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Moral discourses and pharmaceuticalised governance in households

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Research Highlights

We examine moral positions taken by people in relation to pharmaceuticals
This provides insight into roles taken in relation to pharmaceutical solutions
Identified moral positions are associated with views of social and bodily disorder
Pharmaceuticalised modes of governance are resisted by some but not others
Different forms of governmentality arise from these different moral positions

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Introduction

The recent rise of interest in processes of pharmceuticalisation (Abraham 2010a; Abraham 2010b; Bell and Figert 2012; Williams et al. 2011) have engendered debates about the place of pharmaceuticals in societies, what they do, and how they function to construct their consumers (Dumit and Greenslit 2006; India 2011; Martin 2006).

In responding to disease and illness people deploy many terms for their treatment practices. If the practice involves ingestion of a substance we refer to such terms as pharmaceuticals, medications, remedies and tonics. These terms indicate that what is used has some biologically or physiologically ‘active’ ingredient. This paper argues that taking substances with active ingredients is saturated with moral concerns relating to issues of responsibility, identity, stigma, agency and power. The paper

focuses on the downstream aspects of pharmaceuticalisation by exploring the meaning of pharmaceuticals in everyday life (Williams et al. 2011).

Parsons (1958) noted the association of illness with deviance, defining health as "the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he (sic) has been socialized". Failure to fulfil socialised roles is to be deviant and can lead to sanctions. Pharmaceuticals are thus bound to the experience, understanding, perception and representation of health-related deviance.

Research explicitly or implicitly addressing moral concerns of pharmaceutical use has centred on issues of compliance or adherence. In an early review of drug use research, Stimson (1974) noted that studies were undertaken from the doctor's perspective to identify non-compliant "defaulters" who were blamed for not taking their prescribed medications. In a more recent analysis of qualitative studies of medicine-taking Pound and colleagues found that most of this research "focused on why people do not take their medicine as prescribed" (Pound et al. 2005). Reasons for non-compliance included concerns about adverse reactions, dependency, stigma and fears about the impact of some medication regimes on social relationships. Chamberlain *et al*. (2011) report similar concerns of resistance to medication-taking from their research into medication practices within households.

In their examination of medication compliance, Dowell and Hudson (1997) categorized participants into active users of medicines, who could take a sceptical stance, and passive users who were generally 'believers' in medications. They concluded that "patients will attempt to deny their illness and can symbolically do so by reducing or stopping treatment…Understanding the symbolic role of medicines and how illness challenges an individual's identity are key to addressing these issues" (Dowell and Hudson 1997). The symbolic role of medicines is further developed in this research. In particular, pharmaceuticals symbolise forms of governance with different sets or roles and responsibilities.

Research on the lay experience of medications has tended to focus on specific medications, for example retroviral (Johnston Roberts and Mann 2000) or psychotropic medications (Gabe and Lipshitz-Phillips 1982; 1984; Gabe and Thorogood 1986). There are some exceptions to this where discussions have related to medications in general. For example Britten (1996) identified two overarching categories in her interviews with people who attended general practices in England. In one, labelled orthodox accounts, medical opinion was used to justify people's actions and beliefs in relation to drugs and medicines. In the other, unorthodox accounts, people expressed beliefs and opinions that were not based on medical opinion. In unorthodox accounts participants expressed an aversion to medicines because they were not natural, were carcinogenic or would cause other side effects, or failed to get to the root of the problem. In our research we have accounts that could be labelled orthodox and unorthodox, but the starting point of our analysis was to identify moral evaluations of medications mentioned by participants and how participants positioned those moral evaluations in relation to ideas of the social and natural order.

Taking pharmaceuticals can suggest moral failing. Williams (2000) found that teenage boys, rather than girls, saw chronic illnesses, such as diabetes and asthma, as a threat to their status and so concealed their use of medications, such as injecting

insulin, from their schoolmates. Johnston Roberts and Mann (2000) noted how the stigma associated with the illness of AIDS led sufferers to hide their consumption of medications. Gabe and Bury (1996) discuss the moral dimensions of the use of benzodiazepines for anxiety and insomnia, arguing that media representations of this class of drugs changed from an enthusiastic welcome when they first became available in the 1960s to a more critical perspective about their wide-scale use and addictive potential from the mid-1970s. This media-based moral approbation of the drugs was paralleled by the public view that it was better to use willpower than tranquillizers (Gabe and Bury 1996).

In this paper we draw on the insightful view that in order to understand the moral evaluation of pharmaceuticals they can be treated as metonyms or as "physical representations of a larger context of which they are part" (van der Geest and Whyte 1989). When we experience an illness, we suffer from some disorder. We attempt to restore order through some action, which may be the consumption of pharmaceuticals. How we position ourselves in relation to taking pharmaceuticals is an outcome of our understanding of where the responsibility for disorder lie, be it in nature or society, be it externally imposed or internally realized. Responsibility is a moral issue as to be responsible can be to cause something, whether good of bad, or to have an obligation or duty to do something. In attempting to restore order, by consuming pharmaceuticals to overcome illness, moral positions around responsibility are constructed and forms of governance, that we call pharmaceuticalised governance, are enacted.

The research

This multidisciplinary project used households as the sampling unit since we have little knowledge of what happens with medications once they find their way into homes. A total of 55 households were purposively sampled from four cities across New Zealand to ensure diversity. Households included a variety of ethnicities and household compositions; households where chronic illness was present; households with children under 12 years and households where either complementary and alternative medicine (CAM) or the use of dietary supplements occurred. Potential households were sought through a variety of means, which included advertising, snowballing, the use of networks and approaches to support groups.

This sampling classification proved rather arbitrary, since most households fit several of the criteria, with for example, prescription medications, alternative medications and dietary supplements being relatively common. We used the term 'medication' broadly, to include anything taken for therapeutic reasons – to treat, cure or prevent symptoms and illness and to sustain health. Hence we sought discussion about anything that participants understood as medication-like, covering prescription and over-the-counter pharmaceuticals, dietary supplements and alternative medications. We specifically excluded illicit drugs from consideration.

Data collection involved a range of methods, including mapping the home and locating all medications, photographing those locations, asking participants to produce all medications and discuss them as a household group, keeping a medication-use diary, keeping a diary reflecting on medications in everyday life, and completing a photo-elicitation project to show the world of medications. The diaries

and photographs were used as the basis for further interviews where they acted as prompts for the participants. Ethical approval for the project was obtained through an institutional ethics committee.

Taking households as the focus on this research and avoiding a focus on specific conditions or types of medication opened up the world of social practices related to medications – routines, placements, relationships, identities and so forth could be discerned through the variety of ways in which the research elicited medication stories. For the analysis reported here, the first author read household interviews to identify moral evaluations of pharmaceuticals and other medications. Four 'repertoires' of moral evaluation were identified through an iterative coding process. Repertoire is used here in the sense developed by Gilbert and Mulkay (1984) as a resource to justify understandings and achieve something – in this case the achievement is a moral positioning of the householder in response to the use of pharmaceuticals. Initial analysis was revised and developed by the other authors in discussion. The four repertoires outlined here relate how order and disorder were attributed in the medications stories, whether pharmaceuticals were a response to and a sign of a disordered society or a disordering self, or whether pharmaceuticals themselves were positioned as disordering or re-ordering substances.

Disordering society

The disordering society repertoire is one where pharmaceuticals evoke a society in an unnatural state. People are made anxious and duped by the fear mongering and marketing of drug peddlers and enervated by social conditions that weaken and deplete. Active resistance, or at least passive distancing, is the stance taken in relation to pharmaceuticals.

Keith provides a detailed account that illustrates the disordering category. He used the photoelicitation exercise to create his narrative. He started by discussing figure 1 noting a contrast between the anti-flamme (herbal cream used for bruises and musculoskeletal aches and pains) and an inhaler used by his children for delivering asthma medications. Keith noted that

> the Anti-Flamme cream – is good stuff. You know, I've had a bad back for the last few weeks and I've been seeing a physio and the Anti-Flamme cream goes a long way, you know, so it's good stuff. We like it lying around. The purple tub is something that, you know, has its place and is something that we regard fondly

Figure 1 about here

When asked what he felt about the inhalers in the photograph he replied "I sort of see them as a bit of a prop and a crutch, I suppose, because without them things can go seriously awry". The inhaler had a "serious overtone" and is a "mechanised thing…plasticated…belonging…to some sort of industry complex". Later he noted other items in the photograph, photos, birthday cards, the tooth fairy bowl, and that "he felt uneasy" about the photograph with "that stuff intruding" on personal things.

A photograph of a radio allowed for reflections on a programme that he had heard about Japanese "over the top" response to sneezes during the swine flu. He interpreted this as "Japan being such an industrialised society anyway that what we see here is just another facet of industrialisation through the whole sort of medical, pharmaceutical complex that in fact people are very much embedded within that and that their cultural response was something that could not be separated from that". He went on to say that Japan "is very far removed from its natural state" in a "hyper" industrial complex and that the "industrialisation of medicine was something that was very much ingrained culturally within people". He then discussed the contents of the book *In Praise of Slow* (figure 2) stating that the book was "in praise of low technology ...You know, stopping to smell the flowers kind of thing… the point of the book is to try and make some sort of connection between a sort of an undercurrent of stuff that is, that is deliberately seeking an alternative path forward".

Figure 2 about here

Prescription medicines, in this evaluation, are positioned within the context of a society that is disordered and pathological – a signifier of things that are not quite right, but maybe at times a necessity. Many householders drew on similar narratives of being distanced from nature. Louisa argued that "we live in a society where our foods aren't as nutritious as they used to be…What we eat doesn't match our lifestyle in terms of we eat a high fat, high protein diet and yet we're quite indolent…We've normalised things that are actually wrong". As a result of this distancing from nature we increasingly rely on pharmaceuticals. Brett, her partner, chimes in with "You see the ads that come on TV… we seem to be getting paranoid and the paranoia is probably driven by capitalism's desire to sell, sell, sell", emphasising another pathological influence on pharmaceutical consumption – marketing. Similarly, for Tania pharmaceutical companies played an important disordering role. She suggested that doctors prescribe medications because "The drug salesmen's just been through and said, 'Oh, look, we're marketing this and it does this, this and this. Here, try some of this'".

Natasha expressed a concern around a cultural shift where "you take stuff for everything" and we are "oversold on how good we can be". She suggests that unrealistic goals in terms of being in a permanent state of wellness are being fostered, critiquing the aspiration of being forever functional (Marshall 2010). Natasha argued that "I live in a world where I don't have to suffer. I don't have to be without. I can buy it for myself. Somebody can help me fix it or whatever [it is] based on perfect health or perfect bodies or perfect lives that's all tied up in a commercial world of transaction…we're constantly being bombarded with advertising and media and marketing and selling, selling, selling".

Natasha then takes a slightly different view saying "when you think of any number of things that can go wrong with the human body then if you tried to cure or fix or cut off everything before it happened ...you'd be wrapped up in cotton wool somewhere. So it's the risk aversion stuff, the safety stuff that goes along with that, that whole safety culture". A culture of risk aversion and the promotion of anxiety around illness, happiness and functioning perfectly made Natasha suspicious of medications. Verity offers similar sentiments stating that "I think we've decreased our resistance, we're

trying to make life too clean and at the same time we're weakening our own resistance to ... what's naturally out there".

In these narratives pharmaceuticals signify a distancing from a more natural world. They can be a prop to deal with the unnatural state we are in, but ideally they should be resisted. They can potentially be resisted in situations where the 'self' is not reliant or dependent upon medications, allowing resistance to pharmaceuticalised forms of governance where a quality of life is dependent on external medical agents. Illness results from 'upstream' social and cultural influences, and it is those influences that are responsible. Pharmaceuticals only deal with the symptoms and so as a society we are morally obliged to consider social and cultural change to restore order. By contrast, in the disordering self repertoire pharmaceuticals are a sign of personal failing.

Disordering Self

The disordering self repertoire is one where pharmaceuticals signify a moral failing of the individual or a stigmatized failing of the body or both. This failure of the self can be stigmatized by others and lead to forms of discrimination. Access to that which is required to maintain some quality of life can be controlled by others in disempowering ways. Pharmaceuticals are an inconvenience that have to be lived with, suggesting a stance of regretful dependence embedded in a pharmaceuticalised form of governance.

For Keith involvement in the research helped him to articulate his "own cynicism" about pharmaceuticals and health industries. In contrast, involvement in the research for Carole made her aware that she did not want to have to think about her health and the "inconvenience" of pharmaceuticals too often. Keith was generally in a good state of health, but Carole had diabetes, sleep apnoea, arthritis, depression, endometriosis and allergic rhinitis. She did not talk to others about her health conditions because of the potential for stigma and discrimination. There were strong moral evaluations associated with pharmaceuticals. She was on Metformin for her diabetes that had side effects that she described as "not very kind" but it also represented a failure of being able to achieve the self-control required to avoid the drug. She stated that "I lost a huge amount of energy and motivation to keep battling the wanting to eat" and "I just got sick of the effort…they are definitely a sign of a loss of the sort of drive that I had to keep on top of doing x, y and z…instead here I am a blob sitting on the couch, yeah and [the medications] are symptoms of it".

The moral evaluation of self could change depending on the pharmaceutical. Carole's resistance to taking pain-killers for chronic pain positioned her as "quite good":

> all those kind of drugs are not that great for the stomach…I try not to take it unless I really have to and I am quite good at …managing the pain side of it.

Similarly Bruce provides a positive moral evaluation of self for his resistance to painkillers as he did not "do that shit". The avoidance of painkillers relates to a discourse of 'manning up' with Bruce referring to his hard drinking, going out in boats and ignoring medical advice. Justin avoided medications saying "I tough it out". Dave was not taking his prescribed blood pressure pills, arguing that "if you don't

have to take anything it's much better. You feel like you're under your own steam, you're not relying on something else to do what you need to".

Research on people with HIV found that people could forego medications to avoid disclosing their HIV status in public (Johnston Roberts and Mann 2000). Rogers and colleagues collected accounts from people labelled with schizophrenia who were concerned at being 'discovered' taking medication as this would indicate their condition (Rogers et al. 1998). When Carole was on tramping trips and sharing a tent with others she would take her medications quickly "by the fistful" and not in front of others. When she had visitors to her home she hid her medications from view: "the vitamins I might have but, no, everything else will be out of sight". Stigma is attached to prescription medications but not to supplements. Supplements and vitamins do not necessarily disclose a problem that might alter one's life chances – but prescribed medications could do this.

Information control was essential to avoiding stigmatisation (Gerhardt 1989). Carole does not disclose her many ailments: "I've seen quite a lot of unintentional bias towards people with medical conditions or disabilities … I'm dealing with ageism and sexism and that if you add this in, you know, they do impact…I just keep absolutely quiet about it". The medication for Jasmine's son, who has ADHD, had changed from three times per day to a slow release version where he only had to take one in the morning before school. Jasmine said "so he doesn't have that sort of stigma of going to get the tablet and all the kids knowing".

For an antidepressant drug Carole had not "quite got the guts to drop the dose yet". This spoke to her own decision-making in relation to the pharmaceuticals she took where she would monitor and alter dosages and so have a sense of control over determining her own quality of life. Others could frustrate her attempts at control, such as pharmacists questioning the medication regimes she was on. She provided an anecdote of wanting to build up supplies of Benadryl "for swine flu because I've got a bit of a higher chance than some of having a few complications" but resented the questions asked at the pharmacy: "I just object to the third degree".

As a result of a regretful reliance on pharmaceuticals to obtain a quality of life, hindrances to accessing needed pharmaceuticals was resented. Other obstacles to access noted by householders included the rationing processes of state-subsidised pharmaceuticals that would make some brands unavailable, or the inability to access resources because health professionals had made decisions about the functional capacity or the quality of life that could be attained.

For Louisa discourses around illness were important in that they portrayed the kind of person she was. Her neurologist gets annoyed with her when she contests his view of her as being "ill". She states "I have an illness but I am not ill" and in fact she could be well as "wellness for me isn't the absence of illness. Wellness is the ability to lead a full life" even in the face of limitations imposed by illness. She is not able to access laser treatment for her eye because the specialist said he "can't do anything for her" because of her MS. She feels that she has been classified as a certain 'type' who is ill and therefore some health professionals do not consider the ways in which particular treatments could add to her quality of life.

The stigmatized self can be a result of internalized or 'felt' stigma based on a sense of a moral failure of will to sustain a 'natural state' leading to a fall from grace which needs to be hidden from others, or 'enacted' stigma based on the way others, including health professionals, position and respond to you (see Scambler and Hopkins 1986). The self is responsible for the cause, but dependent on external substances to retain some order.

In these two repertoires we see how different moral relationships with medications relate to different levels of pathology or disorder. With Keith, the focus is on social pathology or disorder, where medications are seen as an outcome and sign of that disorder. Resistance to that disorder gives rise to a questioning about the place of medications. With Carole the focus is on bodily pathology and disorder, where medications are a necessary inconvenience to deal with that disorder and are a sign of that disorder. This disorder means a loss of personal control over one's very own body. Medications are themselves neutral, but are a sign of the lowered moral value of the possessor of that body. A pharmaceuticalised form of governance is unavoidable, but this can promote a struggle over the control of one's body and conflict with those who are also tasked with controlling the medications of others.

Disordering Substances

The term pharmakon can mean both poison and remedy (Riley 2010). The disordering substances repertoire is one where pharmaceuticals signify a threat to one's physical or mental equilibrium but may be required. People need to take responsibility for pharmaceuticals and in doing so may need to 'gamble' on them, weighing up costly risks with benefits. They are at times a necessary evil where consumers need to take a stance of vigilant assessment. In consideration of Parsons' sick role the patient has a responsibility to seek therapeutic help (Parsons 1958), but defining 'help' in relation to conflicting goals becomes a moral dilemma.

In one home two householders articulated two very different but related moral evaluations of pharmaceuticals. Kim, who was on multiple medications that related to, amongst other things, mental illness, stated "Well, I have these spells where I rebel" against medications that made her "totally drugged up". Medications are, in this sense, a form of discipline that elicit conformity, but also have side effects of lethargy and weight gain. The consequence of rebelling was to "Go absolutely high and then crash". To rebel is to be "irresponsible".

But for her partner, Sophie, a different story is articulated. This is partially in response to an earlier interchange between the two. Kim had talked about how she managed the complex routine of medications: "Once upon a time I used to put them on a weekly supply pack." At this point Sophie interrupts with "Tell the truth, darling…You used to get me to do it and eventually I said you have to take responsibility for your own bloody medications and not be hand waited on and that was the end of the weekly pack". Much later in the interview Sophie returns to the issue of "responsibility" as an orientation to her concept of health or "wellness".

Sophie had been on "anti-depressants and all sorts of stuff and I just weaned myself off". The concept of "weaning" relates to ideas of dependency, like a child being dependent on a mother's milk and therefore the mother being responsible for the child.

Sophie weaned herself off "Because I wanted to function as a functioning member of society… so in order to get well I had to actually ditch the medication". Wellness is then articulated as being free from medication, taking responsibility for ones-self: "Medications…can often be a cop out".

The position taken here is contingent: "They're wonderful things – medicines" but responsibility and ownership of actions are required. When Sophie was asked if she encouraged Kim to take her medicines she stated "Yes I do…even though I'm anti mine but we're dealing with different things". There is a moral imperative to be responsible, but there are circumstances where that responsibility cannot be achieved, where it is quite appropriate to take on the 'sick role' and hand over responsibility to external agents – such as pharmaceuticals prescribed by health professionals. It has been noted that medications can offer a means of control but for some conditions, particularly related to mental health issues, there is ambiguity as "users of medicine may be both *in* control and *under* control" (Whyte et al. 2002: 50). For Sophie, taking on the sick role in the case of "psychological psychiatric type issues" is the responsible thing to do: "taking ownership of it is part of getting well. So you have to take ownership of your own medication, so understand what your medication's doing to you, how it's affecting you, be responsible for it". The earlier exchange between Kim and Sophie over the weekly pack supply is revisited. It is not for Sophie to take responsibility, but for Kim: "she's got to work out what tablets she needs, make up her own mind to take them and take some responsibility for her own wellbeing". One can variously be well by taking the responsibility to avoid medication, or be well by taking the responsibility to take "the damn pills".

Patients with rheumatoid arthritis have responded similarly where they relinquished control over their bodies to doctors but positioned this as a way of achieving independence. Patients did not simply abandon responsibility for their body in a passive way, but controlled what they could that was in their power (Williams 1993). Similarly, Gabe and Bury note the ambivalent attitude that people have towards medications, which in their case was benzodiazepines (Gabe and Bury 1996).
In the data presented here there is a responsibility to take medications to prevent intolerable situations.

A complicated picture of responsibility and dependency and the social shaping of pharmaceutical practices is articulated in Kim and Sophie's household. In a different household, Viv had a strong response to medications: "I've hated them. I've always hated them …I've never been a pill taker" but when persuaded to go on to Benzodiazepine she "had to fight and fight and fight to come off them". Viv provided accounts of the most disorienting side effects to medications – describing one drug (lithium) as "like the drug from hell" which was "dreadful…you wouldn't be aware of what you were doing half the time". The drug itself is the site of disorder and pathology here, causing disorder in one's very sense of being, turning the participant into a different sort of being, unrecognizable or unknown to herself.

Jasmine, a solo mother with three children in the household, suffered from depression which was difficult to control, and she had been hospitalised on a number of occasions. Her daughter, who had witnessed her mother's illness, had an ambivalent response to medications: "if it makes people better I guess it's a good thing". This is said in front of her mother, perhaps indicating a concern about her mother not taking

her medications and the consequences that might have. The daughter later reiterates this ambivalence "she has to take it so she doesn't really have a choice".

For Jasmine there were multiple levels of concern about her medications. Partly this related to adverse consequences of the medication "I just worry about what it must do to your insides and your body". Her daughter chimes in with "look at all the stuff that's going into her…it's gross when you think about it". Another layer of moral concern for Jasmine related to her duties and responsibilities as a mother, and the way in which medication could interfere with that. "I don't like taking it when I've got the children because…I'm very hard to wake up when I'm on it. Like, it knocks me right out". Her concern is not waking up in the night if her children are unsettled or distressed: "Sometimes at night I won't take it, if there's something going on with Johnnie [her child with ADHD] or whatever". On the other hand, if her children are away "it can knock me right out and I won't have to worry". Research has found that women in particular can be concerned about the impact that medication regimes can have on their relationships with partners (McDonald et al. 2001), but Jasmine has concerns for family relationships. Medications can bring disorder to family roles and a mother's responsibilities. But the consequences of not taking some of her medication can be immediate: "even just missing that one dose I can feel my heart racing". There is clash of responsibilities between the restorative aspects of pharmaceuticals and the care requirements of motherhood.

It was common throughout the data set to find examples of householders weighing up concerns about side effects with the possible therapeutic value of pharmaceuticals. Jim argued that if you took some medications "a little bit too long… you're knackered for life. I think that's a pretty heavy risk to weigh up to gamble to take the stuff". But Jim went further, suggesting that when colleagues were given the "flu jab" at work, as part of a company wellbeing policy, they "all got sick. I was the one that was fine". Jim's views related to the way in which he would see medications as disordering not only individuals, but the entire population and future generations, potentially affecting "the gene pool of the future" and "I think a lot of these medicines and things we do we're going to come a cropper in the future".

Janice avoided pills because she "had migraines for many years and any of the medications would knock me out for several days…[and] even on the very tiny dose, any of the anti-depressive medications just make me like a zombie". In response Janice had a philosophy of resistance: "I resist the temptation to feel like I have to do anything." Resistance also related to family concerns. Her teenage son was put on an anti-depressant after a family member died. For Janice her son was just sad, but the medication along "with the other drugs he was trying he became psychotic and tried to kill himself. It's been a terrible experience".

The following illustrates the complex ordering and disordering of medications for Paula when she is going through her medications: "Now this is a fungicide lozenge because when you're on the chemo tablets you get thrush in your mouth so you've got to suck those … Those are a laxative tablet because once again you have problems when you have all this medication". When she gets to her bottle of sleeping tablets she expresses distaste and states

> They started me on one a night and I refused to take one a night because I thought I might get addicted. Because when you're on Prednisone you can't sleep…You've just got so much energy and you can't sleep so they started me on those. Well, I've got a thing about getting addicted to them. I only take half of one at night of which they're going to get me off them shortly once they get me off this Prednisone.

Her husband did not think she should be concerned about becoming addicted at her age (she was 70), but Paula stated "I don't want to end up like Michael Jackson". This concern was to an extent mitigated by her view that "The biggest problem was because I wasn't taking it and getting no sleep then all this medication that they give you to survive doesn't do me any good because you're not sleeping so your body's not getting any rest".

The moral positioning of householders drawing on a disordering substances repertoire is one of making rational choices based on responsibility and a cost-benefit form of analysis. The 'natural' state is not one of a sustaining nature or a loss of capacity, but is one of a precarious balance, and the moral duty is to maintain vigilance in order to achieve that balance. A form of pharmaceutical governance may be necessary but is nevertheless resisted and, where possible, individual autonomy is promoted.

Re-ordering Substances

Pharmaceuticals can sustain or restore order and many householders describe medications using metaphors of balance, like keeping on an even keel. But even in the absence of 'evidence' of benefit pharmaceuticals can have a restorative function. They may signify obedience and conformity for what is a taken-for-granted good, or they may even have a magical talismanic quality of keeping illness at bay.

The restoration of order may come with a price but that the user is happy to pay. For Lisa it is "important to me to keep on taking the Lithium" despite it having an effect on her blood pressure and thyroid, which was "a wee titch out of kilter". The extreme mitigation of the thyroid problem – *wee titch* – signals the way she downplays potential problems because she "would be really terrified of not taking" Lithium. When her partner, Bruce, was asked about what he took he had "shit loads here":

> Cholesterol pills… gout tablet…These are for my diabetes...this is something for blood pressure, I think…These ones look after my liver…I don't know what they do but I have some of them every day anyway…I just do what the man says.

Bruce takes a great deal of medication and much of it he knows what he is taking it for but for some he does not. The complications in following the medication routine perhaps leads to a 'pragmatic' approach to medications 'I just do what the man says'. To question the 'man' – which is a signifier for clinicians who have prescribed the medications – could lead to a difficult process of weighing up evidence. Bruce aligns with sick role characteristics seen in his statement that "if the doctor says, 'that's what you've got to have,' fine, have it". Clinicians are positioned as experts and trust is placed in those institutions that have a cultural authority – and even if things go

wrong under their prescription (as it had with Bruce who had suffered adverse reactions to pharmaceuticals) that trust is not undermined.

Louisa defends her use of medications: "I come under pressure from other people saying, 'You've been on antidepressants since 1997, do you think it's a good idea?' And my answer would be, 'Yes' because it has made the difference between functioning and not". She has a weekly injection for her MS and notes that there are issues with compliance about such a regime but for her "I wouldn't not do it because the impact of having the medication has been so dramatic."

Some medications had more of a talismanic effect. Paula took fish oil since she had breast cancer 19 years before: "Whether it's done me any good I don't know but they tell me that 19 years is a pretty good record for a person with breast cancer". She thought "that's probably mind over matter as well but I still take it…I mean, if people believe in it enough maybe that's part of the way of, you know, fixing it".

Ingrid described her dependence on medications not in terms of addiction or dependence – but of integration. She had been taking a sleeping pill for about 15 years because "if I didn't sleep properly I couldn't walk properly and I couldn't work properly… So that's why I've stayed with that and that's probably integrated into my body system now as well as the [antidepressant]". And she would probably take them "for the rest of my life. I don't see any reason not to take it".

In this repertoire pharmaceuticals are morally neutral, where the current situation is a 'natural' outcome of some external imposition, summed up by Bruce who says 'shit happens'. There is no responsible agent, so no responsibility is required to consider options and outcomes as that responsibility is handed over to those who know the best way to deal with the problem or those agents that can have a positive impact. Pharmaceuticalised governance is not problematised but is integrated with self-identity.

Discussion

A key pharmaceuticalistion research issue has been identified as "the reconstruction of the role of patients and consumers in the development and use of drugs and the way in which the life world, everyday life and health futures are being colonised by pharmaceutical solutions" (Williams et al. 2011). In the four repertoires of moral evaluation identified in this research we can see different ways in which patients reconstruct their roles in relation to pharmaceutical consumption, roles that entail particular responsibilities and are embedded in narratives of who or what is responsible for the consumption of pharmaceuticals. How responsibility is conceived determines the form of governance in operation.

Governmentality is the 'contact between the technologies of domination of others and those of the self' (Foucault 1988: 19). The definition of governmentality assumes continuity between the rule of self, household and state. Governmentality assumes that power relations are diffuse, and that although the state is important 'so too are the myriad of institutions, sites, social groups and interconnections at the local level' (Lupton 1995: 9). In households we see that some are able to self-govern as agentic selves, a form of governance aligned with neo-liberalism (Pitts-Taylor 2009). Keith is

able to resist his conduct being governed by pharmaceutical regimes. Pitts-Taylor argues that agentic selves can be enacted through "elective forms of medicine" (Pitts-Taylor 2009: 163). Keith is able to choose his medical regimes, and the physical exhibits of that choice are seen in herbal medications that are not prescribed by a doctor. The non-agentic self is represented by the asthma inhaler, that object that sits uncomfortably amongst things to remember or be remembered. For Keith it is a sign of industrialised medicine, which is responsible for excessive use of pharmaceuticals, which he has the agency to resist. His worldview may valorise autonomy and responsibility but by no means conforms to political neo-liberalism. Keith, and many others, do not valorise the market mechanism and are critical of financial motivations shaping pharmaceutical consumption.

With Carole we see the tension between forms of governance. She resists being governed by outside agents and draws on the social vocabulary of neo-liberalism in valorising the autonomous self (Pitts-Taylor 2009). But because of the brute physical facts of her recalcitrant body she loses this autonomy, and exhibits a sense of a failed self as she is forced to shift from one form of governance to another. This leads to a potential crisis of selfhood. She has to carefully manage the presentation of self and how she reflects on her position to avoid the crisis. She struggles between a neo-liberal position of an autonomous consumer who is in control and a patient who has lost agency. She is moving through a process of losing responsibility for her own health maintenance with the responsibility being taken on by those who now govern her conduct through pharmaceutical routines.

Sophie, Kim and others are inadequately governed by medicine, as they have to take on the responsibility of deciding the costs and benefits of pharmaceutical use through a watchful assessment of how their own bodies react and how their pharmaceutical use impacts upon their relationships with others.

For others, such as Lisa and Bruce, the ideal of the neo-liberal autonomous agentic self is eschewed for a form of pharmaceutical governance. As such they conduct themselves through a different social vocabulary, where self-responsibility extends to following the prescription of other agents.

Dowell and Hudson (1997) suggest that a reason for resistance or adverse responses to medications is that they present a shift from not being ill to being ill. The argument here develops that further, suggesting that an important aspect of that shift is to a different form of governance, where illness may already exist but can be controlled by the actions of an autonomous self, to an illness that has defeated self-autonomy. Moral evaluations of pharmaceuticals are not simply based on natural versus synthetic forms, but also incorporate understandings of freedom and control

Having households as the unit of sampling allowed this research to identify the home as a physical space that can be deployed to remove from the public gaze medications that indicate the loss of the autonomous self. They can also be used as spaces to display the autonomous and elective use of medications such as supplements and herbal remedies – that are here signifiers of choice and control. But what pharmaceuticals represent is not static. Accounts are mixed, and classifications are drug-specific. Bruce does "what the man says" but avoids using pain killers. Louisa believes we are too far removed from nature but uses a wide range of prescriptive

medicines to cope with her chronic illness. Social representations of medications are related to a host of factors, including the medical conditions that a person experiences – so the representation is fluid. The representation is not a factor of the individual, but results from an intersection between available discursive resources and the lived experience.

People express themselves through their everyday activities (Williams 1993), and the consumption of medication is an everyday activity for many people. Our relationship to pharmaceuticals is thus tied to our identity, what we want to show of ourselves, what sort of person we want to be seen as, and what sort of world we want to live in. As a consequence of changing states of health and illness these relationships are not static, and this fluidity is further eddied by pharmaceuticals not being treated as a single fixed category, but different pharmaceuticals being evaluated in different ways. Evaluations of pharmaceutical use are an outcome of the roles available to us and the responsibilities associated with those roles in systems of pharmaceutical governance.

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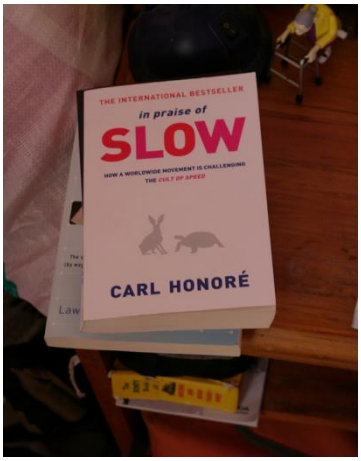
Figures

Figure 1:

Figure 2:



***Ethics approval/Statement EA not required**

Ethics approval was obtained from the Massey University Human Ethics Committee