Article title: Conceptualising Resistance

Abstract

The 1990s saw a proliferation of sociological work applying Foucault's ideas on governmentality to health promotion and public health. This work characterised public health discourses as regimes of power and knowledge employed in the regulation and surveillance of individuals and populations. This paper is concerned with the question of how and to what extent those who are subject to such regimes are able to resist them. We seek to identify the various forms in which resistance to such regimes of power have been manifest in empirical studies of health and illness. Our aims are threefold. The first is to alert empirical researchers who wish to examine resistance in the context of health and health care to the subtle and nuanced ways in which such resistance can be manifested both within and outside encounters with health professionals. This is achieved through tracing both the evolution of Foucault's own concepts around resistance and the way in which these ideas have been mobilised in empirical studies. The second, and related, aim is to demonstrate the complex forms which such resistance takes, problematising the simplistic assumptions that adherence to health promotion advice necessarily implies the collapse of agency, and that resistance necessarily involves the rejection of advice and interventions. The third is to highlight the potentially problematic normative qualities that may be assigned to resistance.

Keywords: power; resistance; Foucault; public health; governmentality;

Introduction

The 1990s saw a proliferation of sociological work that applied Foucauldian ideas on governmentality to public health and health promotion, and argued that individuals were increasingly being constrained to think and act in particular ways in order to maximise their health and be regarded as responsible and moral citizens (see for example Armstrong, 1995; Lupton, 1995; Nettleton and Bunton, 1995; Petersen and Lupton, 1996). Work of this kind drew attention to how health status, and the means for achieving good health, has become a predominant concern in modern society (Petersen and Lupton, 1996). Of particular interest within what has been termed the 'New Public Health' (Green, 2004) is a well-documented shift towards 'promoting' good health and encouraging populations to monitor their own health.

Peterson and Lupton (1996) have argued that this modern incarnation of public health can be conceptualised as an example of the regimes of power and knowledge employed in the regulation and surveillance of individuals and populations. A reliance on apparently voluntary individual action means that, rather than being constraining or regulatory, the power exercised within public health discourses works through the production and creation of individuals who are capable of some form of autonomy and will therefore regulate themselves (Lupton, 1995). Expert knowledge is argued to play an important role within this function (Rose, 1996). The professional, scientific view of what causes ill health, and therefore what should be done to prevent it, is seen, within much sociology,

to be privileged over lay explanations. This kind of argument is mobilised within sociological critiques which examine how discourses within public health help to shape individual identity. These analyses examine the power of knowledge to define and govern subjects (Petersen and Lupton, 1996).

These examinations of the relevance of Foucauldian analyses of regimes of power to public health beg the question of how and to what extent those who are subject to such regimes are able to resist them. This paper seeks to identify the various forms in which resistance to such regimes of power have been manifest in empirical studies of health and illness. Its aims are threefold. The first is to alert empirical researchers who wish to examine resistance in the context of health and health care to the subtle and nuanced ways in which such resistance can be manifested both within and outside encounters with health professionals. This is achieved through tracing both Foucault's own evolution of concepts around resistance and how these ideas have been mobilised in empirical studies. The second is to demonstrate the complex forms which such resistance takes, problematising the simplistic assumptions that adherence to health promotion advice necessarily implies the collapse of agency, and that resistance necessarily involves the rejection of advice and interventions. The third is to highlight the potentially problematic normative qualities that may be assigned to resistance.

The possibility of resistance

Although empirical studies drawing on Foucault's work recognise the subtle and dispersed ways in which power may operate within society, and in particular its

productive rather than merely coercive potential, there nevertheless remains the danger that individuals may be characterised as somehow ensnared within powerful discourses and have no means for resistance. Foucault himself has argued that this portrayal of passive and powerless individuals was never his intention: 'The idea that power is a system of domination that controls everything and leaves no room for freedom cannot be attributed to me' (Foucault, 1984a:442). His later works explore how individuals have the ability to demonstrate resistance to the discourses that attempt to discipline and control them (Foucault, 1984a&b, 1988). He argues that his views on the nature of power have always implied the possibility of resistance, because without this possibility there can be no relations of power (Dumm, 1996). In order for power relations to come into existence there must be a certain degree of freedom on the side of those exercising power and also of those upon whom it is exercised. If there were no possibility for resistance then there would be no power relations.

Foucault's later works balance his previous focus on technologies of domination with an exploration of what he terms the 'technologies of the self' (Foucault, 1988). This idea complements Foucault's earlier work on the ways in which the subject is constituted as an object of knowledge with an analysis of the ways in which individuals come to understand themselves as subjects (McNay, 1994). It is through this concept that a theory of possible resistance is developed. Through what he terms 'technologies of the self' Foucault suggests a more flexible relationship between discourse and the individual, arguing that the process need not be one of straightforward imposition, and opening up at least the potential

for resistance. Foucault argues that possibilities for resistance are located at the level of individuals' daily lives. He suggests a more flexible relationship between the dominant discourse and the individual, and emphasises the formation of a relationship with the self and the methods and techniques used to bring this about.

In his studies of Ancient Greek and Roman morality, Foucault perceives a difference between these classical moral systems and those of the Christian tradition (Foucault, 1984a&b). An important distinction between morality and ethics is identified. Morality is seen as a set of imposed rules and prohibitions, ethics as the actual behaviour of individuals in relation to the advocated morality. Foucault is therefore able to argue that the possibilities for resistance are located at the level of ethical behaviour, that is, at the level of individuals' daily lives. The dominant discourse with which an individual is presented (likened to morality) need not be perfectly reflected in the individual's subject position (likened to ethics). The individual's thoughts, accounts or actions may differ from those advocated by the discourse. Foucault is therefore able to introduce the possibility of autonomous action on the part of the individual. The individual can now be seen as having the opportunity to influence the way in which their subjectivity is constructed. A more flexible relationship between the dominant discourse and the individual is suggested and emphasis is placed on the formation of a relationship with the self and on the methods and techniques used to work out this relationship (McNay, 1994). Burchell (1996) therefore argues the introduction of technologies or techniques of the self implies a

loosening of the connection between subjectification and subjection. A greater element of freedom is allowed within individual behaviour in relation to the normal rules of conduct within a society. Individuals have the potential to interpret the norms of behaviour in their own ways rather than simply conform to them exactly.

Foucault can therefore argue that the process through which large-scale cultural patterns come to be demonstrated at the individual level is not one of straightforward imposition, cultural patterns need not be perfectly reflected in individual behaviour. Individuals may engage in 'practices of the self' and therefore have the potential for some display of resistance. However, neither is the individual free to act in any way they wish,

> ...I would say that if I am now interested in how the subject constitutes itself in an active fashion through practices of the self, these practices are nevertheless not something invented by the individual himself (sic). They are models that he finds in his culture and that are proposed, suggested, imposed upon him by his culture, his society and his social group.
>
> (Foucault, 1984c:441-2)

The relationship is not uni-directional in terms of society merely producing docile bodies, but equally, neither can it be seen as a voluntarist process of self-construction. Instead the process represents a point of contact at which

techniques of domination and techniques of the self interact to produce individual subject positions (Burchell, 1996). The process is complex as particular discourses suggest more than one subject position because, while there exists a preferred form of subjectivity, its very existence implies others and the possibility for reversal (Weedon, 1987). In order to be effective, discourses need to be activated through the agency of individuals and this works best when the subject position assumed within a particular discourse is identified by the individual as compatible with their interests. Where this is not the case then the space for resistance is opened up. As Weedon argues,

> Where there is a space between the position of subject offered by a discourse and individual interest, a resistance to that subject position is produced…The discursive constitution of subjects, both compliant and resistant, is part of a wider social play for power. (Weedon, 1987:112-3)

This later work suggests not only that the possibility of resistance exists but that such resistance may well take complex and flexible forms which extend well beyond the outright rejection of dominant discourses. Feminist scholarship is a useful reference here as it has long had as one of its key concerns the thorny issue of how to reconcile the idea that women can construct their own lives with that which holds that they nevertheless do so within constraining conditions. Developing Foucault's conceptualization of power as no longer centralized and repressive, resistance is regarded as not reducible to a single locus, and rather

attention is focused on how women can be 'negotiating at the margins of power' (Davis and Fisher, 1993:6). Focusing analysis at the level at which individual women interact with powerful discourses allows an exploration of how these discourses are internalized, transformed or resisted, and it becomes clear that women can develop different, and potentially opposing, meanings and conduct on the margins of dominant discourses which allow them to 'mediate between social orders and to invent new forms of knowledge' (Kielmann, 1998:138). Riessman (2000) develops the concept of 'transformative effects' to identify women's thoughts, talk or actions as resistance. Such resistance involves women pressing their own claims in relation to others' and therefore takes the form of thoughts and actions in everyday life that, although not necessarily directly confrontational, nevertheless have the potential to engage with, negotiate and redeploy or transform powerful discourses and bring about a rearrangement of power relations.

A number of writers have argued that empirical researchers have not fully integrated these more nuanced and subtle conceptualisations of resistance into their analyses and, hence, have failed to explore fully the relationship between power and resistance (see for example Grimshaw, 1993; Ramazanoglu, 1993; Ransom, 1993). In this paper, we examine this claim in relation to a number of exemplars in the field of health and illness which, we believe, demonstrate how empirical researchers have indeed achieved a sophisticated understanding of resistance which reflects this later work by Foucault. We believe that, taken together, these authors point the way forwards for those who seek to develop

empirical studies which do justice to the complexities which characterise Foucault's writings on resistance.

Empirical examples of resistance

We turn now to an exploration of some examples of resistance identified within empirical studies in order to provide empirical elaboration of Foucault's later work on resistance and how these ideas have been developed in a number of studies. We examine case studies from within health and illness studies that represent a range of contexts and demonstrate the diversity of forms that resistance may take. A critical examination of the kinds of resistance demonstrated in each study permits a subtle, complex and nuanced exploration of the ways in which resistance may be demonstrated and explored empirically.

Rejection = resistance / acceptance = domination?

Perhaps the most obvious form of resistance occurs when a patient refuses to cooperate with a medical procedure which has been recommended by his or her doctor. However, as work by Markens et al (1999) shows, it is simplistic to assume that rejection of such a procedure is evidence of resistance to biomedicine per se or, indeed, that accepting such a procedure constitutes domination or submission. On first impression, refusing an offer of prenatal testing may appear a fairly overt form of resistance, interpreted as an individual rejecting a biomedical offering. However, a refusal of this kind may actually demonstrate something much more nuanced and subtle. Markens et al. (1999) argue most of the research in the area of prenatal testing, and maternal alpha-

fetoprotein (AFP) in particular, has assumed that those who decline such tests are simply resisting medicalisation and/or are opposed to abortion. Markens et al. explore how such refusals of AFP are framed, conceptualised and thought about. Importantly, they find that both those who accept and those who refuse pre-natal testing frame their decisions in terms of the concept of 'risk' as it is constructed in the public health discourse. As such they can be seen as embracing rather than resisting the medicalised discourse. Within many public health discourses, from cancer screening to vaccination, the minimisation of risk is frequently constructed as one of the hallmarks of a rational and responsible individual. However, while the minimisation of risk is central in many women's accounts, the source of risk is differently understood in each of the two groups. Markens et al. argue that, for acceptors, risk is associated with the absence of prenatal information, whereas for refusers it is the information generated by such tests that poses the risk. Therefore, mothers can deploy the concept of risk to defend their decision, whether that decision is to accept or reject AFP, but this should not necessarily be interpreted as a form of resistance to biomedicine more generally. Thus, it is important to distinguish between resistance at the behavioural level (e.g. refusal to accept a particular recommended procedure) and resistance at the conceptual level (e.g. rejection of the discourse within which a particular procedure is embedded).

Conversely it may be tempting to regard instances in which individuals have accepted a medical offering as resistance-free. However, as Potts, Grace, Gavey and Vares (2004) demonstrate, whilst the intervention may be accepted, the way

in which the problem is framed or understood may be strongly resisted. In their research on Viagra users, the individual men's accounts do not necessarily endorse biomedical constructions of their sexual difficulties. Potts et al. argue that the medical model of erectile dysfunction employs a mechanistic view of the body and treats such dysfunction as a pathology to be treated. However, some users of Viagra challenge this medical presentation and view dysfunction as a natural part of the ageing process. They are therefore critical of the 'pathologization' of their problems as representing some form of medical condition. In an interesting approach, Potts et al. juxtapose extracts from drug company pamphlets that are targeted directly at consumers with the accounts of users themselves. They contrast the pamphlet's framing of 'erection problems' as a medical matter that a visit to the doctor would resolve with participants' discussions of how these were simply one part of a whole range of bodily changes associated with ageing. Potts et al. conclude by arguing that the medical model of male sexuality assumes the universal application of the 'sexual response cycle' and therefore a commonality of experience. However, the diverse range of understandings and experiences highlighted by their research demonstrates the lack of empirical support for this and draws attention to the resistance of users to framing their experience in these terms and their employment of a variety of alternative meanings and significances. The resistance comes through the men's reluctance to think about or perceive their experiences in medical, or medically 'correct', terms. Instead, they put forward their own conceptualisations that demonstrate the heterogeneity of experience. While these differences in approach led some men to stop taking Viagra, many

continued to use this medical solution to their problems while maintaining alternative, non-medical conceptualisations of those same problems. Once again we see that conceptual resistance to and behavioural rejection of biomedical offerings do not necessarily map neatly onto one another.

Kaufert's study (Kaufert 1998) demonstrates a further possible manifestation of resistance. In her research on women with breast cancer she focuses particularly on cases where the medical solution or treatment is accepted, but the ways in which it is delivered, and healthcare consultations organised and managed, are resisted. Kaufert therefore explores the various forms of resistance developed from within the healthcare or treatment system. She argues that women with breast cancer put together an oppositional discourse which challenges the domination of medicine by reinterpreting what it means to be a woman with breast cancer and resists stereotypes of how such women should behave. While such resistance was initially manifested at the micro level of individual encounters with health professionals, 'resistance subsequently turned into a demand for the reformulation of the relationship between women and the medical and scientific research establishment' (Kaufert, 1998:288).

These examples demonstrate the range of ways in which resistance can be manifest and indicate the importance of researchers looking beyond whether individuals do or do not accept behavioural advice. They underline the importance of also exploring how issues or conditions are conceptualised and understood. As the work by Potts et al demonstrates, resistance can be located at

the level of understanding and conceptualisation of an issue or problem, and this need not necessarily be translated into a refusal of the (in this case medical) intervention. As such an important distinction can be made between the exercise of resistance at the behavioural or conceptual level, and empirical work should be equally alert to both possible manifestations and the potential interplay between them. Kaufert's (1998) work is an excellent example of this in that it recognises how many women with breast cancer are unlikely to choose to display behavioural level resistance by refusing treatment, thereby removing themselves from the cancer care system, yet still remains alert to the resistance demonstrated through reconceptualisations of how breast cancer care should be accomplished. As Kaufert explores, this conceptual resistance may be subsequently translated into behavioural resistance, but this takes the form of social movements seeking to remodel breast cancer care, rather than declining of treatment at the individual level.

Resisting expertise and authoritative knowledge

In the first two of the three studies discussed above (those on prenatal testing and Viagra use) the wider socio-cultural context within which patients choose to accept or reject particular biomedical offerings is characterised by some ambivalence. For example, there is extensive ethical debate about the legitimacy of prenatal testing which is linked to the assumption that a positive result will lead to the possibility of abortion. Hence, in the case of prenatal testing, the moral censure that may be associated with the rejection of a perceived health preserving technology such as cervical cancer screening (Howson, 1999) is

mitigated. Similarly, ambiguity about whether erectile dysfunction is best interpreted as a recreational or a medical problem means that such dysfunction is unlikely to be regarded in the same way as declining medical treatment for something like breast cancer.

In contrast, many of the instances in which sociologists have applied Foucauldian ideas of governmentality to public health and health promotion deal with examples in which, it is argued, powerful discourses are very much at work both in constructing a morally acceptable, responsible and desirable outcome (for example, to attend for screening or make dietary changes) and also in directing the way in which the intervention should be framed and understood. While this does not mean that resistance becomes impossible, it can mean that the ways in which this is demonstrated change.

In their work on the production of authoritative knowledge in prenatal care, Browner and Press (1996) show how pregnant woman do not uncritically accept biomedical messages about how they should change their health-related behaviours during pregnancy even though such changes are strongly encouraged and the 'failure' to make such changes is likely to be subject to moral sanction. They cite the example of "Kitty", who was reluctant to give up smoking during pregnancy, despite being encouraged to do so. By explaining that she smoked during her first pregnancy and had a nine-pound baby who scored a 9 on the APGAR (a system of scoring a baby's condition one minute after birth, on which the maximum score is 10), Kitty undermines and ultimately rejects the

biomedical claim that smoking during pregnancy harms the unborn child as it does not conform to her previous experience. Generally speaking, the women in Browner and Press' study accepted those recommendations that were confirmed by their own personal experience, whilst rejecting those that ran counter to pre-existing beliefs about how to care for themselves during pregnancy or those that could not be easily incorporated into their everyday lives. Resistance in this example comes through the selective incorporation of biomedical recommendations, in which those that do not fit with existing experiences or beliefs are resisted.

The potential for resisting the construction of certain behaviour as morally acceptable and others as morally reprehensible is further demonstrated in Murphy's examination of mothers' responses to professional advice about breastfeeding. (Murphy 2003). Murphy suggests that women are subject to powerful medical discourses that clearly set out the 'correct' behaviour, in this case breast feeding for the first sixteen weeks, but all the women interviewed had broken at least some of the expert-defined rules. Murphy demonstrates how mothers engaged with and resisted this normalising discourse of medicalised scientific expertise and offered counter discourses through which their own feeding practices were legitimised. These counter discourses can therefore be understood as a 'rhetorical strategy of resistance' (Murphy, 2003:443), and are comparable to the concept of 'transformative work' advanced by Reissman (2000). Rose (1996) argues that expertise plays a central role in modern forms of government and it is interesting to explore the ways in which mothers in

Murphy's research engaged with ideas of expertise and employed them rhetorically in their strategies of resistance. Many criticised professional, scientific expertise on infant feeding on the grounds that it was not sufficiently adaptable to particular circumstances and individual babies. Through this, women who 'broke the rules' could legitimise their behaviour through appeals to their own expertise in relation to their particular baby.

Women in Murphy's study therefore did not reject the notion of expertise; instead they incorporated this very concept into their production of counter discourses that relied upon their status as holders of a different kind of expertise. Whilst Browner and Press (1996) demonstrate a selective rejection of antenatal biomedical recommendations by pregnant women, Murphy's research suggests a more comprehensive resistance to professional claims of expertise over the whole area of infant feeding. To a degree, Murphy's work echoes that of Browner and Press in that women draw upon, and give preference to, their individual knowledge and experience. However, the resistance demonstrated in Murphy's research goes further than a process of selective incorporation or resistance in that women have constructed and employed a coherent and sustained counter discourse. This may reflect the different degrees of success of biomedical discourses in establishing dominance over the prenatal and postnatal care of healthy infants.

The range of different ways in which people can resist through mounting challenges to biomedical and/or scientific expertise is further illustrated by

Rogers and Pilgrim's (1995) work on opposition to the mass childhood immunisation (MCI) programme. They argue that the resistance they identify in this specific context, which included lay people developing dissenting views on disease aetiology and different assessments of risk, is representative of a wider phenomenon of challenging scientific expertise. Parents choosing not to vaccinate their children drew on what they saw as legitimate reasons to resist the official doctrine that children should be included in immunisation programmes and to justify their decision. It is interesting to note that the position adopted by these parents with regard to immunisation was not necessarily representative of a wider conflict with biomedicine and health promotion messages in other contexts. Instead, these parents were often heavily involved in reducing risks to their child's health by following the recommendations of public health discourses in many other ways, including prolonged breastfeeding, promoting healthy eating and a focus on physical and mental well-being. Therefore, while this demonstration of resistance to medical authority in the context of MCI represents a breaking down of traditional patterns of authority and deference between lay people and medical professionals, it is not a full-scale rejection of biomedicine.

In contrast, the final example for consideration, although still concerned with a specific context, represents a wider rejection of biomedicine and demonstrates a refusal to adopt biomedical ways of thinking. Gold and Ridge (2001) interviewed HIV-infected gay men who had decided not to access antiretroviral drug therapy. Reasons for not accessing treatment were varied but mainly drew upon the

experiences of friends who had used the drugs as only a minority had any personal experience on which to base their decisions. Many felt the medical discourse trivialised the potential side effects of the drugs, for example, and employed their friends' experiences to challenge this. In this way the resistance here differs slightly from that based on personal experiential knowledge, as seen in Browner and Press' (1996) work.

A particularly interesting element of Gold and Ridge's work is their description of how the men themselves thought of their behaviour as designed to resist pressure to access therapy (from both doctors and indeed from the gay community) which they believed to be unreasonable. A certain pride was felt by the men in their ability to resist this pressure. Gold and Ridge argue that these men were in conflict with the biomedical model for the management of HIV/AIDS and that their decisions not to access therapy should indeed be seen as examples of dissent. These men had a fundamentally different way of thinking from the biomedical model – one which values individual experience over medical concepts. In this way, the values of abstraction, detachment and objectivity which are embraced by medical science, and underpin its claims to authority, are rejected in favour of knowledge drawn from the experience of those close to the individual. Therefore, not only do men reject the drug treatment offered by biomedicine, they also reject the underpinning approach and perspective on which it is based.

Discussion

In the course of this paper, we have drawn on a range of empirical work to demonstrate how resistance has been conceptualised and studied, and to explore its manifestations as localised, diverse and diffuse – in accordance with Foucault's conceptualisation of power relations. We do not believe it is helpful, or indeed perhaps even possible, to offer a definitive definition of resistance. Rather, what is crucial is to recognise its heterogeneity and context specificity. The empirical evidence suggests that the forms such resistance may take are many and varied, and it is important to take account of contextual influences when thinking about the potential for resistance in different circumstances and how this may manifest itself.

Rather than a firm definition, it is fruitful to conceptualise the relationship between power and resistance as a complex network with multiple points of potential difference or divergence bringing possibilities for disruption to the discursive flow. Within this, slight variations in interpretation or understanding can potentially lead to a diverse range of outcomes because resisting is not a homogenous process. Rather than a one-dimensional conceptualisation, we need to conceive of this process in terms of a web of potential points of resistance which may ultimately result in individuals adopting very different stances or positions. Our critical examination of a range of recent empirical studies of resistance within health and illness studies has illustrated this point and emphasised how refusal of a biomedical offering should not necessarily be construed as resistance, while adopting a medically recommended treatment

need not represent full acceptance of the medical construction of a particular condition or problem.

This tension is apparent in the dichotomy of attendance or non-attendance which is frequently used within health services research to measure the success of health interventions such as screening programmes or immunisation. While it is clearly important to have accurate information on the uptake or coverage of such services, we should also bear in mind that attendance, or what we might more generally term cooperation, does not necessarily imply a wholesale endorsement either of the biomedical construction of a condition or the intervention offered; just as non-attendance does not necessarily involve a whole-sale rejection. On that basis health services should not assume that cooperation implies full acceptance, just as non-cooperation does not necessarily equal resistance. A focus on the behavioural level in no way adequately represents the diverse range of positions or stances that individuals may adopt, and so is therefore misleading. For example, Potts et al. (2004) showed how, while many men were resistant to the problem of erectile dysfunction being medicalized, they nevertheless took advantage of the medical treatment offered. Similarly, it is conceivable that the currently relatively high rates of coverage in public health initiatives such as the cervical screening programme could quickly be undermined, as the recent case of the MMR vaccination demonstrated.

Attempts to define what resistance might mean, and to apply such definitions or conceptualisations to particular practices within the context of empirical work

can, as we have seen, be complex. Grimshaw (1993) has identified some of the difficulties, including on what grounds we can identify something as resistance, how we can distinguish between effective and ineffective resistance and how we are to determine when a particular behaviour or practice represents the mere reproduction of conventional norms and when it becomes resistance. These difficulties are illustrated to some degree in the discussion above. However, an important problem neglected in this list of difficulties concerns the normative judgements that may, either intentionally or unintentionally, be associated with resistance. There are of course dangers inherent in starting out with a fixed and arbitrary dichotomy between celebrated, active resistance and passive, negative acceptance or cooperation - not least because such a starting point may well over-determine where any subsequent analysis ends up.

This is a significant risk that needs to be avoided in exploring empirically the relationship between power and resistance, and particularly demonstrations of the latter in the face of the former. The recognition that resistance may well be morally-weighted, whether positively or negatively, is important. One key example of this is the need to avoid 'romanticizing resistance' and recognise the issues that may arise from this. In particular, the temptation to 'romanticize' women's resistance and ascribe it a quality that was never intended has been recognized (Abu-Lughod, 1990), and Abel and Browner (1998) have suggested that much of the emphasis upon women's resistance is the result of a desire to describe dominatory patterns while avoiding portraying women as passive victims. This recognition of a desire on the part of some to restore agency to

apparently oppressed individuals or groups is important as it taps into the implicit normative judgements involved in regarding resistance to power as inherently positive and the associated risk of celebrating individuals' actions without a critical examination of their consequences.

Celebrating resistance without adequate attention to the context and possible consequences is a very real danger, and this issue has been highlighted within the context of health and illness by Timmermans and Haas (2008) who argue that sociologists have largely failed to engage with the normative functions of health interventions, i.e. the prevention of ill-health, the curing of disease and so on. They trace this failing back to the decline of functionalism and the rise of a critical social constructivism, which they suggest 'replaced the shared norms of science with the one norm of organised scepticism towards medical authorities' (2008:670). They do not suggest that the sociologist's role is to legitimise the authority of health professionals, rather they argue that 'a critical appraisal of these powers is necessary but such an analysis should take the overall health purpose of interventions into consideration' (2008:671). Similarly, Prior (2003) has argued that, whilst individuals can have extensive knowledge of their own health and illness experiences, and may develop and advance sophisticated theories on the basis of these, there are nevertheless limitations to lay thinking. On this basis, awareness of wider medical or epidemiological evidence may be limited or non-existent (and, as Prior points out, there is no reason why individuals should possess this). This is not necessarily to discount or trivialise lay understandings, but simply to restate the need to critically evaluate the wider

context and possible health implications for themselves and others; for example a pregnant woman's refusal to give up smoking on the basis that it did no harm in previous pregnancies or parents' refusals of childhood immunisation. In these cases individuals' resistance to medical expertise may be characterised as being based on incomplete or flawed evidence. In conceptualising and exploring resistance to powerful medical and public health discourses, it is important not to lose sight of the ultimate goal of treating and preventing disease: the extent to which we should applaud resistance to health promotion discourses if the subsequent behaviours put individuals or populations at greater risk of harm is a moot point.

It is thus important not to make uncritical normative judgements on the validity or appropriateness of such demonstrations of resistance. It may be tempting to applaud individuals for developing strategies of resistance, particularly if one has set up in advance an overly-simplistic dichotomy between powerless, oppressed individuals on the one hand and active, resisting individuals on the other. This is where a simplistic reading and application of early Foucauldian work might lead us. One key question is whether we should simply applaud such resistance as evidence that individuals have been able to develop a sustained and coherent counter discourse which allows them to escape from biomedical domination and account for and defend their actions. Many individuals or groups who are engaged in what may be regarded as deviant behaviour (for example organised crime or speeding in their cars) may be able to advance perfectly coherent and sustained accounts of why they are acting legitimately on the basis of

interpretation, negotiation and framing of key issues and/or the undermining of expert pronouncements in each case.

This review of empirical work has shown that individuals may resist in different ways, employing different resources and pursuing their resistance to differing degrees using a range of strategies. Just as power is diffuse and dispersed, present within all social interactions, so resistance can also be thought of in such terms. The conceptualisations of resistance explored in this paper fit well with, and build on, feminist arguments that resistance cannot be reduced to a single locus and that attention needs to be focused on how women can be 'negotiating at the margins of power' (Davis and Fisher, 1993:6). However, this does not mean that such resistance is meaningless or is not worthy of sociological attention. On the contrary, such resistance, aside from being intrinsically interesting in its own right, is important for the potential and power that it has, and for what it can contribute to our understanding of the relationship between power and resistance in everyday life.

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