Alexander Butchart

The Anatomy of Power

European Constructions of the African Body
Winner of the Hiddingh-Currie Award 1998 for academic excellence

About the author

Alex Butchart is associate professor in the department of psychology, UNISA. A widely published psychologist, he is a long-term activist in democratic public health promotion and was a member of the Goldstone Commission committee.
The Anatomy of Power

European Constructions of the African Body

Alexander Butchart

Unisa Press
Pretoria
Contents

List of Illustrations vii
Preface ix

1 The African Body in History and Histories of the African Body
Histories of medicine as achievement, function and repression /2
Historiography, progress and the present /6
History will teach us nothing /10

2 Power, Knowledge and the Body
The individual as invention /14
Power and the body /24
Analysing power: methodological requirements /32
A trans-humanist frame of analysis /33

3 Renaissance Body Myths and the Spectacle of Strangeness
The body as prose and the renaissance episteme /36
Monstrous men /44
The eye of the explorer and the rise of Classification /50

4 A Body without Volume: the African as Target of Sovereignty and Object of Taxonomy
The problem of the African body as a surface /55
The power of punishment and the sight of sovereignty /59
Natural history: the African body as surface, structure and character /63
From theatres of punishment to theatres of healing /71

5 Missionary Medicine, Moral Sanitation and Fabrication of the Heathen Heart
Creation of the African with a soul and a body of organs /76
Moral sanitation and the medical missionary method /78
From revelation to confession: the speaking subjects of missionary medicine /86
A watershed of power /90
<table>
<thead>
<tr>
<th>6</th>
<th>The Industrial Panopticon: Mining and the Medical Construction of Migrant African Labour</th>
<th>92</th>
</tr>
</thead>
<tbody>
<tr>
<td>The heat chamber as punishment and Panopticon</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>Inventing an economy of human bodies: anatomical pathology and epidemiology</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Debasement and discipline: the mine medical examination</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>A therapeutic operator: compound design and disease control</td>
<td>104</td>
<td></td>
</tr>
<tr>
<td>The disciplinary descent of mining medicine</td>
<td>107</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7</th>
<th>Discipline and Danger: Psychological Science and the African Personality</th>
<th>111</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lunatics and nervous systems</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Impulsive insanity and the perilous black</td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>A ‘better native’: indirect rule and the cultivation of culture</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>Black consciousness and the alienated African</td>
<td>124</td>
<td></td>
</tr>
<tr>
<td>A liberatory psychology and the diffusion of danger</td>
<td>126</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8</th>
<th>Filth, Food and Freedom: Public Health and its Changing African Objects</th>
<th>128</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanitary science and the emergence of a body boundary zone</td>
<td>129</td>
<td></td>
</tr>
<tr>
<td>Social medicine and a psycho-social space</td>
<td>138</td>
<td></td>
</tr>
<tr>
<td>Community health</td>
<td>146</td>
<td></td>
</tr>
<tr>
<td>A new public health: the socio-ecological model</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>Body production lines</td>
<td>152</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9</th>
<th>Birth of the Bantu Clinic</th>
<th>154</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Bantu anatomy</td>
<td>155</td>
<td></td>
</tr>
<tr>
<td>The African patient as a lesion-containing body</td>
<td>157</td>
<td></td>
</tr>
<tr>
<td>The ‘quest for wholeness’ and a subjective patient</td>
<td>169</td>
<td></td>
</tr>
<tr>
<td>Bodies and voices</td>
<td>170</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10</th>
<th>Postscript: On the Anatomy of Power</th>
<th>173</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rewriting the African subject</td>
<td>174</td>
<td></td>
</tr>
<tr>
<td>The relevance of Foucault to socio-medical practice in the present</td>
<td>181</td>
<td></td>
</tr>
<tr>
<td>Afterword</td>
<td>183</td>
<td></td>
</tr>
</tbody>
</table>

Bibliography | 186 |
Index | 210 |
Illustrations

Between pp. 114 and 115

1. Herbert’s 1638 Hottentot man and woman.
3. Linschoten’s cannibals of 1596.
4. Instruments for measuring the skull.
5. Scale for comparing the colour of the eye.
6. Scale for comparing the colour of the skin.
7. Types of Mozambique native.
10. Types of the principal tribes represented on the mines.
15. Bilharzial cirrhosis of the liver and splenomegaly (marked in chalk).
This study applies some of the theoretical tools developed by Michel Foucault to the problem of the African body as it exists to western socio-medical science\(^1\) in Africa. Foucault argued that all methods of knowing the human body relate to it not as a means of discovery against an object waiting to be known, but as a productive power towards an object that is also its effect. The concept defining this productive relationship between method and object is 'disciplinary power' (Foucault 1977), which consists in the techniques by which human bodies are observed, analysed and fabricated as knowable entities possessed of particular attributes and characteristics. For example, each time it enters the surgery to invite clinical examination by the doctor, or is physically inspected and radiographed in the mine medical examination, the African body is not found but fabricated by these socio-medical micro-powers, not so much their discovery as an invention of their power.

The *Anatomy of Power* is therefore a genealogical study in that it examines the relations between socio-medical practices as power and the resultant knowledges of the African body: 'The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces the effects of power' (Foucault, in C. Gordon 1980: 52). The consequence of this is a concern not with what is there but rather with what can be seen, and the study articulates a close historical correspondence between the use of certain methods and the perceived nature of the African body. This makes it possible to analyse changes over time in the identity of the African body as an effect of this productive relationship, rather than a consequence of discovery, the lifting of oppression and ideological distortion, or any other explanatory device drawn from the discourse of progressive humanism that informs conventional analyses of the socio-medical sciences in colonial and most other situations.

The assumptions and aims of the study derive therefore from a plane of cognition independent from that of humanism. Hence it can pose a variety of 'strategic questions' (Armstrong 1987) about particular objects and experiences (such as the body, the mind and subjectivity)
which because they form the philosophical bedrock of humanism cannot be problematized from within the humanist framework itself. How is it possible to speak of the human body in general and the African body in particular as distinct corporeal entities? What made possible the perception of an ‘African personality’ and later ‘black consciousness’ as the psychological component of identity? How could medicine have first asserted and later denied the fact of racial differences in physiology and disease susceptibility? What conditions of possibility had to be present for the ideas of culture and urbanization to emerge into the socio-medical knowledge of Africa? Flowing from this space of strategic questioning are the three aims of the study.

First, to describe the genealogical method by which this study has been produced, and to articulate how the Foucauldian schema conceptualizes body, power and knowledge. Second, to apply these concepts to analysing how the African body has been analysed in western thought from the Renaissance\(^2\) to the 1990s, and in doing so to identify the power implications of changes in how it has been known and what it has been seen to be. Third, to examine the implications of the study’s findings and the Foucauldian method for socio-medical practitioners and scholars of the sociology of medicine.

While most of the source materials for this study concern the socio-medical sciences in South Africa, this does not limit its relevance to that society. Although its generalizability is restricted in respect of the precise details concerning when, how and with what effects the socio-medical sciences emerged, the more general anatomy of power and the bodies that this produces are most certainly applicable to all situations of colonial occupation. Indeed, it is difficult to identify a single example of a colonial or post-colonial society in which the public-health official, the primary-health-care nurse, the hospital doctor, the psychiatrist and many other representatives of the socio-medical sciences are not a ubiquitous presence. It is equally impossible to identify any setting where the population has no knowledge of how to act and react in the ritual of the medical examination by the doctor, inspection by the aid worker, interrogation by the anthropologist or enumeration by the census officer. Wherever such figures and rituals appear, the diagram of power cannot be reduced to a simple equation of power as that which is held and wielded by one group over another, since wherever they appear is also where discipline is at play, fabricating the human body and the social as its visible objects and effects.

However, while this means that colonial power is always more complex and invisible than conventional analyses would suggest, it is also true that its disciplinary underbelly cannot be regarded as evenly dis-
tributed in equal circuits operating everywhere with the same intensity
and the same results. Rather, it should be thought of as a constantly
mutating force field in which socio-medical discipline waxes and wanes
in unpredictable cycles and surges. In turn, this implies that while the
identity of the African body is always in part an effect of this power, its
precise genealogy is situationally specific, demanding that the fine details
of its crystallization be established through equally fine-tuned studies
of the exact mechanisms by which it is examined and by which its
culturally and chronologically specific attributes and characteristics are
determined.

Chapter 1 reviews existing historical accounts of the association
between the socio-medical sciences and the African body. This shows
that despite its prominence in these traditional accounts (which range
from Whig histories celebrating medicine to Marxist histories of medi­
cine as repression), there is no history of the African body itself, which
is unproblematically assumed to be a given object there to be impinged
upon and resist socio-medical practices. By comparing these traditional
accounts with the genealogical method, Chapter 1 explicates how genea­
logical explorations differ from conventional modes of analysis.

Chapter 2 presents a theoretical elaboration of those Foucauldean
concepts concerning power, the body and medical knowledge relevant
to this study. The emergence of disciplinary power and the correlative
constitution by medicine of the human body as a clearly differentiated
collection of organs and tissues occurred with some suddenness and
only towards the end of the eighteenth century. How was the body
seen prior to this great shift? By what languages was the body read, and
how did beings believed to exist on and beyond the fringes of the
known world confirm these ancient ways of knowing?

An attempt to answer these questions appears in Chapters 3 and 4.
Chapter 3 examines texts concerning the body, its properties, and its
possible forms produced in the period of Renaissance thought from
around 1500 to 1650. During this period human bodies were known not
through their direct inspection but through the study of authoritative
texts. These texts repeatedly affirmed the resonance of human bodies
with astrological and climatic forces, which alongside the legends and
virtues attaching to bodies were as much a characteristic of their de­
scription as any morphological features. Roughly coinciding with the
European colonization of Africa, the age of Renaissance thought gave
way from the mid-seventeenth century to the age of Classification.

For the first time, and as examined in Chapter 4, there now
commenced 'a meticulous examination of things themselves' (Foucault
1973: 131). Living beings began to be ordered not according to their
'imaginary' characteristics of old, but in terms of their perceptible physical structures. It was therefore at this point that the African body first emerged into western knowledge in something approximating to the distinctively human form we now take for granted, as along with the plants and animals of Africa it was made an object of natural history and installed in the botanical classification system of Linnaeus as 'Afer Niger' under the category 'homo sapiens'.

While the Classical age produced an African body without organs as the object and effect of its taxonomic vision to the body's surface, it was only towards the mid-1800s and with the emergence of 'missionary medicine' that it became possible to speak freely of this body as an object possessed of an interior anatomy. This transformation is examined in Chapter 5, which analyses the medical missionary method and its fabrication of the relationship between African witchcraft and illness as the primary target of an evangelizing project to 'save' Africans by 'weaning' them from 'heathen' superstitions concerning the body and disease.

Because it is both target and effect of the socio-medical practices that sustain and transform it, the human body as an object of disciplinary power can never be considered finished or approaching completion. On the contrary, its contingent status means that it is constantly created and re-created as different components of the socio-medical apparatus negotiate and install different relationships between the body and its disciplinary micro-powers. This is reflected in Chapters 6 to 10, which examine the multiple African bodies fabricated in four distinct domains.

Chapter 6 focuses upon the machinery of mining medicine and its production of the migrant labour force as a closely monitored economy of bodies, disease and deviance. Through the simultaneous deployment of procedures that penetrated deep within the body to fabricate the space of anatomical pathology, and of surveillance techniques directed to the gaps between bodies, this industrious medicine at once individualized the body of the African miner and encased it in a network of rules devoted to the training of healthy conduct and regulation of bodily functions.

The conditions permitting invention of the African mind as an object of psychiatry and psychology are explored in Chapter 7. First within the asylum, and from the 1920s increasingly in the urban spaces of conflict between Europeans and Africans, the psychological sciences had by the 1930s crystallized an 'African personality' as their object and effect. By the 1980s, and reflecting the irony of a progressive humanism that in its quest for liberation produced precisely the authentic African subject as its effect, rejection of the 'African personality' as an ideological
myth produced a ‘liberatory psychology’, which since then has continued to elaborate its repertoire of subjectifying techniques.

Chapter 8 examines public health to show how its technologies produced the African body not through direct inspection, but through problematization of the spaces between bodies and the fabrication of a social body. From the turn of the twentieth century to the mid-1930s, sanitary science produced the social as a series of gaps between bodies and the environment that were seen as a conduit for the transmission of germs and dirt and so required constant policing through prohibitive measures. In the 1930s, these repressive strategies were displaced by positive techniques directed to recruiting Africans into monitoring and managing their own body-boundaries, as the new method of social medicine transformed the socio-physical space of old into a psycho-social one. The chapter continues with an analysis of the emergence of community health in the 1960s, and concludes with the ‘socio-ecological’ model of the new public health as it lays its lines of surveillance everywhere and throughout the body politic.

Chapter 9 examines what clinical medicine has seen and heard in relation to the African body. Invented in the mid-1930s, the African patient as the objectified effect of a specifically ‘Bantu’ clinical practice was confirmed until the 1960s, when a new strand entered the ‘Bantu clinic’ to enable recognition of the African patient’s culture, beliefs, emotions and ideas as important components of the clinical encounter. The chapter ends with the 1990s’ ‘quest for wholeness’ and fabrication of the clinical encounter as a socially constructed ritual where doctor and patient are equally agentic participants in the negotiation of illness.

As a postscript, Chapter 10 recursively applies the Foucauldean perspective to analysing the failure of social scientists in Africa to apply Foucault’s ideas to the field of socio-medical practice. Closely bound up with the notions of ideology, repression and liberation that dominate conventional critical analyses, this failure is read as an ironic confirmation for the success of disciplinary power in fabricating the African body as an apparently transcendental entity and the socio-medical practitioners who see it as potentially platonic observers.

Itself part of the Foucauldean discourse that makes such an exercise possible, this study cannot be viewed as independent of the domain it analyses. Indeed, precisely because there are no objects of knowledge in the absence of methods for their production, the study is itself a productive component in the discursive context of post-modernism, and it makes no claims to being more correct than existing explorations of the same domain. What is instead hoped is that its analyses of the African body will destabilize what otherwise is experienced as certainty,
to induce an appreciation of seemingly trivial practices as invested with a power that in penetrating and rearranging the objects of medical knowledge actively create and regulate the human body.

Like every other subset of bodies produced by socio-medical power everywhere, the African body is not a fixed phenomenon waiting to be distorted by ideological filters or of which medical doctors gradually achieve a more accurate understanding. The human body as a static phenomenon does exist, but only as a product of the modernist discursive regime upon which both Whig histories of scientific progressivism and Marxist histories of liberal humanism rest. Because these accord an ahistorical essentialism to the body they must themselves be considered instruments of disciplinary power, in so far as they operate to obscure the body’s contingent status as an end-product of the very force relations they construe as emanating from it.

Notes

1. By the socio-medical sciences is meant all those disciplines (e.g. clinical medicine, public health, psychology, psychiatry, anthropology, sociology and so on) that have at some point been deployed in Africa to manage the relation of Africans to disease, illness and the social context in which these occur.

2. Since the very idea of the African body as we now know it was not a possibility in the Renaissance, it is, strictly speaking, incorrect to write as if there was such an entity in this period. However, and as shown in Chapter 3, there certainly was a class of bodies believed to exist in the geographical region now known as Africa, and it is to this class of bodies that use here of the term ‘African body’ refers.
The African body appears everywhere in studies of social science and medicine in Africa. For instance:

The Government and the frontier colonists did all they could and at King-williamstown [sic] droves of hungry and dying natives applied daily to Dr. Fitzgerald for help. His fame as a medicine-man spread like wildfire and by August, 1856 he could report enthusiastically on the treatment of 2,278 cases. (Burrows 1958: 182)

As well as appearing in historical studies, the African body is a central focus of current socio-medical practice:

In Johannesburg a family of surveys has been conducted by the AIDS Virus Research Unit of the Medical Research Council at the National Institute of Virology. These sentinel surveys show that, in STD clinics, 14.6% and 20.4% of black males and females respectively are infected with HIV. This is in comparison to 4.2% and 1.8% of white males and females respectively. (Steinberg 1993: 90)

Despite its ubiquitous presence in historical accounts and contemporary research materials the African body itself is only rarely the subject of historical analysis. Instead, it appears to have been assumed that the African body is possessed of a transcendental ontological status that permits its existence beyond history.

What has therefore been studied in some detail is how representations of the African body in western socio-medical thought have changed over time (e.g. Dietrich 1993; Gilman 1985; Pratt 1992; Seedat 1993), and how its differing treatment within the formal health-care system has reflected the changing social, economic and ideological climate (e.g. De Beer 1984). Because they assume the pre-existence of the African body as an unvarying entity in an external reality round which these historically variable ways of treating it circle, these conventional accounts are not histories of the body, but instead are histories of ideas, images,
policies and professions. The present study does not therefore attempt yet another explanation in terms of an historical progression from the past to the present of why sub-branches of the social sciences and medicine devoted to African health and illness appeared, developed and disappeared. In fact, while many of the texts it assembles come from times well before this study commenced, it would be wrong even to think of it as a history in the conventional sense of the term. Rather, it demonstrates how the African body has been created and transformed as an object of knowledge, how its attributes and capacities are contingent upon the methods applied to know it, and therefore how strategies of the state and industry, along with the various socio-medical sciences that assume its existence, are possible.

How can this question of the African body as a distinct object of socio-medical knowledge have been so thoroughly ignored? An answer to this is offered by distinguishing the genealogical method and its histories of the present from the more conventional notion of the history of the past.

Histories of medicine as achievement, function and repression

Existing histories of the socio-medical sciences in South Africa are all histories of the past. That is, they project backwards from the present concepts such as economy, ideology and epidemiology in an attempt to trace how patterns of disease and health-care have altered over time to produce the present situation. These histories can be classified into three broad categories on the basis of how they explain the emergence of the socio-medical disciplines in relation to Africans and the socio-political order more generally.

On the one hand, there are histories of medicine as achievement that portray the discipline’s unfolding as one of linear progression driven by factors internal to the medical profession and the scientific method. On the other hand are histories of medicine as repression, that emphasize the place of the socio-medical sciences in relation to Africans as instrumental components of colonialism and capitalism, and tend to interpret the achievements paraded by the first class of histories less as triumphs than as markers of tyranny. In between these two extremes, there is an intermediary class of medical histories that construe the socio-medical sciences as having developed into their present configuration because there was so much disease that required treatment. Following Nettleton (1992: 2), this last class of histories reflects a ‘functional approach’.
Histories of medicine as achievement

And so down the ages these ‘mighty medicine men’, … have helped push the boundaries of medical knowledge further forward. Their achievements brought enlightenment and inspiration to succeeding generations, for the work of the present and future is based always on that of the past. (Krige 1939: 72)

In 1939, *The Leech* devoted one entire edition to an historical review of the technological advances underlying the development of medicine in Europe, and how these had enabled the expansion of medical services in Africa. The motivation lay in the idea that a knowledge of the past would limit the possibility of erring in the present: ‘Medical history … prevents us from losing our sense of proportion; its kindly light leads us back to the world of practical realities, and assists us in gaining a proper perspective on health and disease’ (Editorial 1939: 7).

Some fifteen years later, the idea that medical history could help retain a ‘proper perspective’ on the practice and problems of medicine found its first sustained expression in relation to South African medical history with the publication of three books devoted to the topic (Burrows 1958; Hattersley 1955; Menko 1954). Best defined as Whig histories in that they were written for the medical profession, these texts drew upon biographical accounts of people whom their authors considered great doctors to produce heroic accounts of how they had succeeded in establishing western medicine in the barren and hostile context of a new continent and African antipathy toward bio-medicine. ‘A record of the development of medicine in a young country depends upon the origins of its people and the sources of its civilization’, wrote Burrows (1958: 3). Elaborating this theme, he said of ‘the solid achievements of the early pioneers of medical organization’ that:

It was ... they who planted the germ of medical politics and professional union in South Africa; and it was they who were responsible for the emergence of a medical public opinion in the Cape Colony. Without continual pressure of voluntary associations of doctors ... the Colonial Government would probably have delayed its health legislation to the present century ... certainly the profession would have been a great deal poorer in their absence. (Burrows 1958: 367)

In 1959, a Natal newspaper celebrated the centenary of the King William’s Town Hospital with a review of its history to ‘honour the memory of those who went before, those who by faith, courage and fortitude gave a living example in the greatest of all lessons – man’s humanity to man’ (*Mercury* 1959: 4). Producing a similar image of
western medicine in Africa as the triumphal product of remarkable medical pioneers, the dust jacket to Laidler and Gelfand's (1971) volume superimposed sketches of important doctors upon images of Boer trek wagons to connote the unstoppable march of medicine and 'civilization'. A similar theme characterized Gelfand's (1984) *Christian Doctor and Nurse*, which set out the missionary medical struggle involved in bringing 'God's Medicine' to the African.

In the mid-1970s a second wave of Whig histories that attributed medicine's development less to the agency of particular individuals and more to the inevitable progress of science began to appear (e.g. Brink 1988; James 1975; Malan 1988). Epitomizing this tradition is the dedication to Malan's (1988) *The Quest of Health*, where he portrays a medicine that 'through observation and research' rose 'out of the abyss of tradition, myth, superstition and philosophy into the light of scientific understanding'.

Functional histories of medicine Against the parade of progress that marks histories of medicine as achievement, the cardinal feature of functional histories of medicine is their emphasis upon disease and epidemics, which are viewed as provoking the establishment of medical services and health legislation (e.g. Cartwright 1971; Friedlander 1974; J. F. Murray 1963; H. Phillips 1990; Van Heyningen 1989).

The tenor of these functional histories is illustrated by examining how Phillips (1990) tracked the Spanish influenza pandemic of 1918–19 as it 'struck' South Africa in October 1918. First, the text minutely details the piecemeal reactions of health authorities, private doctors and the public to the influenza epidemic in three major cities. Next, this is used to reveal the inadequacies of the public-health apparatus and to expose the otherwise veiled fabric of society. Finally, the materials are marshalled to argue that in the absence of the epidemic South Africa's first substantive public-health act (the Public Health Act No. 36 of 1919) would probably not have been enacted until much later. Phillips could thus write of November 1918:

By this time the need for comprehensive public health legislation had been made undeniably clear by the gross failure of the existing organisation to deal with the epidemic. Throughout the country the demand for rapid and concrete action in this direction was clamorous. *The Friend* was one of several newspapers to express this sentiment, pointing out that the calamity of the 'flu 'affords as terrible an object lesson of the need of a Public Health Act administered in the main by central authority as Nature in her most maleficent mood could have devised'. (H. Phillips 1990: 162)
In like fashion, but adding an economic factor into the complex of needs, Murray (1963: 391) argued that the South African Institute for Medical Research grew in response to 'the need for research into diseases which were of vital economic importance to the mining industry'.

Histories of medicine as repression Histories that explain medicine's development in Africa as achievement or as a functional response to overwhelming need do not lend any special focus to the African. Certainly, Africans are present in these stories, but their role is a peripheral one, subordinate to the heroic deeds of white doctors (the achievement approach) or swept up with Europeans in the all-engulfing tide of disease (the functional approach). In sharp contrast, it is primarily upon the African that histories of medicine as repression (which began to appear in the mid-1970s) are focused. For instance, Swanson's (1977) paper on bubonic plague and urban native policy in the Cape Colony between 1900 and 1909, argued how:

\[\text{M} \text{edical officials and other public health authorities at the turn of this century were imbued with the imagery of infectious disease as a societal metaphor, and that this metaphor powerfully interacted with British and South African racial attitudes to influence the policies and shape the institutions of segregation ... Overcrowding, slums, public health and safety, often seen in the light of class and ethnic differences in industrial societies, were in the colonial context perceived largely in terms of colour differences. Conversely, urban race relations came to be widely conceived and dealt with in the imagery of infection and epidemic disease ... In this context the accident of epidemic plague became a dramatic and compelling opportunity for those who were promoting segregationist solutions to medical problems. (Swanson 1977: 387)\]

Placing equivalent emphasis upon state manipulation of health-care resources in the service of African oppression, the World Health Organization's 1983 volume *Apartheid and Health* stated that 'apartheid has shown itself to be a veritable racist ideology ... And it is this racist ideology which guides all health action in South Africa' (WHO 1983: 6). Extending this theme, a chapter on the origins of South African society and its health system showed how 'The patterns of disease and health care relate directly to the nature of its industrialization and the unequal distribution of resources rather than to any lack of "development" among the black population. Health care policies are directly related to more general government strategies of control through reform' (WHO 1983: 77).

Sharpening the image of medical policy and practices as weapons
wielded by the state in its oppression of Africans, Marks and Andersson (1988) delineated South African government responses to typhus epidemics between 1917 and 1950 as revealing 'the concerns of the state and the ruling class in society, both with their own safety and with the reproduction of the labour force' (Marks and Andersson 1988: 259), an interpretation closely echoed in Packard's (1989) analysis of capitalism, racism and tuberculosis.

At the core of these histories of medicine as repression is the idea that the actions of medical practitioners and policy-makers were inevitably imbued with the exploitative interests and ideology of colonial imperialism. Arnold's 1988 volume *Imperial Medicine and Indigenous Societies* was therefore concerned 'not so much with disease and medicine as such as with their instrumentality – what they reveal about the nature and process, the ambitions and methods of an encompassing imperialism' (Arnold 1988: ii). The emphasis in these histories of medicine as repression is therefore upon the equation of socio-medical power with a physical and symbolic force concentrated in the hands of the ruling elite who use it to negate and constrain the authenticity and freedom of those it is turned upon.

The [South African] health service is the prisoner of this country’s political history ... the prisoner of Apartheid. The homelands and their health services are there because of Verwoerd’s grandiose vision of partition. The own and general affairs divisions are there because of the tightening of the Apartheid noose under the Botha government. (De Beer 1990: 8)

**Historiography, progress and the present**

This brief historiography of the socio-medical sciences in Africa demonstrates how explanations for the discipline’s emergence are relative to the author’s historical context, professional affiliation and political persuasion. This is a far from remarkable observation, the very method of historiography having arisen precisely in response to the observation that histories of the past inevitably reveal as much about the author’s historical and political context as they do about the subject matter. But there is a more fundamental point to be taken from this review that renders what are ostensibly politically polarized versions of the past components of a single discursive formation.

This commonality is twofold. First, all three types of history subscribe to an idea of history as one of continuity and progression. For histories of achievement, these developments are internal to the socio-medical professions, involving increasing altruism on the part of doctors and inevitable scientific progression as new medical techniques make
possible the abandonment of erroneous beliefs. For functional histories, this human agency and intra-scientific development is subordinate to the external pressure of disease. This forces development of the medical enterprise to mean that its shape today is the product of past disasters and current needs. For histories of medicine as repression, the shape of the enterprise at any given point reflects the outcome of repression and resistance, through which the concentration of medical power in the hands of the state and medical professionals is continually usurped and replaced by a more egalitarian system. In their preoccupation with progress, all three types of history thus reproduce what Foucault described as among ‘the most harmful habits in contemporary thought ... the analysis of the present as ... a presence of rupture, or of high point, or of completion or of a returning dawn’ (Foucault, in Kritzman 1988: 35).

The second facet of this commonality derives from the first. Because all three historical types privilege accounts of how individuals and groups seized socio-medical power or were systematically debarred from accessing it, they fail to problematize the African body itself by assuming it to exist independently of the socio-medical practices they address. For only if it is taken to have an existence independent of these practices can there be any progress towards more adequately understanding and treating the African body; or from the repressionist perspective, away from its oppression toward its liberation. In terms of the Foucauldean power schema, they all speak in one way or another to the idea of ‘sovereign power’ (Foucault 1977) alone, the idea that power exists as a commodity or weapon there to be grasped and wielded, fought for and won over. They consequently fail to grasp the significance of such apparently innocent rituals of disciplinary power as the routine clinical examination or school medical inspection: ‘Look at the lines of medical surveillance: “What is your complaint?” “How do you feel?” “Please tell me your troubles.” See the routine clinical techniques: the rash displayed, the hand applied to the abdomen, the stethoscope placed gently on the chest’ (Armstrong 1987: 70).

As Chapter 2 argues, these procedures are the stuff of disciplinary power, repetitive, ritualized and, no matter how repressive the more encompassing socio-political context, strategies to which the entire population at times must yield.

Using the theoretical tension between sovereign and disciplinary power, this study provides a different perspective. It problematizes the African body itself, rather than the legal enactments, professional power-plays and political struggles that constantly envelop and take its existence for granted. It has no interest in whether the South African
Health Act No. 63 of 1977 did or did not represent a move from discrimination towards a progressive politics (WHO 1983: 99). It is unconcerned with whether it really was 'with the arrival of white settlers that our people fell prey to a host of diseases' (WHO 1983: 14); and it has no interest in re-creating the machinations through which the apartheid state suppressed public knowledge concerning the true extent of cholera epidemics in the early 1980s (Marks and Andersson 1988: 257–8). In short, this study does not attempt to reconstruct the past through the conceptual and political lens of the present, but rather to produce a ‘history of the present’ that examines socio-medical objects, concepts and practices within their own temporal specificity.

The genealogical method and histories of the present In a discussion of the genealogical method, Armstrong (1990) distinguished it from quantitative and qualitative methods. Quantitative methodologies trace the extent in society of a given object of interest such as income, age or disease. Qualitative methods provide a means of demonstrating the subjective impact and meaning that a particular income, a certain age or particular disease have upon and for people and groups. However, by elevating to primacy their objects of study and ignoring their own presence in the analytic field, both approaches eliminate themselves from this field. As a result their objects of enquiry appear as given, their existence and form independent of the methods used to define, describe and explain them. The corollary of this is that changes in how objects of enquiry appear are attributed to forces inherent in the object (society has evolved, a person has developed, the disease has mutated), or to scientific progress that by improving investigative methods (enhanced methods of recording and counting events, microscopes with a higher resolution) reveals what was always there, but before such improvements were hidden by darkness (Armstrong 1990). Either way, observers are saddled with the explanatory problem that whatever they may posit cannot be separated from the contemporary universe of explanation and methodology in which the idea is produced, since a recent explanatory category cannot be used to explain itself.

In response to this problem of explanatory anachronicity Foucault drew upon Nietzsche to formulate the concept of genealogical analysis. The ideas of descent and emergence are central to the notion of genealogy. Descent makes no pretensions to going back in time to restore 'an unbroken continuity' (Foucault, in Bouchard 1977: 146) or establish any particular present as 'the unique or fundamental or irruptive point in history where everything is begun or completed again' (Foucault, in Kritzman 1988: 35). Instead, descent 'disturbs what was
previously considered immobile; it fragments what was thought unified; it shows the heterogeneity of what was imagined consistent within itself' (Foucault, in Bouchard 1977: 147). Methodologically, descent means that genealogy avoids the assumption that any concepts (such as life, the body, consciousness or sexuality) are static, in favour of documenting the profusion of events in which such concepts form and fade and outlining the discursive regimes that make them formalized objects of knowledge and targets for intervention. Hence history, life, the human body, disease, society or the psyche are all legitimate foci of descent, lacking any trans-historical stability and all the effects rather than the origins of the play of disciplinary forces. Applied to the human body, this means that 'it is not that the beautiful totality of the individual is amputated, repressed, altered by our social order, it is rather that the individual is carefully fabricated in it, according to a whole technique of forces and bodies' (Foucault 1977: 217).

Because they do not presuppose their objects’ existence, the power mechanisms that co-vary with how the body is known cannot be identified with the works of great doctors or the impact of legal enactments and ideological forces, since all impinge upon and so take for granted the existence of the human body and human interests. Instead, the mechanisms of power discerned by descent are at the extremity of power, 'those points where it becomes capillary' (Foucault, in C. Gordon 1980: 96) – such as 'the single unencumbered gaze of one doctor to an inflamed joint or diseased lung of an individual patient' (Armstrong 1990: 1226). For it is here, as the patient bares the chest to the listening ear of the doctor’s stethoscope, that power has its immediate effects in creating the corporeal objects of human experience.

Following from the concept of descent are the data considered germane to genealogical analysis. In this study, descent meant that rather than the biographies and memoirs of great medical personages or government gazettes detailing public-health Acts, the search was for texts describing the actual procedures applied to African bodies, records of the minutiae by which they were handled by doctors and moulded by architecture, and accounts of what was seen when Africans were opened up to anatomical investigation. As well as privileging accounts of the minutiae of socio-medical practice, the genealogical method also differs from conventional historical methods in drawing no distinction between primary and secondary sources. Instead, all sources (diaries, textbooks, transcriptions of spoken interviews etc.) are considered primary for their own period of authorship. This is because all texts are chronologically specific in that they can only draw upon the conceptual repertoire available to their authors at the time of production. For
example, since it enters African socio-medical discourse only in the late 1800s, it is impossible to speak of a distinctive African anatomy and physiology before then.

If descent disturbs a sense of continuity from the past to the present by fragmenting what was considered immutable, then emergence, or the entry into discursive existence of particular objects of knowledge, upsets assumptions that seek the origins of things in neatly ordered ensembles of indexical events: ‘Historians have been accustomed to a history which takes in only the summits, the great events’ (Foucault, in C. Gordon 1980: 37). Against ‘great events’, emergence casts the effective forces of history as continuous responses to haphazard conflicts, an unending play of dominations, subjugations and struggles, for which the formal centres of power in any society are simply concentrations of disciplinary power within this generalized force field. The human body is thereby constantly appearing and vanishing, changing and continuously being renegotiated as the crystallization of disciplinary power in the shape of medical procedures ‘discovers’ new objects and domains of illness (Armstrong 1985: 112).

Genealogy inverts the approach of conventional history, enabling us to examine power from the assumption that it works not only through repression and inhibition, but also as a creative force that fabricates not only the human objects of social reality, but the social itself: ‘Power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production’ (Foucault 1977: 192). Hence, as Nettleton (1992: 124) comments, where conventional histories of the past find continuity, absolutes, stability and noble origins, the genealogical analysis finds discontinuity, no absolutes, instability and mundane events.

**History will teach us nothing**

As this chapter was being written in late 1994, South Africa was celebrating its first 100 days of democratic government. Among the human sciences history had been propelled to prominence as academics, politicians and ordinary people strived to transcend the politics of oppression embedded in four centuries of colonial and apartheid rule. Underlying history’s perceived importance was the belief that through a critical review of the past it was possible to learn from it and avoid repeating earlier patterns interpreted from the vantage point of the present as corrupt and evil. For instance, a 1993 history of South African public health initiatives had this to say: ‘As South Africa undergoes rapid social, economic, and political change, the rich heritage of public
health and primary health care that has long been overlooked is being rediscovered ... The article ... critically assesses what South African public health professionals could learn from the past while planning for the future' (Yach and Tollman 1993: 1043).

Concerning the psycho-social sciences, critical observers such as Hayes (1993) were equally confident in their claims that careful scrutiny of the past would enhance the probability of a better present.

The history of psychology's complicity with apartheid and oppression cannot simply be wished away. This does not mean either that we have to stay stuck in the shame or guilt of the past. The complex task of transforming psychological theory and practice in terms of a more social liberatory discipline, requires a thorough analysis of the past, so that the lessons of that antipathetic time ... can be properly learnt, and not repeated ... A self-conscious remembering of our history will facilitate an understanding of what constraints and what spaces are available to us. (Hayes 1993: 12)

From the Foucauldean perspective, appeals to history as a teacher in how to tame power in the present are futile in that they are always also components of disciplinary power. Their fault is that they address sovereign power only, repeating the error of Parisian students in 1968 who believed that following De Gaulle's flight from France the state would vanish. To their bewilderment, the state continued without its head. 'Their mistake was to believe that power could be seized from the person who apparently held it; but power simply ran through their fingers' (Armstrong 1985: 113). The body itself is at once object, effect and a conduit of power, the fist raised in defiance of the soldier a sign of the beginnings of a self-existence for the nascent individual. Hence Foucault's famous claim that 'we need to cut off the king's head: in political theory this still has to be done' (Foucault, in C. Gordon 1980: 121). Sovereign power exists, it inscribes pain, torture and deprivation on the surface of the skin and in the workings of the body. But this body, its abuses scrupulously documented by the custodians of human rights and civil liberty (e.g. Silove 1990; Swartz and Levett 1989; Zwi 1987), is always also a fabrication of their practices. For from far below the tumult of sovereign force there arises disciplinary power which is everywhere, not because it embraces everything, but because it comes from everywhere. Sovereign power cannot easily be grasped by everyone but, as shown in Chapter 2, disciplinary power is within the grip of us all.

Notes
1. The first published examinations of medical history in South Africa would appear to be those of Laidler (1937, 1938, 1939), in which he examined
such things as the 'Proclamations' governing the practice of physician or sur-
geon, and the first use of anaesthetics in the Cape of the early nineteenth
century.

2. Use of the terms 'creative' and 'productive' in relation to disciplinary
power is intended to show only that this is a power which fabricates objects. It
does not imply (as the almost unambiguously positive connotation lent to such
terms in their common usage would suggest) that its functioning is 'good' or,
for that matter, 'evil'.

12 • The anatomy of power
CHAPTER 2
Power, Knowledge and the Body

The field of Foucauldian scholarship consists of two broad categories of work. The first is colloquially known as the ‘Foucault industry’. It contains studies that engage in academic reflections upon Foucault’s work, often attempting to plumb the philosophical origins of what Foucault thought, or else offering a critique of his theories by comparing these with those of other theorists and philosophers of the social and the subject (e.g. Hinkle 1986; Lemert and Gillan 1982; Paternek 1987; Rorty 1986). The second category of Foucauldian scholarship is made up of studies that do not so much reflect upon the tools of Foucauldian thought as apply them to particular problems, such as the chronic patient (Arney and Bergen 1983), the profession and practice of obstetrics (Arney 1982), ‘the mouth with teeth and the profession of dentistry’ (Nettleton 1992: vi), the emergence and functioning of the psychological sciences in Britain (Rose 1985), and the relationship between medicine, the individual and the social more generally (Armstrong 1983; Arney and Bergen 1984). To date only Megan Vaughan’s Curing Their Ills: Colonial Power and African Illness (1991) approaches a Foucauldian analysis of western medical practices in relation to the African, although, in her own words, this ‘stopped short of a full scale constructionist approach’, and committed ‘what, for the social constructionist, is the cardinal sin of assuming some material reality to which medical constructs ... refer’ (Vaughan 1991: 7).

It is squarely within the second category of work that the present study belongs, and the theoretical materials reviewed here are restricted to those aspects of Foucault’s work pertinent to the study’s concern with western socio-medical practice and the African body. Given the diverse qualities of Foucault’s work, it must moreover be emphasized that the methodological apparatus derived from it cannot be thought of as illustrating the Foucauldian method. As both Nettleton (1992) and Vaughan (1991) have cautioned, and as attested to by the divergency in their own readings of Foucault, a range of methodologies could and have been derived from the Foucault schema.
The individual as invention

As shown in Chapter 1, conventional histories of the socio-medical sciences in Africa presuppose a human subject along the lines suggested by the model of classical philosophy, endowed with a consciousness which power is then thought to seize upon. Standing at the centre of these studies (whether as dominator or dominated, observer or observed) is the knowing, seeing, feeling and acting person, for this is always the point from which these analyses are constrained to begin.

The human body and the person are also prominent in the Foucault schema. Not, however, as points of departure for the human and socio-medical sciences, but instead as the very opposite, as the result of these sciences and therefore the very locus of insertion of their knowledge. 'The individual is not a pre-given entity which is seized on by the exercise of power. The individual, with his identity and characteristics, is the product of a relation of power exercised over bodies, multiplicities, desires, forces' (Foucault, in C. Gordon 1980: 74). In short, Foucault inverts the human body by viewing it not as the origin of force or source of answers, but as the effect of forces and a problem demanding explanation. How is it possible to conceive of the body? How was it possible that until the end of the eighteenth century the body did not exist in the sense we know today? The human body and subjectivity as problems requiring explanation rather than objects awaiting scientific or philosophical elaboration are therefore at the core of Foucauldian theory and its genealogical method, described by Foucault as:

A form of history which can account for the constitution of knowledges, discourses, domains of objects etc., without having to make reference to a subject which is either transcendental in relation to the field of events or runs in its empty sameness throughout the course of history (Foucault, in Gordon 1980: 117).

This refusal to accept the presence of a transcendental, unchanging subject as an explanatory device has led certain theorists to define Foucault as the 'author of a philosophy of history based on discontinuity' (Kritzman 1988: 99). However, far from a Foucauldian explanatory fiction, the contingent and historically variable subject is in fact a discovery of the genealogical method, and the attendant notion of discontinuity a problem requiring resolution and not an answer.

The discovery of discontinuity and the episteme  The preface to Foucault's great genealogical study The Order of Things began with a passage from Borges that quoted a "certain Chinese encyclopaedia" (Foucault 1973:
An unexpected coupling of ordinary and extraordinary things, the passage produced in Foucault a laughter that shattered

all the familiar landmarks of my thought - our thought, the thought that bears the stamp of our age and our geography - breaking up all the ordered surfaces and all the planes with which we are accustomed to tame the wild profusion of existing things, and continuing long afterwards to disturb and threaten with collapse our age-old distinction between the Same and Other.

This passage quotes a 'certain Chinese encyclopaedia' in which it is written that 'animals are divided into (a) belonging to the Emperor, (b) embalmed, (c) tame, (d) sucking pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification, (i) frenzied, (j) innumerable, (k) drawn with a very fine camelhair brush, (l) et cetera, (m) having just broken the water pitcher, (n) that from a long way off look like flies'. In the wonderment of this taxonomy, the thing we apprehend in one great leap, the thing that, by means of the fable, is demonstrated as the exotic charm of another system of thought, is the limitation of our own, the stark impossibility of thinking that. (Foucault 1973: xv)

Foucault's concern in presenting this passage was to induce in readers a sense that the forms of knowledge peculiar to our contemporary way of knowing are limited by what he called the 'conditions of possibility', or 'episteme' from which they emerge and which they reproduce. For on trying to think out of this epistemic space we are tugged back in by a subterranean current, an unthinkable force that prevents us from considering the 'Chinese encyclopaedia' as anything other than a quaint taxonomic game.

Foucault attempted various definitions of episteme, and consistent with the metaphor of a subterranean force they all referred to an organizing stratum buried well below the level of epistemology, paradigm or philosophy. For instance, an episteme is the 'total set of relations that unite, at a given period, the discursive practices that give rise to epistemological figures, sciences and possibly formalised systems' (Foucault 1972: 191). Or, an episteme consists in:

[The fundamental codes of a culture – those governing its language, its schemas of perception, its exchanges, its techniques, its values, the hierarchy of its practices – [which] establish for every man, from the very first, the empirical orders with which he will be dealing and within which he will be at home. (Foucault 1973: xx)]

Given these definitions' obscurity it is perhaps more useful to clarify what Foucault meant by the term by briefly outlining the contours of the three epistemes he identified: one dominated Renaissance thought, one covered the Classical period, and the last and most recent is that
which has governed Modernist thought in the nineteenth and twentieth centuries.

Each episteme was synonymous with a great swathe in history, and the gaps between them contiguous with the ‘massive disjunctions in knowing that their change implied’ (Armstrong 1987: 13). These Foucault delineated by comparing how Language, Life and Labour were cognitively ordered within each episteme. Take the question of ‘life’ for instance. In the Renaissance, it was not, strictly speaking, even possible to think of living things as possessed of ‘life’, since it was only with the Modernist episteme that biological science became possible and ‘life’ could be seen as immanent in a living thing’s biological constitution. By contrast, living things in the Renaissance were animated by the great cosmic web of which they were mere nodes, and from which they gathered the legends and virtues that were an intrinsic part of their description. With advent of the Classical episteme at around the mid-seventeenth century, the natural world was transformed by a new way of seeing that ordered living things according to their perceptible physical structures. Within the Classificatory age, the ‘imaginary’ characteristics of plants, animals and people (which previously were paraded for edification and entertainment in the circular procession of the show) were jettisoned, and in place of the show living things were grouped according to their perceptible physical resemblances and arranged for scrutiny by natural scientists in the abstract space of charts and tables, such as exemplified by the botanical taxonomy of Linnaeus, or the complex disease classification of Sydenham. A second disjunction occurred towards the end of the eighteenth century, when the taxonomic gaze of Classification to the surface of living things was replaced by a deep gaze that analysed internal structure and its relationship to function. Functions (such as emotion, instinct and metabolism) are, of course, invisible, yet their identification to thought marked the emergence into science of the phenomenon of life, which in its turn became the principal object of the new biology.

Just as the natural history of the Classificatory age gave way to the Modernist science of biology, so the analysis of wealth was replaced by economics, and the study of general grammar by linguistics.

These three new knowledges were a part of a complete reorganization of knowledge in the late eighteenth century; but, more significantly, these three new sciences of Life, Labour, and Language defined a new central object for the modern episteme, namely what Foucault calls ‘Man’; and with the advent of Man arose the specific studies of man in the form of the human sciences. (Armstrong 1987: 62–3)
Epistemic archaeology therefore reveals that, when not projected back into time by conventional histories of the past, a point is reached on the genealogical descent down a continuous present where not only the human subject as the throne of consciousness vanishes but also the very idea of life as an immanent of the body's organization. As a consequence, this same epistemic space and the disjunction between epistemes cannot be explained through recourse to the human subject as a given and the human body as a constant. Hence Foucault's concern to make clear that discontinuity was not an explanation but a problem.

In *Les Mots et les choses* I set out ... from this self-evident discontinuity and tried to ask myself the question: is this discontinuity really a discontinuity? Or, to be precise, what was the transformation needed to pass from one type of knowledge to another type of knowledge? For me, this is not at all a way of declaring the discontinuity of History; on the contrary, it is a way of posing discontinuity as a problem and above all a problem to be resolved. (Foucault, in Kritzman 1988: 100)

In revealing how the human sciences became possible only in the late eighteenth century, *The Order of Things* (1973) had already begun to suggest the historical contingency of biology and human anatomy. It was, however, in *The Birth of the Clinic: An Archaeology of Medical Perception* (1976) that the genealogical method found specific application to the problem of human anatomy, for it was here that Foucault first traced how the concrete individual of conventional history was invented as an object of positive knowledge and opened up to the language of rationality (Foucault 1976: xiv).

The gaze and the problem of human anatomy 'The gaze' is a term that appears frequently in this and other Foucauldian studies of power and medical knowledge. It refers both to how things have appeared to medicine and to the techniques by which medicine has made things appear, in coming to have a particular knowledge of the human body. As such, the gaze is not merely some cognitive or perceptual skill waiting to be grasped by the doctor and cultivated through medical training. On the contrary, while it certainly is through training in the socio-medical sciences that the gaze is reproduced, it is the gaze as technique that makes possible the very idea of a bodily interior and the doctor as its observer, and it is the gaze as limit that circumscribes how the doctor is taught, how the doctor practises and hence what the doctor can see.

The great biological image of a progressive maturation of science still underpins a good many historical analyses; it does not seem to me to be
pertinent to history. In ... medicine ... up to the end of the eighteenth century one has a certain type of discourse whose gradual transformation, within a period of twenty-five or thirty years, broke not only with the 'true' propositions which it had hitherto been possible to formulate but also, more profoundly, with the ways of speaking and seeing, the whole ensemble of practices which served as supports for medical knowledge. These are not simply new discoveries, there is a whole new 'regime' in discourse and forms of knowledge. (Foucault, in C. Gordon 1980: 112)

To illustrate this crucial point concerning the temporal specificity of the gaze and how it produces the doctor and in turn the human body as its objects and effects, Foucault began the Birth of the Clinic by juxtaposing two contrasting images of what was seen by two physicians, one writing in the 1700s the other in the 1800s. First, Pomme’s eighteenth-century description of the treatment of a female hysteric, which relied upon ideas of nervous pathology and derived its description of the body from the study of texts. Assuming the cause of hysteria to be dryness and ‘desiccation’ of an ‘overheated’ nervous system, treatment involved ‘making her take “baths, ten or twelve hours a day, for ten whole months”’ (Foucault 1976: ix), with the result that:

‘membranous tissues like pieces of damp parchment ... peel away with some slight discomfort, and these were passed daily with the urine; the right ureter also peeled away and came out whole in the same way’. The same thing occurred with the intestines, which at another stage, ‘peeled off their internal tunics, which we saw emerge from the rectum. The oesophagus, the arterial trachea, and the tongue also peeled in due course; and the patient had rejected different pieces either by vomiting or expectoration’. (Pomme, in Foucault 1976: ix)

Second, and written less than a hundred years after Pomme’s description, was Bayle’s nineteenth-century account of the anatomical detail of the brain, produced through direct inspection of the body, and relying upon the idea of anatomical pathology:

'Their outer surface, which is next to the arachnoidal layer of the dura mater, adheres to this layer, sometimes very lightly, when they can be separated easily, sometimes very firmly and tightly, in which case it can be very difficult to detach them. Their internal surface is only contiguous with the arachnoid, and is in no way joined to it ... The false membranes are often transparent, especially when they are very thin; but usually they are white, grey, or red in colour, and occasionally, yellow, brown, or black. This matter often displays different shades in different parts of the same membrane. The thickness of these accidental productions varies greatly; sometimes they are so tenuous that they might be compared to a spider's web'. (Bayle, in Foucault 1976: ix–x)
This juxtaposition reveals the gaze itself, since had they witnessed the same event neither physician could have seen what the other saw.

Arising from our contemporary embedment in a world seen according to Gray's Anatomy, the inclination is to dismiss Pomme's description as fanciful or mistaken, for unlike Bayle's account of the brain it fails to confirm the contemporary belief in the truth of disease as residing within the body itself. But the real error is to assume that the earlier vision could be mistaken. For, and as confirmed by their convergence with the epistemic shifts identified in The Order of Things (Foucault 1973), these two visions of the body simply reflected and reproduced two incommensurable worlds. To cast the first vision as mistaken is therefore to create the illusion that the body of modern medicine has always existed as the only body there ever was, and of death and disease as always having inhabited this same anatomical space.

In the history of medicine, this ... illusion functions as a retrospective justification: if the old beliefs had for so long such prohibitive power, it was because doctors had to feel, in the depths of their scientific appetite, the repressed need to open up corpses. There lies the point of error, and the silent reason why it was so constantly made: the day it was admitted that lesions explained symptoms, and that the clinic was founded on pathological anatomy, it became necessary to invoke a transfigured history, in which the opening up of corpses, at least in the name of scientific requirements, preceded a finally positive observation of patients; the need to know the dead must have already existed when the concern to understand the living appeared. So a dismal conjuration of dissection, an anatomical church militant and suffering, whose hidden spirit made the clinic possible before itself surfacing into the regular, authorized, diurnal practice of autopsy, was imagined out of nothing. (Foucault 1976: 125-6)

To identify this history as one that had been imaginatively conjured out of nothing through its fiction of the body as an unvarying entity independent of anatomical practice, required that Foucault demonstrate the alternative, that in fact it was only in the actual practice of the doctor to the patient that the anatomized body of the individual could have emerged at all.

Spatialization

The exact superposition of the 'body' of the disease and the body of the sick man is no more than a historical, temporary datum. Their encounter is self-evident only for us, or, rather, we are only just beginning to detach ourselves from it. The space of configuration of the disease and the space of localization of the illness in the body have been superimposed, in medical experience, for only a short period of time — the period that coincides with
nineteenth-century medicine and the privileges accorded to pathological anatomy. (Foucault 1976: 3-4)

Following Armstrong (1995), the concept of spatialization is a device for analysing the play of the gaze at any given point in the history of the present, and refers to the triumvirate of cognition, perception and practice that configure disease and determine the space and location of illness. The cognitive component refers to what Foucault called ‘primary spatialization’, and addresses the conceptual ordering of the elements of illness, such as sign, symptom and lesion. The perceptual component corresponds to ‘secondary spatialization’, and refers to the location of illness in relation to the body of the patient. The practical component was called by Foucault ‘tertiary spatialization’ and consists in the concrete practices, techniques and institutional arrangements that constitute health-care activity.

To illustrate the notion of spatialization and how it dissolves the certainty of the solid and visible body laid down in the anatomical atlas, it is useful to trace how changes in the spatialization of illness made possible the displacement of ‘bedside medicine’ by ‘hospital’ or ‘clinical’ medicine (cf. Ackernecht 1967). For it was with this respatialization of illness that the body of the disease and the body of the patient first came to inhabit the same space, to invent the anatomized body of the individual as the cardinal object and effect of what remains the dominant model of western medicine.

For bedside medicine, primary spatialization made illness coterminous with the symptoms reported by the patient, so a headache or abdominal pain was the illness. This was therefore a medicine for which there was no lesion, and secondary spatialization thus located illness to a point beyond the body where it hovered until coinciding with the body to induce the symptoms experienced by the patient. Because all diseases would in the course of their autonomous progression move through and out of the body, the physician’s diagnostic task involved capturing this mobility by closely monitoring the sequence of symptoms. ‘Presence in an organ is never absolutely necessary to define a disease: thus disease may travel from one point of localization to another ... while remaining identical in nature’ (Foucault 1976: 10). In this way diseases could be classified after a ‘botanical model’ into the families, genera and species that composed ‘God’s garden of pathology’. Within this garden illnesses sharing similar symptoms were evidence that they shared a common root. For instance, because paralysis, apoplexy (stroke) and syncope (fainting) all result in the abolition of voluntary movement, they were manifestations of the same disease: ‘when they become dense enough,
these similarities cross the threshold of mere kinship and accede to the unity of essence' (Foucault 1976: 7). Since diseases themselves determined when and where they would appear and disappear, tertiary spatialization demanded that doctors avoid extracting patients from the natural locus of the disease, and treatment was ideally accomplished at the bedside of the patient by the physician whose task was to wait and watch as the disease ran its autonomous course through time and the body. ‘The natural locus of disease is the natural locus of life – the family: gentle, spontaneous care, expressive of love and a common desire for cure, assists in its struggle against the illness, and allows the illness itself to attain its own truth’ (p. 17). Primary, secondary and tertiary spatialization thus maintained a medical space in which the body of the patient was a subsidiary problem, and even a barrier to proper diagnosis.

In order to know the truth of the pathological fact, the doctor must abstract the patient: ‘He who describes a disease must take care to distinguish the symptoms that necessarily accompany it, and which are proper to it, from those that are only accidental and fortuitous, such as those that depend on the temperament and age of the patient’. (Foucault 1976: 8)

Where bedside medicine had subtracted the patient and the interior of the body, the tertiary respatialization of illness marking the late-eighteenth-century rise of hospital medicine crystallized a gaze for which the individual body of the patient and its interior were cardinal. Emphasizing the significance to this shift of tertiary spatialization and underlining the primacy of hospital practice to the invention of the body, Foucault argued that the hospital ‘is the point of origin of the most radical questionings. It ... was on the basis of this tertiary spatialization that the whole of medical experience was overturned and defined for its most concrete perceptions, new dimensions, and a new foundation’. (Foucault 1976: 16)

The great desecration of hospital medicine was to move the body of the sick man from the home as the temple of life and shrine of disease, to the neutral domain of the hospital (initially regarded as a ‘temple of death’), and there to subject it to the practice of physical examination. These practices denied the truth of a medicine directed to essential diseases located beyond the body by crowding them together in a space where their purity was corrupted through ‘cross-breeding’. Hence they provoked in their beginnings a marked resistance, as instanced by one physician who noted that it would require a very skilful doctor: “to avoid the danger of the false experience that seems to result from the artificial diseases to which he devotes himself in the hospitals. In fact, no hospital disease is a pure disease”’ (cited in Foucault 1976: 17).
Highlighting the power of practice to overturn the truth of one age and replace it with the next, the sheer repetition of hospital medicine had by the early 1800s imprinted the reality of a new anatomy on the social conscience, and by 1858 it was possible to publish the first edition of Gray’s Anatomy. The origins of this new anatomy lay at a point following the French Revolution when Parisian hospitals underwent an institutional transformation whereby medical research and teaching began to be conducted in ‘teaching hospitals’. This shift in tertiary spatialization inserted the bodies of the sick into a space of systematic observation where patient could be compared with patient and disease with disease. This relocated the locus of medical education from authoritative texts to the new classroom of the ward round, in which doctors took instruction from the very bodies of the patients they surveyed.

Here one would learn not what the old masters thought they knew, ‘but that form of truth open to all that is manifested in everyday practice: “Practice will be linked to theoretical precepts. Pupils will be practised in chemical experiments, anatomical dissections, surgical operations, and in the use of machinery. Read little, see much and do much”’ (Foucault 1976: 70).

The body now isolated to close inspection by sight, touch and smell, the cognitive order of illness could be reconfigured into a three-dimensional framework involving symptom, sign and pathology. As under bedside medicine, the symptom remained an index of how patients experienced illness. But added to this was now the sign. The sign being ‘an intimation of disease elicited by the attentive physician’ (Armstrong 1995: 3) – such as the pulse that betrays the invisible strength and rhythm of the circulation – neither it nor the symptom was the illness. Together, though, they triangulated the position and nature of the underlying lesion within the body that was the disease. A new relationship between surface and depth was therefore established by this clinico-pathological correlation, to dispel the earlier notion of disease as an autonomous and mobile entity. Disease was instead located to a fixed point within the body, demanding innovative perceptual techniques that would allow doctors to see into its three-dimensional interior. The installation of hospital medicine thus necessitated invention of the classical techniques of clinical examination (percussion, palpation, auscultation and inspection), each a means of extending the doctor’s sensory apparatus and making transparent the opaque depths of the body to see the lesion within.

The secondary spatialization of illness to the interior of the body turned death into a tactic of seeing life. For bedside medicine, disease
had departed the body with the patient’s demise, and so it was futile to search the corpse for traces of its nature. Accordingly, while dissection did occur, its aim was not to observe the body's interior but rather illustrate the schemata set out in authoritative texts about its ‘humoural’ systems, ‘members’ and ‘virtues’ (see Chapter 3). In contrast, the post-mortem was an essential component of hospital medicine, for it enabled the exact nature of the hidden lesion to be incontrovertibly identified.

Life, disease, and death now form a technical and conceptual trinity. The continuity of the age-old beliefs that placed the threat of disease in life and of the approaching presence of death in disease is broken; in its place is articulated a triangular figure the summit of which is defined by death. It is from the height of death that one can see and analyse organic dependences and pathological sequences. Instead of being ... the night in which life disappeared, in which even the disease becomes blurred, it is now endowed with that great power of elucidation that dominates and reveals both the space of the organism and the time of the disease ... It is no longer that of a living eye, but the gaze of an eye that has seen death – a great white eye that unties the knot of life. (Foucault 1976: 144)

Where bedside medicine had abstracted the body of the patient from medical space, hospital medicine fabricated a gaze for which it was the body itself that was ill, and therefore the body itself that had to be known in all its fleshy and intimate detail: through the probing fingers to the abdomen; the listening ear of the doctor to the chest of the living, and the penetrating scalpel of the anatomist to the bodies of the dead.

Either side of this shift from bedside to hospital medicine are the very different objects and effects of very different spatializations. As demonstrated in the following chapters, there is good reason to conclude that it is never in what is seen or who does the seeing that the forces governing these shifts reside, but rather in the principle of spatialization and the gaze itself. ‘The order of the solid, visible body is only one way – in all likelihood neither the first, nor the most fundamental – in which one spatializes disease. There have been, and will be, other distributions of illness’ (Foucault 1976: 3). But without any historically unchanging human anatomy and subject to know and be known, how can there be any knowledge of the body and the person at all? Foucault’s answer to this problem was Discipline and Punish (1977), which placed knowledge in a productive relationship to power by demonstrating that ‘It is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power, but power–knowledge, the processes and struggles that traverse it and of which it is made up, that
determines the forms and possible domains of knowledge' (Foucault 1977: 28).

Power and the body

When writing The Birth of the Clinic and The Order of Things Foucault had yet to conceptualize a link between power and the great disjunctions in knowing that these analyses had revealed. With Discipline and Punish this missing piece of the puzzle was found and inserted to complete the diagram of power and knowledge with which the adjective Foucauldian has become synonymous.

‘When I think back now, I ask myself what else it was that I was talking about, in Madness and Civilization or The Birth of the Clinic, if not power? Yet I’m perfectly aware that I scarcely ever used the word and never had such a field of analyses at my disposal then’ (Foucault, in C. Gordon 1980: 229). By analysing transformations from the middle ages to the early twentieth century in the control exercised over people, Discipline and Punish (1977) identified a framework in which the emergence of particular ways of knowing the body could be correlated with changes in how these control strategies operated. The late-eighteenth-century discovery of pathological anatomy by which diseases were localized to the body’s interior as it lay in the strictly ordered space of the hospital could now be seen as contemporaneous with analogous changes in the regime of criminal punishment. From being subjected to torture, pillorying and public display, the criminal started to be incarcerated and subject to continuous surveillance in the closed and cellular space of the prison. Changes in two disparate and opposing domains of practice thus converged around the common pole of isolating the body as the object and effect of an increasingly sustained, intimate and penetrating surveillance.

Foucault defined this moment not as one of humanist enlightenment, but rather as one where power was reconfigured, the point at which what could now be known as sovereign power gave way to what from here on would be seen as the practice of disciplinary power.

Sovereignty and the spectacle of power Symbolized by the majestic visibility of the king, it is easy to appreciate the mechanics of sovereign power, since in addition to its dramatic prominence it is to sovereign power that conventional analyses of control continue to speak when they refer to power as if it were something that is ‘acquired, seized or shared, something that one holds on to or allows to slip away’ (Foucault 1979: 94). Functioning through being visible to those on whom it had
its effects, the force of sovereign power was epitomized in Foucault’s famous description of the public torture and execution of Damiens the regicide.

On 2 March 1757 Damiens the regicide was condemned ‘to make the amende honorable before the main door of the Church of Paris’, where he was to be ‘taken and conveyed in a cart, wearing nothing but a shirt, holding a torch of burning wax weighing two pounds’; then, ‘in the said cart, to the Place de Greve, where, on a scaffold that will be erected there, the flesh will be torn from his breasts, arms, thighs and calves with red-hot pincers, his right hand, holding the knife with which he committed the said parricide, burnt with sulphur, and, on those places where the flesh will be torn away, poured molten lead, boiling oil, burning resin, wax and sulphur melted together and then his body drawn and quartered by four horses and his limbs and body consumed by fire, reduced to ashes and his ashes thrown to the winds’. (Foucault 1977: 3)

Analogous with the less bloody but equally ostentatious displays of monarchial might enacted in rituals, palaces, processions and public displays signifying the royal presence, such ceremonies of torture realized a power that constituted the public as an extension of the monarchial body with the king as its head. ‘In a society like that of the seventeenth century, the King’s body wasn’t a metaphor, but a political reality. Its physical presence was necessary for the functioning of the monarchy’ (Foucault, in C. Gordon 1980: 55). Abstracted as a relationship of visibility, sovereign power was a massive and capricious force dependent for its functioning upon the visibility of itself. It was, accordingly, a regime where the only ‘individuals’ it produced were those (famous and infamous) inscribed on the conscience of the public through privilege, ritual, heroics and ceremony. Because sovereignty depended on its being seen by the unseen eyes of the crowd it moreover demanded that this presence be constantly renewed. ‘The public execution, however hasty and everyday, belongs to a whole series of great rituals in which power is eclipsed and restored (coronations, entry of the king into a conquered city, the submission of rebellious subjects)’ (Foucault 1977: 48). As shown in Chapter 3 where the knowledge implications of this sovereign power are explored, its principle of exertion over bodies to bend them into an homogenous mass was mirrored in its constitution of living things as formed from the outside by the equally capricious forces of God, the planets and the climate.

Against sovereign power (but never instead of it, since the two powers continue to coexist), there occurred towards the end of the 1700s a displacement in power’s point of application. For it was then
that the visibility of sovereign power in the dramatic theatres of punishment started to have effects opposite to its intended consequences. Instead of uniting the masses in sympathy with the king against offenders, the scaffold spectacle began to create a solidarity between the condemned and the watching crowd against the king (Foucault 1977: 63). The moment the effectiveness of these techniques started to fade was when the scenic model of sovereignty became displaced by the secretive device of the prison, and marked not the rise of a new humanism in justice, but rather the switch to a more efficient practice of social control, 'a tendency toward a more finely tuned justice ... a closer penal mapping of the body' (Foucault 1977: 78). Appearing as a complex tissue of events, 'often minor processes, of different origin and scattered location, which overlap, repeat or imitate one another' (p. 139), this moment was the shift to disciplinary power that was shared by the new gaze of pathological anatomy as it magnified the once irrelevant interior of the body. For, just as the medical gaze made individual anatomy into its new point of application, so the regime of criminal punishment began to install the novel practice of the penitentiary and its solitary inmates.

Through its physical assault upon the body, sovereign power had made the body into a screen for broadcasting monarchial might by the inscription of pain. For the penitentiary, it was not the body's surface that mattered, but rather its interior, its rhythms of sleep and waking, eating and hunger, social intercourse, and tolerance for solitude. The great theatres of pain were gone, and in their place

a new 'economy' of the power to punish, to assure its better distribution, so that it should be neither too concentrated at certain privileged points, nor too divided between opposing authorities, so that it should be distributed in homogenous circuits capable of operating everywhere, in a continuous way, down to the finest grain of the social body. (Foucault 1977: 80)

By the late eighteenth century the body of the ordinary person had thus replaced the body of the king as the effect of power, as rituals for restoring monarchical integrity were displaced by remedies and therapeutic devices deployed towards the bodies of everyone.

Panopticism and disciplinary power  Collectively known as disciplinary power, devices directed to ordering and analysing the bodies of everyone found condensed expression in Bentham's 1843 design for an ideal prison, the Panopticon. Disciplinary power inverted the scenic principle of sovereignty, for its functioning demanded not the visibility of itself but
of its target, 'and that target was the individual body which became at the same time both object and effect of the disciplinary gaze' (Armstrong 1983: 4). Hence the mid-nineteenth-century possibility for Bentham to conceive of the Panopticon and Panopticism as 'a way of obtaining from power "in hitherto unexampled quantity ... a great and new form of government"' (Foucault 1977: 206).

The Panopticon was a circular building divided into cells and built as a ring around an observational tower at its centre. Each cell had two windows: an outer one illuminating the inmate, and a shuttered inner one allowing a guard in the central tower to observe the inmates, but not the inmates to observe the guard. Side walls to each cell prevented the inmate from communication with other inmates, and so each inmate was 'seen but does not see; he is the object of information, never a subject of communication' (Foucault 1977: 200). Each cell was thus like a small theatre in which the solitary actor was perfectly individualized and constantly visible, yet never certain of actually being watched and so perpetually subject to the gaze of the guard. 'In short, the principle of the dungeon is reversed; daylight and the overseer's gaze capture the inmate more effectively than darkness, which afforded after all a sort of protection' (Foucault, in C. Gordon 1980: 147). The Panopticon therefore made the operation of power continuous by inducing in the inmate a state of conscious and permanent visibility that assured the automatic functioning of power (Foucault 1977: 201). Initially conceived of as a prison, the Panopticon was also a principle of power through surveillance, and so could extend beyond convicts to the lunatic, the schoolchild, the patient, the worker and the entire population.

With the swarming of such techniques for monitoring and manipulating the gestures, capabilities, behaviours, illnesses and ideas of everyone, the political axis of individualization underlying sovereignty found its final reversal, to allow the spread of discipline. Individualization under sovereign power had been 'ascending', such that the closer bodies were to the king the more they were marked off by ceremony. In the disciplinary regime individualization is 'descending', for as power increases its anonymity and functionality, so those on whom it is exercised are more strongly individualized. Not by ceremony, but by surveillance, and not by commemorative accounts with ancestry as their referents, but by comparative measures against a 'norm'.

The moment that saw the transition from historico-ritual mechanisms for the formation of individuality to the scientifasto-disciplinary mechanisms, when the normal took over from the ancestral, and measurement from
status, thus substituting for the individuality of the memorable man that of the calculable man, that moment when the sciences of man became possible is the moment when a new technology of power and a new political anatomy of the body were implemented. (Foucault 1977: 193)

While maximized where new innovations in architecture laid down particular places for particular individuals, the exercise of discipline was not restricted to concrete domains, and its manifestations appeared wherever the techniques of bodily surveillance emerged to prominence in the eighteenth and nineteenth centuries. In schools, pupils began to be tested to ascertain their scholastic proficiency; in the army, the new routine of drill and parade-ground inspections operated to create a disciplined soldier, and in workshops, schools and hospitals the timetable - long used in monastic communities to prevent idleness - was widely introduced to subject bodies to temporal ordering through the establishment of rhythms and regulated cycles of repetition. These were just some of the 'means of correct training' necessary to a power that replaced the homogenizing effect of the crowd under the regime of sovereignty with a collection of separate individualities.

The means of correct training  Inherent in the Panopticon's arrangement of lights, lines of sight and barriers, were the three instruments by which discipline jumped the walls of the prison to infiltrate the most intimate elements of the social and the individual.

The first of these instruments was hierarchical observation. This refers to the principle of concretizing inconspicuous surveillance in the way that built space is configured around the problem of who can see and who can be seen. For instance, how should the tents of a military camp or dwellings in a housing estate be arranged so that each occupant comes to be part of a network of gazes that supervise one another? Or, what is the optimal layout in the classroom that will ensure scholars know they are being seen while allowing the watching teacher to remain the discrete observer? Or, when the number of bodies to be supervised becomes too great to be seen by a single eye, how to install further observational relays? Each time such questions are asked it is to the instrument of hierarchical observation that they speak.

The second instrument of disciplinary surveillance is normalizing judgement, by which individuals can be assessed and measured through their comparison with others. As the term implies, normalizing judgement refers to all those procedures (even that as simple as having people stand in line according to their height), which in creating a field of comparison between different individuals allows the generation of a norm with which to grade the capacity, attributes or performance of
the subjects. It therefore contains within it an element of correction and the correlative concept of deviance, which together permit disciplinary power to fabricate and embrace 'the whole indefinite domain of the non-conforming' (Foucault 1977: 179).

The workshop, the school, the army were subject to a whole micro-penalty of time (latenesses, absences, interruptions of tasks), of activity (inattention, negligence, lack of zeal), of behaviour (impoliteness, disobedience), of speech (idle chatter, insolence), of the body ('incorrect' attitudes, irregular gestures, lack of cleanliness), of sexuality (impurity, indecency). (Foucault 1977: 178)

Against the bloody spurts of public torture through which sovereign power renewed itself, the steady pulse of discipline is the subdued practice of the examination. A synthesis of hierarchical surveillance and normalizing judgement, in the examination 'are combined the ceremony of power and the form of the experiment, the deployment of force and the establishment of truth. At the heart of the procedures of discipline, it manifests the subjection of those who are perceived as objects and the objectification of those who are subjected' (Foucault 1977: 184-5).

Functioning in three crucial ways, the examination is that 'tiny operational schema', so widely spread from psychiatry to education, and from the diagnosis of disease to the hiring of labour, that every member of the population must at some time participate in its ritual and so be recruited into the wider disciplinary network that this most nodal form of surveillance enables.

The examination is analogous to a cell of the Panopticon, and is therefore a functional site that transforms the economy of visibility into the exercise of power. For in the examination it is not the examiner that emerges to visibility, but the subject being examined, who once a participant in this minute ritual of surveillance carries for ever 'the fact of constantly being seen, of being always able to be seen that maintains the disciplined individual in his subjection' (Foucault 1977: 187). Second, intrinsic to the examination is the procedure of recording, the power of inscription by which the identity and attributes of the individuals it fabricates are traced in a network of writing (or computer databases) that captures and fixes them in a permanent analytic space. The examination thus functions to produce the individual and the collective, for through their aggregation the records of individuals may be sorted and seriated to fix the individual as a calculable entity within the tabular order of an arithmetic collectivity. Third, in fusing the power of surveillance with its documentary techniques of notation, registration and
filing, the examination ‘makes each individual a case ... a case which at one and the same time constitutes an object of knowledge and hold for a branch of power’ (p. 191).

Limited only by these parameters, the flexibility of the examination makes it the quintessential disciplinary device, a compact and portable Panopticon that requires no walls, towers or guards for its successful operation, and which through its properties of recording can interlink every point in the disciplinary regime to every other, so making the distribution of power continuous and autonomous of any ‘control centre’.

To summarize this analysis of power, the spectacle of punishment and the ritual of the examination invoke the principles of two very different diagrams of power, and with them two equally distinct domains of possible objects and effects.

1. Where sovereignty exerts control through violence and restraint, discipline does so through surveillance alone.
2. Where sovereign power requires the visibility of itself, the unseen force of discipline makes visible the individual as object, effect and target of power.
3. Where sovereign power emanates from a central point, disciplinary power is relational and distributed into each body and every gap between bodies.
4. Where sovereign power is sporadically eclipsed and restored, discipline functions constantly and automatically through recruitment of the individual and the social as its relays.
5. Where sovereign power destroys and conceals beneath its weight, disciplinary power creates and illuminates its points of articulation in the objects, effects and knowledges it sustains.

Despite these clear distinctions between sovereignty and discipline, their operation is never mutually exclusive. As demonstrated in the substantive chapters of this study, the shift from sovereignty to discipline has been one of emphasis. For while the late-nineteenth-century demise of the public execution as a legal means of justice in many parts of Africa marked the point where sovereignty formally bowed to discipline, this inversion in the relationship of visibility between colonial power and the African body enabled a new complex of calculable sovereignty to emerge. In this, the analytic gaze of discipline produced as visible objects those individuals and groups on whom the dramatic spectacles of sovereignty could then be selectively visited: in the shape of the missionary doctor’s theatres of healing aimed at demonstrating the power of ‘God’s medicine’ to the watching witch doctors; in the form
of the heat chamber as a spectacle of the mining industry's might over the body of the African; and in the technique of the psychological test and its isolation of the African as a 'dangerous individual' to be targeted by the tactics of violent repression.

**Discipline as power and the disciplined society**  How should this theory of power be read, especially in Africa, where every day sees the mob against the spectacular might of the army or police, where conventional history over even the last decade is punctuated by burning barricades, brutal acts of state violence and waves of 'ethnic cleansing'? Certainly, this speaks to societies that are not 'disciplined' in the sense of consisting in people who mechanically obey the dictates of the state and meekly conform to their politically and economically allocated place in the social order. But, and precisely because this notion of a 'disciplined' society reflects the idea that certain groups could hold power and exert it over others, this has no bearing upon whether African societies are or are not disciplinary societies. As is made abundantly clear in the following chapters, most African societies have since at least the turn of the twentieth century been constructed and organized in ways that starkly reflect the programmatic structure of the Panopticon, confirming that while not 'disciplined' they most definitely are disciplinary societies.

What then is to be made of the resistance to colonialism that constituted so great a part of the African past? Surely, in refuting the tactics of repression and subjectification aimed at inducing acceptance of their place as the 'dominated', black Africans have given the lie to discipline? Such critique assumes that resistance is contrary to disciplinary power, that where there is resistance there is no power, or at least a sufficient weakening to let the 'authentic' person emerge from beneath its crushing weight. But this too is mistaken, for not only do such arguments speak to sovereign power alone – which can and must be resisted – but also to the idea of 'freedom', which in its modern guise is itself a product of disciplinary power. For freedom today means the freedom of the individual, but since it is the individual who is a product of disciplinary power, the struggle to defend the 'rights of man' is itself as no more than another facet of discipline. Far from being a threat to the disciplinary regime, resistance is precisely that through which it ceaselessly expands and reproduces itself. 'Disciplinary power ... provokes and works through resistance: an up-raised hand to avert the gaze of surveillance marks the beginning of a self-existence for the nascent individual' (Armstrong 1987: 69).
Analysing power: methodological requirements

Flowing from the Foucauldian analysis of power into its sovereign and disciplinary manifestations are a number of methodological requirements.

The first requirement is that analyses avoid thinking of power as having a fixed form, for it is only through variations of the practices outlined above that it condenses into the political diagrams of sovereignty and discipline. Hence 'it is necessary to be a nominalist: power is not a stricture, or a certain force with which people are endowed; it is a name given to a complex strategic relation in a given society' (Foucault, in C. Gordon 1980: 27).

Second, because power creates itself in concrete practices, analyses should address power not at its formal centres in society (which are simply points of concentration within a generalized force field) but 'at its extremities ... those points where it becomes capillary' (Foucault, in C. Gordon 1980: 96), such as where the pincers are applied to tear the flesh, or, in a disciplinary regime, the gaze of the psychiatrist to the electroencephalogram of the patient. The Foucauldian analysis is always ascending, moving from these capillary points of application to the more general mechanisms (like the monarchy, the economy, the state or the liberation struggle) that require the human objects and subjects that power invents.

The third requirement holds that since power is not the product but the producer of human interests, desires and motives, analyses must not concern themselves with power at the level of conscious decision or intention: 'It should refrain from posing the labyrinthine and unanswerable question: “Who then has power and what has he in mind?” ... Instead, it is a case of studying power at the point where its intention, if it has one, is completely invested in its real and effective practices' (p. 97). The emphasis upon 'real and effective practices' is important also to underline the point that the Foucauldian analysis of power avoids linguistic reductionism. When it does use the term 'discourse' (as in parts of this study) what is referred to is not the meaning of the body created through language and dialogue alone, but also the concrete practices of the socio-medical sciences (such as the way the doctor's hands palpate the body, or how built space conditions hygienic habits).

The final methodological observation addresses the question of ideology which, because it forms so central a theme in the conventional discourse around colonialism and the socio-medical sciences in Africa, is more fully addressed in the Postscript (Chapter 10). Suffice here to note that in the Foucault schema power is never to be thought of as ideological.
It is both much more and much less than ideology ... It is the production of effective instruments for the formation and accumulation of knowledge – methods of observation, techniques of registration, apparatuses of control. All this means that power ... cannot but evolve, organise and put into circulation a knowledge, or rather apparatuses of knowledge, which are not ideological constructs. (Foucault, in C. Gordon 1980: 102)

A trans-humanist frame of analysis

This review of Foucauldian theory establishes an analytic framework by filtering the ideas set forth in *The Order of Things* (1973) and *The Birth of the Clinic* (1976) through the concepts of power and knowledge articulated in *Discipline and Punish* (1977). The result is a theoretical and methodological apparatus able to problematize the existence and transformations of the human body as an object and effect of socio-medical power by disrupting all humanist assumptions concerning the idea of it as a transcendental, unchanging entity, and, reciprocally, of knowledge as something that progressively accrues to enhance steadily the truth of what we know.

Instead, a continuous present is set in place in which the body is always contingent upon the force relations that concretize themselves in the procedures deployed to know it and the bodies of socio-medical knowledge that result. Substitute for the Panopticon as prison the hospital or clinic; replace the unseen but all-seeing guard with the doctor or nurse; see the silent, mystifying experience of the medical examination as the side walls prohibiting communication among the inmates, and construe the ever-expanding archives of disease statistics and patient files as the raw material from which the ambient infra-penalties of normalizing judgement silently form themselves. The seemingly unambiguous object language of textbook medicine metamorphoses, as do the actions of the researcher, clinician and health administrator, into the components of a finely wrought disciplinary regime, geared to the surveillance and subtle modulation of the interior and the exterior of the body, of the relations between different bodies, and of the social itself.

Turning now from this abstract and general anatomy of power, Chapter 3 commences its application to the production of a specifically African anatomy of power, by entering a present where how the body was understood and became an effect of power confirmed the existence of bodies in Africa which in their shape and form are today unimaginable to conventional historians, except as bizarre and grotesquely prejudiced distortions of the 'truth' as it appears in *Gray's Anatomy*. 