4

MEDICINE, HISTORY AND THE PRESENT[1]

Nikolas Rose

Much of Foucault's thinking was concerned with what has traditionally been called the history of medicine. But, as other essays in this volume show, Foucault felt uncomfortable with the label 'historian' in so far as it signalled traditional attempts to trace continuities from antiquity to modernity. Believing in the importance of deep structures and in discontinuities, Foucault preferred to use designations like 'archaeologist of knowledge'. It is little surprise then that Foucault never wrote a 'history of medicine'. Rather, as Nikolas Rose maintains, he preoccupied himself with certain foci of interest of a medical nature: the differentiation of the medical domain into specialties; the institutions within which medicine had been practised (indeed which *create* particular medical knowledges and technologies); the formation of distinct types of expertise; and the invention of particular shapes of inquiry.

Above all, perhaps, Rose shows that in Foucault's way of analysis these different discourses and technologies of medicine were inseparable from distinctive ways of constituting the human body, both in the eyes of the medical gaze and through the cognition of the individual subject. From his early *Birth of the Clinic* through to his late and unfinished *History of Sexuality*, Foucault maintained a twin concern with knowledges respecting large populations (for instance public health) and practices respecting individual bodies (for example diagnosis) and probed their interconnections. He likewise played upon the creative ambiguity of the idea of the medical subject, simultaneously *subjected* to the medical gaze but also in some measure self-directing (as in the idea of 'care of the self' to which Foucault gave prominence in the later volumes of the history of sexuality).

Perhaps the key consequence of these thrusts is that Foucault dissolved and, in some measure, reconstituted the domain and orientation of medical history – his phrase 'history of the present' is a mark of a shift of viewpoint. As Rose emphasizes, the traditional doctor-centred story is deconstructed and new territories assume greater salience, including sexuality, hygiene, the family, and the analyses of populations. To some degree, Foucault was charting what others have termed 'the medicalization of society' – of everything! But insofar as that

label typically flags assumptions about the rise of medical dominance, it may be misleading if applied to Foucault, whose concerns were epistemological and discursive rather than directed to the rise of the professions.

Michel Foucault's 'fieldwork in philosophy' drew him repeatedly to medicine. Foucault encountered medicine as he sought to discern some of the central coordinates that have defined our contemporary experience of ourselves, and the present which we inhabit. Medicine was bound up with the delineation of the unique human being, the human person in his or her very individuality and vitality, as a possible object for *positive knowledge*; that is to say, as a territory which could be mastered by a form of truth regulated by rationalities proper to the codes of scientific reason. Medicine was perhaps the first positive knowledge to take the form of *expertise*, in which the human being was not only to be known but to be the subject of calculated regimes of reform and transformation, legitimated by codes of reason and in relation to secular objectives. Medical sites and personnel were bound up with the mutation of political thought into its modern *governmental* form, in which political authorities in alliance with experts seek to administer a diversity of problematic sectors, locales and activities in the population in the attempt to promote a well-being that has become inescapably 'social'. Medicine was linked to the secularization of the *ethical regimes* through which individuals come to describe themselves in the languages of health and illness, to question themselves in terms of norms of normality and pathology, to take themselves and their mortal existence as circumscribing their values. The history of medicine, that is to say, is bound up with the historicity of all the different ways in which we have come to understand what is involved in making us better than we are.

It would, however, be a mistake to try to put together something like a general 'history of medicine' from these encounters, let alone to place them within a story of the progessive 'medicalization of existence'. Foucault offers us a philosophical perspective that sets itself against such a wish for the general, the universal, the linear; it is one which encourages us to attend to, not to reduce, the *heterogeneity* of the events with which 'medicine' has been engaged. What we must discern is the diversity of medical values, the diversity of interventions carried out in the name of health, the diversity of ways of relating the language of medicine to the language of politics. This 'medical complex' has no essence, be it epistemological (the 'medical

model'), political ('social control') or patriarchal. Rather, an account of this engagement of medicine with our present would need, first of all, to see clinical medicine as merely one component in a complex of forms of thought and practice which question aspects of individual and group life from the point of view of health, and in relation to which medical knowledges, medical experts and medical practices play a variety of different roles. In this chapter, I would like to sketch out some ways in which the researches of Michel Foucault might encourage others to investigate further the part that medicine has played in making up our present.

METHODS

Nothing would be more counter-productive than an attempt to crystallize a 'methodology' from Foucault's studies, a recipe that could then be 'applied' to diverse 'topics'. I do not offer these notes in that systematizing spirit. Rather, I would simply like to offer some reflections to those who wish to carry forward the lines of enquiry opened up by Foucault's researchers – to those who might wish to practise as 'historians of the present'.

Any investigation that would seek to diagnose our present 'medical complex' in terms of its historical constitution would need to begin with an act of decomposition. A historian of the present must decompose the great certainties in which medicine and our present are bound together – the valorization of health and of the sanitization of suffering, the powers ascribed to the medical personage in relation to the disquiets of body, soul and social order, the sense of ourselves as perfectible through the application of medical techniques. This decomposition would not be in service of a critique of medicine, a wish to replace one form of medicine with another or to replace medicine with something that was not medicine. Rather, it would aim to help us to diagnose the conditions under which these profound linkages between medicine and our contemporary reality were formed, and to carry out some kind of assessment of their costs and benefits. What we have come to call medicine is constituted by a series of associations between events distributed along a number of different dimensions, with different histories, different conditions of possibility, different surfaces of emergence. Drawing upon Foucault's own encounters with medicine, perhaps I can suggest five lines of enquiry along which such analyses might proceed.

Our modern medical experience is, first, constituted in certain

dividing practices: the heterogeneous practices within which sickness has been distinguished from health, illness from crime, disease from fate, madness from sanity, idleness from incapacity and the like; and the diverse problematizations of existence in terms of degeneracy, efficiency, productivity and the like within which these forms of division were applied. Here one would locate a description of the configurations of processes within which persons and populations were produced as objects of medical attention, and were separated from those which would be the focus of other authorities and apparatuses – religion, law, education.

Second, medicine is a matter of *assemblages*: the combinations of spaces, persons, techniques within which medicine has been deployed – not merely in the hospital, the clinic, the dispensary, the consulting room but also the town, the factory, the army, the home, the schoolroom, the insurance system, the community. Here one would seek to characterize the complex and heterogeneous apparatuses – which Foucault termed *dispositifs* – in which activity has been problematized and acted upon in the name of health. In general one might say that, starting from the nineteenth century, medical activity has been organized into five great *dispositifs*: a medico-administrative apparatus for regulating social space, incorporating within itself a range of activities from the directly political to those involving architecture and urban planning; the transformation of the home and the family into a hygienic machine; the medical staffing of the population in the form of general practitioners and innumerable other medical agents; the varieties of the clinical and curative hospital; the apparatus of security which transforms fate into risk and enables individuals and societies to secure themselves against disease.

Third, our contemporary field of medicine is a site for the deployment of diverse forms of *expertise*: all the various types of knowledgeable persons who have made disease their business and made a business out of sickness and health. Here one would need to examine the involvement, at different times and around different persons and populations, of religious, architectural, medical, nursing, social, legal, psychological and administrative personnel. This entails not only an examination of the various rivalries between these different modalities (as, for example, between doctors and lawyers in the courtroom) but also research into the practical divisions of labour established between them (as, for example, between psychiatrists and clinical psychologists in the treatment of different forms of behavioural pathology). And further, it would involve an investigation of the

diverse forms of legitimacy – in terms of objectivity, efficacy, humanity, rationality, efficiency and the like – which different types of expertise have claimed or been accorded.

Fourth, contemporary medicine has composed within itself an array of *technologies of health*: technical forms within which one seeks to enact the business of curing sickness or producing health. This is not a matter of the repeated discovery of a 'medical model'. The relation between subjects is different in the general practitioner's surgery, the hospital ward, the tuberculosis sanatorium, the medicine of public health, in the practice of medical inspection of schoolchildren, in campaigns for vaccination and inoculation, in the advice of the health visitor to the mother, in the rituals of traditional Chinese acupuncture, in the murmuring of the stress counsellor's session, in behaviour modification programmes for those with 'eating difficulties', in the techniques of rehabilitation, in the injunctions to 'self-health' and the instrumentalization of lifestyle in the name of health. These relations empower medical personages in diverse ways and attribute diverse responsibilities to them in relation to the process of healing or normalization; they locate subjects in different relations to the decisions and actions made about their problems, and require them to disclose, identify and reform themselves differently.

Fifth, medicine has a dimension that one might term *strategic*: the particular ways in which medical thought and medical activity have sought to realize themselves through campaigns of social hygiene, through the reform of medical institutions into liberal spaces of reason and cure, through the staffing of the population with medical officers of health, through medical inspection, health visiting and campaigns for inoculation, through the exhortation to a healthy diet and modifications of lifestyle. Along this dimension one would also need to consider the different ways in which political tasks have been problematized and political objectives have been specified in the vocabularies and grammars of medicine – and vice versa. And one would need to analyse the various enactments of the 'social vocation' of medicine, as, for example, in the medico-politics of degeneration in the late nineteenth century and in the opposed strategies of eugenics and welfare in the first half of the twentieth century.

This rough-and-ready analytic division is sufficient to make two simple methodological points. First, a historian of the present must refuse the distinction between a realm of reason conceived of as a system of representations and a realm of power conceived of as a system of functional dominations. Such a historian cannot conceive of

separating the concept of an epidemic from the sites within which it is identified, charted, and policed. She cannot conceive of distinguishing the discourse of clinical medicine from the structuring of the medical spaces in which it is deployed, the technologies of diagnosis and intervention to which it fused, the positions of doctor and patient in which it is embodied. It is not a question of 'discourse/meaning' on the one hand and 'power/domination' on the other; on the contrary, it is a matter of the meticulous investigation of the varied and complex ways in which practices of truth situate persons in particular relations of force.

The second 'methodological' point is also a simple one. The territory of medicine is formed through the complex interconnections between events and processes with diverse temporalities. To that extent, to study the history of medicine from the point of view of the present is necessarily to be perspectival – to trace out, from the point of view of a problem that concerns one today, the diverse connections and liaisons that have brought it into existence and given it its saliency and its characteristics. Rather than a 'general history of medicine', then, the task for a historian of the present is the writing of a perspectival genealogy of problem spaces, rationalities, authorities and technologies.

In what follows, I shall attempt to illustrate some of these issues, through a discussion of four distinct but related themes: medicine as a 'social' science; technologies of medical truth; the apparatuses of health; and medicine and the sufferings of the self.

MEDICINE AS A 'SOCIAL' SCIENCE

Medicine and the body appear to be fundamentally linked. To conjure up the image of the doctor is simultaneously to visualize the sickbed on which the ill body is isolated, the case notes that individualize the progress of the condition in relation to medical norms, the charts and records – temperature, pulse, blood pressure, X-rays, path reports – that inscribe the state of the body as disciplined by medical technology, the drug protocols that aim to influence this or that organic function, indeed all that is embodied in the fundamental proposition of clinical medicine – the body itself is that which is ill. But a critical historian of the present should not take this primary spatialization of medicine as establishing the nature and limits of her task – to chart the rise to power and monopoly of clinical medicine, its 'medical model', its focus upon illness rather than health, on cure

rather than prevention, on the corpse rather than the person, on the enclosed disciplinary space of the hospital rather than the real life of the human community. For medicine, since its inception, has been a profoundly 'social' science.

Medicine, for a historian of the present, must be analysed as constitutively social. To say that medicine is constitutively social does not mean that medicine has to be understood in a 'social context', that it has been subject to 'social influences', or that its activities have been 'socially determined'. Rather, medicine has been bound up with the ways in which, since the end of the eighteenth century, the very idea of *society* has been brought into existence and acquired a density and a form – society as a domain 'with a complex and independent reality that has its own laws and mechanisms of disturbance . . . its specific characteristics and variables'.[2] Society, as it is historically invented, is immediately accorded an organic form and thought in medical terms. As a *social body* it is liable to sickness: that is to say, it is problematized in the vocabulary of medicine. As a social body it needs to be restored to health: that is to say, its government is conceptualized in medical terms. And, in relation to these forms of government, medical personnel enter into relations with many other authorities who come to concern themselves with issues of sickness and of health, and medical techniques such as the segregation of the sick and the monitoring of contagion are accorded a special place.

To understand the part played by medicine in making up our present, we need to trace out the diverse relations that have been established between medical reason and political reason. From the moment that European political reason came to assume its modern governmental form, it had a medical dimension. Foucault and others have suggested that the form of political rationality which termed itself 'the science of police' can be seen as the moment when political power came to address itself to a new task – that of administering life.[3] As deliberations of statesmen, merchants and pamphleteers came to connect the political well-being of a nation to its *population* – its size, its strength, its well-being – a new set of tasks arose: how was the state of this population to be known; how could it be best administered to enrich the coffers of the state, secure the wealth of the population, ensure good order and public tranquillity.

There were 3,215 texts on 'the science of police' published in German-speaking lands alone during the seventeenth and eighteenth centuries; the police of health and cleanliness took its place amongst the police of religion, customs, subsistence, highways, commerce,

beggars and the various other domains for which regulations were to be drawn up and enforced. By 1779, when Johann Peter Frank published the first of six volumes of his system for a comprehensive *medical* police, medicine had encouraged itself fully within the rationalities of government.[4]

Medicine was to be fully enmeshed in the two central axes of police. There was the axis of *statistics*, which mapped out the population as a territory to be known, with its rates of birth, illness and death, which were stable enough to be known yet varied across time and space – in the towns and in the countryside, in the different geographical regions of a territory, between the well-to-do and the labouring classes.[5] And there was the axis of *administration*, which sought to invent the mechanisms for regulating events in widely dispersed and heterogeneous locales, forms of conduct and types of difficulty, not merely to avert illness, but to promote well-being.[6] Thus medical thought and medical activity, through the rationalities that unified the inhabitants of geographical space as a social body, through the compilation of statistics of birth, death, rates and types of morbidity, through the charting of social and moral topographies of bodies and their relations with one another, played a key role in 'making up' the social body and in locating individuals in relation to this dense field of relations bearing upon the individual body. Medicine, that is to say, has played a formative role in the *invention of the social*.[7]

Medicine was to engage itself with one of the most fundamental sets of questions that troubled and provoked governmental thought during the nineteenth century and which inspired the invention of the basic administrative knowledge and techniques of modernity. This set of questions concerned the regulation of life in towns. Over the first half of the nineteenth century, medical police was to problematize the life of populations in towns in terms of health, and to devise a whole variety of schemes for its improvement. The diversity of tactics adopted ranged from grand schemes of architectural renewal of public space in the name of health and civility to a host of more mundane projects of social hygiene, sanitary reform and sewage arrangements, pure air and pure water, paving of streets and controls on burial of the dead. Of course, in one sense it was a concern with particular problems of illness that energized these campaigns of police. The epidemics that ravaged European cities in the eighteenth and nineteenth century struck terror into the inhabitants of the towns and those who would exercise government over them – cholera,

typhus, what the 1842 *Report on the Sanitary Conditions of the Labouring Population of Great Britain* simply called 'fever'.[8]

The miasmic conception of epidemics as inhering in the relation between social space and human character lent itself to a medicine of social spaces: diseases were produced in certain types of social space, circulated around social space, alighted upon those predisposed by character or habits to succumb and ran its course in them. Disease could be spatialized, a topography of disease could be constructed and superimposed upon a topography of the towns to produce a disease map where the high points of infection could be seen to coincide with physical squalor and moral degradation. Hence medicine had a task that was directly political: the struggle against a disease had to begin with a war on bad government. From this time onwards the doctor, as Foucault points out, 'becomes the great advisor and expert, if not in the art of governing, at least in that of observing, correcting and improving the social "body" and maintaining it in a permanent state of health'.[9] And, from both grand enquiries into the health of populations and less flamboyant local and municipal collections of information on cases, diagnoses, addresses and districts, a 'medico-administrative' knowledge begins to develop, of a human and 'biological' space of society, of its health and sickness, of the relations of these to housing, to moral habits, to types of labour and the like. Thus it is medicine as much as philosophy which will provide the foundation of the 'positivist' sociology and social statistics of the nineteenth century.

But over and above this, one sees here the ways in which, for at least a century, the task of government was thought within a medical vocabulary. Medical rationalities provided the matrix within which government problematized the population – delinquency, criminality, indigence, inebriety were construed as sicknesses afflicting the social body, they were rendered thinkable in medical terms, as so many products of the foul moral miasma circulating at the heart of the great cities. This medicalization of rationalities of government was not merely a matter of metaphors, for it was embodied in a range of programmes of moral hygiene entailing opening up these swamps of vice to the purifying gaze of civilization. For if bad housing interacted with temperamental predispositions to produce *physical* ills, no wonder it produced the same effects upon the vulnerable *moral* constitution, especially that of the young. And, of course, this relation between medical and political reason was to be maintained into the first half of our own century. It was to exist – although with a reversed

direction of causality – in the theories of degeneracy that emerged towards the end of the nineteenth century. And it was to find its culmination in the eugenic movement with its politics of race and blood.[10]

TECHNOLOGIES OF MEDICAL TRUTH

The persons and populations with which medicine concerns itself do not merely exist, sickly and mutely awaiting its attention: they are formed by differentiation. Medical thought and medical practice always exist in relation to other forms of thought and practice – those of charity, assistance and social security, those of law and order, those of religion and the church. An analytic of medicine thus needs to examine the divisions within which its objects are formed, the *lines of differentiation* which define certain persons, groups, sites, locales as appropriate for medicine and others as not: the mobile divisions and relations between the sick and other troubling social categories, as, say, in the late nineteenth century when the tubercular, the neuropath, the inebriate, the indigent, the unemployable and the prostitute were all different manifestations of a degenerate constitution; the distinction between normality and pathology, as, for instance, in the new relation established between madness and everyday life during the first half of the twentieth century in the category of the neuroses, or the more recent realignment of the relations between illness and health in the lifestyle strategies of health promotion; the disputed linkages and differentiations between poverty and health – and between the poor and the sick – as in the debates in England in the 1930s on food, health and income, or those concerning 'inequalities in health' fifty years later.[11]

The problems and populations with which medicine will concern itself, that is to say, do not form naturally in some ancient space of communion between the medical personage wishing only to cure and the sufferer wishing only to be cured. Of course, the moment of the consultation has a long history, and one that needs to be documented and understood. But, as I have suggested above, from at least the nineteenth century, the persons and conditions with which medicine will deal have been produced within other social practices, and in a range of practical sites and encounters. Encounters within the legal system, between the juridical apparatus and the wayward child, the infanticidal mother, the perpetrator of a crime without reason. Encounters within the domestic space, with the hysterical wife, the

ignorant mother, the undisciplined infant. Encounters within the apparatuses for the conservation of abandoned or ill-treated children: the foundling homes and systems of fostering. Encounters within the factory, with industrial accidents, with absenteeism and occupational illnesses. Encounters within the school system, with the various classes of children who cannot or will not learn their lessons – the maladjusted, the feeble-minded, the delicate. Encounters within the army, with those who cannot or will not fight, those who are too sickly to be recruited, or those who must be discharged as suffering from 'shell shock'. Encounters within the security system with those claiming pensions, benefits or insurance on grounds of sickness or disability.

The phenomena that will be the concern of medicine are formed within all these various apparatuses for managing the conduct of individuals: it is their problematizations and classifications that begin to demarcate the diverse and heterogeneous field of concerns that medicine will take as its own. These classifications and systems of segregation divide those objects, events and persons to be problematized in medical terms from those to be rendered intelligible through other modes of rationality. And they impose a certain pattern of unification upon the concerns of medicine, patterns which will, in important ways, delimit the objects about which medicine will be able to speak.

These lines of differentiation are not 'merely conceptual': they are practical. To differentiate is also to classify, to segregate, to locate persons and groups under one system of authority and to divide them from those placed under another. Placing persons and populations under a medical mandate – in the asylum, in the clinic, in an urban space gridded by medical norms – exposes them to scrutiny, to documentation and to description in medical terms. It is here that one can discover the conditions for the emergence of 'positive' knowledges of the human individual. This is, perhaps, the most general and significant point of method that emerges from Foucault's studies – for it goes to the heart of the history of truth. Truth, at least in the human sciences, arises out of the institutional and organizational conditions which gather humans together and seek to act upon them in order to produce certain ends. The history of truth, the constant schisms, oppositions, transformations and successions of rationalities, is to be understood as a 'practical matter' – that is to say, as always a matter of practices. We can best grasp the relation of truth to our experience of its effects through a study of what one might term *truth*

machines: the machinery of forces, spaces and subjects which bring into existence and configure the space which truths inhabit, and for which truths themselves provide the fuel.

This 'machine' metaphor is rather misleading – it suggests something bright, shining, designed, engineered, gears smoothly meshing, inputs linked to outputs and so forth. The 'truth machines' that Foucault describes are assemblages of parts of different provenance, connected together in ways that are often the result of contingencies, producing unexpected yields in strange places. They thus resemble the fabrications of Tinguely or Heath Robinson rather than those of Audi; in the manner in which Foucault describes France's legal system as 'one of those immense pieces of machinery, full of impossible cog-wheels, belts which turn nothing and wry gear systems: all these things which "don't work" and ultimately serve to make things "work" '.[12] Gilles Deleuze, discussing Foucault's use of the notion of *dispositif*, thinks of them in terms of lines – tangled, multilinear ensembles of vectors and tensors making up a 'social apparatus'.[13] It is out of this regime of lines, this regime of spaces and gazes, that new knowledges of human individuality can be born – in the asylum, in the school, in the factory and, perhaps first of all, in the clinic.

Foucault's account of the birth of clinical medicine in *The Birth of the Clinic* is instructive in this regard. It exemplifies the ways in which that which is new comes about neither through the forward march of reason nor through the relations of 'meaning' in an abstracted realm of 'discourse' but within a 'clearing' opened up by the connections between diverse elements, practices and surfaces. The transformation of eighteenth-century hospitals into 'curing machines' was itself a complex occurrence involving shifts at many levels.[14] The increasing hospitalization of the poor during the eighteenth century was certainly related to the processes of urbanization and industrialization. It was also linked to changes in the laws of assistance which made institutionalization of the poor a condition of medical treatment. Yet, correlatively, the legitimacy of the hospital was thrown into doubt, as a place of the heterogeneous and confused gathering of different conditions and persons, a place of miasma and hence of danger: its very existence was questioned as incompatible with the imperatives of a liberal social order. To justify its existence it must become not a place of darkness but a place of light: a curing machine.[15]

As the hospital responded to these demands that it become a curing machine, it established new relations between patient and patient,

between patient and doctor and between doctor and doctor. Following Deleuze once more, we could say that the hospital established certain 'lines of visibility', lines which distributed the visible and the invisible in particular ways. Out of this organizational force arose a new epistemology. An organizational form such as a hospital entails a certain structuring of light which brings certain objects into focus. This 'regime of light' makes visible *the case* as the unique intersection of a body and a life history: the case as the proper object of the cure.

Making visible, here, is meant in an entirely literal way, enabling time and space to be perceived, divided, inscribed, utilized. It was the collection of large numbers of sick people in a single institutional space under medical surveillance that enabled illness to be normalized. To make the hospital a proper liberal space required it to be organized according to a concerted therapeutic strategy. This entailed 'the uninterrupted presence and hierarchical prerogatives of doctors, through systems of observation, notation and record-taking'.[16] As the medical record meticulously inscribes the details of the individual history of the patient in a stable, transferable, comparable form, it renders the sufferings of the sick person knowable in a new way, in relation to the population of patients of which he or she forms an element. Doctors could now observe a whole series of instances of any particular condition. Observed empirical regularities could now be constructed between symptoms at different levels – a coated tongue, trembling of the lower lip, the tendency to vomit. Further, one could now, for the first time, observe the similarities and differences between symptoms in different individuals at any one time and over time. This provided the conditions for a statisticalization and normalization of diseases: a new classificatory system, which would reduce the uncertainty inherent in medical diagnosis by the location of the individual facts of any particular case within a field structured by norms. A symptom was now to become intelligible because it was a fact that could be assessed in terms of its convergence or divergence from such norms.

Of course, the conditions for the triumph of the empirical within the clinic were not 'merely' institutional; certain revolutionary transformations in systems of thought established the perspective from which the eyes and hands of doctors applied themselves to their objects. Sensationalist philosophies of knowledge, represented in France most notably by Condillac, encouraged a certain empiricism of values, according an epistemological dignity to the act of observation.[17] Statistical thought, associated with Laplace and Condorcet,

made possible probabilistic forms of reasoning and thus transformed the evidential status of discrete and variable facts.[18] But it was within a particular *dispositif*, in a truth machine that arranged bodies, spaces, gazes, inscriptions within a certain regime of light, that sickness – and with it, health – became relocated in a thoroughly empirical domain of observable events and mathematical regularities. The empirical knowledge of the human individual was made possible here – as in the case of the asylum and psychiatry, the school and the psychology of individual difference – by the regulated organization of persons under the gaze of authority.

Truth, at least as far as the human sciences are concerned, is a technological matter. Thus it was the technical form of the clinic that permitted that 'exact superposition of the "body" of the disease and the body of the sick man' which Foucault describes at the opening of *Birth of the Clinic*.[19] The technology of the clinic brings together three elements of different provenance: vitalism, dissection and case histories. None of these elements was particularly new. Cases had been recorded before, as we have seen above, and symptoms traced from inception to death, without producing the epistemological shift in which the body itself became that which was ill. While the philosophy of vitalism enabled observations of lesions in tissues to be organized within a matrix of the body as a vital order, vitalism was not unique to Bichat. While pathological anatomy enabled the gaze of medicine to penetrate from the surface of the body to the depths of its tissues, bodies had been dissected before. But when these heterogeneous elements – a mode of inscription, a kind of philosophy of life, a practice of cutting and looking – were assembled together in a particular configuration in the hospital, a clearing opened in which something new could appear. It was the fusion of pathological anatomy and the empirical experience of the hospital that enabled the progress of symptoms to be traced to their interior sources in a system of life: it allowed successive events to be followed not merely to the point of death but beyond it. Thus the signs recorded in the case history ceased to be merely 'superficial' and statistical; immediate dissection of the corpses allowed the link between sign and lesion to be solidified and deepened. It is true that the most fundamental experience of modern medical thought is that in which 'the human body defines, by natural right, the space of origin and distribution of disease: a space whose lines, volumes, surfaces and routes are laid down, in accordance with a now familiar geometry, by the anatomical atlas'.[20] But no great leap of the human imagination gave birth to that

experience, nor did it arise out of some mystical mutation in an abstracted realm of 'discourse'. An event in philosophy, here as elsewhere in the sciences of man, owes everything to the mundane material practices of looking, seeing, experimenting, calculating, measuring, and writing.

I have been trying to make a methodological point which is simple yet fundamental to the work of a historian of the present. The phenomena which medicine – and other human sciences – will 'think' as well as the very forms of thought itself, emerge out of the institutional and practical conditions of its operation. Thought, here, should not be understood in a contemplative sense – as medical 'theories' or medical 'discourse', medical 'concepts' or medical 'explanations'. Certainly one must attend to the changing rules that govern medical reason and its truth claims: the different codes of truth embodied in, say, the notions of the morbid processes within miasmatic theories of epidemics in the nineteenth century as opposed to the revised conceptions of illness that emerged with the notion of the body itself as a vital order whose normal processes serve to maintain it in health.[21] But forms of medical reason are articulated into more complex regimes of truth, entailing not merely explanation but also the material and conceptual means by which illness is rendered thinkable, describable, calculable, predictable.

An analysis of medical technologies of truth thus involves, for example, an investigation of the ways in which medical reason has come to require a diagnostic moment, and the diverse ways in which this diagnostic moment has been given form. This has entailed complex procedures through which actuality has been rendered thinkable: the collection of statistics on the distribution of morbid phenomena; the dissection of corpses and the drawing of the organs; the use of instruments, from stethoscopes to ultrasound, to chart and visualize the existence of the disease. It has entailed constituting certain phenomena as symptoms and connecting them in various ways to one another and to other processes to which they relate. Further, an investigation of medical truth would call for an examination of the *performative* character of medical judgement – that is to say, the ways in which medical judgements are integrated into systems of action in relation to pathology. And it would require an investigation of the various *legitimating* and *justificatory* mechanisms whereby medical truth claims are sustained, in relation to varying criteria – of which objectivity, rationality, efficacy, humanity are only some of the possibilities. A historian of the present needs to think of thought as

itself 'technical'; the task is not one of interpreting 'discourse' in terms of the meanings embodied in systems of representation, but of analysing the *intellectual technologies* by which thought renders being amenable to being thought.

THE APPARATUSES OF HEALTH

Medicine is characteristically thought of as that activity which, since the nineteenth century, has been carried out in certain institutional locales, notably the hospital, the asylum and the consulting room. However, as I have suggested, these sites form only the most obvious and 'concentrated' zones for the practice of modes of diagnosis and intervention conducted in medical terms. The nineteenth century may have seen the invention of the modern 'clinical' hospital and a range of other enclosed locales such as sanatoria and isolation hospitals. But, in the dreams of medicine from the eighteenth century onwards, the hospital was to be the hub of a web of other medical activities, the focus for a medical corps spread throughout the population offering medical treatment 'in the open' and also accompanied by the recurrent theme of the dispensary, which would extend consultation and medication to patients without the need to intern them.[22]

The nineteenth century saw the establishment of a number of other apparatuses of health. As complex regimes of medical practice spread across urban space, the town became a multifaceted apparatus for fighting disease and securing health. The domestic environment – the home and family and all the relations amongst persons and activities within it – was constituted as a site subjected to scrutiny and administration in medical terms, principally through alliances and dependencies between doctors and mothers. Over the course of the twentieth century, a whole variety of places of medical scrutiny and health regulation were added, notably through the transformation of schools and factories into 'inspection machines' and institutions gridded by norms of health, and through the establishment of sites of institutional care for the old, the young, and the disabled. Further, each of these apparatuses was located within a new insurantial rationality, in which security for each and for all was to be maximized through the application of a calculus of risk.[23] In our own times, the ideal territory of the community serves as the basis for innumerable utopian projects for the reintegration of the practice of medicine, a territory to be traversed by community physicians, community

nurses and numerous other professionals and dotted with micro-territories for the practice of medical cure and reform.

The pervasiveness of medicine in our modern 'liberal' experience owes as much to these other apparatuses of health as it does to the hospital and the medicine of the clinic. Each of the five great apparatuses of health – the medical administration of public space, the hygienic regulation of domestic life, the curative clinic, the medical staffing of the population, the insurantial mitigation of suffering – is bound up with a different set of relations between experts and subjects. Each apparatus embodies a different distribution of the rights of speaking and listening, of prescribing and obeying; different ways of making up the persona of the expert as a technician of health, linked to different images of the person of the sufferer and tied to different ways in which subjects themselves are urged to problematize aspects of themselves and their lives in the name of health and to act towards them according to a logic prescribed for them by experts.

The medicalization of social space and the hygienic transformation of the family can serve as two exemplars of the technical enactment of medicine's 'liberal' vocation. Within the rationalities of medical police, the town was constituted as a fundamental site for the operation of medical reason and medical technique. Police, in its earliest forms, was an 'anti-liberal' art of government – the population to be governed was ideally to be comprehensively known, rendered visible and transparent to the gaze of authorities and criss-crossed by detailed regulations for all aspects of life from the weight of a loaf of bread to the proper dress to be worn on the sabbath. These anti-liberal moments of medical government have not disappeared; the dystopian dream of a regulated calculus of social relations in the name of health recurs in certain moments of crisis – as, for example, in certain strategies for policing AIDS. But over the nineteenth century, the government of conduct in the name of health was to assume a more liberal form, that is to say, it operated according to a division between a 'public' domain to be rendered pure, clean, healthy and sanitized by authoritative action, and 'private' spaces to be governed not by reducing freedom but by regulating it.

In the name of the health of the social body, public space was to be reconstructed through town planning in order to penetrate the dark and fetid locales where disease bred untouched by the purifying effects of light, air and civility.[24] This medico-administrative government of public space was not merely a matter of medical offiers of health,

sanitary reformers and the policing of food and drink. It also entailed the development of spatial technologies of health, in the form of a new set of relations between medicine and architecture. In the schemes of planning space, at the the macro-level of the towns and in the micro-territory of the design of buildings – prisons, asylums, schools, homes, bathrooms, kitchens – one sees the desire to make space healthy. Architects and planners seek to enact a medical vocation, by organizing the relations between persons, functions, objects, effluents, activities in order to minimize all that would encourage disease and to maximize all that would promote health. This dream of the healthy body – the healthy city, the healthy home – has, perhaps, done more than most to embody a medical aspiration within the territories upon which we manage our individual lives. Yet it is an enlightened dream; one in which the relations between experts and subjects are essentially liberal. On the one hand, a certain image of what humans are, and what humans can and should be – rational, healthy, normal – is embodied within each scheme for the programming of space. On the other, space is organized only as a field of possibilities, and within the vectors and tensors, visibilities and invisibilities, probabilities and improbabilities established by this field of organized space, individuals are to conduct themselves freely.

This liberal vocation of medicine was also to be manifested in the ways in which it sought to construct private space, in particular the domestic environment of home and family, in a form conducive to the promotion of both physical and moral health.[25] From the eighteenth century onwards, within the great apparatus of alliances and descent that was its time-honoured role, the family will consolidate itself as an apparatus for securing 'the healthy, clean, fit body, a purified, cleansed, aerated domestic space' and doctors 'will have the task of teaching individuals the basic rules of hygiene which they must respect for the sake of their own health and that of others: hygiene of food and habitat, exhortations to seek treatment in case of illness'.[26] The initial wave of the medical offensive on the family bears on the care of children and their conservation, especially that of babies. The focus, in England as well as France, is first upon the wealthier classes, whose lineage is threatened by the death rates consequent upon wet nursing and poor domestic hygiene: the mother is to be brought into a kind of alliance with the doctor that will secure her role as against the patriarchal authority of the father, but at the price of transforming her into an agent of medical supervision of the domestic sphere: a system of medical care organized around the child, within which the

family is to bear both some of the moral responsibility and some of the economic cost for illness and health.

Throughout the nineteenth century the campaigns to medicalize the family, by enjoining the mother to take responsibility for the health of her child and her spouse, were embodied in many forms: in journals, in philanthropic interventions, in schemes of model housing, in feminist campaigns to encourage marriage and the responsibilities of fathers and much else. The key point here concerns the ways in which these campaigns sought to make the family into a quintessentially 'private' space, yet ensure that it accepted its responsibilities for securing the 'public' objectives of the social health. As Foucault puts it:

> The family is assigned a linking role between general objectives regarding the good health of the social body and individuals' desire or need for care. This enables a 'private' ethic of good health as the reciprocal duty of parents and children to be articulated on to a collective system of hygiene and scientific technique of cure made available to individual and family demand by a professional corps of doctors qualified and, as it were, recommended by the State.[27]

Medical expertise here reveals its capacity to act as the relay between political objectives and individual desires and responsibilities, thus constructing 'private' spaces that will simultaneously come to secure social goals: acting as an exemplar for all those other forms of expertise that will follow, and which will ensure that, in a liberal society, individual well-being will assume an inescapably social form.

MEDICINE, ETHICS AND THE SELF

In 'the great disputation on sickness and health' in *The Magic Mountain*, Thomas Mann contrasts two ethics of suffering and redemption.[28] For the humanist, and Freemason, Ludovico Settembrini, modern medical science, the embodiment of reason and humanitarianism, is to fight back epidemic disease and pestilence through hygienic reform. The triumph of reason is, at the same time, the triumph of the principles of health over sickness and virtue over vice – in short, the triumph of a social morality, the morality of the normal man. For the Jesuit, and revolutionary, Leo Naptha, this

ethic of the normal man and the triumph of reason is banal and vulgar. Human spirituality and human freedom are not bound to a veneration of the healthy body, but to an acceptance, an embracing, a mastery, of bodily suffering. Disease is indeed very human, for the essence of man is to be ailing:

> There were those who wanted to make him 'healthy', to make him 'go back to nature', when the truth was, he had never been 'natural'. All the propaganda carried on today by the prophets of nature, the experiments in regeneration, the uncooked food, fresh-air cures, sun-bathing, and so on, the whole Rousseauian paraphernalia, had as its goal nothing but the dehumanization, the animalization of man . . . the more ailing he was, by so much more was he the more man.[29]

Against the principle and value of the normal person, the healthy person, let us pit the abnormal, the genius, the mad, the sufferer, the outcast – for the normal have lived upon their achievements since time began.

No doubt there are still some who, like the pious Christians of the Middle Ages, would drink the water in which they had bathed the wounds of the afflicted, as a manifestation of reverence for the transfigurative nature of suffering. But for the most part, in our own times, care has become a matter of cure and normalization, and even supervision of the dying has become a project in which those who suffer are to be reclaimed to a humane and social world. Our present is suffused with the ethic of the humanist, the ethic of the normal social person, which is intrinsically an ethic of the healthy body. All aspects of our care for ourselves are to be judged in terms of a logic of health and reorganized in terms of a quest for normality. As the secular value of health replaces older non-corporeal or theological virtues and becomes one of the principal dimensions according to which we seek to compose a style of life for ourselves, the remit of medicine extends beyond the dimension of illness and cure and into the management of normality itself.

Sociologists have proposed various explanations for this transformation, for example medical entrepreneurship or the collapse of religious faith. However Foucault's own account seems to offer a particularly productive path for future research. If, in our present times, medicine has come to play such an important role within this ethical complex, it is in part because it has come to link the ethical question of how we should behave to the scientific question of who we

truly are and what our nature is as human beings, as life forms in a living system, as simultaneously unique individuals and constituents of a population.

The Birth of the Clinic has at its heart a consideration of the reorganization of our relationship to individuality, to suffering and to death that has made this new regime of the self possible. The mutation in medical thought and practice that is traced in the book marks, claims Foucault, an ineradicable chronological threshold. The underside of disease – illness – comes to light, offers itself to the gaze, to language and to the practice of the cure in the same moment as it distributes itself in the enclosed but accessible volume of the body. This mutation has epistemological and ethical dimensions which are not confined to the territory of illness. Clinical experience and the anatomo-clinical method have a decisive *epistemo-ethical* significance, in constituting 'man' as an object of knowledge, in making possible a science of the human individual as a complex of specifiable processes and attributes that can be diagnosed, calibrated, compared and generalized. Foucault suggests that in the same way that a positive knowledge of individual human mental life became possible only on the basis of the experience of unreason – of madness – so a positive knowledge of human corporeal life becomes possible only on the basis of integration of death into medical thought.

When the positive knowledge of the individual inaugurated by the clinic internalized illness within the body of the sick person, it initiated that springtime of reason which would progressively seek to eliminate the metaphysical and spiritual significance of suffering in favour of a propaedeutic of health and an ethic of happiness. When language and vision connect death to life, when death becomes embodied in the living bodies of individuals, then science can take the 'natural order' of the body as an object of knowledge. Thus we should not be surprised that health has replaced salvation in our ethical systems, that the doctor has supplanted the priest, that the discourse of medicine has become saturated with questions concerning the meaning of life. For while medicine constantly reminds the inhabitants of our present of the possibilities of disease and death that they carry within them, it offers them the possibility of vanquishing the sufferings of the flesh, or at least postponing them, through the instrumentalization of life by medical criteria and procedures:

> The importance of Bichat, Jackson and Freud in European culture does not prove that they were philosophers as well as

> doctors, but that, in this culture, medical thought is fully engaged in the philosophical status of man.[30]

Foucault's early writings on medicine thus link up with his last writings on ethics and technologies of the self. For this philosophical engagement of medicine is a very practical matter: the doctor as an expert in the arts of living. The infusion of medical values into ethical judgements can be located in relation to the successive ways in which humans have been urged to engage in practices of self-formation, to master themselves, improve themselves and regulate themselves in the name of certain problems and through the use of certain techniques. At a time when we have lost faith in the sanctity of moral codes, have no wish to be bound by legal imperatives and are forced to rationalize our fate in terms of our choices, the new ontology of ourselves constituted by medicine appears to offer us a rational, secular and corporeal solution to the problem of how we should live our lives for the best; of how we might make the best of our life by adjusting it to our truth, by letting medicine enlighten our decisions as to how to live it.

In her classic text *Illness as Metaphor*, Susan Sontag seeks to strip medicine of its metaphorical significance, both to free disease from the weight of representation that it has come to carry and to free the experience of the sufferer from the burden of morality imposed when disease is in some way linked to personality, to diet or to forms of life.[31] She dreams of a time when a disease will be no more than it is – a biological malfunction susceptible to biological methods of treatment. But Foucault's researches enable us to recognize this dream as the final point of the very trajectory which, over the last two hundred years, has progressively demythologized suffering and sought to discipline sickness in the name of health. In its name we have come to celebrate normality, but simultaneously to live under the constant dread of all that which would threaten it. And in the very same movement as illness becomes amenable to an explanation in terms of the biology of the body, medical experts come to take up their role as masters of lifestyle. In the subsequent search for a normality conceived in terms of health, we have come to experience ourselves and our lives in fundamentally medical terms. Like Hans Castorp upon his Magic Mountain, our stay in the sanatorium is not limited to a brief and terminable episode of illness. It is a sentence without limits and without walls, in which, apparently of our own free will and with the best of intentions on all sides, our existence has become

bound to the ministrations and adjudications of medical expertise. For a historian of the present, to recognize this is not to condemn it, not to participate in that fashionable scorn which cultural critics, in the Jesuitical tradition of Leo Naptha, like to pour upon the banality of an ethics 'beyond good and evil'. It is merely to open the possibility of posing certain questions about the costs of organizing our experience of ourselves in this way.

CONCLUSIONS

An engagement with medicine, from a range of different angles and perspectives, is thus part of what Foucault terms, in *The Use of Pleasure*, an analysis of 'the *problematizations* through which being offers itself to be . . . thought – and the *practices* on the basis of which these problematizations are formed'.[32] Foucault's work may be historical, but it is aimed at the heart of our present, and the field that defines the possibilities of our experiencing, recognizing and valuing ourselves in that present. The present here figures as a field of heterogeneous vectors and forces in which objects and actions can appear, make sense, enter into relations with one another.

In addressing the history of that present, Foucault's researches aim to disturb and fragment our understanding of the lines of descent that have made us what we are. But this rejection of unities was not done in the name of a post-modern metaphysics that celebrates diversity. Rather, Foucault's studies proceed in the light of a more sober and, dare one say, more historical conviction that that which 'is' is much less determined, much more contingent, than we think. We do not merely need to abandon the comforting thought that our present is the outcome of a process of History. We also need to jettison all those forms of narcissistic historicism that read the past in terms of the present that it has become, the present here being portrayed as a culmination of everything that is 'progressive' in that which preceded it.

This is not to engage in some game of 'deconstruction', nor to delegitimate that which we take to be pure by revealing its 'impure' origins. Rather, in delineating the complex contingencies that have made up the territory we inhabit and the horizons of our experience, in showing us that things could have been different, such analyses encourage us to weigh up the costs as well as the benefits of the present we inhabit. They thus allow us to dream of a time in which our times could be different again. Perhaps Gilles Deleuze captures

this relation between Foucault's philosophy and his historical investigations most aptly:[33]

> If Foucault is a great philosopher, this is because he uses history for the sake of something beyond it: as Nietzsche said: acting against time, and thus on time, for the sake of a time one hopes will come.

NOTES

1 Thanks to Thomas Osborne and Gary Wickham for helpful comments on an earlier draft of this paper.

2 M. Foucault, 'An ethics of pleasure' in S. Lotringer (ed.), *Foucault Live: Interviews 1966–84*, New York, Semiotext(e), 1989, p. 261. Cf. G. Kendall and G. Wickham, 'Health and the social body' in S. Scott et al. (eds), *Private Risk and Public Danger*, Aldershot, Avebury Press, 1992.

3 On police, see M. Foucault, 'Governmentality' in G. Burchell, C. Gordon and P. Miller (eds), *The Foucault Effect*, Hemel Hempstead, Harvester Wheatsheaf, 1991, pp. 87–104; and P. Pasquino, 'Theatrum Politicum', ibid., pp. 105–18.

4 G. Rosen, 'Cameralism and the concept of medical police', *Bulletin of the History of Medicine*, 27, 1953, pp. 21–42.

5 I. Hacking, *The Emergence of Probability*, Cambridge, Cambridge University Press, 1975; I. Hacking, *The Taming of Chance*, Cambridge, Cambridge University Press, 1990.

6 A. Small, *The Cameralists: Pioneers of Social Policy*, New York, Burt Franklin, 1926.

7 Cf. J. Donzelot, *L'invention du social*, Paris, Fayard, 1984.

8 E. Chadwick, *Report on the Sanitary Conditions of the Labouring Classes of Great Britain*, ed. M. Flynn, Edinburgh, Edinburgh University Press, [1842] 1965.

9 M. Foucault, 'The politics of health in the eighteenth century' in M. Foucault, *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*, Brighton, Harvester, 1980, p. 177.

10 Cf. M. Foucault, *The History of Sexuality 1: An Introduction*, London, Allen Lane, 1979, pp. 148–50.

11 Cf. J. Boyd Orr, *Food, Health and Income*, London, Gollancz; P. Townsend and N. Davidson, *The Black Report: Inequalities in Health*, Harmondsworth, Penguin, 1982.

12 M. Foucault in *Le Monde*, 21 October 1978, cited in C. Gordon, 'Afterword' in Foucault, *Power/Knowledge*, pp. 229–59.

13 G. Deleuze, 'What is a *dispositif*?' in *Michel Foucault, Philosopher*, tr. T. J. Armstrong, Hemel Hempstead, Harvester Wheatsheaf, 1992, pp. 159–68.

14 M. Foucault, B. Barret-Kriegel, A. Thalamy, F. Béguin and B. Fortier, *Les machines à guérir: Aux origines de l'hôpital moderne*, Paris, Institut de l'Environnement, 1976.

15 Foucault, 'Politics of health', pp. 178ff.

16 Ibid., p. 180.
17 M. Foucault, *The Birth of the Clinic*, London, Tavistock, 1973, ch. 6.
18 See esp. I. Hacking, 'How should we do the history of statistics?' in Burchell et al., *The Foucault Effect*, pp. 181–95.
19 Foucault, *Birth of the Clinic*, p. 3.
20 Ibid.
21 See esp. G. Canguilhem, *The Normal and the Pathological*, New York, Zone, 1991.
22 Foucault, 'Politics of health', p. 180; cf. D. Armstrong, *The Political Anatomy of the Body*, Cambridge, Cambridge University Press, 1983.
23 F. Ewald, 'Insurance and risk' in Burchell et al., *The Foucault Effect*, pp. 197–210.
24 P. Rabinow, *French Modern: Norms and Forms of the Built Environment*, Boston, Mass., MIT Press, 1989.
25 Foucault, *History of Sexuality 1*; J. Donzelot, *Policing the Family*, London, Heinemann, 1979.
26 Foucault, 'Politics of health', pp. 173–6.
27 Ibid., p. 174.
28 T. Mann, *The Magic Mountain*, Harmondsworth, Penguin Books, [1924] 1960.
29 Ibid., p. 466.
30 Foucault, *Birth of the Clinic*, p. 198.
31 S. Sontag, *Illness as Metaphor*, London, Allen Lane, 1979.
32 M. Foucault, *The History of Sexuality 2: The Use of Pleasure*, Harmondsworth, Penguin, 1986, p. 11.
33 Deleuze, 'What is a *dispositif*?', pp. 164–5.

5

INVENTING MOUTHS

Disciplinary power and dentistry[1]

Sarah Nettleton

It is a basic assumption of Foucauldian analysis – as it has been of much radical sociology of knowledge over the last generation – that the body is not a natural datum. By consequence, disease is not a self-evident thing which medicine unproblematically treats. They are in different degrees and in various ways 'invented' or 'constructed'. Different schools of historical and sociological interpretation have emphasized distinct factors in the making of such 'inventions': 'labelling theory' has been influential, stressing the power of words to create realities and showing how supposedly neutral and scientific terminology routinely carries moral charges, resulting in scapegoating and stigmatization. The diagnosis 'hysteria' is an obvious example.

Foucault's distinctive approach to such problems was to emphasize the symbiotic relations between knowledge and power (*savoir* and *pouvoir*), in a manner perhaps somewhat reminiscent of the Marxist notion of the unity of theory and practice. In other words, the objects of science and medicine were not simply there waiting to be studied but were realized by certain viewpoints (the gaze) and certain technologies of intervention (experiments, modes of data collection and recording, kinds of interrogation). Psychoanalysis affords a case Foucault often used of the creation of such a technology of power. Sarah Nettleton shows the applicability of Foucauldian analysis to the creation of the objects and the discourses of dentistry. The transition from mere tooth-drawing to the science of dentistry that has developed during the last century has involved not merely new scientific knowledge (bacteriology and so forth) and better instruments, but the elaboration of new conceptualizations of the mouth as a disease focus and of the dentist as an agent of public hygiene. The dentist's chair might serve as a superb microinstance of a 'laboratory of power'.

A certain sort of bluff empirical historian might be tempted to scoff at such Foucauldian analyses, implying that they make heavy weather of the simple business of fixing bad teeth. A cogent counter-argument would run that dentistry occupies such a disproportionately large part in the public phobic imagination that some interpretative schemes like Foucault's of the power relations involved in dentistry is positively