The History of Medical Geography after Foucault
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Medical geography is a small sub-discipline of academic geography. Its presence within histories of geography depends in part upon whether geography is considered as a discipline or whether there is a broader understanding of geographies as forms of practical and popular knowledge. lf we take the second approach, medical geography would seem to be quite important in the development of geographical imaginations. There are connections of cause and responsibility between these popular and academic geographies. Quite often, popular knowledges get treated as precursors of academic disciplines yet the connections are reciprocal and continuing.

Medical topics appear in histories of geography under two main guises: as an occasion of environmentalism or as a field of spatial analysis (Mayer 1990). These two form the backbone of this chapter. I begin by indicating some of the ways these two aspects of medical geography have featured in histories of geography. Then, I consider these aspects in the light of three tactics from Foucault's historical writings (see Table 1). I take up the question of the relations between discourses and practices. I look at the processes whereby subjectivities are shaped. Finally, I look at the political issues raised in history writing, illustrating my account with reference to the imaginative geographies '(Said 1978, 55) of AIDS.

	Tactics and themes in Foucault's historical writings		
Styles of Medical Geography	Discourses and Practices	Governmentality and Subjectivation	Critical and Effective Histories
Environmentalism	'Of Airs, Waters and Places'	Dietetics and 'Of Airs, Waters and Places' (Subjectivation)	Africanization of AIDS
Spatial Analysis	Exemplary institutional Archipelago	Ecological analysis (Governmentality)	Diffusion and Diffusionism in AIDS studies

Table 1. Some links between medical geography and the historical writings of Michel

Medical Topics in Histories of Geography

Hartshome's sectarian The Nature of Geography (1939) is largely a polemic against Geography considered as a form of environmentalism. Medical matters are absent both from his account of those who came to prepare the way for Humboldt and Ritter and of the contemporary heresies which geographers following the classical model should denounce as deviations. Glacken s broad church in *Traces on the Rhodian Shore* (1967) deals only with Hartshorne s Old Testament and stops before the nineteenth-century era of Hartshorne's Classical Geography.

By virtue of his treatment of Geography as a science of dynamic distributions, Sauer, Glacken s mentor, was one of Hartshorne's heretics. For Hartshorne, the true geographer did not dabble in change. Historians and geographers should be good neighbours, comfortable in their good fences. Glacken appeared to ignore these debates and wrote a biography of a set of intellectual ideas about the environment; not properly geographical ideas at all according to Hartshorne. Up to the late eighteenth century, environmentalists, according to Glacken, took up three questions: is the earth a fit home for people; has it actively shaped cultures; and has it been irreparably damaged by people? The last of these was a central concern of Sauer's, particularly after the Second World War. His anxiety about the environmental impact of industrialism informed both his optimistic reading of the carrying capacity of preindustrial (and pre-Conquest) Meso-American agriculture, and also the doomwatch tone of the conference he instigated on 'Man's Role in Changing the Face of the Earth '(Thomas 1956). Glacken writes the prehistory of his mentor s moral vision. Environmental medical themes receive careful attention. Disease bore upon both the question of the fitness of the earth for habitation and on how natural forces had shaped settlement and society. Hippocrates' works, such as *Of Airs, Waters and Places*, and their rediscovery by Bodin, were treated carefully in Glacken's book. There is nothing on human modification of the environment as a precondition of population increase. Like Sauer, Glacken is sceptical about human mastery of nature.

Glacken s work has been criticized of late. His studies of environmental ideas fail to address their context. This means at least two things. At one point, before 1989 perhaps, it seemed as if 'We're all Marxists now'; no doubt on grounds which would have led Karl Marx himself to repeat his claim to Paul Lafargue: 'As for me, I am no Marxist' (Draper 1978, 5). Since the landmark collection, *Geography, Ideology and Social Concern* (Stoddart 1981), historians of geography have been invited to ask of any geographical idea: what was the social or economic demand for this view of the world? By and large, this has served to make geography a moment in the history of imperialism. For example, one of Glacken's former research assistants returned to the issue of environmentalism and presented it as capitalism's alibi for the dirty business of class exploitation (Peet 1985). The second use of context brings me to the central issue of this chapter for in some, equally superficial, senses we are all Foucauldians now insofar as we treat geography as a discourse which establishes its own truth conditions anew in each context: 'He possessed that rare capacity as a thinker to open us to an optic ... whose perspective now seems so familiar that it is difficult to see how we previously failed to bring it to bear' (Soper 1995, 21).

Livingstone's *The Geographical Tradition* (1992) is a somewhat unstable marriage between these two versions of context. As Latour (1993 [1991]) suggests of the approach of the Edinburgh School to the history of science, a conventionalist reading of science has been placed alongside a realist reading of material determination. Livingstone is concerned both with how environmentalist ideas work and with what needs they serve in each period. The geographical tradition turns into a relay race in which each generation finds its own environmental voice to address the current needs of the hegemonic social order: comes the time, comes the geographer. At least, that is, until

the present, when the relay race breaks down with runners wandering off in postmodern indifference, each thinking they have the baton but uninterested in where to take it.

Livingstone takes up Glacken's reading of medical geography as a branch of environmentalism. He goes back to Hippocrates, back to Bodin and on to the nineteenth-century debates over the natural limits to white settlement in the tropics. The two senses of context are laid alongside each other. Bodin's writings are considered in the light of the Age of Discovery but also against attempts to read God through his creation, specifically to produce an astrological anthropology. Likewise, the nineteenth-century moral climatology is presented as an ethical reflection on racial responsibility and difference, although here the voice of Marx prevails over Foucault's since the instrumental value of these writings for commercial imperialism is repeatedly stressed. I do not want to adjudicate this ambivalence, although I find Latour s discussion of what Haraway has called hybrids a useful way to think about objects of knowledge which are yet embedded in practices and in networks of verification and replication.

If we tum to the second of my styles of medical geography, that is as spatial science, we find an even more fragmented conception of its history. In the first place, the spatial scientists were disinclined to take up Hartshorne's challenge and write a story of the emergence of geography which justified their approach. Bunge (1966 [1962]) suggested that the history of the discipline was more or less irrelevant to current practice because modem geography contained the accumulated wisdom of geographies past. Haggett (1965) was a little more guarded and proposed that a version of geography as locational analysis could call upon a long tradition of geometrical studies going back to the Greeks. Yet neither Haggett, nor any other scientific 'geographer made any serious attempt to document or use that tradition. In the second place, when the quantitative geographers spoke of diffusion studies in the 1960s they almost always meant the diffusion of innovations and not of diseases. This reflected the strongly economic nature of the topics that models in human geography were intended to address. To some extent, it was the attacks (Blaikie 1978) on the validity of innovation diffusion as a model for economic growth which shifted the attention of the modellers from an area (innovation adoption) where there seemed to be a need to complicate models with a whole set of inaccessible behavioural postulates to an area (the spreading of diseases) where there seemed to be no such need. Modelling now had a different set of antecedents, and modem works in quantitative geography now make reference to John Snow and the BroadStreet pump among other early studies in 'medical geography' (Cliff and Haggett 1988, ch.I; Gould 1985, ch.19). Although Haggett (1965) referred at first to these medical studies as the application of geographical methods outside geography, they are now admitted more readily to the canon. It might be possible to take up Haggett's invitation to consider a history of the geometric tradition in geography, and to document its connections with popular and scientific understandings of disease diffusion or other medical matters. In this way Philo (1995) has provided a contextual account of the so-called Jarvis Law describing the distance decay function covering the use of mental health institutions. However, I am not going to follow up that work here.

Instead, I want to return to Foucault and excavate some different medical geographies that we might historicize. Then, I shall tum to modem medical geography. There is a connection between the particular vision of medical geography current in

histories of geography and some of the limitations of modem medical geography. Livingstone is always looking for versions of popular geographies around which the discipline can heroically, if embarrassingly, institutionalize by the late nineteenth century. There is value, I think, in recovering a more dispersed medical geography by continuing with the study of the connections between popular and academic geographies beyond the period when university departments were created.

Discourse and Practice

In 1984, Foucault suggested that his work had covered three topics: 1 tried to locate three major types of problems: the problem of truth, the problem of power and the problem of individual conduct' (1988a, 243). If we take Foucault at his word, it is possible to locate some of his central obsessions in terms of the relations between truth, power and the individual (see Figure 21.1). It would perhaps be more consistent with Foucault s suspicions to speak of truth-effects, power-effects, individual-effects and social effects detectable in the practices they inflect and allow.

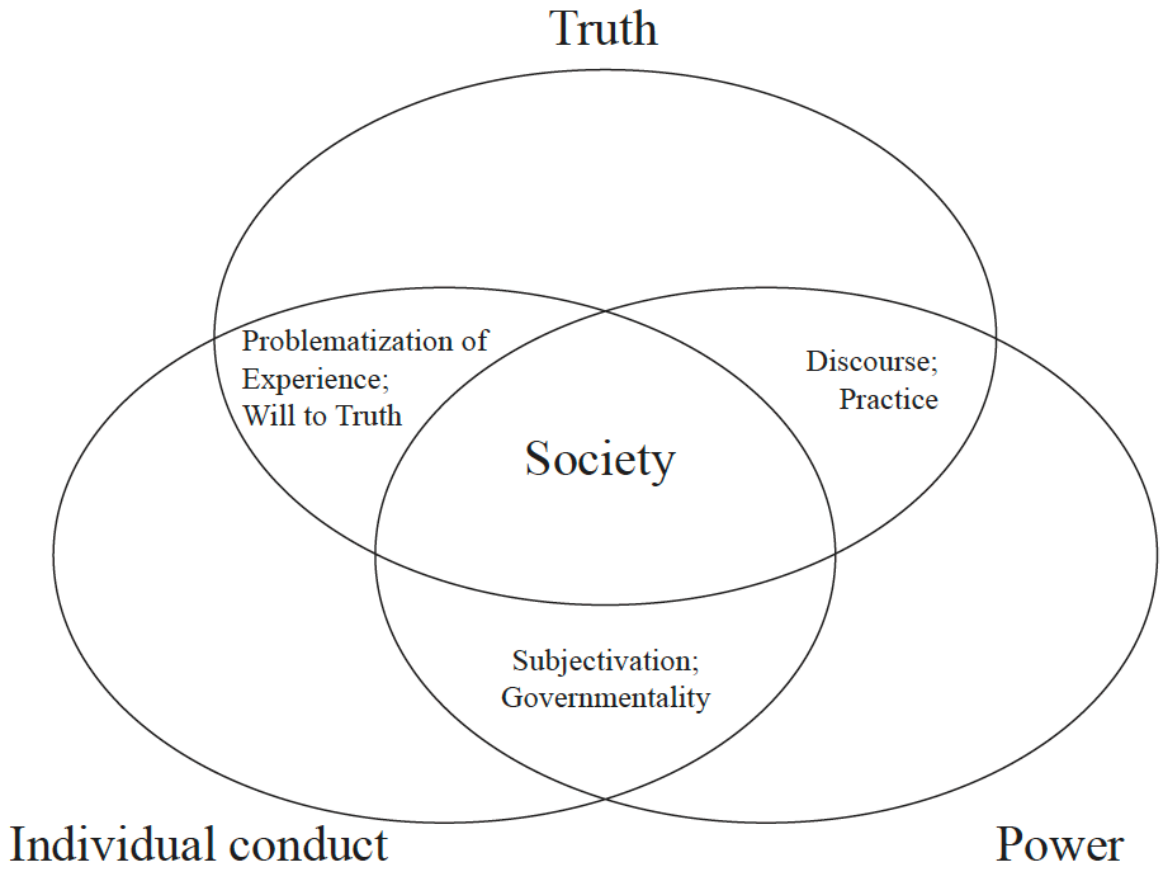

Figure 1. Some themes in the work of Michel Foucault

Works such as *The Birth of the Clinic* (1973 [1963]), *Madness and Civilisation* (1965 [1961]) and *Discipline and Punish* (1977 [1975]) concern the relations between power and truth. In *Madness and Civilisation*, Foucault, as is well known, connects discourses about madness to the disciplines practised upon the mad. In the name of having the true understanding of madness, people locked up the mad, first in all-purpose hopitaux generaux and later in specialist asylums. Madness was rendered as a fit subject for

incarceration by being seen as homologous with other forms of refusing the universal imperative to labour. The result of madness was an unfitness to labour and thus incarceration was appropriate. Through incarceration a new subjectivity could be formed in which, by physical and moral means, regularity and a moderation of habits could be made second nature. Individuals, now in control of themselves, could be trusted to take up again their obligation to earn their living by the sweat of their brow. Foucault insisted upon the interrelations between the discourses of madness and the practices of institutions such as the asylum. The conditions of existence of the propositions of madness discourses include both adjacent discourses (on poverty, on the body) and specific institutions (the asylum, the church, the sovereign). Some things can only be thought because other things can be done, while some things can only be done because they can be thought that way. Lest this seem overly deterministic, Foucault also insisted, more fully in interviews and lectures than in the text of *Madness and Civilisation*, that there are counter-discourses and counter-conducts (Bouchard 1977). Yet these contests are not even. The sovereign appropriation of Truth is an attempt to censor counter-discourses and to block counter-conducts.

In some ways this is the Foucault who is closest to the Edinburgh School and to David Livingstone. This is the Foucault who proliferates distinctions specifying the mechanics of the formation of discourses (1991a). Those practical and discursive conditions of existence of practices and discourses that are sedimented in earlier times can be isolated and linked in temporal genealogies. Likewise, discursive systems can be made comprehensible through mapping their interrelations as an episteme of promiscuously bifurcating divergences and dependencies. The archive of any earlier episteme can be approached as an archaeology.

Madness and Civilisation opens up a rich field for histories of medical geography. In terms of my earlier distinction between environmentalism and spatial science, let me mention but two. First, it gives a particular inflection to the *Of Airs, Waters and Places* writings treated by Glacken and Livingstone. The healing role of nature, in the case of madness, valorized nature for temporal regularity and spatial variability. The travel cure and the walking cure stand in some sort of relation to contemporary anxieties about madness, about fitness to labour. Hippocrates is not, therefore, rediscovered so much as reworked. Second, the quasi-networks of poorhouses, prisons and hopitaux generaux express two things. On one hand, an exemplary geography of the right to confine is created. Any geography of medical service delivery needs to treat this symbolic element. It needs to consider why medicine became an appropriate vehicle for such an archipelago of the right to confine. On the other hand, in a later period, the new rural asylums created a new geography of the caress of nature, in which marginal places were lauded as soothing to the worried brow. This geography of asylums was a direct spatial critique of the urbanization of modem society. Nature was valorized against the city, against modernity, in the name of a rather different symbolic geography of health services: 'Nature ... has the power of freeing man [sic] from his freedom '(Foucault 1965, 194).

As I say, this is perhaps all too familiar although in directing the attention of historians of medical geography away from their esoteric texts towards the contemporary disciplinary spaces and geographical practices, it has yet to yield all its

treasures (for some further suggestions of what these might be, see Philo 2000; Kearns 2001). In some ways, though, I am more excited by what happened to Foucault s work when he triangulated his mistrust of power/knowledge systems with a new concern for individual conduct.

Governmentality and Subjectivation

Governmentality was treated by Foucault (2004a; 2004b) in two of his annual series of lectures (1978 and 1979) to the College de France. In his published works, notably the second and third volumes of the History of Sexuality (1985, 1986; published in France in 1984), he turned instead to subjectivation. The two are related but not identical. Governmentality produces more than subjects. Subjectivation involves more than just the actions of the state.

Modem states rely upon power rather than mere violence. In some respects they require the consent of the ruled. The practices of government presuppose people with choices, people as decision-making subjects. The modern state, suggested Foucault (1991c; see also Pasquino 1991; Burchell 1991; Procacci 1991; Donzelot 1991; Castel 1991), was essentially created in the seventeenth and eighteenth centuries when the population became the focus and instrument of government. Formerly, the acquisition of estates paying taxes had been the goal of a successful monarch. Now, population became the focus of government, replacing territory as the thing that defined the well-being of the state. Intellectually, population was increasingly seen as having its own laws of motion, detectable in swings relating to national prosperity. The good of the state was seen as best served by a numerous and contented population. Foucault argued that this period saw the emergence of a form of governmentality, of a governmental rationality based on police theory. This combined the religious, pastoral concern for individuals with the civic, abstract management of the many. The police state individualizes, normalizes and totalizes.

The individualizing dimension of the policing state centres on good conduct and the problems of the moral order of the city. When Foucault tried to specify what this involved he began to describe the forms of self-examination that we learn and to show how these relate to notions of individual good conduct in social life. He had already described how madness served to reinforce an injunction to labour, but in his later works he was increasingly concerned to explore how our obsessive regulation of sexuality might teach and reinforce forms of good conduct that make us governable subjects. In The Use of Pleasure (1985), Foucault took fourth-century Greek society as an example of one form of this self-regulation of private conduct in the public good, suggesting in addition that there were significant respects in which early Christian writers drew upon these ideas. Foucault identified four dimensions of the self along which Greek male citizens were encouraged to examine their conduct, particularly with regard to sexuality (see Figure 2). Greek male citizens were asked to examine their relations with their own body, to problematize their use of it. This discourse of care for one's body was called dietetics. In part, it depended upon recognizing the part of one's self that should be subject to moral conduct. One was expected to be other-regarding in various situations among which Foucault examined those areas covering the relations between the male citizen and his spouse and between the male citizen and his boy lovers. The first of these referred in particular to various forms of courtship and was known as

erotics. In each case, the forms of self-reflection took on a particular character relating, respectively, to ethics and ascetics. Integrating and overseeing all these areas of self-examination was the question of the Greek male citizen s relations with truth and the problematization of this set of relations constituted philosophy. Cultivating this last dimension of wisdom involved submitting to a particular moral regimen. Moderation and self-control allowed the cultivation of pleasure and the pursuit of that moral perfection which was most consistent with fulfilling the obligations laid upon one as a citizen.

Discourses	Problematize one's relations with	Subjectivation: Practices of the Self
Dietetics, Health	One's own body	Aphrodisis/Ontology: Identify the part of the self which is subject to moral conduct
Economics, Household Management	Women, Spouse	Chresis/Deontology: Identify the ways one must relate to the rules of good conduct
Erotics	Men, Boys	Enkrateia/Ascetic: Elaborate exercises which make one ethically fit, and develop self control
Philosophy	Truth, Wisdom	Soprhosyne/Teleology: Recognise the broader sense of moderation to which cultivation of the self must tend

Figure 2. The dimensions of the subjectivation of adult male citizens in fourth-century (BCE) Greek society

These inter-related concerns with govemmentality and subjectivation invite extension and elaboration. In the course of this, new histories of medical geography might be broached. Clearly Foucault's account of dietetics provides a further way of exploring the 'Of Airs, Waters and Places' discourses in terms of how climate affected the body and how the prudent management of one's exposure to different sorts of weathers and places might be part of a regimen for good living. The anxieties and

promptings of these discourses suggest a range of things that might be at stake in what Livingstone terms moral climatology. Stoler's *Race and the Education of Desire* (1995) develops some of these.

Stoler argues that European bourgeois identity was framed by the experience of being colonizers and that it was this colonizing European who defined domestic nervousness around cleanliness and health. These agitating worries were learned as part of an attempt to define civilized conduct in a place where race trumped class, and where the colonial encounter proliferated a whole set of subject positions which seemed to be not quite European, not quite native. A regimen of domestic cleanliness set against a background of environmentally-derived moral danger was charged with holding the European line in the face of what Spivak would term hybridity. McClintock shows in Imperial Leather (1995) that health and cleanliness became central concerns of bourgeois subjectivation. Indeed, the race experience of the colonies increasingly served as a grid for articulating other dimensions of difference in nineteenth-century Britain. Soap became a fetish. Strict spatial distinctions created pools of purity in dangerous seas. Here we have a medical geography that brought the empire back home and used health and cleanliness as a way of racializing the domestic sense of bourgeois superiority. Moral climatology was more than just part of the practice of colonialism; it was also part of the practices of the self.

These practices of the self were elaborated not only with regard to a temporal sensibility, as Foucault notes (the play of the seasons in dietetics, of the fleeting moment in erotics), but also as a spatial sensibility around environment, and across public and private spaces. This spatial sensibility carried its own dangers relating to the elements of the envirorunent, to shame in public space, and to scarcity in the domestic household. The moral topography of disease and dirt articulated these concerns in the form of a medical geography for the British imperial bourgeoisie and its associates.

Governmentality also disposes a new set of fields for histories of medical geography. The concentration on population gave rise, argued Foucault, to a state technology he termed biopower (Legg 2005). To a large extent this involved the management by the state of the ecology of populations located in various spaces; in particular in either urban or rural spaces. The aggregate description of this managed population in census and vital registers was both an instrument of policy as well as an objectification of the state s new field of competence.

In his book on the decline of British fertility in the late nineteenth century, *Fertility, Class and Gender in Britain, 1860-1940*, Szreter (1996) shows just how tenaciously a certain strand of liberalism held onto the ecological method, with its urban-rural divide, as an instrument of knowledge which allowed certain policies and not others. Thus, when a class analysis threatened to legitimize eugenics policies, the liberals at the General Register Office fought tooth and nail to retain control of the census. In this way they hoped to preserve an ecological treatment of the British social structure that could be married to their geographical framing of the collection of vital statistics. More importantly, perhaps, this geographical framework was ill-suited to articulating anything other than an ecological account of how populations should be managed. Medical geography as spatial science was a very distinct dimension of governmentality.

Critical and Effective Histories

I want to conclude this discussion of Foucault's tactics by turning to the politics of history. Kritzman finds in Foucault s work an unquestionable suspicion toward any order through which knowledge is transformed into power and vice versa '(1988b: xvii). This seems right, as does Deans (1994) account of the relations between critical and effective histories in Foucault. By showing the odd nature of earlier links between knowledge and power, Foucault could denaturalize the present, undermine its self-evidence (1991b, 76; Bouchard 1977), create space for thinking how it might be different. Thus a 1984 interview found him proposing that: possibility that it might indeed exist as a. discourse of power. The ways historical work problematizes the present, its fatal self-evidence, is ultimately an imaginative and political question. It is not dictated by or guaranteed by historical scholarship. With that important caveat, I tu1n to modem medical geography and to AIDS (surveyed in Kearns 1996).

What are the connections between modem medical geography and the old environmentalist discourses of *Of Airs., Waters and Places* or the population discourses of biopower? In some ways they remain close. The environmental focus is still important and valuable work is still written under the sign of the ecology of disease. Secondly, the practices of biopower are still present in two ways. On one hand, we have pure epidemiological models retooled as a form of spatial science. On the other, we have the managerial perspective of service delivery with its account of hierarchical regionalization, health care systems in space, and so on. This caricature makes medical geography sound rather old-fashioned in the light of current trends in modem geography. This is unfair, and I shall return to this point in my conclusion, but it is certainly striking how far medical geography retained an environmental focus long after determinism coughed its last in human geography more generally. It is also striking how far medical geography has retained its status as a purely spatial science long after the behaviourist critique had undermined the neoclassical foundations of geographical models n1ore generally. All this is to say that medical geography remains concerned with some of the persistent questions about health, society, space and place that animate popular as well as academic discourse.

This is where the matter of AIDS becomes relevant and this is where a work such as Gould s (1993) *The Slow Plague*, written, so he tell us, *pro bono publico*, requires more extended commentary than I can give here. Let me take the three dimensions of medical geography to which I drew attention in the previous paragraph and see how they correlate with the dispersed medical geographies of the popular imaginary when it comes to AIDS. Take environmentalism. In films such as *Outbreak* (Petersen 1995) or at the beginning of works such as Shilts' (1987) *And the Band Played On*, in television documentaries which treat African AIDS as an expression of the same identity of nature and culture which brought famine in the Sahel, the early deaths displayed in charity commercials, inter-tribal violence, and so on; in all these places dark Mother Africa sweats disease, tragedy and threat (Packard and Epstein 1991; Watney 1989). This is a threat that is racialized in ways recalling directly its colonial referents. It is an imaginary environmentalism equating Black people with African nature, and African nature with evil, in a discourse of origins that is actually a discourse of blame. In the case of Haiti, in the case of the inner-cities of the United States, this is the race discourse of AIDS as

WOGS (the wrath of god syndrome). Geography can counter this by producing non-environmentalist discourses of poverty in Africa, by questioning the significance accorded the holy grail of origins.

The objective space of epidemiological models runs many of the same dangers. Instead of the conflation of nature and culture we get their almost complete discounting. Diseases are autonomous spatial processes and may be figured as diffusions. As Brown (1995) argues powerfully, this amounts to a decontextualization of the spread of the virus erasing the sufferings and achievements of the specifically gay communities which first confronted HIV and AIDS. The diffusion model is a dangerously seductive and powerful figuring of disease. Disease comes from somewhere else; it is external to our society at least. Disease moves across space and down urban hierarchies, it is contagious. The population ecology is understood as risk groups rather than risk behaviours (Oppenheimer 1992). Yet AIDS is largely a function of internal arrangements, what Blaikie et al. (1994) term the social distribution of vulnerability (see also Barnett and Blaikie 1992). It is not contagious. It is not spread by casual contact. It poses no threat to everyday sociability. Finally, a non-stigmatizing emphasis on education for behavioural change may be the only effective preventive measure available for so1ne time. The lazy, dangerous geographies of the public imagination need challenging, not encouraging; *pro bono publico*.

Lastly, the technocratic focus on health service delivery emphasizes intelligent direction from the centre and implementation in the periphery; a conceptualization that Blaut criticizes as diffusionism '(1977; 1987). Against this, I would urge us to acknowledge the striking effectivity of place not just the disciplinary regulation of space. Let me give two examples. Shilts' *And the Band Played On* documents such indifference on the part of the government of the United States towards what they saw as a gay plague between 1981 and 1987 that Kramer (1989) is certainly justified in concluding that the conservative Right, many of whom purport not to believe in natural selection, saw gay people as expendable. It was a gay man, Michael Callen, who preached the gospel of safe sex at a time when the Jeremiah's of the 'Just Say No' campaign were urging an insulting and deadly double standard: thou shalt have no sex other than marital heterosexual sex. It was a gay voluntary organization in New York, Gay Mens Health Crisis, which developed the techniques of buddying and of domestic support for the sick. It was the gay men in San Francisco who humanized Ward 5 (Wolf 1991) of the San Francisco General Hospital, turning it into a beacon of hospice care which has eased suffering in a myriad of other Western cities. It was from the counter-discourses and counter-conducts articulated around the solidarities of place and community (Geltmaker 1992), that effective and dignified health care sprang. Kayal (1993) describes this as an ethic of voluntary communalism and while I would look more at the political structures that render communalism more or less effective from place to place, I think Kayal is right. The technocratic discourses of centralized health care management can be murderous. The lesson will only be learned if we find ways to talk about and valorize these resistances.

Finally, let me turn briefly to the question of the passivity of the Third World. Within the same technocratic discourse of diffusionism, the West is presented as the source of all wisdom and Third World countries are berated for their fatalism in not

recognizing the urgency of the Western agenda. Again, there are counter discourses and counter practices to recover (Kearns 2006). There have been, as Farmer (1992) shows in AIDS and Accusation, Haitian scientists resisting the racialized construction by scientists in the United States of Haitians as a risk group for AIDS *sui generis*. The Haitian scientists conducted their own research. They re-questioned HIV-positive Haitians and found, contrary to the answers given to epidemiologists by illegal aliens in the United States, that many had indeed engaged in relevant (illegal) risk practices. They showed that HIV cases clustered in a part of the Haitian capital that served as a red-light district for American tourists. They questioned the lazy acceptance of speculative reports about blood rituals in voodoo and about green monkey business in Haitian brothels. Haitians in the United States demonstrated against and occupied the headquarters of the Food and Drugs Administration, urging that the embargo on people of Haitian origin giving blood be rescinded. The government of Haiti lobbied the government of the United States on the same issue. This is enlightened David confronting bigoted Goliath.

Much the same is true of certain Asian and African countries. Rejecting the expense and false security of testing, they have tried to develop appropriate technologies of prevention including comics, theatre and advertising (Reid, 1995). On occasion, these have shown a frankness that should shame the West with its own rather coy advertising campaigns. Yet when it comes to thinking about poor countries, the Western geographical imagination is willing to entertain almost any bizarreness given only that the picture presented is bad, fatalistic and bestial. Geographers should not collude with this, they should not, as did Gould (1993), offer inappropriately sweeping generalizations about, say, sexual mores sustained by little more than anecdote. In short, we can only counter Eurocentrism by looking for the agency of others, not by imagining it away (see Coronil 1996; Dussel 2000).

Conclusion

To some extent, of course, I am pushing against an open door in arguing that the works of Foucault be taken seriously by those writing historical studies of the subject matter and approaches of medical geography. Ogborn (1993a, 1993b) has taken up Foucault s work on the law, Driver that on poverty (1993) and Philo (1992; 2004) that on madness. These works are particularly strong on the links between geographical discourses and geographical practices in these areas of social policy as they pursue 'research in both the historical geography of ideas (with its concern for the spaces of knowledge production and consumption) and the historical geography of social institutions (with its concern for the spaces of control, correction and care)' (Philo 1996, 2-3). A moral-locational analysis was part of the institutional practices in these fields and through this lens of moral topography the city of dark and light took on an almost apocalyptic hue (Driver 1988). Philo (1996) builds on this work to reflect upon the sites and tracts of Reason and Unreason in the nineteenth-century city.

It is also clear that many of the topics which Foucault s historical works introduce are also being urged upon our sets of agenda through the practical politics of those who fight against the limitations and disciplines of medical discourses and practices. Bell (1995) is right to point to the sites of resistance and new configurations of power thrown up by new social movements as crucial in the re-education of political geographers. Dorn and Laws (1994) and Brown (1995) have said much the same of

medical geographers. Some of the most exciting work on the geography of AIDS calls upon the methods of cultural studies and ethnography to draw these experiences into the reflections of geographers upon the epidemic (Geltmaker 1992; Brown 1994). Of course, these separations between discourse and practice were never complete, for Foucault's work was both informed by and in turn taken up by several groups in struggle.

I have suggested that there are links between the way we conceive of the history of medical geography and how we might continue to practise medical geography. Most often this relationship is rather loosely figured as the license given by history to some particular account of the essence of the sub-discipline and its wider relations with geography and medicine (Mayer 1990; Paul 1985; among many others). I would propose that medical geography should include within its remit the nature and consequences of medical-geographical ideas and strategies in popular as well as policy circles. It should include within its remit the ways space and place are taken up by medical disciplines and in resistances to those disciplines. It should concern itself with the power relations implicit and explicit in the areas of science, academia, medicine and health; in particular with respect to those ways its own authority requires and reinforces such power relations. To some extent, social theories offer sustained reflections upon such political topics and it would not be difficult to excavate the critical and utopian projects at the heart of structuration theory, symbolic interactionism and humanism as discussed by Jones and Moon (1993) in their review of the relations between medical geography and social theory. In this connection, it is fine to note the number of medical geographers who are engaging seriously with the geographical ideas formulated in Canada and now embedded in the Health for All strategy of the World Health Organization (Taylor 1990). This is not the place to enter into any serious consideration of their work but clearly the operationalization of health indicators (Hayes and Willms 1990), the notion of place-based communities (Coombes 1990; Dorn and Laws 1994) and the utopian idea of total health (Kearns 1993; Mayer and Meade 1994) raise important questions about the relations between discourses and practices.

As medical geographers explore the dispersed medical geographies that emerge when we follow medical geographical ideas out of the sub-disciplinary corral, I believe they might find Foucault s historical tactics of continuing value, and although I have presented three distinct tactics and even illustrated them with separate sets of Foucault's writings, the tactics I have described are certainly interrelated. A concern with what was done as well as said in the name of medicine, returned Foucault to that 'corporeal spatiality' which the much-vaunted objectivity of positivist medical science denied (1973, 199). An interest in the way institutions trained individuals led to an investigation of the way that training was carried out in the wider society both through the state (governmentality) and through individual self-examination (subjectivation). All of this was motivated by a wish to learn from and help those struggling to resist the normalizing powers of the state, medicine and a bourgeois conscience. Critical histories reveal the tangle of strategy and contingency that has produced the apparent naturalness of these present arrangements. Effective histories move us to recognize the legitimacy of challenges to this normality and also serve to further empower resistance. Here is an important set of issues for those tempted out into the wider world of discourses,

practices, institutions and subjectivities where instances, analogies and homologies of medical geography may be found.

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