



12. Human Rights and Qualitative Health Inquiry

On Biofascism and the Importance of *Parrhesia*

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There is a time when the operation of the machine becomes so odious, makes you sick at heart, that you can't take part: you can't passively take part, and you've got to put your bodies upon the gears and upon the wheels, upon the levers, upon all the apparatus, and you've got to make it stop. And you've got to indicate to the people who run it, to the people who own it, that unless you are free, the machine will be prevented from working at all.

—Mario Savio, 1964

Our title invokes issues of (qualitative) method. Method is the means by which knowledge claims obtain their validation. It exposes the basis on which we come to understand claims about subjects, bodies, health, illness, and prescriptions to constitute a truth that deserves our observance in collective action. We agree with Koch (2007) that this specific methodological issue brings about questions of context as knowledge claims are always generated out of a context where the perspectives and values of a culture preexist matters of judgment and action. The discussion of political power, therefore, cannot be removed from the discourse on method. We, along with other qualitative inquirers,

particularly those of the poststructuralist type, have written about a framework highlighting the inherent problems with the modern epistemology underlying the evidence-based movement and mainstream health research (Cohen, Stavri, & Hersh, 2004; French, 2002; Freshwater & Rolfe, 2004; Goldenberg, 2006; Holmes, Perron, & O'Byrne, 2006; Holmes et al. 2006; Murray, 2009; Murray et al., 2007; Rail, 2009a, 2009b; Rail & Lafrance, 2009; Staller, 2006; Traynor, 2002; Walker, 2003; Winch, Creedy, & Chaboyer, 2002). The result of our deconstructive effort has been to reveal the power dimension of knowledge construction in health inquiry.

Speaking out against a powerful aggregate of coordinated forces from a position of relative powerlessness was bound to be met with extreme resistance. Unsurprisingly, then, proponents of “normal” health sciences have shot back at us, from blogs to journal articles, accusing us of relying on jargon-filled postmodern theories that stand in the way of the number-one priority, to “better man’s lot,” as one author put it (Jefferson, 2006, p. 393). This chapter briefly addresses this rhetorical strategy but mostly extends some of our previous discussions to comment on the contemporary discursive terrain characteristic of health inquiry in neoliberal societies. In doing so, we note the biomedical, bioeconomic, and biocultural discourses that we associate with biofascism. We then present two problematic and interconnected examples of the effects of such discourses on health inquiry: evidence-based health sciences and medical ghostwriting.

Discussing the epistemological conditions that invite such phenomena, we then argue that qualitative inquirers are better positioned to address the matters of “speech” they pose, to exercise and defend this most fundamental human right in academia, and to perturb the current politics of health knowledge production. We conclude the chapter with a call to qualitative health inquirers to inscribe themselves in the role of the “specific intellectual” (Foucault, 1980) and to engage in *parrhesia* or “fearless speech” as a way to disrupt the epistemological status quo and to unpack the play of power in health research. Our antifoundational stance thus contains a political commitment of its own. In our endeavor to undermine the foundational claims of dominant health sciences

discourses and order, we aim to promote plurality, difference, conversation, and freedom of dissent as the ethical elements of de/re/constructed health sciences and research. Furthermore, we aim to disrupt demands for conformity to singular and universal bodies, subjectivities, care, prescriptions, and ways of being healthy or not as we argue that they increasingly take on the character of biopolitics and biofascism, phenomena to which we next attend.

From Biopolitics to Biofascism

Foucault's (1997) concept of "biopolitics" is useful for the understanding of current phenomena within contemporary health care and inquiry. Foucault defines biopolitics as "the endeavor, begun in the eighteenth century, to rationalize the problems presented to governmental practice by the phenomena characteristic of a group of living human beings constituted as a population: health, sanitation, birthrate, longevity, race" (p. 73). Foucault thus argues that, in modernity, *bios* or the "life" of the population increasingly comes to inform the ways in which individuals are subject to governmental control, surveillance and regulation. Gradually, he claims, individuals are replaced by "biological processes" and individual lives are displaced by "species-life." This conception of life gets adopted as an ideology, soon becoming a pervasive public morality that is internalized and perpetuated at the micro-level.

As a form of "biopower," this ideology is invisibly deployed in the ways that individuals come to understand, govern, and care for themselves. Through the concept of healthism, Crawford (1980) discusses how this political ideology shifts the responsibility for health from the state to the individual. In his 1994 book entitled *The Death of Humane Medicine and the Rise of Coercive Healthism*, Skrabanek picks up the discussion and links healthism to fascism as he discusses how governments begin to use propaganda and coercion to establish norms of health and "healthy lifestyle." Skrabanek claims that healthism either leads to or is a symptom of totalitarianism in that it justifies racism, segregation, and eugenic control. According to him, what is "healthy" is moral, patriotic, and pure, whereas what is "unhealthy" is foreign

and impure. Skrabanek adds that state actions to prescribe what is healthy or forbid what is unhealthy are limitless in scope and jeopardize many civil and human rights. Although Skrabanek's version of healthism may seem useful to our arguments, we actually find Rose's (1999) version of healthism more useful in that, according to him, capitalist society finds coercion unnecessary. Because people desire health, the apparatus of advertising and other means of capitalist persuasion lead to people appropriating the dominant discourse of healthism without much need for coercion. For Rose (2006), the burden of remaining healthy shifts from the government to individuals, who then are blamed if they get sick.

Rose's conceptualization of healthism aligns with our view of biopolitics in the context of health inquiry. Indeed, in recent years, health research has been marked by biopolitics. Furthermore, we agree with Murray that such research has entered an era of "biofascism," which is understood as the nexus of three interrelated phenomena: biomedicalization, bioeconomics, and biocultural discourses (Murray, 2009). In brief, the first link to fascism rests with the biomedicalization of health care management and delivery and what they mean for health research. In a previous piece (Murray et al., 2007), we argued that the health care and research "industries" are a mind-boggling nexus, a tangled web that includes Big Pharma, innumerable government lobbies, government agencies and public policymakers, academic health sciences and its research sponsors, the convergence of research and business with its multiple public and private "stakeholders," and the insurance industry, to name just a few. For the average person, this complex system can be incomprehensible, if not barely navigable, and it is not farfetched to imagine the individual disappearing into this apparatus, subject to its "disciplining" (Foucault, 1977 [1975]). These multiple nodes of influence and control are not simply the expansion and reticulation of medical authority and practices into new realms; together, they represent a new way of understanding the relation between medicine, health, and life itself. We take our term from Clarke and her colleagues who have dubbed this phenomenon "biomedicalization" (Clarke et al., 2003). Biomedicalization is characterized by

the new political economic valences of biomedicine, the rise of risk surveillance, the medicalization of risk factors, technologization, and the emergence of biomedical and technoscientific identities, to name a few elements.

The impulse of biomedicalization maps seamlessly onto the political economy of neoliberalism, the reigning hermeneutic and narrative of contemporary Western democracies. Here, mainstream health care and research are aligned with a second discussion of “fascism” where neoliberal political economic discourses feed on and supplement biomedicalizing discourses. Both types of discourse demand greater efficiency and greater economy in the face of dwindling public resources and soaring health care costs. Biomedicalization is enabled by the neoliberal ideology that expresses an almost evangelical faith in free market capitalism, where nonmarket forces are either monetized or ignored (see Barry, Osborne, & Rose, 1996; Bunton & Petersen, 1997; Miller & Rose, 2008). From academe and its research-granting bodies to hospital ethics review boards and the medical insurance industry, dominant discourses are purchased wholesale from the corporate sphere, an Orwellian catalog that includes: the client-based mantra, key performance indicators, outcomes, best-practice guidelines (BPGs), knowledge mobilization and transfer (also known as scientific transfer), capacity building, operationalization, commercialization, and so on. “Client” patients are encouraged to conceive of themselves in entrepreneurial terms: They begin to relate to their own bodies and genetic material in instrumentalist and economic vocabularies. Here, we can think about “biocapital” (see Sunder Rajan, 2006) or the phenomenon of “biobanking,” where the storage of umbilical cord blood, eggs, semen, or other stem cells serves to reify the economic relation to one’s own body (see Waldby, 2006).

In Foucault’s terms, the neoliberal subject is “an entrepreneur and an entrepreneur of him- or herself” (Foucault, 2004, p. 232; our translation). The individual becomes a producer-consumer in the sense that she is imagined to produce the satisfactory health and well-being that she will enjoy and “consume.” Under neoliberalism, the subject’s own self-improvement is internalized as a moral duty to one and all; health care models are increasingly fueled by the self-care ideology. The person who is ill accrues a kind of social

debt that must be redeemed by locating herself within compensatory discourses and praxes that are both rhetorical and corporeal.

Biomedical and bioeconomic discourses work together to inform wider cultural perceptions of health and the individual’s public relation to his or her body and to the health care system and industry in general. Here we identify a third link to “fascism” that is sociocultural. It has less to do with biomedical “facts” or with economic “imperatives” and their measures than with shifting popular perceptions toward the acceptable terms and widely held beliefs that circulate and on the ways in which such terms shape our self-understanding in the quotidian. Consider, for example, the ways in which the word “gene” has entered popular discourse and has come to inform how we understand human life and the body. As Murray suggests, genes are considered to be:

the most elementary particles of the body, the very authors of who we are, from eye colour to personality. The “genetic” discourse is compelling. In a world of disenchantment, where transcendent truths are increasingly unfashionable, genomics fulfills a deep cultural desire for Truth. [...] DNA has become fundamental to identity, charged with the tremendous power to explain individual differences, moral order, and human fate. [...] The gene thus operates as a cultural science fiction, offering what is at times a deeply moralistic vocabulary that masquerades as Science and Truth. (2009, p. 103)

In our arguments so far, we have connected with the term “fascism” to emphasize the ideological obedience to, and the totalizing terrain of, what might loosely be termed “scientific” authority. We see in health research and sciences that such authority is neither objective nor straightforward, but situated within the constellation of the biomedicalized, bioeconomic, and biocultural ideologies that we have sketched above. In other words, biofascism invites a totalitarian obedience to scientific authority, to the ideological political economic coordinates of neoliberalism, and to the cultural science fiction of biomedical “truths.” These spheres overlap; they are mutually implicated in complex ways. Together, they form a totalizing ideology that governs the *bios*. We propose that it is this latter aspect that is of the greatest rhetorical significance in biofascism: It is “life itself,”

as the Master Signifier, that gets filled in by fantasy, ensuring that this value can be deployed differentially across a range of social spheres in the project of biopolitical governance. Our use of the term fascism aligns with Foucault when he suggests that:

the major enemy, the strategic adversary is fascism [...] And not only historical fascism, the fascism of Hitler and Mussolini—which was able to mobilize and use the desire of the masses so effectively—but also the fascism in us all, in our heads and in our everyday behavior, the fascism that causes us to love power, to desire the very thing that dominates and exploits us. (Deleuze & Guattari, 1977, p. xiii)

But biofascism goes one step further and can be envisaged as both personal and public. Biofascism exploits the slippage between these classic but obsolesced categories, first locating power here, then there, but always as a ruse to ensure maximal compliance and buy-in. The three discourses we associate to biofascism *appear* to safeguard the civil and human rights as well as the ethical treatment of autonomous persons, offering them the tools for self-surveillance and self-regulation so that they can become entrepreneurial managers in the development and maintenance of their own health. In reality, however, the individual is increasingly tied to health research and industries, systems of health care management, and a cadre of medical authorities increasingly inculcated into a regime that ultimately hijacks the subject in the guise of freeing it (Miller & Rose, 2008; Novas & Rose, 2000; Rose, 2006).

Discursive Effects: Governing Health Inquiry, Governing Life

Biomedicalizing, bioeconomic, and biocultural discourses have a number of extremely problematic effects, particularly as far as health inquiry is concerned. We would like to summarize two pertinent and interrelated examples here: evidence-based health sciences and medical ghostwriting.

Evidence-Based Health Sciences

Our first example has to do with the evidence-based trope that is now prominent in Western countries such as Australia, Canada, the United Kingdom, and the United States. Not unrelated to this, evidence-based medicine (EBM) has gained great momentum. Although the majority of health sciences try to distinguish themselves from medicine and the biomedical model that supports it, dominant discourses within health sciences betray a strong subjection to the biomedical paradigm and have become part of the evidence-based movement. As we argue elsewhere (Holmes et al., 2006), evidence-based health sciences (EBHS, which we mean to encompass EBM) reflect clinical practice based on scientific inquiry. The premise is that if health care professionals perform an action, there should be evidence that the action will produce the desired outcomes. These outcomes are desirable because they are believed to be beneficial to patients (Sackett, 2000).

In 1993, the Cochrane Collaboration, serving as an international research review board, was founded to provide clinicians with a resource aimed at increasing clinician–patient interaction time by facilitating clinicians’ access to valid research (Holmes, Perron, & O’Byrne, 2006). The Cochrane database was established to provide this resource, and it comprises a collection of articles that have been selected according to specific criteria (Winch, Creedy, & Chaboyer, 2002). For example, the collection works with the assumption that the randomized control trial (RCT) is the gold standard and that all other research (i.e., non-RCT research, which is actually 98% of health research) is below standard (Traynor, 2002). Although EBHS acknowledges that health care professionals possess discrete bodies of knowledge, EBHS defends its rigid approach by rationalizing that the process improves health care and health care funding (Bonell, 1999; Sackett, 2000).

One of the most disturbing consequences of EBHS’s methodological fundamentalism is that health sciences come to be gradually reduced to EBHS. In the starkest terms, we are currently witnessing the health sciences engaged in a strange process of devaluing and disregarding some ways of knowing, qualitative

inquiry being on the losing end of this process. As Denzin, Lincoln, and Giardina suggest, qualitative researchers need to address the implications of such attempts to regulate scientific inquiry by defining what good science is: "Around the world, governments are attempting to regulate scientific inquiry by defining what counts as "good" science. These regulatory activities raise fundamental, philosophical epistemological, political and pedagogical issues for scholarship and freedom of speech in the academy" (2006, p. 769).

In terms of *epistemological issues*, we note that EBHS is built on a single (positivist) paradigm. EBHS advocates who are wedded to the concept of "evidence" maintain what is essentially a Newtonian, mechanistic worldview: They tend to believe that reality is objective, which is to say that it exists, "out there," absolutely independent of the human observer, and of the observer's intentions and observations. They fondly point to "facts," while they dismiss "values" as unscientific. EBHS becomes an ideologically driven practice that tends to ignore contexts of experience and certain types of evidence (e.g., evidence generated from qualitative inquiry or based on participants' narratives). Creativity and plurality in health research are disregarded in the name of efficiency and effectiveness. It is not so surprising, then, that EBHS has been presented as a possible answer to the crisis of legitimation confronting health care practitioners: "EBHS is predicated on an internally consistent ideology that "hard" science (via empiricism, positivism, economic rationalism and pragmatism) is the best and only way to further our understandings and the practices which flow from those understandings" (Walker, 2003, p. 152).

Of course, we would argue that there is great danger when health sciences and inquiry become governed by technicians and bureaucrats and when qualitative researchers and critical thinkers are driven to the margins or altogether expelled. The result, as Denzin, Lincoln, and Giardina have suggested, "turns subjects into numbers" and "turns social inquiry into the handmaiden of a technocratic, globalizing managerialism" (2006, p. 772).

The crisis of legitimation also speaks to *political issues* as suggested by Holmes et al. (2006). Indeed, in an age of financial turmoil that demands cost effectiveness and the efficient use of

scarce resources, allied health care professions had to struggle to safeguard their position and professional contribution within the health care system. The extension of EBM to EBHS and the establishment of strict practice guidelines ("best practices guidelines" or BPGs) arrive "ready-made" and "ready-to-use": they provide the illusion of legitimacy and accountability because they tend to standardize and quantify health care work. Murray and colleagues (2007; Murray, Holmes, & Rail, 2008; Murray et al, 2008) further argue that EBHS's way-of-seeing is informed by a politically dangerous ideology as it wholeheartedly adopts neoliberal models of efficiency and accountability, right down to a corporate lexicon.

Finally, in terms of *practical and pedagogical issues*, EBHS constitutes an ossified language that maps the landscape of the professional disciplines as a whole. The Cochrane taxonomy and its derived BPGs denigrate clinical expertise and evacuate the social and ethical responsibilities that ought to distinguish health care professions. As BPGs become ingrained in the policies and normal everyday procedures that make up health care pedagogies and practices, the knowledge that health providers utilize becomes highly regulated and increasingly automatic. The price of this purported efficiency is very steep: Thoughts and actions are increasingly governed by guidelines based on specific and "acceptable" forms of knowledge, which impedes critical thinking. Given the lack of critical thinking, the individual internalizes certain practices, discourses, and types of knowledge that are supposedly "necessary" and desirable. The disciplined health care provider, then, embodies and reproduces the practices and discourses that fit within and maintain the dominant epistemic, sociopolitical, and economic power matrixes within which she navigates and operates. The blind obedience to protocols and procedures is the new ethos upon which the health care *dispositif* functions.

Medical Ghostwriting

With regard to the effects of biomedicalizing, bioeconomic and biocultural discourses, our second example concerns medical ghostwriting. In 2009, Goldacre, a self-anointed medical

watchdog, broke the story in the British press about the recent ghostwriting scandal at the academic journal publisher Elsevier. In his column for *The Guardian*, Goldacre expresses moral indignation that Elsevier published no fewer than six “journals” sponsored by the pharmaceutical industry. In this case, Merck & Co. recruited scientists, medical doctors, and academics, paying them an undisclosed sum to put their name to the company’s own ghostwritten research—infomercials effectively marketing Merck’s products in the guise of independent research (Grant, 2009; Rout, 2009). This is not a new phenomenon; the ethical problem of ghostwriting in medical literature has been widely discussed (e.g., Angell, 2004; Blumsohn, 2006; Fugh-Berman, 2005; Gøtzsche et al., 2007; Kassirer, 2005; Larkin, 1999; Lexchin et al., 2003; Moffatt, & Elliott, 2007; Mowatt et al., 2002; Ngai et al., 2005; Sismondo, 2007; Smith, 2006).

We bring this example here and make connections to the issue of EBHS because less than 3 years earlier, the same Goldacre, in the same British newspaper, published a commentary expressing moral indignation at our recently published article in the *International Journal of Evidence-Based Healthcare* (Goldacre, 2006a). A journalist and medical doctor, Goldacre generated a good deal of press for us from his blog *badscience.net* (Goldacre, 2006b). Our article (Holmes et al., 2006) sought to expose some of the hidden political and economic dimensions of EBM and EBHS. We did not hesitate to draw some disturbing links between medicine’s administrative systems, its machineries of power, and its microfascist political discourse. The political economy of microfascism, we wrote, operates ideologically, which is to say, through subtle, diffuse, and invisible forms of control that become internalized and naturalized. Our critique was lost on Goldacre, who chose instead to excoriate us for our writing style and research methods, rather than attending to the substantive claims we made. Indeed, had Goldacre understood our article, he would have seen the recent ghostwriting and marketing scandal at Elsevier as an obvious instance of the kind of political power that we discussed. A cultural critic and qualitative inquirer would have further seen that the biomedicalizing, bioeconomic, and biocultural discourses present in contemporary Western societies

provide the epistemic conditions for more or less ethical ways of doing and “banking on” health inquiry.

In expressing moral indignation, Goldacre was not alone. Many researchers working within the dominant (positivist, quantitative, biomedical) paradigm denounced our critiques of EBM and EBHS (e.g., Buetow, 2007; Couto, 2007; Jefferson, 2006; Miettinen & Miettinen, 2007). For them, apparently, some forms of power, some vested interests, and some backroom dealings are worthy of moral censure, but others are not. The last line of one published response to our original paper sums this up nicely: “We do not care what paradigm is chosen, we care what works” (Jefferson, 2006, p. 393). According to this perspective, what does it matter who speaks or who writes? Those who defend the (modernist, positivist, economically rationalist) logic of EBM find themselves in contradiction when they censure Elsevier on these grounds. Interestingly, their moral condemnation is usually framed by the kinds of terms and commitments we find in qualitative (postmodernist, poststructuralist) research. If proponents of EBM were true to their quantitative methods of probabilistic induction, wouldn’t they be forced to accept that many ghostwritten articles are quantitatively sound? They should not worry that research sponsored by the pharmaceutical industry is more likely to have outcomes favoring the sponsor (Lexchin et al., 2003). And they should not be concerned with critiques of RCTs that indicate a “high prevalence of ghost authorship in industry-initiated randomised trials” (Gøtzsche et al., 2007, p. 49) or in the Cochrane Collection (e.g., Mowatt et al., 2002). Shouldn’t they be willing to submit ghostwritten articles to meta-analyses and to accept or reject them on the usual grounds alone? Isn’t the evidence supposed to speak for itself? It is more than ironic, then, that some of the greatest defenders of the epistemological paradigm underlying EBM, EBHS, and BPGs are those who express the greatest moral outrage at Elsevier. They protest too much.

Bad Faith and the Politics of Health Inquiry

Elsevier is an easy target because the ghostwriting scandal is not an instance of subtle, diffuse, or particularly invisible forms of

power and its abuse. Moral outrage is the easy response: It is politically correct posturing and it glibly and publicly performs the very the kind of moral rectitude that is expected. But is this enough? Clearly the answer is “no.” The outraged individuals are often those who are unwilling or unable to turn a critical gaze back on their own endeavors, which continue quietly behind their public protests to support the very methodological and epistemological conditions that are truly outrageous. We have called this an instance of “bad faith” (Murray et al., 2007). Our original article (Holmes et al., 2006) sought to probe what remains hidden behind the seemingly benevolent face of power. Fascist regimes are not without a benevolent face; the Nazi regime, for instance, had a very public and progressive campaign for animal rights, while human rights were systematically violated (e.g., Proctor, 2000). How many researchers are not embedded within—and thus, forcibly in bed with—a tangled web of interests, the vectors of power of which are subtle, diffuse and invisible? Our work asks that researchers cease self-deception and begin to take account of the tangled web that includes Big Pharma, innumerable government lobbies, academia and its research sponsors, the convergence of research and business with public and private “takeholders, paradigms rewarding the “bioentrepreneurship” of biotech companies, service industries from the human genome sciences to multinational pharmaceutical and agribusiness complexes, corporate models from the ground up, the legal-juridical complex, and the insurance industry (Murray et al., 2007).

We cannot hope to generate a theory—let alone a practice—of human rights without an ethical commitment to expose the many guises of power in the production of scientific knowledge. We are responsible not only for what we say or write, not only for abstract scientific “matters of fact,” but also for the myriad conditions under which we say what we say, the conditions under which free speech is possible, human knowledge can be generated, and human freedoms ensured. Here we leave the ethic of abstract reason and autonomy behind; we begin to acknowledge that individuals extend into the world and that they are responsible to that world and for that world. We have begun to envisage such an ethics as “an ethic of authentic practice” (Murray et al., 2008).

To be perfectly clear, we agree that Elsevier ought to be the subject of moral censure, but this alone is insufficient. We ought to take account of the attitudes and practices that aid and abet these practices—looking at the conditions of possibility for the production of scientific knowledge, in its many forms, to acknowledge that we are, each of us, responsible. Elsevier’s recent ghostwriting and “ghost management” (Sismondo, 2007) scandal is only the tip of the iceberg. Even the “normal” practices of academic publishing are riven by economic and ethical conflicts. Which multinational corporations own *MedLine*, *BioMed*, and *PubMed*, for instance? How do certain journals justify charging a “publication fee” to authors (or their research sponsors)? What administrative systems and machineries of power are at work in the indexing, cataloging, and ranking (“index factors”) of scholarly journals? Which will count for academic tenure and promotion? Research is “policed,” but this is a sloppy metaphor. As Foucault remarks, power does not subjugate through blatant or obvious means, but it is *productive*, strategic, capillary, and, not least of all, seductive.

As utopian as it may sound, qualitative inquirers are perhaps best positioned to address the matters of speech and authenticity because these pose ethical and rhetorical questions that deal with the way in which power circulates in and through the production of scientific knowledge. Quantitative research can help us support these arguments, but it is less equipped to reflect on the significance of research in the life-world because such reflection calls for a deeper understanding of the historical, political, social, cultural, and economic production of scientific regimes of truth. As Shapin has argued, “speech about natural reality is a means of generating knowledge about reality, of securing assent to that knowledge, and of bounding domains of certain knowledge from areas of less certain standing” (1984, p. 482; also see Shapin & Shaffer, 1989). Securing assent is a multivalent endeavor, Shapin argues, relying on the intersection of material, social, and literary technologies—communication strategies that establish the communal conditions in and through which scientific knowledge will be produced, debated, disseminated and delivered. This is more reason, then, to be vigilant about the politics of health inquiry and the production of health knowledge.

"Fearless Speech": On the Importance of *Parrhesia* in Academia

Given the political dimension of health inquiry and contra the superficial critique of problems such as ghostwriting, we believe that the qualitative inquirer's engagement must be more direct and courageous: It must inscribe itself in the role of the "specific intellectual" (Foucault, 1980). This fundamental role of the professor-researcher is closely linked to a freedom of speech given to our society's intellectuals (academic freedom); it involves the demanding (and often risky) duty prescribed to them of intervening and providing critique when it seems required for the public good. Critique thus constitutes not only an intellectual activity but a public duty. To "critique" means to use politically charged concepts as tools to disrupt the status quo and unpack the play of power: a theoretical/practical revolt (Eribon, 2003). This is also the duty of educators, who must foster such courage in their students—and it is particularly crucial in medicine and allied health sciences (see Papadimos & Murray, 2008). We know too well that career academics are often reluctant to critique from such a radical standpoint, and this is especially true for those who believe that there is an unassailable truth "out there." Current scientific production emerges under the yoke of complex political games in which intermingled stakeholders impose political agendas often irrelevant to scientific methods. Ghostwriting is a trenchant example in this regard: "Under contract" scientific articles find their way into so-called rigorous systematic reviews. This scaffolding of "knowledge" is elevated to the rank of truth, whereas the whole process has evidently escaped the rigor of an elementary critique. We agree with our University of Toronto colleagues that, within academia, this most fundamental human right must be exercised and defended:

Within the unique university context, the most crucial of all human rights are freedom of speech and freedom of research and we affirm that these rights are meaningless unless they entail the right to raise deeply disturbing questions and provocative challenges to the cherished beliefs of society at large and the university itself. It is this human right to radical, critical teaching and research with which

the university has a duty above all to be concerned; for there is no one else, no other institution and no other office, in our modern neo-liberal democracy, which is the custodian of this most precious and vulnerable right of the liberated human spirit. (University of Toronto, 2010, np)

Universities are not the vassals of health institutions, pharmaceutical companies, corporations, or governmental and para-governmental agencies. As such, they must maintain a safe distance vis-à-vis these structures that might compromise, even pervert, their social function. In reality, though, this distance is threatened by the financing of universities by powerful systems (military, Big Pharma, etc.) capable of positioning an institution's guiding principles regarding education and research (Giroux, 2007). As intellectuals, professors-researchers must ensure that the university remains a fertile site of multiple pedagogical and political resistance. We must be present in the public arena and help thwart the ascent of silencing ideologies; we must expose the fetishization of global capitalism in all of health sciences' spheres and the end result in terms of the contamination of every step of health inquiry, from the allocation of research funds to the publication of results.

In this spirit of resistance and using multiple *assemblages* (or noncoordinated associations) of all kinds, intellectuals must institute *espaces de liberté* (spaces of freedom) in which the formation of alliances would permit the development of new political arrangements capable of resisting truth regimes like those highlighted in this chapter. The privileged relation between the qualitative health inquirer and certain spheres of knowledge, often foreign to the general population, makes it possible to bring back to public spaces these knowledges that must be deconstructed and critiqued. This demanding, but important back and forth, between the world of the initiate and that of the profane, makes it possible for the specific intellectual to demonstrate how some political rationalities, associated with powerful disciplinary technologies, compete to legitimize dominant knowledges at the detriment of other disparaged and marginalized knowledges. In this way, the task of the specific intellectual is directly inscribed in what Foucault calls "*parrhesia*" (2001). Foucault defines *parrhesia* as:

[A] kind of verbal activity where the speaker has a specific relation to truth through frankness, a certain relationship to his own life through danger, a certain type of relation to himself or other people through criticism (self-criticism or criticism of other people), and a specific relation to moral law through freedom and duty. More precisely, *parrhesia* is a verbal activity in which a speaker expresses his personal relationship to truth [...] because he recognizes truth-telling as a duty to improve or help other people (as well as himself). In *parrhesia*, the speaker uses his freedom and chooses frankness instead of persuasion, truth instead of falsehood or silence, the risk of death instead of life and security, criticism instead of flattery, and moral duty instead of self-interest and moral apathy. (2001, pp. 19–20)

This fearless speech, undoubtedly linked to an aesthetics of existence characterized by a constant concern over rights, ethics, and social justice, is the product of a *travail de déprise* (endeavors to get “unstuck”) regarding mainstream health sciences and research. In an article entitled “Towards an Ethics of Authentic Practice,” Murray et al. (2008) discuss the ways in which the self is constituted and how this determines the modes of its resistance, the avenues that are open to that self for dissent and criticism whereby that self will struggle to define new, more ethically just, modes of existence for itself and for others. Such thinking must be clearly distinguished from technological know-how, from the mindless implementation of (best practice) guidelines or the fulfillment of moral codes. Instead, as Murray and colleagues note, it entails an ethics of *authentic* risk—a risk that involves a meditation on human finitude (existential, ethical, intellectual). It is the risk of the self itself, when it dares to call itself into question, when it dares to speak its name, and when the very meaning of its existence is tied to that meaningful speech. This kind of speech does not blindly advocate the rejection of authority, but it questions the manifold of authority and power, despite the risks and dangers. We believe that scholars, as specific intellectuals, have this duty. Ethical speech is only possible when we are free to choose from a plurality of points of view, when speech and meaning are not foreclosed, as they are in methodological and epistemological fundamentalism.

Conclusion: On Deconstruction and the Creation of *Espaces de Liberté*

The poststructuralist program we propose for health inquiry is not only epistemological and methodological, but also theoretical, practical, pedagogical, and political. Is this a “positive program”? Yes. First, deconstruction and critique are necessary activities that allow for the creation of *espaces de liberté*—space for new possibilities. Viewed from this perspective, they serve a positive function. As there currently exists a “regime of truth” surrounding health research funding and inquiry, there exists a scientific and ethical obligation to deconstruct this regime. Given the privileged relation of knowledge to the intellectual mission, intellectuals are well located to “speak truth to power,” to use Foucault’s expression. They must open up critical debate and question those mechanisms that work to seduce health inquirers into complacency. Deconstruction is essential to bring to light the biomedicalizing, bioeconomic, and biocultural discourses at work in the health field, promoting a dangerous ideology that threatens to reproduce the justificatory rhetoric of human pharmaceutical testing in developing nations and of eugenic programs intended to “better man’s lot,” to offer two gruesome instances where human rights are so explicitly violated. Research *is* a political enterprise, and health inquirers must not recoil from this reality.

Of course, most would prefer not to hear resistant discourses because the latter tend to expose the very power relations that create the current situation and prop up those health inquirers with a vested interest in the status quo. However, we believe that one of the roles of the intellectual is to engage in *parrhesia* and help deterritorialize the vast field of health sciences. In neoliberal societies, such deterritorialization also entails struggles against “corporate epistemology” in health inquiry. Indeed, institutions of higher learning are currently being colonized by corporations involved in the production of knowledge and associated discourses of truth, deviance and normalization. The private ownership of knowledge is being made possible through the intellectual property regimes that are part of national laws (e.g., the Bayh-Dole

Act in the United States) and international trade agreements (e.g., GATT, APEC, CBI, AGOA). Companies such as Pfizer, Merck, Johnson & Johnson, Bristol-Myers Squibb, Wyeth, GlaxoSmithKline, AstraZeneca, Novartis, and Aventis have invested in a great number of universities and seriously impacted on knowledge creation and dissemination in the field of "health." In light of this, health inquirers must interrogate the production of hegemonic knowledge and ask a number of necessary political questions: Who decides what is health? Who controls health inquiry? Who establishes "truths" and in whose interest?

Second, our program is positive because it involves creation—the creation of breaking points to prise open the dominant bio- and health discourses and to work to imagine how things might be other than what they have become, no matter how "naturally" they present themselves, no matter how forcibly the so-called evidence speaks to us. It also involves the creation of a space of freedom within which a plurality of discourses and knowledges is encouraged. In this way, we hope to resist the Orwellian "Newspeak" that reigns in the health sciences and that works to impose a highly normative, uniform and rigidly circumscribed way of seeing, speaking, and thinking. Creation involves the provision of epistemological support for counterdiscourses, of an epistemological basis from which marginalized individuals (i.e., people, patients, health professionals, and qualitative health inquirers) can respond to the institutions of power and thus legitimize alternative evidence and expand their rights in the process. This aligns with Foucault's (2003) call for the promotion of *savoirs assujettis* or subjugated forms of knowledge. Paradoxically, an honest plurality of voices will open up a space of freedom for the radical singularity of individual and disparate knowledge. When we can witness the emergence of health discourses within which diversity takes center stage; when stories and histories of health and the everyday relations of power, domination, resistance, and struggle may circulate in *espaces de liberté*, then we can better unpack the play of power in health inquiry and guard against the project of biopolitical governance.

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