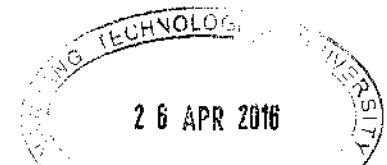


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Consuming Health

The commodification
of health care

Edited by Saras Henderson
and Alan Petersen



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What's wrong with medical consumerism?

Arthur W. Frank

The juxtaposition of two images of medicine begins to suggest what has changed. The first is a late nineteenth-century painting (later an engraving) by Sir Luke Fildes, entitled 'The Doctor'. Physician Alfred Tauber, who chose it as the cover for his recent meditation on medicine and its ethics, describes the painting and its significance as an icon of medicine:

This Victorian pastoral drama shows a country doctor sitting contemplatively [leaning forward at a 45 degree angle, one hand supporting his chin; the figure is utterly still yet poised to move forward] at the bedside of a sick child, whose parents look on in dismay and fear. Portraying the medical reality of that period just before the explosion of scientific medicine, Fildes's evocation of the empathic doctor, helpless in the face of nature's ravage and yet steadfastly committed to remaining with his young patient, both reflected the sentimentality of that era and also stated clearly the ethical relationship of the physician to his charge ... Today, the painting still occupies a prominent place at the Tate Gallery in London, and I think it commands attention not so much for its large size and effective naturalism but more so because Fildes captured a human relation that is of time immemorial, and we respond instinctively to his depiction of this relation. The painting is a powerful image of my own philosophy of medicine – not the posture of a helpless physician watching the relentless scourge of nature, but the physician as empathic witness.

(Tauber 1999: 106–7)

I once saw Fildes's painting presented as a slide at a medical meeting, and the audience response leads me to generalize Tauber's interpretation. To physicians dealing with the restraints of managed care on the one hand, and the expanding frontiers of medical services on the other, the painting offers nostalgia for a medicine in which technical practices may have been primitive by contemporary standards but goals and ethics can seem uncomplicated in their idealism.

Disease in Tauber's gloss of the painting is 'nature's ravage' and 'the relentless scourge of nature'. The patient is most emphatically not a 'consumer' in any sense of that world; her life is in danger. The physician opposes nature with few resources at his (the appropriate pronoun for the time) disposal, but what he lacks in interventive technology he makes up in 'empathic witness'. Tauber realizes that many contemporary physicians would regard the painting as 'the posture of a helpless physician', and he deflects this interpretation. For him the primacy of the caring relationship occasioned by human vulnerability to nature is the enduring significance of the painting. Medicine is founded on the recognition of human suffering: when the physician can no longer cure, he continues to care.

The history of Tauber's own relationship to the painting does not exactly undercut his interpretation but suggests the fragility of his version of the image. His father, also a physician, was given a reproduction of 'The Doctor' by 'a pharmaceutical house'. 'Knowing my attachment to this lithograph hanging in his waiting room,' Tauber writes, 'he gave me a small three-dimensional porcelain facsimile of the scene – also supplied by the drug company' (1999: 106). The caring relationship of father to son mirrors that of physician to patient, yet a third party has intervened: the drug company that produced both reproductions and distributed them as gifts to physicians. New pharmaceuticals would render the fever watch of Fildes's physician (happily) obsolete, but writing a prescription would increasingly (and perhaps less happily) replace the 'empathic witness' that Tauber idealizes. In distributing the image as a publicity give-away, the drug company commodified nostalgia for a kind of medical practice that it itself was instrumental in ending, for better and for worse.

I move forward more than a century to a very different image: an advertisement on the inside back cover of a new Australian-American magazine, *The Art of Cosmetic Beauty*, which had its inaugural issue in Summer 2000. The magazine is 8.5 inches by 11.5 inches, printed on high-quality paper providing excellent resolution to its graphics; its price and production values elevate it above supermarket check-out 'beauty' magazines.

The advertisement is for the services of Dr R, Plastic and Reconstructive Surgery.¹ The centre of the image, 7.5 inches, is a portrait of Dr R. He looks straight at the camera with a slight smile; hands on hips, wearing bright blue surgical scrubs (looking fresh from the laundry) with a surgical cap and mask (open, worn around his neck). On the upper border (just under 2 inches) is the copy: 'When the eye of a gifted artist and the hand of a skilled surgeon come together, every part of you can be more beautiful.' Down the side borders (with Dr R's elbows blocking parts of some images) are six photographs of parts of women's bodies: eye, hip, abdomen, shoulder and breast (discretely in shadow), full face, and nose and mouth. The bottom border specifies his name, Board Certification, services ('Facial Rejuvenation, Breast Augmentation, Liposuction, Endermologie^(TM)'),

address, and – a ubiquitous feature of such advertising – his website. The bottom line of the image says, all in capitals: 'Call to schedule your complimentary consultation.'

The last line is particularly interesting since, in another article, readers are warned by Dr Harlan Pollock, identified as 'chair of the Public Education Committee of the American Society of Plastic Surgeons', that 'Free consultations are a gimmick that are used in obtaining patients and they're worth about what they cost ... They are an opportunity to sell an operation and serve very little purpose' (Bishop 2000a: 87). The apparent contradiction between this caveat in the text of an article and the advertising image is typical of magazines generally and of *The Art of Cosmetic Beauty* particularly. The editorial introduction to the first issue specifies, 'Never far from our articles will be the message that surgery is surgery and any reputable surgeon will tell you that procedures can enhance the way one looks but it [sic] doesn't alter the person' (Grujovic 2000: 6). That message is repeated throughout even as it is undercut by advertising copy such as that on the back cover: 'Celebrate a reflection of the true you by scheduling a consultation with Dr W ... medical professionals dedicated to helping you discover your beautiful side.'

In the transition from Fildes's doctor to the cosmetic surgeon, the image of medicine shifts from Tauber's empathic witness to the 'gifted artist' with the surgical skills to shape the human body to his aesthetic vision. 'Nature', as the object of the physician's work, ceases to be what Tauber calls 'ravage and scourge' and becomes instead the raw material awaiting the human intervention that will perfect it.

Fildes's physician gazes at his sleeping patient, alert to whatever he can do – probably nothing – that might affect the outcome. Dr R, the cosmetic surgeon, is surrounded by fragments of beautiful women. In the synecdoche of these images, the perfection of each fragment creates the imagination of a plenitude that includes not only perfect bodies but perfect 'lifestyles'. There need be no direct statement specifying that the photos of women surrounding Dr R are the outcome of his work; this association is less than crucial. The message is that the body's wholeness and happiness lies in the perfection of each of its parts. In beauty the 'true you' is simultaneously released and invented. Thus the surgeon no longer contemplates human suffering; rather he perfects contingent imperfection. Fildes's physician seems to wonder what he can possibly do; Dr R stands ready to show his next patient how much he can do.

What is to be made of this juxtaposition of images? Critique risks lapsing into a moralism (whether neo-Marxist or neo-Calvinist) that can become what psychiatrist Peter Kramer (2000) calls 'the valorization of sadness'. Kramer, it should be noted, is author of the best-selling *Listening to Prozac* in which he coined the term 'cosmetic psychopharmacology'. He builds a compelling case that there is a long-standing critical bias that identifies the

serious (in whatever cultural field) with the sad. Happiness, in itself, is often regarded as trivial.

The critique of medical consumerism is not about the triviality or authenticity of the individual lives of people who seek and purchase these services. The object of critique is the society in which these services are offered as they are. Sociological interpretation begins from the counterintuitive presupposition that the effects of medical consumerism may ultimately be as great, and possibly greater, on those who do *not* themselves receive these services but who live in a society of which these services are a part. What counts is how common-sense perception of bodies and lives are affected by the publicizing of available services.

Most discussions of medical consumerism take a should-they-or-shouldn't-they perspective. Individual decisions to seek or not to seek commodities were understood by Georg Simmel (in his 1903 essay, 'The Metropolis and Mental Life') as part of a historical tendency by which 'individuals who had been liberated from their historical bonds sought now to distinguish themselves from one another' (1971: 339). 'Regardless of whether we are sympathetic or antipathetic with their individual expressions,' Simmel concluded, 'they transcend the sphere in which a judge-like attitude on our part is appropriate.' What counted for Simmel was to study 'the totality of historical life to which we belong'. The point is neither 'to complain or to condone' individual acts but 'to understand' their place in that totality (1971: 339). Thus my concern is not with the true motives of individual consumers, but rather with consumption as an increasingly prevalent social discourse that legitimates a variety of attitudes and practices (Wernick 1991).

Simmel's rejection of complaining or condoning does not, as I read him, imply abandoning critique. How society complains about and condones medical consumerism seems crucial in the future of the historical totality that I will follow others in calling neo-liberalism. If the most salient characteristic of neo-liberal society is its capacity to assert itself as not having any viable alternative (Bourdieu 1998), then developing a critique of medical consumerism is a crucial demonstration of the continuing possibility of critique itself.

In asking what's wrong with medical consumerism I present attempts to purchase cosmetic beauty as my primary examples with the recognition that these practices may become an increasingly minor part of the medical consumerist future. Genetic interventions seem poised to be the dominant form of consumerism and are the issue of concern among leading bioethicists (Buchanan *et al.* 2000) as well as disability activists (reviewed by Parens and Asch 1999). If the promissory notes of the new genetics have any validity, we can imagine a clinic advertisement in the next decade or two that might read: 'When the dreams of parents and the right genetic technology come together, your child can enjoy every opportunity life offers.' The ques-

tion of this future has high stakes for medicine and for society. Economic interests and technical possibility will create this future, but perhaps critiques can act – in Weber's famous metaphor of 1913 – as switchmen, deflecting the course of this future slightly but consequentially (Weber 1958: 280).

Beauty as medical commodity

We would hardly expect to find the word 'consumerism' in *The Art of Cosmetic Beauty*, but what is surprising is how completely the whole aspect of payment for products and services is rendered invisible. Even articles specifically devoted to the promotion of 'products' ('face, body, hair, make-up' and later, dental) do not mention prices. One of the few places where dollar signs can be found is in a fascinating set of 'recommendations' for the age (by decade) when different 'skin changes' occur and what interventions are recommended; thus: '30s Blotchiness, frown lines, crow's feet, forehead wrinkles. Treatment: Use Botox, approx. \$500' (Muzik 2000: 66; prices presumably in US dollars). An article comparing the benefits of 'Blue Peel treatment' to laser resurfacing (\$200–\$800 versus \$2,500–\$5,000; Bishop 2000b: 70) and a couple of mentions of spa treatments are, on my perusal, the only other places where it is suggested that payments are made. Thus, at the high end of consumerism, what for Simmel was the underlying form of the activity – the money economy – is set discretely out of view.²

In medicine as elsewhere, first-world consumerism is often most explicit when viewed in the mirror of third-world adaptations; thus to locate the act of consuming I turn to a recent report of cosmetic surgery in Iran. 'So a cool thing to do in Tehran these days is to get a nose job,' reports *The New York Times*.

So cool that unlike women in many places, who hide the chiseling and sawing and stretching done to their faces, Iranian women wear their post-surgical bandages like badges of honor, or at least indicators of a certain wealth.

(Sciolino 2000)

The description points towards an operational definition of the dense keyword, *consumerism*. As the post-surgical bandages themselves become worth wearing, the surgical enterprise takes a reflexive twist. The surgery is not only the instrumental means to achieve a desired end; surgery itself is also a desired end, as a display of wealth.

The Iranian report also offers some remarkably candid statements of what is desired from surgery. In these we hear the voices of consumers, however ungeneralizable. I quote these women not to suggest that what they say reveals the truth of their motivations, but rather for these quotations'

expression of the discourse of consumerism. The quotation of these voices in *The New York Times* will doubtless be read differently by different readers: some will regard the *Times* engaged in a neo-colonialist deprecation of the Third World, other readers will find legitimation of their own attitude towards medical consumerism, and still others will read the quotations as I do, actually saying what Westerners act upon but are reticent to express.

The mother of a 17-year-old whose nose had been changed surgically said: 'We did her nose so she could become more beautiful and enjoy her face for the rest of her life. I could see that she had a flaw in her face, and I was very glad we could get rid of it.'

'Unfortunately, in my family everyone has bad noses', said a 20-year-old called Haleh after she had had her nose shrunk. 'This is a very, very serious flaw. Their faces change after the operation. They suddenly look beautiful. So all our family members are very sensitive about the shape of our noses, and everywhere we go we make comments about people's noses.'

'I want a smaller nose, like a doll's nose', [Ms Moghimi] said. 'I'm willing to pay lots of money to a plastic surgeon to give me a new look. I don't want to have any faults in my face. I'd like to look beautiful, like Marilyn Monroe.'

(Sciolino 2000)

These statements provide at least three parameters to consumerism in general. First is the pleasure of spending money. As these women are quoted, they seem somewhere between the ideal type that Simmel called the spendthrift, for whom 'the pleasure of waste depends simply on the expenditure of money for no-matter-what objects' (1971: 182) and Veblen's ([1899] 1953) understanding of conspicuous consumption as acts of displaying wealth. There is pleasure in wearing the bandages as well as pleasure in the reconstructed face.

Second we can hear intimations of what Simmel called 'the curse of restlessness and transience ... every pleasure attained arouses the desire for further pleasure, which can never be satisfied' (1971: 185). Reading what the Iranian women say, I am not alone in wondering how long it will be before other 'flaws' have to be got 'rid of'. That the whole body awaits improvement – and, with age, constant improvement – is evident on one surgeon's website (described by *The Art of Cosmetic Beauty* as 'very reader friendly – fun and informative' (McCloskey 2000: 34)) where the homepage features an idealized nude woman (simulated or real? a cartoon or the result of surgery? who can tell, and who bothers to ask?) with the invitation to click on part of her body to learn about surgery to that area. The *Times* quotes an Iranian

cosmetic surgeon (American trained) saying: 'What's in fashion right now is getting the nose done. After that come face-lifts' (Sciolino 2000).

The third parameter I want to single out – among others that could be observed – is that consumerism individualizes the bases and morality of action. The self is the sole referent. In particular the consumer defines money as his or her exclusive resource to expend as she or he chooses. In the following quotation, also from Ms Moghimi, quoted above, a narrative account that initially points in the direction of culture turns to focus on the isolated self:

'Part of the reason for spending so much attention on the way I look is that it's in our culture. ... It's in the nature of Iranian women to want to look beautiful. Part of the reason is that I don't have anything else to do. My only job is to cook and take care of my home. So I spend time [and money, as stated in the earlier quotation of Ms Moghimi] on myself'.

(Sciolino 2000)

Neo-liberalism elevates consumer choice to the level of a right that society is organized to defend; the right of each to spend his or her own resources as he or she chooses is the organizing principle behind the privatization of government services. 'Giving money back' to taxpayer/consumers and allowing them to spend it *as they choose* is the recurring slogan of neo-liberal political parties. Advertisements by cosmetic surgeons join this presumption of consumer right with psychotherapeutic imperatives to discover or liberate an inner self that has been repressed or hidden; thus messages such as the one quoted above, 'celebrate a reflection of the true you'. That the celebration has to be paid for does not go entirely without saying, since many websites include an 'online financing' link.

Many Western consumers of cosmetic beauty would doubtless find the quotations of the Iranian women embarrassing. For them the Fall/Winter 2000 catalogue of The Body Shop, an international merchandiser of beauty products, offers the message of celebration a spiritual and eco-political twist: 'It's enlightenment, empowerment, activism. Knowing the score and wanting more. We're talking all-round well-being – in body and soul, in our communities and in our global environment.' Body Shop products 'incorporate the wisdom of world communities and the knowledge of the ages'. The Canadian version of this catalogue ends its introductory message with a note about hours of 'paid staff time' donated to violence-prevention programmes and the amount of money raised for these programmes.

The Body Shop's publicity exemplifies and legitimates two central tenets of neo-liberal ideology. First, any meaningful social action can only occur through volunteer activity with corporate sponsorship; 'partnership' is the

current buzzword. The idea of government is conspicuously absent; it is *not* worth stating how much The Body Shop paid in corporate taxes that sustain government services. What Zygmunt Bauman calls 'Politics with a capital P' (2000: 70) has dropped out of the discourse of social improvement; in its place, buying at The Body Shop is depicted as the means to the good society. Thus the second neo-liberal tenet: social progress occurs through globalized trade. The catalogue features 'the power of community economic initiatives to effect positive change' in their 'Community Trade programme'. Shoppers are invited to 'discover some of the world's most amazing natural ingredients grown through traditional practices'. Bauman expresses the most sceptical interpretation of this message and the practices of production and consumption behind it: 'The freedom to treat the whole of life as one protracted shopping spree means casting the world as a warehouse overflowing with consumer commodities' (2000: 89). In The Body Shop catalogue, this warehouse includes 'the knowledge of the ages' as well as 'amazing natural ingredients' the purity of which is guaranteed by 'traditional practices'.

What most critics would attack in either *The Art of Cosmetic Beauty* or The Body Shop catalogue is the merging of needs and wants. Medical consumerism renders the needs/wants distinction ambiguous because the same medical service often addresses both wants that seem utterly discretionary and needs that seem as real as that of the patient in Fildes's painting. *The Art of Cosmetic Beauty* includes an article on corrective surgery with a subtitle reading: 'Cosmetic surgery is not only a matter of vanity. For some it is a necessity. Approximately 12,000 children are born in the US each year suffering from a cleft palate or deformity of the head and face' (Bishop and Stapleton 2000: 98). As before-and-after photos of surgeries transforming badly deformed babies' faces into 'normal' happy children mix with those removing wrinkles, presumably some of the wrinkled would argue that their condition too is not vanity but necessity.³

The ambiguity over which are 'necessary' cases leads to the more extensive question, crucial to the critique of consumerism, of whether any experienced need can be judged false or manipulated.

The social mediation of need

'Consumerism' takes its pejorative force from an underlying assumption that people either seek to fulfil real needs with unsatisfactory objects, or they are manipulated by producers into pursuing false needs. In an argument that remains current despite being twenty-five years old, William Leiss (1976: 53) suggests three 'patterns of thinking about needs'.

The first pattern includes arguments that attempt to distinguish biological from cultural needs; the objective is often to establish some category of 'basic human needs'. Leiss argues, convincingly on my reading, that like all

attempts to separate nature from culture, this effort fails. Citing anthropologist Dorothy Lee, Leiss (1976: 54) argues that

needs themselves are derivative, not basic. They are not the underlying foundations which explain the orientation of individual behaviour, but rather are themselves derived from a more fundamental set of values, varying [perhaps less in the age of the Internet] from culture to culture.⁴

The second pattern includes attempts to establish a hierarchy of needs 'said to have differing degrees of urgency and significance' (1976: 55). Leiss shows that establishing such hierarchies requires, like the argument above, positing dichotomies of nature/biology versus culture. These dichotomies ignore the contextualizing force of what he calls the 'high-intensity market' (1976: 57). In societies based on such markets, 'The needs of self-esteem and self-actualization are expressed and pursued through the purchase of commodities, which are not simply material objects but things that have a complex set of meanings of "messages" associated with them' (1976: 57). The conventional claim is that market forces intervene via some form of advertising to distort people's sense of what is self-actualizing. Leiss suggests that in high-intensity-market societies the ideal of self-actualization is always already 'expressed and pursued' through commodities.

The final pattern argues that needs are distorted by social processes, e.g. socialization and the market economy. While Leiss readily acknowledges that the market endlessly seeks to manipulate needs, he points out that this manipulation does not in itself render those needs false. He returns to a variant of his earlier argument: 'All wants arise out of social conditioning ... individuals learn to interpret their needs and to adjust themselves to prevailing modes of approved behaviour' (1976: 58).

Though he does treat the high-intensity market as a contextual condition not likely to change, Leiss's argument is not neo-liberalism *avant la lettre*. He is clear that 'individuals become increasingly confused about the relationship between their needs and the means through which they try to satisfy them' (1976: 63). What he is arguing against is the possibility of doing what many bioethicists currently hope to accomplish: 'develop fixed and abstract categories' that would distinguish real needs from false ones (1976: 60). The problem for Leiss is not false needs but a market environment that makes it increasingly difficult for individuals who necessarily lack sufficient information about most if not all the products and services they purchase to interpret 'the relationship between their perceived needs and the possible sources of satisfaction for them' (1976: 63).

Leiss (1976: 93) forces critics of consumerism to acknowledge that needs and objects define each other, reciprocally and recursively. While some needs certainly have greater intensity than others at certain moments – Fildes's 'The Doctor' depicts such a moment – attempts to fix categories of real,

objective needs versus false, manipulated needs fail to acknowledge that social schemes of value precede any such distinctions.⁵ To ask whether bodies in the 'before' photos of cosmetic surgeons *needed* fixing – to seek categories that fix the 'flaws' that are worthy of fixing – engages in what Leiss calls 'Sunday sermons' (1976: 57) designed to assert one aesthetic – one preferred form of life – over another.

Of course any person intuitively feels that some needs are real and others are false. Thus I immediately perceive surgery correcting babies' facial deformities as meeting a real need and I am cynical about what *The New York Times* writer Elaine Sciolino (2000) calls 'chiseling and sawing and stretching' to improve what is already (as I see it) a 'normal' appearance. Leiss's anthropology-based argument requires recognizing that my common-sense response, like any understanding of human needs, will always be socially mediated. This inevitability of social mediation does not mean, however, that any particular form of mediation is above critique; depending on one's ethical criteria, some forms of mediation can be judged preferable to others. Thus the question of what's wrong with medical consumerism becomes two intertwined questions. First, how is reshaping the understanding of 'health' crucial to the specific mediation of needs that is typical of neo-liberal societies at this historical moment in those societies? Second, what negative effects does this neo-liberal mediation of needs have?

Distorting bodies, medicine and society

Three critiques of medical consumerism are hardly exhaustive but seem fundamental. The first level of critique concerns the body. The conventional criticism is that body consumerism is manipulated by messages that pair images of an ideal body with a product that promises to close the gap between the consumer's body and that ideal. Critics argue that the ideal is an aberration (for example, the super-model) and probably also a fabrication as well (the photos have been retouched); thus body images and needs are being manipulated. A response interpolated from Leiss is that such criticism – while descriptively accurate of marketing practices – ignores that any culture has its dominant aesthetic of bodies and so any body image always already confronts a gap between itself and some ideal. A response could be that contemporary advertising strategically manipulates that gap. Still, the accusing critics *depend no less* than the accused manipulators on presupposing some *a priori* body: the natural, unmanipulated body presupposed by the critics is no less idealized than the commodity-enhanced body of the manipulators. As I observe incitements to medical consumerism, their capacity for distortion lies less in presenting a false ideal (though it may be false) but in obliterating *any* coherent sense of the body image. Incitements may begin with some idealized image but this image soon deconstructs, leaving only endless fragmentation.

The ideal bodies of models (in photos that seem to call attention to being computer enhanced) do invite consumers to websites. But cosmetic surgery websites show few ideal bodies; because the pin-up image of the woman's body that serves as a link to different surgical services (by clicking on part of her) is such an exception that most viewers will probably see it as a joke. The vast majority of website images are detailed fragments of bodies – the before-and-after shots of body parts.⁶ The extreme clinical detail of these images gives bodies a new literalness, not a fantasy perfection.

One effect of the accumulated fragmentation is to efface any referent – natural or ideal – of a whole body. Fragmentation renders the body perpetually unstable; no body can ever be idealized because the fragments never compose into a coherent whole. Of course the body's 'coherence' is always an idealization – and as critics of advertising point out, a dangerous one in some respects. However unreachable the telos of the body's coherence, it provides one basis of the telos of the self's coherence – equally unreachable but nonetheless important as an ideal. The body-in-fragments reduces the telos of coherence to perpetual shopping for marginally improved parts.

Some form of commodification of the body is to be expected in what Leiss calls a high-intensity-market society. The problem is not that the body is commodified; rather the problem is a form of commodification that requires fragmentation in order to assign a cash value to each increment of improvement of each part. Leiss's description of the effect of fragmentation remains the best articulation of how cosmetic surgical websites do not distort bodies themselves but do distort lives:

Thus the expression of need itself is progressively fragmented into smaller and smaller bits The constant redivision and recombination of need-fragments renders it increasingly difficult, if not impossible, for individuals to develop a coherent set of objectives for their needs and thus to make judgments about the suitability of particular goods for them.

(Leiss 1976: 88)

What is distorted is the possibility of living a coherent life *as* the body that a person is.

Leiss's critique of fragmentation anticipates Richard Sennett's (1998) evaluation of the 'corrosion of character' in contemporary conditions of work life. For Sennett corrosion results from the absence of the possibilities for temporarily coherent careers and what he calls 'legible' work functions. Unsure of what they will be doing tomorrow, or exactly what their work today actually accomplishes, people cannot develop a coherent set of objectives for their lives or make judgements about the suitability of their next career and family choices. Their sense of what they value about themselves,

and how they are valuable to each other, corrodes. Their lives lack a coherent narrative (Sennett 1998: 24ff).

Medical consumerism does not so much distort people's images of their bodies; as I suggest above, it may provide many people with far more literal images of many more real bodies. However, the fragmentation of the body into images, necessary for commodifying the body, can distort people's character because character is embodied. In the constant instability of these fragments – i.e. never coming together as a whole – character is corroded because people lose the coherence that begins in the body and is sustained (if always partially unrealized) in the body. When Alfred Schutz observed that 'we grow old together' (1971: 220), he recognized that a person's experiences of his or her own body ageing, set amid mutual perceptions of other's bodies ageing, are a fundamental condition of intersubjectivity. The capacities for setting coherent objectives and making judgement about acts in a world of others – the capacity for character in Sennett's terms – depend on believing in the coherence of one's own body amid other bodies.

To summarize my first level of critique, fragmentation distorts because it renders bodies like other merchandised commodities: collections of 'features'. Homes, cars and stereos are now advertised with a bulleted list of their features; the number of features sets one version of a commodity above another. As transformed by the language of merchandising, 'homes' are no longer places that achieve value through the accumulated experiences of lives transpiring there but instead become collections of features – hot tubs, bars, decks, views, and so forth. Features can be added and upgraded, enhancing value. Cosmetic surgery fragments the body into a set of features that can be serially upgraded. The full importance of imposing the language of merchandising on the body is not that cash value is inherently degrading; Leiss seems right in granting the capacity of the high-intensity market to put a price tag on anything. The point is that if genetic engineering is anything more than a fantasy, the decomposition of the body into features is preparing for that future. Far more consequential than upgrading the ageing features of the adult body may be preselecting features in the embryonic body and changing DNA structure in order to do this.

My second critique of medical consumerism is that it distorts perceptions of medicine as a social good. Again, Leiss's analysis of needs arguments renders the case for distortion less than self-evident by showing that it depends on contrasts between the all-too-evidently flawed present and a past idealized in such nostalgic objects as Fildes's 'The Doctor'. 'The Doctor' gives self-evidence to the idea that medicine once had, and could again have, a core mission that is pure and unquestionable. Tauber's gloss on Fildes's painting, quoted above, can now be reread as depending on its explicit opposition between the nature that brings the ravages of disease and the physician who, as a representative of culture, opposes nature. The physician

opposes the ravages of nature (bad, unnatural nature) and seeks to restore his patient to her natural health (good nature).

The idea that medicine ever had a pure mission that could be distorted in contemporary consumerism is rendered all the more questionable when we recall what some of the 1890s colleagues of Fildes's country physician were engaged in. Michel Foucault's (1976) history of sexuality recollects that the medicine of this period defined masturbation as a disease and engaged in horribly invasive surgery to 'cure' this ravage of nature. Medical historian Rachel Maines (1999) describes how the mechanical vibrator was developed during this same period as a medical device for use by physicians.⁷ These examples are necessarily eclectic but can be found in any medical generation. The definition of health has never been based only on 'nature's ravages' as real as these are, but also on medicine's perceived capacities and market opportunities. Just as the body is always already socially mediated in its needs, so medicine has never had pure objectives transparently defined as responses to nature's unnatural moments.

The nostalgia aroused by Fildes's painting can also cause us to forget that physicians of that time collected fees for their services, at least from enough patients much of the time to compensate for those to whom care was offered *pro bono*. Perhaps the parents in Fildes's painting were charity cases, or perhaps somewhere in their worries was concern about how they were going to pay for this doctor's attention, however empathic it might be. A genuine social advance of the twentieth century was most countries' adoption of government health insurance guaranteeing some level of medical services to all regardless of ability to pay.

Medical consumerism may not threaten an abstract ideal of medicine, but at a time when, as Bauman (2000: 106) notes, 'the idea of "the common good" [has been] branded suspect, threatening, nebulous, or addle-brained', consumerism does erode the ideal that medicine can be one such common good. In neo-liberal society an increasingly fragile public consensus supports the idea that medical goods are different from other goods traded in the market and the government has some responsibility to protect all citizens' access to these goods. Because a collective sense of responsibility for the vulnerable seems essential to sustaining the idea that society has common goods, here my argument shifts to a third level of critique, how medical consumerism distorts society.

The Art of Cosmetic Beauty is organized in sections which progress not only by degree of invasiveness but also by cost: 'Bottled Beauty' leads to 'the Non-Surgical section' (including laser skin treatments, for example). Then following the 'Dental' and 'Men's Only' (mostly on pectoral implants) sections comes, 'at the top of the ladder', the 'Surgical section' (Grujovic 2000: 6). The almost explicit message is that medical intervention is part of a continuum of products among which a consumer gets as much as he or she

can afford. In the neo-liberal debates over provision of health care, this message quickly becomes generalized as the following example describes.

In January 2001 the Canadian Broadcasting Company news reported that another privately operated, fee-for-service magnetic resonance imaging (MRI) clinic opened in the Province of Quebec, intensifying a controversy between the provincial ministry of health and the federal Canadian government. The federal government maintains that all medical services that are publicly provided should *only* be publicly provided; the only private services will be those completely outside public provision (for example, most cosmetic surgery). 'Queue-jumping' goes against universalism. The neo-liberal counter-position was expressed by a Quebec physician who described the new clinic as giving patients 'another option'. That option is to pay for their own MRI scan, possibly receive early diagnosis, and move more quickly to treatment in the publicly-funded system. The federal government fears that provincial health ministries, whose budgets pay for public health care, will let waiting lists grow longer to push more people into private treatment. The neo-liberal response is that fee-for-service treatment shortens public waiting lists while allowing consumers to spend their money as they choose; those who can afford private treatment and those who cannot both receive better service.

Whether consumers progress from Bottled Beauty to Surgical interventions is genuinely optional in that none will live or die depending on whether they can exercise the option; one can choose to spend one's money elsewhere and possibly be healthier by doing so. Neo-liberalism then generalizes that perception of medical services as options to treatments like MRIs which can determine whether someone lives or dies.⁸ Bourdieu's observation that neo-liberal ideology 'is based on a kind of social neo-Darwinism' (1998: 42) is literally true in health care. Of course no one would say that if the poor receive care later than the rich and die as a result, that's little loss; yet that brutal conclusion is inescapable.

Contemporary cosmetic interventions may, if anything, be detrimental to the health of their consumers.⁹ These cosmetic interventions, however, create a milieu in which more medical goods, more of the time, are regarded as commodities which people have the option to purchase, just as they have options to purchase other commodities. Cosmetic interventions, and the publicity around them, also intensify the body as a site for more complex investments of capital. Here my argument returns to the Iranian women wearing their surgical bandages. Today's consumerism may end in conspicuous displays of the resources that the person can invest in the body – or some means of reconversion of this investment may be possible; for example, the Iranian daughter's now unflawed nose may display her as available for a more advantageous marriage that solidifies an economic alliance between families. But these displays of investment in beauty and the reconversion of those investments into other forms of capital can only provide what might be

called secondary or derivative value; the perfected nose has no intrinsic value but only creates terms of recognition that can attract other values. The potential of genetic medicine is that investments might yield *direct* returns in enhancing the body's capacities and resistances. The most significant consumption value of genetic medicine will not be conspicuous but rather will provide significant competitive advantages precisely by being invisible.

Ultimately medical consumerism affects society by insinuating health as the contemporary basis of what Weber argued religion traditionally reinforced: 'the theodicy of good fortune'.

In treating suffering as a symptom of odiousness in the eyes of the gods and as a sign of secret guilt, religion has psychologically met a very general need. The fortunate is seldom satisfied with the fact of being fortunate. Beyond this, he [sic] wants to be convinced that he has a *right* to his good fortune. He wants to be convinced that he 'deserves' it, and above all, that he deserves it in comparison with others.

(Weber 1958: 271)

This general need that was once met by religion is now met by the political-economic orthodoxy of neo-liberalism, our contemporary theodicy of good fortune. Medical consumerism instantiates this good fortune in the body. This theodicy of good fortune requires believing that one has caused one's health and thus deserves it, just as others deserve whatever health they have caused. Davis (1995:163) emphasizes this sense of agency among the women she interviewed about having cosmetic surgery: 'In a context of limited possibilities for action, cosmetic surgery can be a way for an individual woman to give shape to her life by reshaping her body.' Given the ambivalent outcomes of their surgeries, the language of agency of these women could hardly be called a theodicy of *good* fortune, but it is a language in which one's fortune is what one brings about. As I have emphasized above, what counts is what this language prepares for. The literal embodiment of the theodicy of good fortune will be (not too distant) future parents speaking this same language of agency about their genetically perfected child, and that child believing that these purchased advantages are her or his birthright.

That future – contested as to its possibility as well as its desirability – is not yet here. Of the present state of medical consumerism, Davis may offer the most humane conclusion: 'For a woman whose suffering has gone beyond a certain point, cosmetic surgery can become a matter of justice – the only fair thing to do' (1995: 163; cf. 173). Perhaps behind the *The New York Times*' quotations of Iranian women there are untold stories of suffering. These stories are as serious as the stories of families with congenital diseases who anxiously await the possibility of genetic modifications (Beeson and Doksum 2001; Cox 1999). I began this essay by quoting Simmel. The objective is neither to complain about nor to condone

individual choices; rather the objective is to understand how individuals shape the social totality that shapes their and others' choices, whether or not individuals intend to shape that totality.

Medical consumerism is being recreated, in ideology and substance, to reinforce the neo-liberalism of the high-intensity market. But resistance is not futile. Bourdieu (1998: 55) writes: 'We, as sociologists, without denouncing anyone, can undertake to map out these networks and show how the circulation of ideas is subtended by a circulation of power.' Bourdieu proceeds to call neo-liberalism 'a fatalistic discourse' (1998: 55). The analysis of this discourse – the attempt to think through the circulation of power that subtends medical consumerism – may be the best antidote to that fatalism.

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Notes

- 1 A vague paranoia about liability leads me to designate physicians by a letter rather than their names, though these names are readily available by consulting *The Art of Cosmetic Beauty*.
- 2 As Simmel noted almost a century ago, 'Thus they imply that their best customers are the Best People – those who do not ask about prices' (1971: 183). The true pleasure of spending money often includes not having to ask how much.
- 3 Dermatologists Arthur and Loretta Pratt Balin (1997) present numerous and compelling testimonials to how their cosmetic interventions have improved the lives of their patients. Among sociological studies, Davis (1995) reports in-depth interviews in which women present their cosmetic surgeries as personal necessities. Bordo (1998) critiques the utility of these stories. For a discussion of the controversy between Davis and Bordo, see Frank (2000).
- 4 For an insightful critique of how such 'basic human needs' arguments fail with respect to medical services, see Silvers (1998).
- 5 Controversies over assisted suicide and the 'right to die' suggest that even the ultimately ontological value – life itself – is socially mediated as to the limits of its value.
- 6 Which patients allow themselves to be photographed, and in what terms they give consent, are separate issues. The present point is that my own utterly subjective scan of these images supports the findings of Davis (1995) that most women selecting cosmetic surgery seek not an ideal but rather what they define as normal. Thus, women were not as dissatisfied as Davis had expected with less than ideal surgical outcomes.
- 7 'When the vibrator emerged as an electromechanical medical instrument at the end of the nineteenth century, it evolved from previous massage technologies in response to the demand from physicians for more rapid and efficient physical therapies, particularly for hysteria. Massage to orgasm of female patients was a

staple of medical practice among some (but certainly not all) Western physicians from the time of Hippocrates until the 1920s, and mechanizing this task significantly increased the number of patients a doctor could treat in a working day' (Maines 1999: 3). Maines also discusses clitoridectomy as a surgical intervention to prevent masturbation (1999: 5; see also 56–9).

- 8 The neo-liberal case is strengthened by the ambiguity noted above, that the same treatment serves diverse patient needs. Next to the MRI patient who waits anxiously to see whether cancer has spread may be a patient getting a scan to see how soon she or he can get back on the golf course. The problem is that the more discretionary use tends to trump in defining the public responsibility for offering the treatment, since clear lines between discretionary and necessary uses are difficult to draw.
- 9 Although cosmetic surgeons might consider Davis's data dated in terms of their current surgical practices, her observation is worth quoting: 'Nearly every woman I spoke with complained of some discomfort or side effects following her breast augmentation' (1995: 143).

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Fabricating 'health consumers' in health care politics

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The category 'consumer' has developed through historical conditions to the point that it now features prominently not only within the sphere of private market relations but within wider areas of public life, from health, education, welfare, to law and politics. While the literature using this concept is well established, the 'health consumer' construct has provoked intense and conflicting responses. In contrast to the claim that modern patients act in the manner expected of market consumers (Haug and Lavin 1983; Sawyer *et al.* 1994) theorists such as Lash and Urry (1994: 207–10) draw attention to the practical, structural and ideological differences that differentiate public sector organizations from the private sector – differences which are said to make it logically impossible for patients to conduct themselves as consumers. This argument has found some support at the everyday level of social and political experience. In a study on the conduct of patients attending an Australian general practice, Peter Lloyd (1991) and his associates found that traditional consumer behaviour has neither solidified into a set of routine social practices nor been established as a new mode of reasoning. In the concrete world of living actors, it appears that people continue to think and act in a manner consonant with traditional models of patienthood. Thus, the concept is dismissed in some quarters because it fails to describe accurately the actual behaviour of patients in the concrete setting of the hospital, the clinic or the general practitioner's surgery.

But to fix 'the consumer' merely in terms of a set of behavioural traits against which actual behaviour can be assessed, reduces this complex term to a one-dimensional concept. Consumer discourse does not simply convey social experience, it plays a part in constituting social subjects, and relations between subjects. McKnight (1986) and Grace (1991), allude to this when they argue that the consumer imaginary¹ has been engineered through professional discourse and narrative, and then strategically deployed in a 'top down' fashion by the medical profession in an attempt to defuse grassroots resistance to medical power and authority. Following McKnight and Grace I propose to 'read' 'the consumer' as a historical product of social