred around the use of noxious chemicals and dangerous tools. Women's roles have changed dramatically within this contained space. Now, the activities undertaken by women are not always viewed as naturally feminine; work has been redefined (Probert, 1990). These sites are also those in which the substance of domestic health is produced: nutritious food in the kitchen, clean and germ free clothing in the laundry. Furthermore, women are conceived as the natural care givers of children in the nursery and as the lovers of men in the bedroom, yet also as pathological in relation to their offspring and spouses. Foucault (1976), among others, calls this the hysterisation of women:

> a threefold process whereby the feminine body was analyzed – qualified and disqualified – as being thoroughly saturated with sexuality; whereby it was integrated into the sphere of medical practices, by reason of a pathology intrinsic to it; whereby, finally, it was placed in organic communication with the social body (whose regulated fecundity it was supposed to ensure), the family space (of which it had to be a substantial and functional element), and the life of children (which it produced and had to guarantee, by virtue of a biologico-moral responsibility lasting through the entire period of the children's education): the Mother, with her negative image of 'nervous woman', constituted the most visible form of this hysterization (p. 104).

Here again, in representations of illness and the feminine there is a strong connection which has its confluence in the site of the home, and a reliance on specific understandings of nature and the natural.

In the constitution, surveillance, and normalisation of gender, of particular sites such as home, and of nature, 'who then are the disciplinarians?' (Foucault, 1975, p. 222). How is a biopolitics about public health deployed, and with what effects on whom? First, people produce and are products of specific representations of health and illness. They attempt to discipline these representations and the intersecting realities arising from them to domesticate fears about the otherness that illness stands for in the symbolic order (Gilman, 1988). Second, people also produce gendered and localised subjectivities and corporeal realities by practising disciplinary techniques such as dieting; observing and following fashion trends; practising home economics; adopting and changing lifestyles; or participating in rituals of social movements that prescribe certain modes of action and thought.

Finally, there is a need to return to specifically Foucauldian assessments of the histories examined here. These texts present rarefied narratives. The author-function, the commentary, the field of knowledge, the methods by which information is generated, constructed, distributed, and critically received are all part of the rules of discourse. Each text presents a generally uncritical acceptance of a series of binary oppositions that do not serve to create open sites and emancipatory analytical spaces in which to examine heterodoxies and heterogeneities.

Health and illness, progression and regression, reform and disorder; each of these joins a range of highly problematic binaries in the construction of much of the knowledge that comes from these texts. This observation is not meant to suggest that it is easy or even possible to stand outside of traditional conceptions of historical and analytical categories. Likely, it is not. For almost three decades now, poststructural theorists have been concerned with asking whether it is possible to generate discursive and social spaces that do not rest on these binaries. Even if its 'practitioners' have not been able to answer the conundrum about oppositional language, poststructural theory has provided the means by which to begin a decentring analysis that does shake these binaries. Perhaps in the shake-up, we have come to constitute health, the feminine, the home, and nature in ways that concede that power and knowledge are contingent, and that subjectivity is a polyvalent category more broadly based than is typically assumed.

Endnote

1. For useful summaries on the debate, see Jardine (1985) or Grosz (1990), both of whom argue that woman as a category has been colonised in masculine poststructural work. Weedon's (1987) text on these issues is also an excellent summary.

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