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**A BODY OF TRUTH/A TRUTH OF THE BODY:  
HOW MEDICAL SCIENCE NORMALIZES**

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*This essay engages with several themes from Michel Foucault's texts in order to examine the intricate connection between the normalizing power of medical discourse and its implicit ontological and epistemological commitments. I argue that medical discourse is inherently a medico-ethical discourse and its normalizing power is sustained through its being situated within a discourse on truth that allegedly establishes medical discourse as objective and scientific. In this context, in order to account for the non-coercive normalizing power of the medical sciences, I claim that medical sciences can authorize themselves as objective only on the basis of a metabody, rather than real bodies. Through an appeal to the metabody, normal and abnormal are instituted as objective evaluations, and medical scientific discourse renders ethical normativity and epistemological normativity virtually indistinguishable.*

This essay engages with several themes from Michel Foucault's texts in order to depict a notion of somatic health that is crafted in and through a scientific discourse. Of fundamental significance to this depiction will be the claim that medical scientific discourse, explicitly or implicitly, operates within a certain conception of truth. The conception of truth incorporated in medical scientific discourse is, in turn, accompanied by regulative roles regarding how one lives and conducts oneself and thereby serves a normalizing function. Importantly, the normalization pertinent to medical discourse does not take place as a coercive discourse that operates in the form of orders and prohibitions. Rather, as I proceed to argue, medical discourse exercises a normalizing power and operates as an ethical discourse in and through which certain forms of subjects are created. Medical discourse gives rise to these forms of subjectivity in virtue of its being situated within a discourse on truth that itself operates on the

basis of certain ontological commitments regarding the nature of subjects and their health/illness. In this way, I seek to elucidate how a truth of the body is formed within a body of truth.

In order to elucidate medical discourse as a normalizing discourse situated within a larger discourse on truth, I utilize the concept of *metasomatization*, which I present as the presumed ontological ground for the epistemological claims of the medical sciences. Foucault formulates *metasomatization* as a concept in his 1974–1975 lecture series on *Abnormal*<sup>1</sup> and deploys it on a restricted scale, particularly in reference to the ancestral body. Within the context of psychiatric disorders, Foucault formulates the concept of metasomatization as the method that presumably provides an etiology for psychiatric disorders in the absence of a somatic cause. Here, while I acknowledge that this is a bold extrapolation from Foucault’s application of the term, I suggest that metasomatization and the metabody as its artifact could be employed in order to make sense of the normalizing power of contemporary medical discourse.

As a general cautionary remark, it needs to be stated that in Foucault’s texts medical discourse is problematized mostly with regard to psychopathology. Although somatic medicine is certainly implied in Foucault’s line of thinking and conceptual framework, it is not really thematized within Foucault’s archaeological framework outside of *The Birth of the Clinic*<sup>2</sup>, where it is rather obscured within the not so well-structured facets of institutionalization, gaze, etc.<sup>3</sup> In

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<sup>1</sup> Michel Foucault, *Abnormal: Lectures at the College de France, 1974–1975*, (tr.) G. Burchell (New York: Picador, 2003). Hereafter referred to parenthetically in the text as A.

<sup>2</sup> Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, (tr.) A. M. Sheridan (New York: Vintage, 1994). Hereafter referred to parenthetically in the text as BC.

<sup>3</sup> Foucault thematizes somatic medicine in several other places, the most important of which are the three lectures given in October 1974 at the Institute of Social Medicine, Rio de Janeiro, Brazil. The texts appear in English as “The Crisis of Medicine or the Crisis of Antimedecine?” (tr.) E. C. Knowlton, W. J. King, and C. O’Farrell, *Foucault Studies*, no. 1 (2004): 5–19; “The Birth of Social Medicine,” (tr.) R. Hurley, in *Power: The Essential Works of Michel Foucault 1954–1984, Volume 3*, (ed.) J. Faubion et al. (London: Allen Lane, 2000); and “The Incorpora-

Foucault's approach, psychiatry is seen as "the science of normal and abnormal behavior" and, in terms of Foucault's historical presentation at least, psychiatry "could really become a medicine only through a number of...imitative processes," which later evolved into a correlative framework and sought to shape itself after organic medicine's model of classification and diagnosis. (A, 306) This essay extends this depiction to the field of organic medicine by offering a reading of *The Birth of the Clinic* through the methodology Foucault provides in *The Archaeology of Knowledge*<sup>4</sup>. In particular, I approach *The Birth of the Clinic* with a focus on the epistemological and ontological concerns indicated therein regarding the "objects" and "objectivity" of medical sciences. It should be stated, however, that this essay neither aims at an analysis of Foucault's philosophy, nor does it attempt to justify his theories strictly understood. Rather, it aims to apply the tools of Foucault's methodology in order to say something that is left *unsaid* by Foucault himself.

## I. Formation of Objects and Concepts

The discipline whose history one is studying actually changes with each epistemological break, even if linguistic habit leaves its name unchanged.  
— Georges Canguilhem, *Ideology and Rationality in the History of the Life Sciences*

In *The Birth of the Clinic: An Archaeology of Medical Perception*, Michel Foucault presents a history of the clinic by focusing on a shift that took place in the way medicine was practiced at the end of the 18<sup>th</sup> century in Europe. At the same time, however, the text is a methodological work in the "domain of history of ideas." (BC, 195) In

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tion of the Hospital into Modern Technology," (tr.) E. C. Knowlton, W. J. King, and S. Elden, in *Space, Knowledge and Power: Foucault and Geography*, (ed.) J. W. Crampton and S. Elden (Aldershot, UK: Ashgate, 2007). These lectures, however, are shaped around the thematic of "social medicine" and could thus be understood along the same lines with Foucault's presentation of the relationship between medicine and social regulation in the *Birth of the Clinic* insofar medicine is understood as an institution. Even when Foucault speaks of the normative aspects of somatic medicine in these lectures, his level of problematization is not the ontological and epistemological (conceptual) repertoire of medical science.

<sup>4</sup> Michel Foucault, *The Archaeology of Knowledge and the Discourse on Language*, (tr.) R. Swyer (New York: Vintage Books, 2010). Hereafter referred to parenthetically in the text as AK.

accordance with his overall understanding of history as unearthing the “unspoken,” or silent element of past discourses, Foucault’s aim in *The Birth of the Clinic* is *critical* in essence, concerned with “determining the conditions of possibility of medical experience in modern times.” (BC, xix)

It is questionable whether Foucault agrees with modern medicine’s consideration of the 18<sup>th</sup> century as its time of birth in the form of “positive medicine.” In any case, Foucault certainly questions the picture of “positive medicine” as one “that has made an ‘objectal choice’ in favor of objectivity itself.” (BC, x) Overall, *The Birth of the Clinic* problematizes the role and status of the major elements of medical theory and practice, *viz.* the observer and the object of observation. The underlying question throughout the text is *what does it mean to observe?*—that is, what is the status of the “object” being observed? Moreover, what is the status of the “subject” who is observing? In this context, Foucault employs the theme of medical *gaze* in order to examine the so-called change of object in medical discourse that occurred in the process of its purportedly becoming a positive science, specifically in terms of the relationship between the medical observer and the object of her observation.<sup>5</sup>

According to Foucault, the medical *gaze* is not only the product, but also the condition of the maintenance of the observer-observed relationship. However, an understanding of this relationship in terms of the clinical encounter between doctor and patient, which remains the prevalent framework in contemporary discussions, is far from adequate. Indeed, taking the clinical encounter as primary is predicated upon certain convictions regarding the epistemological framework within which the binary characterization of this encounter operates. What is needed to surpass the boundaries of this epistemological framework is first and foremost a critical ontological approach to the nature of the medical object in question that would in turn shape the epistemological “superstructure,” so to speak.

It is beyond the scope of this essay to offer an analysis of the nature of scientific observation in general. Suffice to say, observation as a procedural step in scientific practice is usually treated without much theoretical scrutiny and is largely limited to the framework of

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<sup>5</sup> See Foucault’s concluding remarks that say the text deals “on the whole, with the development and methods of medical observation over less than a century.” (BC, 195) However, it is worth noting that in *AK*, Foucault considers in retrospect the choice of the term *gaze* (*regard medical*) to be “not a very happy one” on account of its connotations of “referring back to *the* synthesis or *the* unifying function of a subject.” (AK, 54)

the questions concerning the value and attainability of objectivity within scientific activity. Appearing on the radar of philosophy of science as a possible problematic rather late, in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, observation is generally taken for granted as the first step to scientific investigation *per se*. For our purposes here, we cannot further examine the question in “hard sciences” of whether “observation statements” are marred with “theoretical” concerns. With that in mind, the issue pertinent to observation, to the extent that it is expressed in *The Birth of the Clinic*, concerns the way in which the clinical encounter could be “attributed with the power of assuming...the general form of all scientific observation.” (BC, xv) In order to address this concern, due attention must be paid to the questions, “can we have *objective observations* in medicine the same way they are performed in hard sciences?” and “what is the ontological status of the medical object?”

The ontological reference point in medical sciences, *i.e.* the kind of entity that medical gaze is supposed to be directed upon in its effort to make objective statements, is far from having a unified status and nature in the history of medicine. Foucault tells us that classificatory medicine, for instance, is characterized as a medicine of species that sees diseases as independent entities to be examined. In this model, the particular patient, as the spatial support of a certain species of disease, is considered only as a hindrance that adulterates the purity of the full manifestation of the disease. Accordingly, organs are “the concrete supports of the disease” rather than its “indispensable conditions,” and “in order to know the truth of the pathological fact, the doctor must abstract the patient.” (BC, 8–10) Alternative models to classificatory medicine—for instance, the medicine of symptoms or anatomico-clinical medicine—are characterized by alternative sets of concepts and focus their investigations on new fields of objects, *i.e.* tissues, entire organisms, etc. However, this depiction should not give the impression that the constitution of the objects of medical observation is a passive selection process from a multiplicity of objects that are already there. For Foucault, the process by which objects are constituted is formative and can only take place in and through a discursive unity.

As expressed in *The Archaeology of Knowledge*, medical science constitutes a discursive unity characterized, like other discursive unities, by an overarching notion of continuity that manifests itself in forms that include tradition, development, and evolution. Within a framework of progress, for instance, there is a unifying character to medical science despite the fact that some practices could retrospectively be considered proto-scientific. However, Foucault explains

that, notwithstanding the apparent immediacy and familiarity of a given discourse, behind this unity and continuous progress lurks a certain discontinuity. Although the nature and ground of this apparent unity remains largely untouched by theoretical examination, the question as to what characterizes these discursive formations as unities is certainly worth examining—unless one contends that they are arbitrarily formed or merely of instrumental value.

To that end, Foucault makes several hypothetical suggestions only to subsequently refute them all. The possible explanations entertained by Foucault are: the unity and singularity of *the object* of the statements in a discourse, *the form* of the connection between statements, the permanent *concepts* involved, and the enduring presence of certain *themes*. (AK, 32–35) In examining these alternatives, Foucault examines the discourse on psychopathology and asks if it is the object of “madness” that maintains the psychopathology’s discursive unity. Albeit not as conspicuous as in the example of “madness” (in terms of its situatedness in a number of discourses other than psychopathology, *e.g.* legal, punitive, ethical etc.), the group of statements and their objective reference point in somatic medicine, I suggest, could be construed along the framework Foucault offers for psychopathology. Accordingly, in somatic medicine, statements are “far from referring to a single object, formed once and for all, and to preserving it indefinitely as its horizon of inexhaustible ideality.” (AK, 32) Rather, during changes in medical discourse, the nomenclature, the taxonomic preferences, the fundamental characteristics, and the etiological framework that situate a disease all go through a drastic change.<sup>6</sup>

As suggested above, one possible explanation for this change in the focus on the object might be the result of a continuous, progressive effort wherein certain mistakes are corrected within a consistent discursive unity. This perspective would be predicated upon the assumption that what gives a discourse its unity is the *style* in which statements are made and connected to one another such that the scientificity of the discourse is sustained. Foucault states that the scientificity of medical discourse in the nineteenth century is allegedly warranted insofar as there prevailed a descriptive endeavor, that is, insofar as medical observation is understood as a set of descriptive statements. (AK, 33) Hidden in this alleged descriptiveness, however, is a certain ontological and epistemological assump-

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<sup>6</sup> For an epistemological case study, see Ludwik Fleck, *The Genesis and Development of a Scientific Fact*, (ed.) T. J. Trenn and R. K. Merton, (tr.) F. Bradley and T. J. Trenn (Chicago: The University of Chicago Press, 1979).

tion that presupposes a *supposedly* direct access to a *supposedly* well-formed object. To clarify, we can refer to the way in which the patient's bedside is utilized in medical discourse as the spatial medium in which this allegedly direct connection between the observing eye and the observed object takes place. According to this perspective, the bedside is the bedrock of medicine insofar as it is not contaminated with *theory*. In this framework, clinical observation is considered as the support of the "positive accumulation" in medical discourse that "enabled medicine not to disappear entirely with each new speculation, but to preserve itself, to assume little by little the figure of a truth that is definitive, if not completed...to develop...in a continuous historicity." (BC, 54-55)

It should not be overlooked, however, that Foucault does not aim to undermine the role of the above mentioned factors in the unification of medical discourse. Yet, despite appearances and the way in which medical science treats its own history, these factors do not have essential and fundamental roles; rather, they function only as strategies and only in connection to one another. These connections are bound up with rules but only insofar as these rules are "conditions to which the elements of this division (objects, mode of statement, concepts, thematic choices) are subjected." (AK, 38) Any discursive unity exists only insofar as it is a *unity of possible statements* in which "a variety of objects were named, circumscribed, analyzed, then rectified, re-defined, challenged, erased." (AK, 41) For Foucault, this whole process is not a matter of discovery: "[T]he object does not await in limbo the order that will free it and enable it to become embodied in a visible and prolix objectivity.... It exists under the positive conditions of a complex group of relations." (AK, 45) Accordingly, "new" objects as well as new concepts are the outcomes of a formative process, which, in turn, is bound to take place only within a new set of possible statements. When a certain theoretical unity is replaced by another, the relationship does not take place between a disinterested and objective knowing subject that gazes upon certain objects, loses interest in them, and has the epiphanic moment of discovering a new object that "preexists" her disinterested being. Rather, the change takes place as "the result of a recasting at the level of epistemic knowledge (*savoir*) itself, and not at the level of accumulated, refined, deepened, adjusted knowledge (*connaissances*)." (BC, 137) In other words, one does not have to deny that there exists an accumulation of knowledge; however, one must qualify that the accumulation in question takes place at a certain level of knowledge (knowledge as *connaissance*). Yet, formation of objects itself is "not a 'stone-by-stone' edifice" (AK, 54) that assumes that

changes in statements and object choices of scientific discourse are merely about acquiring better eyesight, a sharper comprehension and epistemological clarity. What is happening is not an “epistemological purification” where observation cleanses itself of theoretical prejudices through the accumulation of knowledge. Instead, what seems to be an epistemological clarification with regard to the object of knowledge (*connaissance*) is in fact a change in “the forms of visibility” entailed by knowledge (*savoir*). (BC, 195)

According to Foucault, a discursive unity is formed in and through the formation of objects and concepts. Yet, to support this “unity,” these formations require links and associations that connect them to one another. In this respect, in terms of what Foucault terms “enunciative modalities,” the first question to ask is “who is speaking? Who among the totality of speaking individuals, is accorded the right to use this sort of language (*langage*)?” (AK, 50) He writes: “Medical statements cannot come from anybody; their value, efficacy...and generally speaking, their existence as medical statements cannot be dissociated from the statutorily defined person who has the right to make them.” (AK, 51) Demarcation between *medical statements* and statements that could be called statements of *medical relevance* is fundamentally tied to *who* is making these statements. That is, the questions stated above are to be understood within the framework of who is entitled to form and make use of concepts that would be *proper* medical concepts and refer to objects that are pertinent to medical concerns. In this respect, Foucault says, in the 19<sup>th</sup> century, “daily medical practice integrated the laboratory as the site of a discourse that has the same experimental norms as physics, chemistry, or biology.” (AK, 52) Notably, the laboratory as the institutional site is not exerting its sets of concepts and objects by force. Rather, the discourse is produced and practiced as a form of knowledge (*savoir*) with its “specific objects and instruments for verification.” This enunciative power is the result of

the establishment of a relation, in medical discourse, between a number of distinct elements.... [T]his relation between different elements...is effected by clinical discourse: it is this, as a practice, that establishes between them all a system of relations that is not ‘really’ given or constituted a priori. (AK, 53–54)

Hence, clinical observation is not only serving a therapeutic function but also institutionalizing a body of knowledge. It is not only communicating a certain *techne*, but also creating its legacy as the truth of this *techne*. As Foucault expresses, “the clinic figures...as a structure that is essential to the scientific coherence...of the new

medical organization.” (BC, 70) Together with the changes in medical sciences, of its tools and methods in 19<sup>th</sup> century Europe, medical scientific discourse will be the only “speaker” in the array of enunciative modalities. In the next section, I will examine the notion of truth as the seat of the enunciative authority medical discourse claims to itself.

## II. Truth

Truth is simply what science speaks.  
— Georges Canguilhem, *Ideology and Rationality in the History of the Life Sciences*

As I argued in the previous section, the *epistemological objectivity* attributed to the *medical object* and, correspondingly, the *objective* nature of medical observation are formed within a certain understanding of objective (medical) truth. In turn, the “truth discourse” establishes certain discursive practices that are formed on the basis of this idea of “Truth.” “Truth” is one of the key terms, if not *the* key term, in Foucault’s corpus, for which Foucault offers various forms of analyses at different levels of problematization.<sup>7</sup> Unfortunately space does not allow me to give a comprehensive account of the diverse ways in which Foucault approaches “truth.” I will confine the discussion here to Foucault’s Nietzschean account of the value and, pertinently, the ground of the authority of truth. Very briefly, for Foucault, “truth” is to be understood as a regime, rather than a set of disinterested and supposedly objective statements. Within this framework, essentially incorporated in the truth discourse is the power of truth to bring about certain acts that are in turn shaped within and justified through the discursive power of truth. In other words, in a regime of truth, truth is “justified” not only by reference to a supposedly veridical account of things as they

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<sup>7</sup> Foucault lists the five traits of truth in “Truth and Power,” in *Power*, 131. This list, despite being suggestive of Foucault’s line of thinking on the topic, is not exhaustive in terms of the variety of aspects of truth Foucault thematizes in his other works. I want to thank one of the blind reviewers for calling attention to Carlos Prado’s *Searle and Foucault on Truth*. Although the presentation of the different senses of truth in Foucault in Prado’s book is quite intriguing and pertinent to my argument here, space does not allow incorporating it into the present discussion. See, C. G. Prado, *Searle and Foucault on Truth* (Cambridge: Cambridge University Press, 2006).

really are but also by directing the way in which subjects conduct themselves on a non-discursive level (More on that later).

In accordance with our purposes here, Foucault's 1970–1971 lectures on the *Will to Know*, fashioned against the thematic backdrop of “truth formation,” have a lot to offer. As Foucault contends in these lectures, Nietzsche dissociates the *will* to know (*savoir*) from knowledge (*connaissance*) and founds the “will to know” on the notion of will to *power*. In other words, the way in which knowledge acquisition takes place is always situated within a structure of knowledge (*savoir*) that postulates the rules of knowledge acquisition. Knowledge acquisition, in turn, is always taking place in the form of a knowledge production, in which what would count as knowledge in the first place is always already imposing strategies both for the manner in which knowledge is conceptualized and the way it is produced.

According to Foucault, the distinction between will to know and knowledge enables Nietzsche to emphasize the “instinctive” and “struggle-like” aspect of this *will* to know over the claim to achieving *the* truth that precedes a rigorous endeavor and informs it. In a similar fashion, for Nietzsche and Foucault alike, truth is not achieved but “produced as an event.”<sup>8</sup> Foucault explains the theme of truth production in *Psychiatric Power*<sup>9</sup> with reference, again, to the Nietzschean metaphor of truth as a *thunderbolt*. Nietzsche frequently utilizes the metaphor of a thunderbolt in emphasizing the shaking, shocking aspect of a phenomenon. In this connection, Foucault contrasts “truth-sky” with “truth-event” and associates the former image with “truth realism.” Within the context of the discourse on truth that Foucault presents in these lectures, realism would correspond to the account in which truth is seen as independently existing and shrouding everything from above. The latter, that is, “truth-event,” is the result of an array of states of affairs which is itself nothing more than an event. The truth-sky, which Foucault also calls “attested truth,” or “truth of demonstration,” justifies itself, at the practical level, only through demonstration. (PP, 235–47) From this position, truth is out there, this or that discipline has the authoritative role in engaging in, or, more correctly, forming the discourse on

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<sup>8</sup> Michel Foucault, *Lectures on the Will to Know (Lectures at the Collège de France 1970–1971) and Oedipal Knowledge*, (ed.) D. Defert, F. Ewald, and A. Fontana (*Houndmills*: Palgrave Macmillan, 2013), 197–98.

<sup>9</sup> Michel Foucault, *Psychiatric Power (Lectures at the Collège de France, 1973–1974)*, (ed.) J. Lagrange, (tr.) G. Burchell (New York: Picador, 2003). Hereafter referred to parenthetically in the text as PP.

it thanks to its holding this “truth” at its disposal—whenever necessary demonstrating its affiliation to this “objective” state of affairs. Truth is something that is possessed and utilized. So, in Foucault’s terms, the distinction is between “the technology of truth-event, truth-ritual, truth-power relationship, as opposed to the truth-discovery, truth-method, truth-knowledge relationship, as opposed, therefore, to truth that is presupposed and placed within the subject-object relationship.” (PP, 238) Foucault sees the relationship of the subject to “truth as thunderbolt” as one of a “shock” or “clash” that changes the supposedly independent and disinterested status of the subject. The prescriptive power of “truth,” on the other hand, owes its condition of possibility to the allegedly objective existence of the objects in the epistemological as well as the ontological plane. Aptly, in terms of the role and the status of subject, this view is predicated upon the subject’s ontological distance to the realm of objects and the former’s accompanying distinctive status in investigating various states of affairs.

At this point, it is important to note that this seemingly purely theoretical discourse is not limited to its theoretical concerns. As Foucault says, there is no “theoretical or analytical discourse which is not permeated or underpinned in one way or another by something like an imperative discourse,”<sup>10</sup> I will say more about what I see to be the intricate connection between the normative and the epistemological frameworks in the final section. Very roughly, it is my contention that whether or not one’s goal in analytic investigation is extending an explicit objective beyond its theoretical realm, even the most apparently disinterested “knowledges” carry with them some instructive and directing power, whether this power is deployed in terms of a program or not. This is even more clearly the case with the objects of the “human sciences,” where the object status bestowed upon human beings is infinitely challenged by their state of being simultaneously objects and subjects. Foucault says, “you can already see it [the subject] as an object, that is to say, as that on which and towards which mechanisms are directed in order to have a particular effect on it, as well as a subject, since it is called upon to conduct itself in such and such a fashion. (STP, 43) The efficacy of this instructive and prescriptive function is dependent upon the capacity of the discourse at issue to make a claim to being in the privileged position of holding the truth in its hand. Hence,

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<sup>10</sup> Michel Foucault, *Security Territory, Population (Lectures at the Collège de France 1977–1978)*, (ed.) M. Senellart, (tr.) G. Burchell (New York: Picador, 2007) 17. Hereafter referred to parenthetically in the text as STP.

discourse on truth is the background of all praxis insofar as any particular praxis aspires to being the *correct* one. As Foucault says,

knowledge of the kind we call scientific basically presupposes that there is truth everywhere, in every place and all this time.... [F]or scientific practice in general, there is always the truth; the truth is always present, in or under every thing and the question of truth can be posed about anything and everything. (PP, 235)

Within this framework, this ubiquitous truth is always to be *discovered* rather than *formed*. After the discovery, the scientific discourse authorizes certain acts and delimits certain others on account of their being in accordance with and conducive to this truth. In this sense, the authoritative power in question gains its effectiveness from the discourse on truth. However, this instructive power and its truthfulness are co-constitutive in the sense that only in being constantly affirmed through its effectiveness in “ordering” the sphere of praxis that the truth discourse gets consolidated. Accordingly, on the basis of the claim to the objectivity of the truth of the body and its *pathology*, which I have articulated in the previous section, medical science crafts the *truth of health*, meaning, what counts as health and what does not.

As Foucault states, “if [knowledge], passes itself off as knowledge of the truth, this is because it produces the truth through the action of a primary and always renewed falsification that posits the distinction between true and false.”<sup>11</sup> To put it another way, the assumption, or the assertion, that there *is* truth and that one possesses it pretends that falsity encountered in the process of achieving the truth has only a negative function—it is an accidental hindrance. However, following Nietzsche’s account, Foucault presents falsity as an essential condition for the ontology of truth; in other words, truth is, in terms of normative as well as epistemic value, not accessed but rather produced together with its opposite “false.” Moreover, the possessor of the true discourse is the possessor of the criterion as to what counts as true too. Foucault provides an example of this for the case of psychiatric discourse in *Psychiatric Power*:

In crude terms, psychiatric power says: The question of truth will never be posed between madness and me for the very simple reason that I, psychiatry, am already a science. And if, as science, I have the right to question what I say, if it is true that I may make

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<sup>11</sup> Foucault, *Lectures on the Will to Know*, 227.

mistakes, it is in any case up to me, and to me alone, as science, to decide if what I say is true or to correct the mistake. I am the possessor, if not of truth in its content, at least of all the *criteria* of truth. (PP, 134)

In terms of what I have expressed in the previous section regarding the role of enunciative power, “medical statements cannot come from anybody.” (AK, 51) Scientific discourse (as exemplified above in connection with psychiatric discourse) claims for itself, and indeed possesses exactly *insofar as it is* scientific, the power to pronounce whether or not a statement is qualified to be called scientific or whether it is merely an expression of pseudo-science, superstition, etc.

Scientific discourse, insofar as it manufactures the true discourse, gains its power from this very act of manufacturing. This furnishes it with tools of verification/falsification that it would define and apply whenever it wishes and on whatever “objects” it wishes. In this respect, it is the paramount example of the way power “functions.” As Foucault expresses, “[p]ower cannot be exercised unless a certain economy of discourses of truth functions in, on the basis of, and thanks to, that power” and hence it creates a peculiar “relationship among power, right, and truth.”<sup>12</sup> This all-pervasive power, which is characterized not in its localization but its dis-localization and decentralization, does not simply rule over individuals taken as the external objects of power; it is not only exercised on the individuals but also continuously reinforced, re-invented, and empowered by and through individuals insofar as they are objects and subjects of power simultaneously. In the next section, I will articulate how medical scientific discourse, having established its enunciative authority on the basis of its supposed objectivity within a discourse on truth, fabricates subjects through its normalizing functions without drifting into the precariousness of moral discourse.

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<sup>12</sup> Michel Foucault, *Society Must Be Defended (Lectures at the Collège de France, 1975–1976)*, (tr.) D. Macey (New York: Picador, 2003), 24.

### III. Normalization

Medical science is philosophical when the sheer power of man's reason to master his sensuous feelings by a self-imposed principle determines his manner of living.  
—Immanuel Kant, *Conflict of the Faculties*

Foucault's theorization of normalization is situated within his discussion of the various ways in which power operates in a society. Foucault portrays a system of law as the pre-modern form of power and explains that such a system is characterized by legal power instead of normalizing power. The legal discourse of the system of law essentially serves a prohibitive, and thus negative, function, whereas the normalizing discourse is characterized as being fundamentally and distinctively formative and *positive*, although it may utilize prohibitive regulations as well. Legal power is exercised in terms of practices that do not aim at creating certain kinds of subjects, although they may by extension be doing that. Within the framework of disciplinary power, on the other hand, the prevention of the violation of the law and the response to this violation is taking place in the form of supervisions and checks, as well as corrective mechanisms. (STP, 4)<sup>13</sup> Unlike the system of law, a disciplinary society is one of thoroughgoing control—one that intervenes “without halt from the first moment, the first action.” (PP, 51) In the third form of power Foucault mentions, power of security, the way in which the positive control mechanisms function is different from those of disciplinary power. The concerns in terms of which the power of security articulates itself are expressed through average rates, statistics, and cost-benefit analyses, all of which are understood and utilized as both symptomatic information and as data for future-directed planning. In the context of security, the general concern is to keep a certain type of social phenomena “within socially and economically acceptable limits and around an average that will be considered as optimal for a given social functioning.” (STP, 4–5) Note that the key words here are “average,” “optimality,” and “acceptability.” From the standpoint of security, it is through these concepts that any phenomenon is understood in terms of probability and kept under control through calculation.

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<sup>13</sup> I think it worthwhile to problematize the “spectacular and definitive moment” of the punishment practice not only in terms of legal discourse but also that of normalization where the level of operation would be the spectator. Yet, this is not the place to do that.

In accordance with the different mechanisms at work, disciplinary and security discourses work with different models of “norm” and “normalization.” The disciplinary model operates through surveillance and transformation programs in which the normal is distinguished from the abnormal on account of desired ends and the performability of these behavioral ends by individuals. (STP, 57, 83) Here, the desired consequence stands as the norm by reference to which the normal and the abnormal are distinguished. Due to the “primacy” of the norm over the normal-abnormal distinction, Foucault calls this process “normation” (*normation*.) In other words, the priority in disciplinary discourse is the norm as the ideal that is to be achieved. Whoever achieves this norm counts as being normal whereas the one who fails to achieve the norm is deemed abnormal in accordance with the “originally prescriptive character of the [posited] norm.” (STP, 57)

The apparatus of security, on the other hand, functions at a different level.<sup>14</sup> In the context of “security,” there is not one but many “normals” that are achieved as the result of calculation techniques, from within which the most desirable one is selected as *the* normal and posited as the norm. Hence, “the norm is an interplay of different normalities.” (STP, 63)

[T]he operation of normalization consists in establishing an interplay between these different distributions of normality and [in] acting to bring the most unfavorable in line with the more favorable. So we have here something that starts from the normal and makes use of certain distributions considered to be...more normal than the others, or at any rate more favorable than the others. These distributions will serve as the norm. (STP, 63)

What is revealed in the way normalization/normation operates in different power formations is the way in which these mechanisms are not only grounded upon but also sustained in and through a discourse on knowledge. A norm does not stand as authoritative simply owing to its being established once and for all (as in the legal discourse) but through its continuous affirmation in the realm of praxis insofar as it is a form of knowledge. In this respect, Foucault makes reference to Canguilhem’s understanding of normalization as

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<sup>14</sup> For the purposes of this essay, I will not go into the details of the way in which “normalization” works in apparatus of security through an array of new tools such as statistics, calculations of curve, etc. See Mary Beth Mader, “Foucault and Social Measure,” *Journal of French Philosophy*, vol. 17, no. 1 (2007): 1–25.

a “polemical concept,” adding that it could also be a “political concept” on account of its possessing both a “qualificatory” and “corrective” power and, hence, is a “normative project” (A, 50)<sup>15</sup> While not disagreeing with this polemical/political aspect of normalization, in the following, I will focus on how this normative project, which I understand as an ethical project, sustains an *ethos*, a certain way of living, not by coercion but by creating subjects that reproduce this ethos by actively conducting themselves.

As is well known, Foucault sees an intrinsic connection between the body and the way in which power, in all its forms, operates. In addition to this, for Foucault, the operation of power should be understood as “a rational, calculated, and controlled game” (PP, 14) rather than an external oppressive mechanism. As a result of this exercise, certain kinds of behaviour and living will, ideally at least, become a habit for the subjects. (PP, 47) Within this framework, it would be rather banal to maintain that medical science normalizes insofar as social and cultural aspects of living, in addition to the physiological, are increasingly understood through medicalization. It is also obvious enough that medical science plays a critical role in creating an ever-growing scope of discursive power for computational approaches to the understanding of health of individuals as well as populations.<sup>16</sup> More interestingly, however, the power of medical discourse over the way subjects perceive themselves as close or afar from “health,” which stands as an all-desirable trait, and its effectiveness in creating more and more habituated life practices would be hard to overlook with even a cursory overview of the non-professional distribution of medical knowledge. With that in mind, what is the basis on which medical sciences are normalizing? What conceptual framework could be deployed to understand medical normality? In accordance with the foregoing exposition, I suggest that in medical discourse, the two types of normalization (normation and normalization) operate on the basis of an intricate connection in this context.

On the one hand, we can understand medical discourse in terms of the kind of normalization Foucault presents in connection to discourse on security. Medical knowledge in the contemporary

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<sup>15</sup> Also see Georges Canguilhem, *The Normal and the Pathological*, (tr.) C. R. Fawcett and R. S. Cohen (New York: Zone Books, 1991), 239.

<sup>16</sup> For a comparison of Foucault’s views with the orthodox perspectives on medicalization see Deborah Lupton, “Foucault and the medicalization critique” in *Foucault, Health and Medicine*, (ed.) R. Bunton and A. Petersen (New York: Routledge, 1998), 94–107.

world is, more than ever, tied to diagnostic tests.<sup>17</sup> In order to identify disease phenomena, various measuring and scanning techniques (e.g. laboratory reports, medical imaging, etc.) are used that refer not to qualificatory states but certain quantificatory data. Once the quantifiable information is gathered, it is compared to and run against reference ranges, also called *normal values*, for a given test.<sup>18</sup> Inasmuch as medical discourse establishes itself on empirical, numerical data, it is operating within the type of normalization that is captured in Foucault's notion of the apparatus of security. That to which the test results are compared is the differential normalities in the forms of acceptable quantities. Hence, what comes first is not the norm, but the "normal" in the form of an instantiation of normal values. The normal values, although expressed numerically, could be understood in a phenomenological sense as well; an individual of normal health could be simply taken to be in a state of health that does not pose significant or disturbing challenges in the way she interacts with her environment. However, these reference points in the form of acceptable averages are not referring to real ontological states in the sense that there is not a normal individual that has the perfect quantificatory values that would immediately suggest her "health." The statistical curve achieved on the basis of individuals in favorable and not so favorable conditions does not have to coincide with the norm that is achieved as the result of the interplay of differential normalities. In other words, the norm that is posited as the ideal conditions of the actual situation, I suggest, is always informed by a "norm" in the sense Foucault understands it in the disciplinary apparatus. The medical "norm," albeit acting on the basis of empirical data based on actual bodies, is essentially *disembodied*, inasmuch as it is informed by the ideal that sets the objective standard for the ordinary understanding of "healthiness" or "normality." Thus, medical "norms" are ontologically ideal, not real.

Hence, I argue, a certain concept of norm is implicit in every medical discourse, and insofar as this is the case, the normalization in medical discourse coincides with *normation*. Within this framework, the norm in comparison to which the normal and abnormal are determined and distinguished is not *only* the average of differential normalities, although this does play a role as well. More importantly, medical discourse operating through normation always already

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<sup>17</sup> For a historical account, see Richard H. Shryock, "The History of Quantification in Medical Science," *Isis*, vol. 52, no. 2 (1961): 215-37.

<sup>18</sup> Mader aptly calls this a "statistical panopticism." See "Foucault and Social Measure," 3.

equates “normal” with “healthy” where the latter is something over and above the average. Hence, I suggest, the normative reference point of medical sciences is a certain conception of health that is already taken for granted and, therefore, normalization takes place in the form of *health-ization*. In this sense, health is simultaneously the norm and the normal. It is through the normative charge of the concept of health that medical scientific discourse could create certain kinds of subjects that conduct themselves in certain ways in terms of dietary concerns, exercises, etc., as well as the way they objectify and evaluate themselves and the others as more or less healthy, more or less strong, more or less meeting a standard that is beyond actual capacities to meet.

Then, the question is, what is the ground of the normative power of medical sciences, or, what I called “the medical as the medico-ethical”? Why is it so obvious to us subjects that health is what the medical discourse informs us it is? The normalizing power of the modern medical discourse that transforms the normative into the normal lies in the epistemic power of the sciences that is founded upon the enunciative authority that stems from their claim to objectivity. Within this normalizing framework of power, subjects perceive the normativity of medical science as the truth of themselves and conduct themselves accordingly. However, the alleged objectivity and the accompanying enunciative power of the medical discourse are sustained through a non-existent ontological reference point. To clarify, I will make use of Foucault’s notion of *metasomatization*.

In *Abnormal: Lectures at the Collège de France, 1974–1975*, Foucault presents somatization as a medicalized discourse, which is an alternative to a moralizing discourse. Somatization refers to the ways in which a certain form of behaviour, generally understood, is discouraged or let prosper by means of a reference to future as well as present well-being or illness.<sup>19</sup> According to this framework, the deterrent against a form of behaviour was not a reference to a moral discourse (prospective debauchery, vice, etc.) but a medical discourse, *i.e.* a “life crippled with illness.” Hence, the process is not a moralization but somatization or pathologization of a particular form of living. (A, 237) According to Foucault, the key to the operation of somatization is the “fiction of total illness,” which is a sort of all-inclusive illness that would allegedly result from the mode of living

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<sup>19</sup> In the *Abnormal*, Foucault presents somatization particularly in connection to the new way child masturbation is problematized in the nineteenth century through a medical rather than a moral discourse.

in question. By positing an artificial connection between this mode of behaviour and an imaginary state of total-illness, the individual is charged with the responsibility for the well-being of her own body that Foucault calls “pathological responsibility of the subject for [her] own illness.” (A, 241)

The process of somatization is supported by what Foucault calls a “background body” that serves as the causal reference point for dysfunctional states and for which there is no acceptable organic etiological framework of explanation. In this context, Foucault introduces a process called “metasomatization” through which the body of heredity as the “background body” is constituted.<sup>20</sup> The idea of metasomatization serves the function of tracing the illnesses (particularly psychiatric illnesses for Foucault’s use of metasomatization) of the individuals back to the “body” of their ancestors. Through the process of metasomatization, the absence of the somatic entity in psychiatric disorders, an absence that was preventing the medical scientist from building a viable etiology, is filled in with an imaginary body.

I suggest that the metabody could be used to scrutinize the claims to objectivity in medical discourse in terms of the role it plays in filling in the absence of the somatic entity, an absence that impairs the conceptual framework of medical theorization. In other words, the distinctive normalizing power of medical science (which I tried to articulate by means of Foucault’s delineation of normalization in terms of power), requires a certain metasomatization in order to be able to assert itself as an objective truth discourse (which, as I argued in the preceding sections, is an indispensable requirement for the enunciative power of medical science). That is, if medical science is to have any normative power, it cannot limit its epistemological claims to particular concrete bodies, either taken singularly or as a population. When subjects are taken as mere individual bodies, it is not possible to talk about “health;” all we can express is, at most, a “well-being” or “non-well-being.” On the other hand, when scientific

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<sup>20</sup> In Foucault’s particular framework, this background body is the body of heredity. Foucault explains that this body, “by its own causality confirms and explains the appearance of an individual who is the victim, subject and bearer of this dysfunctional state. What is this background-body, this body behind the abnormal body? It is the parent’s body, the ancestors’ body, the body of the family, the body of heredity.” (A, 313) As I have expressed in the introduction, the way in which I utilize the concept of metabody is analogous to Foucault’s use *only* insofar as both serve as the ontological/epistemological reference point. For an exciting deployment of the concept of metabody, see Mary Beth Mader, “Foucault’s ‘Metabody,’” *Bioethical Inquiry*, vol. 7, no. 2 (2010): 187–203.

statements are limited to treating the “health” of individuals in isolation and, in order to transcend the differential normalities and have a robust reference point for standardization, comparing one particular individual (or, for that matter, one particular society or population) to others, they open themselves to allegations of being ideologically or pragmatically contaminated by epistemic as well as normative prejudices (presuming the distinction between both). Moreover, one individual body’s health is not a matter of its relative health to another body. Epistemologically speaking, there is no objective ground for making the claim about this relative health. In terms of all these points, then, medical discourse needs to create and implicitly work on a “metabody” as its object that would serve as the norm from which the individual bodies would be said to deviate. In other words, health functions as both the norm and the normal, and the metabody is needed as the ontological ground for conceptualizing both kinds of health.

## **Concluding Remarks**

In this essay, I claimed that medical discourse is inherently a medico-ethical discourse insofar as it is an ethical discourse informed by and justified through a medical discourse. Medical discourse does not consist in simply ordering individuals on the basis of its expert knowledge. Distinctively, instead of functioning as a coercive power in the legal sense, the normalizing power of the medical discourse operates as a truth discourse in which medical sciences purportedly speak the *truth* of a body. Presumably, “body” as the medical object is constant and we can have a more or less unified and uncontroversial conception of its health. Contrary to this depiction, I sought to show that the objects of medical sciences are not pregiven in a ready-to-observe character but rather formed as a field of inquiry in a discursive formation and that the enunciative power of medical sciences plays an indispensable role in preserving the body as an object. Accordingly, in order to account for the non-coercive normalizing power of the medical sciences, I claimed that medical sciences can allegedly authorize themselves as objective *only* on the basis of a metabody that frees the medical discourse from the epistemological burden of what I see to be the incongruity between the abstract notion of health and health as it is achievable by actual bodies. In other words, the reference point of the medical statements is not the real bodies but the body of the metasomatization that serves a function akin to the “ideal conditions” presumed to underlie chemical equations. In this sense, these statements are speaking the

word of “truth” that is embodied in the un-bodied body that is the artifact of metasomatization. Thus, while medical science functions as a control apparatus that produces subjects through a normalizing power, “normal” and “abnormal” are instituted as objective evaluations with reference to the truth of the body of metasomatization. By means of this reference to objective truth, scientific discourse frees itself from the “do’s and don’ts” of traditional morality or the system of law and yet preserves a normative discourse by embedding a kind of ethos into the way individuals live and relate to themselves. Grounded in the “metabody,” medical scientific discourse renders ethical normativity and epistemological normativity virtually indistinguishable and thereby secures its claim to objectivity.

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