AM
Rivista della Società italiana di antropologia medica / 17-18, ottobre 2004, pp. 163-178

1.6 *Risk, choice and self-management of type 1 diabetes.*

Reflections on medicalisation, resistance and the political ethics of agency

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The original title for this paper was *The political technology of in/formation and choice*. My aim was firstly, to present a key discussion in my dissertation on the operations of the risk concept in contemporary Norwegian diabetes care. This discussion relates to the practices through which individuals are "in-formed" into particular subject positions in the increasingly prominent medical regimes referred to as self-management (1). Essential to the establishment of such regimes are the specific practices, rationalities, and techniques through which risk is construed as a governable entity. Secondly, I wanted to link these discursive practices of medical information to a prominent rhetorical feature in Norwegian society, beyond the confines of health discourse strictly defined. This feature I refer to as the rhetoric of "choice". It involves a bourgeoning practice whereby the verb *to choose* is used actively and explicitly in accounts of actions, experiences and histories of oneself and others. It includes the use of the active verb even in contexts characterised by the opposite of choice, in the conventional sense; as when there are only illusory alternatives or when choice is between attractive and indisputably unattractive alternatives. Through this rhetorical practice, it appears, actions and experiences are grounded in the individual – now the determining source of what transpires – and made into the historical expressions of personal, individual natures.

However, as I pondered how to best present the argument, I was once again struck by a difficulty that arose in my original analysis of the tension between empowerment-based self-management regimes in serious illness and the contemporary rhetoric of choice. The difficulty I believe is a general one affecting studies of contemporary medical practice in the so-called late modern societies, and it involves the problem of how to account theoretically for subjection in a social field dominated by widely endorsed philosophies of individual agency, empowerment and independence (CRUIKSHANK B. 1994). In the wake of the sweeping medicalisation critiques of the 1970s, as Margaret Lock has pointed out, ethnographic research in the 1990s has demonstrated that «the responses of individuals, families and communities to medicalisation are complex» (LOCK M. 2001: 481). In Lock's example from the context of fertilisation technologies, the dilemma is states clearly:

> «[When] women seek out and make use of biomedical technologies, this may not be evidence of independent agency on their part, although often it is or is claimed to be the case. Biomedical technologies can assist women in achieving a modicum of independence from oppressive circumstances, or they may permit them to fulfil personal desires, often to have a child. However, women's behavior can equally well be due to a desire to "please" others [...] or, alternatively, to untoward pressure exerted by others. It is clear that women frequently respond to the expectations of partners, extended families, women's groups, or communities rather than single-mindedly pursuing what might bring about their own personal desire or comfort» (LOCK M. 2001: 481-482, emphasis added).

According to Lock, these findings give rise to a call for a refinement of concepts such as agency and autonomy, medicalisation and resistance, to enable analysis to accommodate the pragmatism with which people appropriate medical knowledge and technologies (LOCK M. 2001).

This task is today complicated by the dominance of panoply of research undertaken by health behaviourists in the fields of (health) psychology, nursing, and medicine, but also certain sociologies and anthropologies of medical thought and practice (OGDEN J. 2002). Although it is rarely accounted for theoretically, this surging wave of research is one that treats their object of study to as rational consumers of what medicine has to offer, strips them of context or treats social environments only to the extent that the rational individual subject brings such forces into her/his narrative), and de-socialises the determinants of sickness and people's perceptions. It is characteristically carried out through quasi-quantitative research procedures, albeit frequently under a prominently advertised commitment to qualitative method (BOURGOIS P. 1999).

In my view, these researches are influential today in part because they operate with formalised and easy-to-use research protocols that make such studies seem replicable and capable of generating comparable results. In other words, they appear to meet the hallmark criterions of scientific objectivity that make research findings palatable to many largely quantitatively oriented institutions responsible for health research and public health interventions. However, it seems plausible to suggest that their prominence is driven also by their correspondence with a historical, cultural and political moment that acknowledges only the individual body, that dissolves intermediary levels of community (between state and individual), insists on an ideology of individual responsibility, privileges the subjective point of view, and which is inherently sceptical to analyses that threaten the ideologically invested autonomous individual. It is a moment, therefore, in which analyses of intentionality, agency and autonomy sit uneasily. For, in such a setting, what can be said about participants in research that they do not already themselves articulate verbally? The tension is discernible in Lock's discussion of autonomy quoted above, in two conspicuous distinctions: on the one hand, the distinction between *real* and *claimed* individual agency, and, on the other, that between intentionality that emerge from within the individual ("single-minded pursuit" of "personal desire and or comfort") and intentionality that intrude, as it were, from (the social) outside ("responses" to the "expectations of others").

In what follows, I will present my argument concerning what we may call the moral informatics of the self-managing Norwegian subject, in order to question it from its own point of view, as it were; that is, from the ideologically charged questions of legitimate and illegitimate sources of individuality and agency. The discussion is based on data generated in the course of fourteen months of fieldwork in southeastern Norway, based primarily in two health care institutions (a local hospital and a specialised institution for patient education)(2). In addition to participatory and non-participatory observation data from these context, the main bulk of the material was generated from following a group of 10 young adults with type 1 diabetes and their friends and families over a twelve to eighteen months period; attending national and international medical scientific meetings, analysis of textual and audiovisual material, and interviews with key informants in specific fields. A full description of the methodology and analysis of the study is available elsewhere (HILDEN P. K. 2003).

A normative practice of self-governance

As my original title reflected, I consider the phenomena of information and self-management to be part of a general economy of discourse through which political functions are performed and political ends are pursued. In everyday usage, information has a simple meaning of imparting knowledge. However, in the context of the risk-epidemic (FUREDI F. 1997, SKOLBEKKEN J.A. 1995) and the audit explosion (POWER M. 1997, STRATHERN M. 2000) as emergent pivotal modes of governance in medical and meta-medical domains of Euro-American societies, the concept of information is accumulating moral and political (in Douglas terms "forensic") weight well beyond its everyday innocence (CASTELLS M. 1999, DOUGLAS M. 1990). My analysis of patient education processes in this study demonstrates how the health education and training offered to persons with diabetes aim at *forming participants into particular roles or positions* through the projection of particular individualities. On this view, diabetes health education can be seen as a process which provides *the inner form of possibility and "choice"*, A person who is thus *informed* may be taken to enter a certain point or position from which some phenomena are within sight and others not, from which certain 'facts' emerge or triumph, and others do not, and, hence, from which certain "choices" are rational and others not. In order to mobilise this more subtle sense of the term, I proposed to speak of "in/formation" rather than the every day "information"(3).

As my choice of terms indicates, my approach to these issues has been guided by a perspective derived from the conceptual framework of governmentality and biopower, as developed after Foucault(4). Here, micro-level social lives in the context of neo-liberal European societies are not seen as miniscule objects upon which monolithic institutions of state power work but, on the contrary, the localised everyday sites of decentralised and, even, more or less unwitting and voluntary, self-policing exertions of power. In fact, the type of ethnographic questioning I have been involved in is centred on an attempt to raise a very Foucauldian type of question. What kind of subject does such a mode of governance require? How does this subject come about? What kind of subject is a morally integrated Norwegian person today? There are reasons for *medical* anthropologists to be particularly vexed by such lines of questioning. As has been pointed out by a number of sociological commentators, «'health' is a key concept in the fashioning of identity for the modern and contemporary middle class» (CRAWFORD R. 1994). Indeed, as Joao Biehl and colleagues will have it, «contemporary techno-scientific and medical developments are [not only] restructuring social interactions [but also] the very processes by which individual subjectivity is formed» (BIEHL J. - COUTINHO D. - OUTEIRO A.L. 2001, cfr. also DUMIT J. 1997, RABINOW P. 1992, RAPP R. 1999). In the view of one commentator, the downfall of collective ideologies of progress in the West has turned Westerners in on their bodies, as the ultimate remaining site for late modern progressive projects; hence the public domain is saturated with "somatopic" imagery, activities, lifestyles (CHRYSANTHOU M. 2002)(5).

In line with a governmentality perspective, my analytical approach to the social phenomenon of therapeutic self-management regimes frames the phenomenon in the demands of a socially reductive model of subjectivity. Biomedicine is centrally involved in the production of this model. It permeates Norwegian health discourse and, eventually, contemporary Norwegian understandings of moral personhood. The model is one that imbues the individual with the responsibility of tracking down and controlling sources of health risk in her or his life. As Richard Crawford has pointed out, at the crucial centre of this model sit intensified mandates of self-control (CRAWFORD R. 1984). These mandates involve an insistence that such action on the part of the individual is not only possible but also the definitive trait of a morally integrated, rational, responsible and purposeful person.

This model subject has been scrutinized from many perspectives, not least of which are critical analyses of citizenship and neo-liberal politics (CRUIKSHANK B. 1994), and what Alan Petersen and Deborah Lupton refer to as the New Public Health (PETERSEN A. - LUPTON D. 1996). What is important to emphasise here is that the *wellspring of health* for the model subject of the New Public Health, is to be found intra-subjectively, in the optimal configuration and mobilisation of intra-subjective resources(6). While the surroundings are of course of relevance to the health of the individual, the environment is here treated as a space from which information emerges, to be processed by the individual who "reads" it. According to this view, it is in the nature of the adequately constituted individual subject to act upon such information in specific ways once it is received and processed. We find the indications of this intra-subjective dynamic in the headings of a panoply of research programs undertaken under this paradigm, with the Health Belief Model (HBM) as the prominent point of departure (BECKER M. 1974, ROSENSTOCK I. 1966), but since then amended through notions such as "*locus of control*", "*sense of coherence*", "*self-efficacy*", and so forth. The early critique of HBM denounced its rationalist bias, its lack of recognition of variations in symptom perception, its inconsistent operationalisation, and so forth. Soon, however, the main objection focused on the failure of HBM to include the question of the individual's degree of confidence that what he or she set out to do could be accomplished. Hence Bandura famously introduced the tremendously influential (in health research) notion of self-efficacy (BANDURA A. 1977, 1997). Building upon Bandura's work, we find amendments in programs such as Protection Motivation Theory (ROGERS R. 1983), the Health Action Process Approach (SCHWARZER R. 1992), among quite a few others. I suspect that a closer history of science review would reveal that a conspicuous proportion of these theoreticians have worked in the field of diabetes care.

In a recent essay, Jane Ogden has called the model of the subject involved here the model of the intra-active individual. This is a model, Ogden points out, that in effect localises *health risk* in the depths of the intra-individual psyche (OGDEN J. 2002). Thus, for example, although the HIV-virus was seen as the carrier of disease, AIDS prevention soon identified the ability of the individual to control sexual "behaviour" as the risk factor for infection. Hence, the determinants of behaviour were established as the appropriate target of intervention, and since these were localised internally in the individual subject, that internal psychological space was established as the site of intervention. In this perspective, «diseases such as cervical cancer do not constitute a risk to health in themselves but reflect the individual's ability to have regular screening and to take preventive action.» (OGDEN J. 2002: 27)

In my own research, I have called the figurehead of this model the *risk actor*, and emphasised the model's normative moral nature in self-management education, in addition to whatever methodological and analytical uses to which it is put as constituent of contemporary research programs. In fact, it is Ogden's argument that the normative moral thrust of the model derives in no small part from its apparent scientific origin in the social science disciplines(7). The rhetoric of choice is conspicuously positioned with regard to this model in the context of self-managed diabetes. Type 1 diabetes is a chronic disease with fatal consequences lest the deficient insulin production is compensated. Thus, there is no choice but to adhere in some measure, to the treatment plans one is offered. Nevertheless, the rhetoric of choice permeates two dimensions of diabetes treatment discourse. On the one hand, rhetoric of choosing saturates self-management philosophy. The choice invoked here, however, refers to the choice to adhere to a particular treatment modality, namely intensive, multi-injection insulin therapy. This treatment modality involves a comprehensive set of daily practices through which a normalisation of blood glucose levels is pursued. Multi-injection insulin therapy, the default treatment modality in current diabetes care in Norway, is a treatment modality that takes its rationale not primarily from the wish to alleviate symptoms of diabetes in daily life, but from the prioritized objective to minimize the risk for late complications. The treatment modality is comprehensive, and replaces daily life symptoms with daily-life self-doctoring practices of self-surveillance and self-medication.

When the term choice is used in this setting, its idiom is individual mastery and control. This discourse positions the attractive choice as the choice to "take control", and the attractive subject as a masterful agent, in control of her/his own fate and circumstances. The marketing of diabetes pharmacological products and treatment technologies provide the perhaps most explicit and conspicuous examples of this, as illustrated in figure 1. Here, a computer software application that offers to perform statistical analyses on blood sugar measurements downloaded from portable electronic self-measurement devices, is advertised with a free-falling sky diver. The accompanying text reads: «Accu-Chek Compass. Full control and total overview/ survey(8).»

Fig. 1

The second practiced invocation of the action and possibility of choice can be found in the accounts of individual persons with diabetes themselves. In particular, the notion of choice occurs in accounts of self-treatment failures, in conversations and reflections triggered by poor clinical tests and laboratory measurements that point to poor risk status with regard to the development of diabetic late complications. Thus, one may admit to having performed poorly in that one has ignored blood sugar measurements, skimped insulin injections, and so forth, yet gain recognition for such "failures" through reference to these actions as the results of choice. In fact, a normative pressure can be discerned in the following direction: adherence as well as non-adherence – or periodic skimping – *should* be accounted for by reference to active, individual choice, and this is the crucial point I wish to point to here. While in everyday clinical parlance compliance in the diabetes care context is understood as adherence to treatment plans, a second, more fundamental evaluation of compliance is in operation, whereby adherence to treatment plans may ultimately in fact constitute "non-compliance". To make myself clear, it is an understanding according to which perfect adherence to treatment, accompanied by perfect, on-target, clinical and laboratory scores may nevertheless be in breach with the ideology of self-treatment. At the centre of this paradox is the notion and rhetoric of (individual) choice.

Choosing to be a chooser

Let me elaborate briefly. On the one hand, surrender to a comprehensive dependence on a medical regime is necessary. It is appropriate to speak of surrender here, in the sense that the viability of the dependence inheres in the medical knowledge, pharmaceutical substances and medical technologies that combine to make up the therapeutic regime. It therefore inheres in objects and knowledge whose production and constitution is mostly beyond the sphere of influence of the person whose survival relies on them. That person must trust in their capacity to perform the promised therapeutic effects; in short, she/he must take them or leave them.

On the other hand, this surrender "must" happen because the individual *wills it to happen*. In addition to the conventional explicit understanding of compliance, a tacit set of assumptions – a tacit ideology (YOUNG A. 1980) – is in operation that demand the individual surrender to come about as a result of an active, independent choice. Several narratives circulate in diabetes care to bring out this feature. For instance, one anecdote, which has the form of a hearsay tale, tells of a young girl who, a few years after diagnosis, has accomplished perfect blood sugar control. This is evident from her laboratory tests, which all demonstrate on-target average blood sugar levels. Her diabetes diary, in which instant self-measured blood glucose levels and insulin dose adjustments are meticulously recorded, indicates it also. However, upon closer investigation, the story goes, the test results turn out to hide a peculiar everyday practice. Having been taught by medical personnel how to measure blood glucose levels, calculate rapid acting insulin doses, inject insulin, and so forth, the girl is revealed to have assumed a life in social passivity and seclusion, so as better to pursue the medical advice she had been given. Seated in front of a desk, with all her implements in front of here, she let her life be transformed into a self-less and ceaseless execution of self-doctoring practice: measuring, dosing, eating – measuring, dosing, eating.

The operation of the risk actor model of the subject in Norwegian diabetes care is indicative of a contemporary conceptual poverty with sinister consequences. By virtue of this model, the subject, whose diabetes self-treatment is inescapably embedded in social relationships that may obstruct its perfect operation, is left to be rescued by yet another appeal to inner nature. Yet it is a strange impasse, fraught with unarticulated dilemmas. It is evident to all that, firstly, occasional downs in self-management quality happen to the most knowledgeable among persons with diabetes. Few even among the most hardheaded diabetes educationalists would contest this proposition. Second, it is generally recognised also that the management of diabetes is inescapably embedded in social life. Indeed, the nature of the disease begs the question. Diabetes is a disorder in metabolism of glucose. Not only is “the metabolism of glucose” a medical technical term, one may say, for the social practice of nourishment and energy expenditure; the metabolic process is also considered sensitive to almost every imaginable aspect of life, including physical activity levels and emotional states. This means that perfect management, it is generally acknowledged, is a theoretical possibility, to be adjusted by real life concerns. The glass-of-milk anecdote indicates as much.

Type 1 diabetes and the operative notions of choice with the link between the paradoxes of freedom and contingency manifest my interest here. Needless to say, then, if self-management is self-doctoring, the story was unequivocally understood to exemplify self-medical “malpractice”. Countless illustrations could be given of this pattern of evaluation. Indeed, I would propose that, to medical personnel, a non-adherent patient who presented her or his non-adherence in the ideological terms of independence is less enigmatic and, in practice, an “easier” patient to deal with, than a person who refuses to emulate the risk actor model by refusing to assume a position of independent choice. This analysis is corroborated by what I observed also dialogues and interactions in clinical settings. Briefly put, wrong choices are much more acceptable than no choices at all.

If reliance on others is an ideological liability, it is tempting to understand the insistent last-resort appeal to inner individual desires as an effective compensatory strategy. To claim that the demands of others are responsible for one's own poor blood glucose regulation would be as self-negating as the self-therapeutic failure it was mobilised to explain in the first place. Instead, any reference to the demands of others must be made via the active, unrestrained will of the individual to accommodate these demands. Only then is the ideological compliance realized and this, I concluded, is what is accomplished by the rhetoric of choice. The ultimate non-compliance would be to abdicate one's position as a "chooser", to insist that others should choose on one's behalf. Thus, the ideological demand, permeating diabetes treatment discourse may be stated as a command: "Thou hath no choice but to be a chooser." In this matter, and in this matter only, there is no viable choice.

Power, resistance, and the subjective point of view

While I wish to sustain the basic argument, I reread literature while preparing this paper that made me question it in a crucial respect. The problem is related to resistance, and it is made more alarming by two related implications of the analysis First, the analysis in effect contradicts the understanding of moral subjects expressed, even celebrated, in the cultural world it describes. Among other things, it therefore raises the question of what grounds one may invoke in defence of a differential epistemological status of researcher and researched. Secondly, the analysis may be taken to suggest by implication the possibility of an emancipated, extra-discursive space for human subjectivity. Thus, it raises problems related to positionality and grounds for criticism.

These issues are of course each too large to be considered adequately in this paper. The Norwegian situation presented here may nevertheless contribute a dimension to an understanding of how the problems of positionality and criticism are currently situated. It is my contention that social studies of medical phenomena are under the influence today of an ethics of representation that promotes a simple *re*-presentation of verbalised reflections elicited in the course of quasi-quantitative, structured qualitative research to the detriment of the development of analytical linkages, interpretation and analysis. In terms of the old anthropological problem of emic understandings and etic analyses, that is, the problem of the relationship between indigenous models of reality on the one hand, and those described and compared according to the anthropological observer's criteria on the other, we are under pressure to stick to the emics of our research. That is, in research undertaken under the aegis of individualist consumerism, etics are done away with, as it were, by appeal to the articulated interpretations offered by participants ("informants") themselves. At the basis of this ethics of discourse is an epistemological privilege on subjective experience; it is an epistemological outlook that translates Geertz' "native point of view" into "the subjective point of view". It is an orientation that prioretises the utterances of individuals and undermines the power of observation. Thus, to my view it is an outlook that not only castrates ethnography but, more gravely, one that misrepresents the process of social science research through strategies of legitimization that cloak interpretation in quotations, and obscures the nature of analytic work through rhetoric styles that overstate the co-authorship of participants in research.

A large and growing corpus could of course be reviewed to substantiate and nuance these claims. I do not wish to overrate the dominance of these orientations in actual processes of investigation, although I fear it is great and increasingly adopted in research among impoverished and underserved populations. Moreover, as I have indicated, the emergence of this ethics of investigation is historical and its historicity deserves proper investigation. While these tasks cannot and should not be taken lightly, neither is my task here. What I wish to emphasise is that, however influential this wave of research may turn out to be in terms of practiced research models in health research, it seems plausible to suggest that it is indicative of a general epistemic turn towards the individual as a self-contained unit of psychosocial analysis, and one that impedes our current ability to integrate in research a sensitivity to the "messy actualities" (BARRY A. - OSBORNE T. - ROSE N. 1993) of power in micro-social relationships.

On the other hand, analytical modesty may also be warranted. In my own analysis, I view the rhetoric of choice as an ideological device, a discursive technology of governance. Thus, the use by individuals of this rhetoric in discourses like the ones described here, is seen to provide ideologically sanctioned «moments of verification of moral aptitude», to use Monica Greco's phrase (GRECO M. 1993). I took great pains to elucidate empirically the discursive means by which the hegemonic discourses were challenged, resisted and subverted. But the question is how instances of resistance and subversion can be understood analytically, given the pervasive nature of the ideology of individualism that characterises the contexts in which it occurs. Indeed, how can resistance be conceptualised if the basic tenets of the risk actor model saturate all available concepts for animating the subject? For, there is an uncanny congruence of concepts here; if choice is used to ground submission to medicine in the will of the subject, it is certainly used also to ground resistance! Thus, for instance, a 38 year old driver and self-declared workaholic, who suffered several strokes, the onset of diabetic blindness and several other, severely debilitating developments in the course of our acquaintance, accounted for his demise with reference to his own "bad choices". On the other hand, these choices were also "right" since, *qua individual choices*, they were linked to his true desires and inner nature. Hence they mobilised an underlying dimension of the rhetoric of individuality and choice, by which truthfulness to inner nature may be turned against the pressure to conform to standards set by others, including biomedical others (9). Thus, the driver could turn his problems to be the outcome also of the "bad choices" of others, such as "insensitive doctors" and "moralising nurses". It seems to me that there is a danger in analyses of such cases, to simply view them as instances of cultural, subcultural or other "difference", and thereby reproducing assumptions of boundaries built into the intra-active risk-actor model itself.

I believe my problem here to be illustrative of a general difficulty in medical anthropological research. This difficulty is embodied in the tendency to assume a too dichotomous perspective on hegemony and resistance. Among the consequences of such rigid binaries are, firstly, that we thereby complicate the analysis of change. Secondly, failure to situate resistance within the discursive field dominated by hegemony may lead us to underestimate the mutual complicity of hegemonic and resistant discourses. As Lorna Weir points out, we thereby run the considerable danger of erasing the history of counter-discourses from the histories of the programmatic, hegemonic discourse in question (WEIR L. 1996, quoted in O'MALLEY P. - WEIR, L. - SHEARING C. 1997). This would lead to a serious impasse for any account of the history of diabetes and diabetes care in Norway. Here, perhaps more than elsewhere, the evolution of treatment and care has moved through a series of disputes and collaborations between grass roots lay advocacy and biomedical expertise, both incorporated in one diabetes organisation since the inception of the Norwegian Diabetes Association in 1948. Thirdly, a too dichotomous perspective on hegemony and resistance risks mystifying the sources of resistance. In effect it suggests the possibility of an extra-discursive subjective space for the "truly independent" person with diabetes. While this is admittedly in line with what Giddens refers to as the emancipatory politics of

Western modernity (GIDDENS A. 1991), it is fraught with analytic difficulties (cf. MCNAY L. 1994, ROSE N. 1996).

In conclusion, then, I would like to suggest that what is needed is an approach capable of integrating a privilege on the subjective point of view with an analysis of how subjection is *linked also to the possibilities of resistance*. This integration may fruitfully approach hegemonic discourses, such as that of self-management on diabetes and other chronic diseases, and resistance to hegemonic discourse as existing within a commonality of discourses. Examples of such a mode of analysis can be found among a segment of studies in the so-called governmentality literature (cf. e.g. ASHENDEN S. 1996, DEAN M. 1999, GRECO M. 1993, WEIR L. 1996, for a review of the governmentality literature from the perspective of resistance, cf. O'MALLEY P. - WEIR L. - SHEARING C. 1997). But a similar logic can be found also in Richard Crawford's article, *A cultural account of 'health'*, published in 1984, in which he explores the central prominence of notions of self-control *as well as* notions of release in North-American health-discourse (CRAWFORD R. 1984). Crawford does not situate the notion of release as external to the imperative to execute self-control prominent in medical and public health discourse. Rather, he places these notions in a mutual cultural dialectic, and links that dialectic to the larger structural opposition in American society between discipline – as workers, on the labour market – and indulgence – as consumers of commodities. Contemporary Americans, Crawford writes,

> «[...] are the objects and subjects of two opposing mandates, two opposing approaches to the attempt to achieve well-being. The opposition is structural. At the level of the social system it is a principal contradiction. The culture of consumption demands a modal personality contrary to the personality required for production. The mandate for discipline clashes with the mandate for pleasure» (CRAWFORD R. 1984: 92).

Despite significant cultural differences between the Norwegian and the North American societies – the persistence in Norway of a pietistic scepticism towards indulgence perhaps being among them – I believe a similar dynamic can be discerned also in the Norwegian situation.

In other words, resistances may be envisaged as generated by, or at least embedded in, the same discursive technologies that generate biomedically proscribed self-management (DEAN M. 1999). A useful starting point for such an analysis may be to add to Foucault's notion of technologies of self a notion of *technologies of agency*, as suggested by Lorna Weir (WEIR L. 1993) and others (10); that is, the symbolic, discursive and practical means by which subjectivity is continuously achieved (11).

The evocation of choice, then, may very well function to align the person with type 1 diabetes with the individualizing and privatizing ethics of responsibility that characterises the treatment regime to which she or he is expected to surrender. On the other hand, one may see subjection and resistance as mutually reliant on a set of discursive technologies of agency. Hence, the evocation of choice – both to surrender to medical regimes and to resist them – may be understood as dimensions in a ritual of identity and justification, without overstating the ideology of self-determination that remains foundational to action and moral justification in the cultural order of our societies.

Notes

(1) The English term self-management is translated into *selv-behandling* (lit. "self-treatment") in the Norwegian context from which this paper is drawn, which corresponds with the sometimes synonymous use of "self-management" and "self-treatment" in English language literature on treatment of diabetes and other chronic disease. A distinction can be drawn between self-management, which refers to the proscribed practices that form part of medically defined self-treatment regimes, and self-care, as a more general term denoting practices directed towards self-protection and self-sustenance as defined by individual actors. Following Foucault, the philosophy and practice of self-management that is considered in this paper, may be seen as a historically and culturally specific example of a notion of self-care that has long antecedents in Western thought (FOUCAULT M. , 1988, 1990).

(2) The hospital unit featured an endocrinological ward as well as an out-patient clinic. With the exception of patients hospitalised because of acute diabetic complications (hyperglycaemia and hypoglycaemia), and also of elderly patients with diabetes hospitalised for other reasons, diabetic patients were to be found in the out-patient clinic, where they come for routine consultations with a medical doctor responsible for their treatment (normally once a year), diabetes nurse (every 3-4 months) and, in some cases, consultation with other health personnel (dietician, physiotherapist). The specialised institution for diabetes patient education.

(3) I am grateful to Thomas Csordas who first pointed out to me the etymological potential of the term information. The verb 'to inform' derives from the Latin *in-* and *formare*: to form, to give form to, to put into form or shape. Among the historical uses of information in English, the entries of the Oxford English Dictionary mentions "to give form to the mind, to discipline, instruct, teach, furnish with knowledge," and "the action of forming or moulding the mind or character" (SIMPSON J.A. - WEINER E.S.C. 1989).

(4) Various branches of Foucault's interests are drawn upon by these authors, but his later work on sexuality and technologies of the self on the one hand (1990, 1988), and selected lectures and writings on governmentality and biopower on the other (cf. FOUCAULT M. 1991 and several selections in RABINOW P. 1994 and in MARTIN L.H. - GUTMAN H. - HUTTON P.H. 1988).

(5) Chrysanthou proposes the neologism *somatopia* to refer to this phenomenon, since, in his view, it involves the replacement of collectivist *utopic* political projects of the modernist past, with *somatic* projects of postmodern individuals (CHRYSANTHOU M. 2002).

(6) This dimension of the model subject is analysed by OGDEN J. (1995), who traces its production and maintenance also in social science health research (OGDEN J. 2002), cf. below.

(7) While Ogden speaks of social science broadly, her analysis is in fact based on the rather restricted fields of health psychology and selected subfields of medical sociology.

[8] The Nowegian term used, *oversikt*, is a combination of the preposition “over”, equivalent to the English “over”, and *sikt*, which can be translated as view/gaze/sight/visibility.

[9] I describe elsewhere the sinister psychological paradoxes that are generated by this phenomenon, since it positions the subject both as his own master and executioner (HILDEN P.K. 2003).

[10] Cf. e.g. Cruikshank’s discussion of the technologies of citizenship (CRUIKSHANK B. 1994).

[11] Vincent Colapietro’s book, Peirce’s approach to the self, provides an eloquent and instructive discussion of the semiotic approach to subjectivity that underlies my reformulation of agency technologies here (COLAPIETRO V. 1989).

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