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Comment

Medicalisation

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Medicalisation means first of all a science – medicine – going beyond its boundaries: from the art of healing individuals, or systematically classifying useful information to treat diseases affecting individuals, it gradually turns into a pervasive development of knowledge and practices that, from the 18th century onward, are applied to collective issues, which traditionally are not regarded as medical issues, thus moving toward large-scale protection of the social body health. The physical wellbeing of people, as well as the protection and improvement of their health condition, become one of the main objectives of the political power, which aims not only at dealing with social marginalisation and poverty to make them productive, but also at "planning society as sphere of physical wellbeing, optimal health and longevity".[1]

However, going beyond the boundaries of individual relationship first requires the involvement of the individual in the medicalisation process. Such an involvement starts from identification and leads to expectation. Identification takes place when the splitting between psyche and soma turns the body into *Körper*, a mere physical body, an object like any other natural object, which is no longer a living body (*Leib*) perceivable in a phenomenological horizon.[2] The subject identifies himself with an ill object, as maintained by his physician. Therefore, medicalisation means first of all creating a consensus on the objective nature of the ill body and the need for distance between the patient and his physician. Then, starting from this premise, comes expectation, which is the shape taken by medicalisation nowadays, i.e. the public expectation that medicine enables to get rid from more serious social problems by treating pathological symptoms of individuals.[3] Medicine is vested with an all-solving power, although at the cost of simplifying, "reducing need to illness" with a full range of consequences, among which "translating into medical terms problems that ought to be tackled with social measures; exploiting the patient's dependence on his physician's aid for exerting control over him; using knowledge for exerting power over the patient".[4]

Two strategies make this "medical imperialism" possible: hiding the "dead body" and showing the "miserable body". The dead body is the body of pathological anatomy, the foundation of modern medical knowledge. It is the time when clinical observation of symptoms turns into dissection of corpses, thus turning death into the source of truth on life. By going beyond all boundaries, medicalisation conceals them; by hiding the dead body, medicalisation conceals the cut that deeply wounds Western medicine, i.e. death as "absolute point of view and window on truth",[5] because medicalisation is the invasion and colonisation of life: "power takes control over life and its whole course of action; death stands as its boundary, the time when it escapes from its control".[6] Its object becomes the miserable body,[7] the body of alms-houses and asylums, the body of disgraceful people,[8] the body of lost lives in total institutions, the nameless mass of bodies segregated in *hôpitaux generaux* on which a knowledge made of separations and classifications, subjugations and disciplines is built.

The birth of mental medicine is a clear example: it creates an extraordinary system of power and knowledge because it must somehow make up for one of its original vices, the lack of the anatomic body. Even though asylums are provided with autopsical rooms and increasingly apply organicistic theories, their practices are not based on the dead and dissected body. Their structures remain disciplinary, their treatments remain moral: their aim is turning the miserable body into a docile body. Nosographic distribution has no impact on the organisation of the asylum space; distinctions are only made according to inmates' behaviours (restless and calm, dirty and self-sufficient, unable and able to work, low and high surveillance).[9] This is the first true departure from the emerging clinico-experimental model of medicine that psychiatry tries to rectify resorting to neurology: however, the illusion that organic foundations of will can be found in superficial signs of the "neurological body" has a very short

life. The reaction to this attempt to somatise instinct entails an even more insidious medicalisation of the body as a "sexual body".[10] It is not by accident that, today, topics such as sexuality and reproduction are the most fertile domains of medical biopower, from decoding love behaviours to plethora of specialised manuals and advice, from allegedly liberalising sexual behaviours to launching alarming signals against deviations from rules, from assisting fertility to controlling births with all the relevant debates on genetics (in vitro fertilisation, prenatal medicine development, embryos and stem cells, genome manipulation and cloning).

In other words, owing to this lack of the anatomical body, mental medicine is a special medicine with special places to be practised in. And through it, the initial steps of the medicalisation process – the transformation of disciplinary power into biopower – can be tracked. The process starts from medicalising workhouses and asylums, thus reducing misery and madness to illness: the French act adopted in 1838 on asylums paradoxically turns them into lawless places, since the law can only enter them through medicine and its mediation. Judicial extraterritoriality, suspension of the right of citizenship… Pinel is a "citizen" before Couthon visiting Bicêtre, but the people committed to the asylum that Pinel would like to set free are only "animals".[11] Pinel turns those animals into "lunatics": he removes their chains, but he does not set them free and confines them to "therapeutic" isolation, which transforms the miserable body into a "storyless body", detached from the social body to which it belongs. "The *raison d'être* of an asylum is turning rational into irrational. When a lunatic is committed to an asylum, he ceases to be a lunatic and turns into a patient, and as such becomes rational".[12] Medicalising means naturalising a social problem and replacing political sovereignty to tackle it. Medicalising means taming a body and turning it in the place of election where disciplinary power is exerted: hence, the body of the person committed to the asylum is a "body to be normalised" (mass pedagogisation and psychologisation); a "body to be watched over" (prejudice of dangerousness, prevention and protection strategies); a "body to be measured" (physiognomic recording and statistical collections).

Along these three lines, the medicalisation process also goes beyond the walls of total institutions, unlimitedly spreads into the social body and colonises political sovereignty through normalisation strategies, thus asserting a general medical authority that extensively establishes within society as a centre of decision-making power over community health. If segregation in institutional spaces works well on the therapeutic illusion of isolation, strengthened by the prejudice of patient's dangerousness and the need to put him under protection, the return to social tissue corresponds to a different form of control. Protection, which at the beginning is conceived as "expropriation of bodies", as segregation to protect society to the detriment of the miserable body deprived of all rights, develops into an enhanced model of "assisted invalidation", i.e. assisting unproductive marginality without breaking into its core of social inequality, thus reducing autonomy, self-government, responsibility of the individual to himself, his life and the community.[13] Medicalising means adopting a general prevention model within the social body (against abnormality in the broadest sense up to epidemic risk), based on the invalidation of the right of citizenship disguised as social welfare need. The perverse exasperation of this prevention strategy leads to aberrant expressions where biopolitical rationality explodes with homicidal power, as for the eugenic policies in the 20th century (from mass sterilisation in the United States to extermination of mental patients and medical experimentations on deported convicts in Nazi Germany).[14]

However, medicalising is also measuring, appraising, assessing, projecting; governing peoples through a public health project; organising administrative systems for recording and keeping health data for the purposes of statistical and epidemiological comparisons; shifting the attention from the "disease" object to other fields of action such as urban environment health, healthiness of buildings and spaces, air and water quality;[15] totalising the "health imperative", to be considered a duty of both the individual and society. In this context, singular only means particular, in other words just a link of knowledge in the chain of population. Medicine, which still gains ground on the public arena thanks to the image of a noble and compassionate struggle against morbid events, conceals the reality of medicalisation, which has already turned into meticulous and general imposition of a discipline. This is the silent triumph of a collective regime of community health, which "implies a certain number of authoritative actions and control assumptions by medicine";[16] and against which any attempt to assert any ideal of solicitous proximity to the patient's body or biopsychosocial synthetic knowledge of the patient and his

environment is useless because this humanism is also involved in the pastoral subjugation of the knowledge that has risen up against the biopower of modern technosciences.[17]

Therefore, medicalisation is the process that leads to the establishment of a "medicine of the social body", which is permanently present in the painful capitalistic transformation of society. In Europe, there are three main models: the German "State medicine", the French "urban medicine", and the English "labour force medicine".[18]

In Germany, at the beginning of the 18th century, the development of a *Medizinischepolizei* (medical police) program corresponds to a step in the construction of a knowledge on the operation of the political structure of the State: establishment of a system for controlling not only public health for the purposes of more efficient monitoring of epidemic morbid phenomena, but also medical practice for the purposes of medical power and knowledge normalisation and their full integration in the State structure. As far as training is concerned, disciplinary teaching at the university level is made homogeneous; as regards collection and keeping of documentary records, administrative centralisation is set up; as for healthcare staff organisation, physicians are hierarchically included in the category of officials. Hence, medicine is put under State control, and this step precedes its clinical-oriented theoretical reorganisation, which occurs in the 19th century, thus making a project aimed at controlling and strengthening the resources of the social body – as construed according to its meaning of "State force" rather than labour force, having its own economic, but especially political and military weight – explicit.

In France, a project of social medicine gains momentum in the second half of the 18th century. It mainly results from the need to make up for the lack of coordination in town administration powers in the face of a too fast and chaotic urbanisation process. In this framework, medicalisation plays an important role through special projects of spatial partition and control: health monitoring strategies to tackle epidemic dangers range from an "exclusion model" based on rejection out of the urban environment (such as in the case of leprosy), which then dramatically extends to other marginal classes of population such as lunatics, offenders, deviants or poor people, to an "inclusion model" (such as in the case of plague) with a whole town being put in quarantine.[19] Therefore, infected people are no longer segregated; instead, a whole population is subject to extensive territory monitoring regime. Urban spatial partition is an extraordinary system for observing, recording, selecting and separating the body of citizens so as to grasp subtle differences between individuals. The quarantine model as the ideal for town health organisation is the foundation of the urban medicalisation policies adopted in the second half of the 18th century, which pursue specific public health objectives through strategies aimed at controlling, on the one side, the places for disposal and accumulation of anything susceptible to be a cause or carrier of diseases, from corpses to urban wastes (relocation of graveyards, charnel houses, waste disposal sites, slaughterhouses, etc.); and, on the other side, air and water circulation in the town area (rearrangement of public work sites, fountains, washhouses, sewerage systems, etc.). Therefore, this is a medicine of objects, living and working places, environment and elements, rather than a medicine of man and his body: the notion of healthiness – to be understood as state of the environment – precedes the notion of health referred to man as a living organism. If the physician ends up by showing an interest in this organism, such an interest only results from the effects and transformations provoked in its functions by the environment.

In England, medicalisation processes will develop later and with reference to policies aimed at controlling indigent classes of population: at the beginning of the 19th century, as a consequence of the French Revolution, which shows the political potential of large masses of population, as well as of the social unrests connected with the concentrations of workers typical of the industrial age, some suspicions, or even fears, start to be rife against poor people. Health regulations are mainly focussed on issues such as the health condition of indigent classes, thus leading to the development of free or low-cost healthcare provision policies, which at the same time are also aimed at preserving labour force integrity and exerting control over public health among social classes at risk so as to protect well-off classes against the danger of contagion. Paradoxically, the organisation of free healthcare provision services for the population as a whole triggers contestations and uprisings because all general prophylaxis actions (vaccination campaigns, environment healthiness checks, identification and segregation of infectious cases) are seen as abusive and coercive medicalisation impairing the privileges of religious social welfare circuits and weakening individualised treatment practices to the benefit of collective prevention strategies.

Current healthcare systems are based on the English model because of its ability to combine social security of working classes (protection of productivity), social welfare extension to the population as a whole (socialisation of medicine) and general prophylaxis (social control through medicalisation) within extremely precise limits of sovereignty between public and private, individual and collective fields. The emerging notion of "right to health"[20] to replace the notions of physical power integrity, productivity, or labour force shows a shift in the political focus of the State, as well as a different allocation of economic resources: from the duty to be healthy, through the individual's obligation to keep good health condition and serve the State, to the right to be sick, through the State obligation to provide the individual with treatment, support and rest from work whenever he is sick. This so-called nosopolitical regime of the State – health as the main objective of the actions taken by the government – explains the ubiquitous power of medicalisation processes in the present world in terms of body-population normalisation functions: "Society exerts its control over individuals not only through conscience or ideology, but also in and with the body. To capitalist society, the biopolitical, biological, somatic, corporal dimension prevails. The body is a biopolitical reality; medicine is a biopolitical strategy".[21]

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Notes and references

[1] M. Foucault, "La politica della salute nel XVIII secolo", 1976, in *Archivio Foucault*, vol. 2, Feltrinelli, Milan, 1997, p. 191.
[2] E. Husserl, *Meditazioni cartesiane*, Bompiani, Milan, 1994.
[3] "Gli scopi della medicina: nuove priorità", Rapporto dello Hastings Center, *Politeia*, year 13, number 45, Milan, 1997; A. Ehrenberg, *La fatica di essere se stessi. Depressione e società*, Einaudi, Turin, 1999.
[4] F. Ongaro Basaglia, G. Bignami, "Medicina/medicalizzazione", in F. Ongaro Basaglia, *Salute/Malattia. Le parole della medicina*, Einaudi, Turin, 1982, p. 158; I. Illich, *Nemesi medica. L'espropriazione della salute*, Mondadori, Milan, 1976.
[5] M. Foucault, *Nascita della clinica*, (1963), Einaudi, Turin, 1969, p. 177.
[6] M. Foucault, *La volontà di sapere*, (1976), Feltrinelli, Milan, 1978, p. 122.
[7] F. Ongaro Basaglia, G. Bignami, "Medicina/medicalizzazione", cit.
[8] M. Foucault, "La vita degli uomini infami", 1977, in *Archivio Foucault*, cit., vol. 2, p. 245-262.
[9] M. Foucault, *Il potere psichiatrico. Corso al Collège de France, 1973-74*, Feltrinelli, Milan, 2004.
[10] *Ibidem.*
[11] M. Foucault, *Storia della follia nell'età classica*, Rizzoli, Milan, 1963.
[12] F. Basaglia, *Conferenze brasiliane*, Raffaello Cortina, Milan, 2000, p. 34; Id., *Scritti*, 2 vol., Einaudi, Turin, 1981-82.
[13] F. Ongaro Basaglia, *Tutela di diritti e saperi disciplinari*, Lectio doctoralis at the award of the Laurea Honoris Causae in Political Sciences, University of Sassari, Political Sciences Department, April 27, 2001.
[14] R. Castel, *L'ordine psichiatrico. L'epoca d'oro dell'alienismo*, Feltrinelli, Milan, 1980; Id., *La gestion des risques. De l'anti-psychiatrie à l'après-psychanalyse*, Les Éditions de Minuit, Paris, 1981; A. Ricciardi von Platen, *L'extermination des malades mentaux dans l'Allemagne nazie*, Éditions Érès, Ramonville St-Agne, 2001; A. Lallo, L. Toresini, *Psichiatria e nazismo*, Ediciclo editore, Portogruaro, 2001.
[15] M. Foucault, "Crisi della medicina o crisi dell'antimedicina?", 1976, in *Archivio Foucault*, cit., vol. 2, p. 202-219.
[16] M. Foucault, "La politica della salute nel XVIII secolo", cit., p. 195.
[17] M. Foucault, "Omnes et singulatim. Verso una critica della ragion politica", 1981, in *Biopolitica e liberalismo*, Edizioni Medusa, Milan, 2001; Id., "Il soggetto e il potere", 1982, in H.L. Dreyfus, P. Rabinow, *La ricerca di Michel Foucault*, Ponte alle Grazie, Florence, 1989; Id.,"*Bisogna difendere la società"*, Feltrinelli, Milan, 1998; P. Pascual, "La généalogie foucaldienne de la médecine familiare en Amérique du Nord", in A. Beaulieu, *Michel Foucault et le contrôle social*, Les Presses de l'Université Laval, Canada, 2005, p. 139-158.
[18] M. Foucault, "La nascita della medicina sociale", 1977, in *Archivio Foucault*, cit., vol. 2, p. 220-240.
[19] M. Foucault, *Gli anormali. Corso al Collège de France, 1974-75*, Feltrinelli, Milan, 2000.
[20] M. Foucault, "Crisi della medicina o crisi dell'antimedicina?", cit.
[21] M. Foucault, "La nascita della medicina sociale", cit., p. 222.

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