

welfare – the state, the commercial providers and the voluntary sector – have drawn closer together, and the spaces in which they ‘work’ have become less clearly demarcated. This process, they argue, was driven by increasing government financial support of the voluntary sector, as the state, under Margaret Thatcher, ‘rolled back’, and gave rise to additional ‘hybrid’ organisations exemplified by social enterprises, which used business models, operated with a voluntary sector ethos and received government funding. However, as Mold and Berridge note, the government was not a disinterested financier. Central government initiated and directed the actions of some voluntary groups. Moreover, it became increasingly difficult for voluntary organisations to claim autonomy. The state had not so much ‘rolled back’, rather, voluntary organisations were ‘rolled into the state’.

At the same time, government perceived voluntary organisations as well placed to evaluate welfare services and to inform policy makers. This drew some voluntary organisations closer to ‘the heart of government’. Nevertheless, Mold and Berridge question the influence of the ‘voice of the user’, noting that at the turn of the twenty-first century, government policy, whilst outwardly supporting the campaigning role of voluntary organisations (which broadly promoted the liberalisation of drug use), had, in practice, returned to abstinence as treatment, demonised methadone maintenance and delivered an increase in criminal measures to ‘deal with’ offenders.

Additionally, the authors highlight that, in the drugs field, other organisations, such as the Exchange Supplies, have not sat comfortably with any particular sector in this welfare economy.

Their narrative, arranged chronologically in three parts, argues for the existence of an adaptive and flexible voluntary sector, which has responded to many elements, among them

government departments, healthcare workers, and users of welfare services; and crises, such as the explosion in heroin use in the 1960s, and the arrival of HIV/AIDS in the 1980s. It is not a story of linear progression and not, they point out, without its difficulties. Yet it is one of survival.

For all the blurring of boundaries between service users and providers, Mold and Berridge conclude that the voluntary sector, with its ability to develop in changing environments, has and will continue to play a significant role in the public health and welfare sectors of British society.

Historians will find the use of secondary and primary literature in this monograph engaging and their argument ably made. The authors make excellent use of oral histories, alongside archive material, including recent material from the Department of Health and privately held personal papers. As with previous studies by Berridge and co-authors, healthcare practitioners, sociologists and policy makers will find much in this analysis of past patterns to consider future directions in their particular areas of endeavour.

Katrina Gatley,

The Wellcome Trust Centre for the History of
Medicine at UCL

**Adele E. Clarke, Laura Mamo,
Jennifer Ruth Fosket, Jennifer R. Fishman
and Janet K. Shim** (eds), *Biomedicalization:
Technoscience, Health and Illness in the US*
(Durham, NC: Duke University Press, 2010),
pp. xi + 498, £20.99, paperback, ISBN: 978-0-
8223-4570-1.

This is an important book for historians, and not only because it largely substantiates its bold opening claim, ‘that since around 1985, dramatic and especially technoscientific changes in the constitution, organization, and practices of contemporary biomedicine

have coalesced into *biomedicalization*, [which constitutes] the second major transformation of American medicine' (p. 1). Above all, its importance lies with extending the scholarship that has now coalesced around the belief that we have entered a new epochal order in which the epistemic grounds for life itself have changed – the new 'vital politics', as Nikolas Rose calls them, 'concerned with our growing capacities to control, manage, engineer, reshape, and modulate the very vital capacities of human beings as living creatures' (p. 7). Deeply indebted to Foucault in its orientation (especially Foucault on 'biomedical governmentality'), this new scholarship has emanated primarily from the domains of anthropology, sociology, and science and technology studies.

After a sustained mission statement on the meaning of 'biomedicalisation' and how its theory operates (reprinted from *American Sociological Review*, 2003, and written by the same 'gang of five' who edit this volume), there follows a chapter on the history of '(bio)medicine' and '(bio)medicalisation' up to the present, and another on gender in relation to this history and its theoretical framing. Two sets of case studies come next, the first focusing, in turn, on fertility, medical imaging, heart disease, environmental health, and drug development; the second, on the biomedicalisation of 'sexual dysfunction'; 'bariatric surgery' as a biomedical failure; breast cancer (to illustrate the biomedicalisation of 'risk'); and biopsychiatry and the informatics of diagnosis (to reveal the governing of mentalities). Wrapping it all up is an epilogue on the transnational travelling of biomedicalisation, which serves both to cut through any notion of American exceptionalism, and to justify biomedicalisation studies within specific geopolitical and historical 'healthscapes'.

'Biomedicalisation' – awkward as the word may be – should not put anyone off, especially not historians of medicine with attachments to the 1960s and 1970s sociological concept of 'medicalisation'. Central to the original concept was the perception of the conversion of 'social' problems into 'medical' ones (such as alcoholism, obesity, and homosexuality), a process always negatively and reductively understood in terms of extensions of the power of the medical profession. This formulation fell out of fashion with the rise of Foucauldian analyses of medicine and biomedicine in the 1990s. If modern culture was already thoroughly somaticised, as Foucault argued, then the idea of 'medicalisation' as something simply meted by and for the medical profession was wide of the analytical mark, if not somewhat tautological. The idea simply of an increasing medical jurisdiction over social life came to seem all the more limited analytically, not only because of the problematising of 'the social' in postmodern discourse, but also because of the ever-greater realisation by scholars of the extensive commercialisation of the body around 'enhancement' and 'wellness' technologies, as opposed to those merely around the treatment of 'sickness'. The more pervasive and systemic notions of 'biocapital' and 'biocitizenship' had to be the critical concern, rather than any instrumental notion of a power-seeking profession ('power' in that sense also having been blown out of the water by Foucault).

But the 'gang of five' make a convincing case for not throwing out the baby with the bathwater. Indeed, they stress that 'the potential for the generation of biocapital relies deeply on the *legitimacies* of medicalisation (extensions of the jurisdiction of medicine) and biomedicalisation (extensions of biomedicine through technoscience)' (p. 22). Biomedicalisation practices, they argue, in contrast to medicalisation ones concerned *only* with

control over medical phenomena, ‘emphasize *transformations of* such medical phenomena and of bodies, largely through sooner-rather-than-later technoscientific interventions not only for treatment but also increasingly for enhancement.’ (p. 2). Biomedicalisation also applies to the ‘panoply of biomedical institutions... organizationally transformed through technoscience, along with biomedical practices (diagnoses, treatments, interventions) and the life sciences and technologies which inform them’ (p. 2). Further, it extends to the would-be ‘collective countertrends’ to biomedicalisation, such as the ‘moral pioneering’ now going on around end-of-life care, or the metamorphosis of ‘patienthood’ through the integration of information from social health movements, the media and the Internet – all essentially means to the public’s further scientisation, despite often being driven by the fear of a biology moving out of human control. At one and the same time, then, biomedicalisation theory appropriates, expands, and transforms the concept of medicalisation.

The biomedicalisation of ‘sexual dysfunction’, discussed in the chapter by Jennifer Fishman, provides a good illustration of how biomedicalisation need not be conceived as representing a radical break from the processes that preceded it, but rather, ‘can often represent “medicalization *and*” – that is, medicalization formed through traditional medical channels plus new channels that incorporate biomedicine’s turn to lifestyle and to the molecularisation and organisation of the human condition’ (p. 290). The medicalisation of ‘sexual dysfunction’ in the older sense of the concept is clear in the fact that it was the surgical specialism of urology that first turned to ‘the problem’ in the 1980s, at a moment when it was increasingly feeling the market pinch from new non-medical methods and treatments for urological problems of all kinds. At this point, ‘sexual dysfunction’, while always having some history of organic or physiological conception, was primarily

understood psychologically. But this was to change after a meeting of the American Urology Association in 1983 when one speaker proceeded to inject his own penis with an erectile pharmacologic solution and then walk the isles of the conference hall to let his colleagues inspect and touch the new organic ‘reality’. It was indeed a legendary turning point; thereafter, urologists made concerted efforts to reconstruct impotence as a biomedical disorder rather than a psychological condition – and succeeded. This was not biomedicalisation, but a visibly palpable medical re-conceptualisation of what had been hitherto a different sort of ‘problem’. It was a brazen effort at extending a specialism’s market at the expense of psychologically indoctrinated sex therapists. But at the same time ‘the problem’ was biomedicalised, for the organic physiological explanation of what would now come to be called ‘erectile dysfunction’ was extended and normalised among ever greater populations of men, and became tied to other ‘risk factors’ accompanying aging. The avoidance of what was now to be conceived organically as ‘erectile dysfunction’ was thus to take its place in the ascendant cultural discourse on ‘healthiness’, which (market driven again) would come to be expected for *everyone* as they grew older.

Fishman’s point, like that of other contributors to this volume, is that the two processes of medicalisation and biomedicalisation proceed in tandem, with the latter dependent on *and interactive with* the former, rather than simply superseding it or eradicating it. Herein lies another aspect of the volume that renders it instructive to historians in general: its commitment to, and illustration of ‘intersectional theory’. The value of this lies in its refusal to privilege the explanatory power of ‘context’ for understanding the lives of people. Instead, in a somewhat Latourian way, it insists that the analyst must simultaneously consider the situatedness of people *vis-à-vis* race, class,

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and gender. Dynamic, changing, and co-constitutive, race, class, and gender are perceived as non-exchangeable categories, and cannot, according to this theory, be meaningfully understood in separation from one another. Although only in a few chapters of this volume is a concerted effort made to discuss intersectional theory in relation to processes of biomedicalisation, all of the authors (as with Fishman) hold the theory in high regard, more or less. The result, overall,

is a timely, informative, engaging, and above all, heuristic achievement. It may be that we are still too much in the forest of the new epochal order to see the trees, but *Biomedicalization* provides a significant empirical and theoretical clearing.

Roger Cooter,

The Wellcome Trust Centre for the History of
Medicine at UCL