THE GAZE, LANGUAGE AND DEATH IN 21ST CENTURY MEDICAL DISCOURSE
A critical analysis based on Foucauldian historico-philosophical analysis of the birth of modern medicine

Number of words: 8000
Name student: Senned Karrar
Name supervisor: Prof. dr. L.M. Huijer
Name advisor: Dr. B. Leeuwenburgh
Main study: Medicine
Date of completion: 1st of May 2019
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Introduction

This bachelor thesis is a critical analysis of the book of Michel Foucault, named *The Birth of the Clinic*. Michel Foucault is a French poststructuralist and postmodernist philosopher, born in Poitier, France on October 15, 1926. He has held several positions as a professor in universities in France and was eventually elected to the very prestigious Collège de France. He also lectured frequently outside France, especially in the US and eventually taught classes annually at the University of California at Berkeley.

Foucault occupied himself with several academic disciplines, namely psychology, history and philosophy. His academic works were often a combination of these disciplines. Foucault used a specific type of historical analysis in his works, namely an archaeological and genealogical method. The archaeological method is a method through which Foucault tries to display that systems of thought and knowledge are governed by rules, which exercise power on the individual subject and demarcate thought in a given period or domain. Foucault partly derives his genealogical method from Nietzsche. The genealogical method tries to lay out that a certain system of thought (which is brought to light by Foucault's archaeological method), is the result of a contingent series of events in history, and not, as commonly conceived, the result of a rational series of events.

In *The Birth of the Clinic* Foucault conducts an archaeological analysis of the rise of modern medicine. *The Birth of the Clinic* focusses on several general themes, especially the themes that Foucault mentions at the beginning of the preface:

“*This book is about space, about language, and about death; it is about the act of seeing, the gaze.*”¹

This analysis of Foucault revolves around the upcoming of modern medicine during the 18th and 19th century and focusses on developments in France. Foucault wrote this book in 1963. Medical practice has changed since this book has been written and of

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¹ Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (London: Tavistock, 1973), ix
course has changed greatly since the 19th century. Therefore, it is interesting to research to what extent his analysis is relevant to modern medicine as known in the 21st century. Concepts, such as patient-centered medicine and shared-decision making mark a change in the patient-doctor relationship. These contemporary concepts are common practice in 21st century medicine and encompass the idea that not only the doctor decides what treatment will be commenced, but also the patient. The patient should even play an active role in this particular process. This can lead one to think that a different discourse has occurred in the medical profession. However, whether this change has actually occurred is an interesting philosophical exercise.

Furthermore, in the Netherlands the debate about euthanasia and end-of-life clinics is also ongoing. The perception that death has to be within your own power is becoming more internalized amongst the medical profession and also presumably amongst the general population. It is an exciting exercise to look whether this trend has already been set throughout the previous centuries. Besides this, the concept of brain death has been introduced which was not present in the 19th century. Whether this resonates with the analysis of death in modern medicine remains unanswered.

The thesis I will defend is as follows:

Foucault has given a historical account of the birth of modern medicine and I will argue that the paradigmatic trend this birth has set, has continued up until 21st century medicine, with slight modifications concerning the clinical methods used. However, the conception of how death is defined has changed in 21st century medicine.

In the first chapter space and the gaze are discussed in a chronological manner, as outlined by Foucault throughout his book. In the second chapter the importance of language in developing a medical science is laid out, also in a chronological manner. In the third chapter, the changed stance towards death by the medical profession and the general people will also be chronologically discussed. In the final chapter a contemporary analysis of these concepts will be conducted in order to compare it to the historical analysis Foucault has performed.

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In his book, Foucault describes plenty historical events. These will be out of the scope of this bachelor thesis, because they aren’t relevant to answer the thesis.
Chapter 1. The epistemic changes in 18th and 19th century medicine

In this chapter I aim to perform an analysis of Foucault’s historico-philosophical overview on the development of modern medicine. Alongside this analysis, I aim to elucidate on how the medical gaze has transformed alongside the development of modern medicine.

The gaze of the hospital

The first stage of 18th century medicine that Foucault describes is the hospital. The hospital is characterized by classificatory medicine and a distinct spatialization of disease. The spatialization of disease is divided into the primary, secondary and tertiary spatialization.

Classificatory medicine

Classificatory medicine is a mode of practicing medicine through a pedigree-like structure. Classificatory medicine also resembles the structure of taxonomy. This taxonomy is spatial and hierarchical, because diseases are labeled under specific families, genera and species. This can be considered as a kind of ‘table’. A disease is manifested in the patient, but in classificatory medicine a disease is localized in the ‘table’. The classification of diseases is done through similarity and analogy of diseases, through which a rational order can be made. The focus lies here on the diseases and not the diseased, in which the diseased is the patient. So, in order for a doctor to find the disease, he has to put the patient in between brackets, and thus subtract the diseased in order to come to the disease. The medical gaze in this case serves as a de-disturbing mediator, in which the doctor tries to get rid of the qualities of the patient that disrupt the true nature of the disease, which can be found within the patient. The localization of the disease in a table is what Foucault calls the primary spatialization of disease.

The secondary spatialization of disease is the instance in which the disease is actually placed within the patient. The secondary spatialization of disease occurs in the hospital when doctors start to embrace the importance of the patient in the display of diseases, because the disease manifests itself in the patient, disturbs the state of normality in
the patient, and is thus embodied by the diseased. This is the moment in which the disease and the diseased are united. The problem that arises with primary spatialization is that the disease is seated within the table, whilst it is actually characterized by its seat in an organism, and thus the patient. So now, in order for the doctor to find the disease he has to adopt a different gaze, namely one of analytic perception, which takes into account the qualities of the patient. A qualitative component is added to the gaze of the doctor. However, every disease remains to have its own essence, which is irrespective of space in the body and irrespective of the patient in which it is manifest. This essence of a disease is determined through kinship with other diseases in the table. An example is cramp: cramp in the lower abdominal area causes menstrual pain, constipation or digestive issues. Cramp in the chest area causes palpitations, dyspnea and a cough and cramp in the head causes epilepsy, collapse and coma. Cramp is the disease, defined by analogy.

The difference between this primary and secondary spatialization is that the patient in the latter has a positive position, compared to a negative position in the former. The patient now supports the qualitative phenomenon of the disease, whilst he/she firstly was the disturbing factor when unravelling the disease is what the doctor sought after.

The tertiary spatialization exceeds the connection between individuals, e.g. patients and doctors, but extends itself into other domains than the ‘table’ and the medical gaze, but now the disease is given a place in society, in which structures are set in place to facilitate the treatment and research of the disease to an optimal extent. This tertiary spatialization encompasses the infiltration of medicine, and thus disease, into the broader sphere of society and politics, in which political struggle, demands and social and economic considerations about the disease have to be made. Furthermore, it also encompasses the notion that the true being of a disease lies within the domestic sphere, because that is where the disease starts to present itself. The notion that prevailed is that the family is the natural locus of the disease, because the actual nature of the disease resides in the home. Foucault also makes clear that the tertiary spatialization is a not a less essential structure of disease, even though semantically it sounds like it is derived from the first two. The tertiary spatialization of disease actually encompasses a holistic grasp of disease, because the primary and secondary spatialization take place in this third space.
The gaze of the proto-clinic

What follows after the hospital is the proto-clinic, the predecessor of the clinic. The clinic arises in 18th century France in order to constitute learning hospitals. The proto-clinic, as Foucault calls it, is supposed to accept patients in such a manner, that all kinds of patients are present in the hospital, in order to reach a ‘didactic totality of an ideal experience’, to eventually form a clinic which is ‘constitutionally, a structured nosological field’\(^3\). In order to reach this there should only be a limited amount of patients, and preferably those from which young doctors can learn the most. This is in stark contrast with the hospital, in which the aim was to find the disease in the patient. The aim of the clinic is to use the patient as a means to knowledge, as a means to reach truth about diseases, in order to learn what to do in the future. The truth of the disease is found in naming the disease. Through thorough dedicated investigation of the patient, the doctor tries to know what is wrong with the patient so that it can give the disease of the patient a name. With the name you reach two goals, namely the goal of revealing the hidden, and by revealing the hidden you are able to deduce the outcome and the necessary means to treat the patient. In the hospital the patient suffers from the disease and is seen as the sufferer of disease, but in the clinic the patient happens to be diseased, and thus by accident becomes the object of study. The gaze of the proto-clinic is thus significantly different from its predecessor. It functions as an investigative glass in order to name the disease; the power does not lie in the gaze in this particular scenario, it is mainly supportive for reaching the ‘synthetic truth of language’.\(^4\) It is thus a process of unravelling, rather than thorough examination.

The gaze of the clinic

The proto-clinic tried to bring about a grammar in medical language and thus tried to create a science in the medical field. However, according to Foucault, the first attempt to actually ‘scientify’ the gaze was at the time of the clinic. This is due to the fact that the gaze was no longer an individual entity formed by the experience of only one doctor but was the product of the education of the doctor, which was constituted by an

\(^3\) Foucault, *The Birth of the Clinic : An Archaeology of Medical Perception*. 59
\(^4\) Ibid., 60
institution, an institution that gave the doctor the right to make diagnoses and do interventions. These institutions were created at the end of the 18th century, after the French revolution. This is explained in great detail in the 5th chapter of the book “The lesson of the hospitals”. Because the doctor has now been educated by an institution, a body of knowledge, the doctor is more sensitive to deviance of diseases and thus the doctor is able to perform more attentive examination. Furthermore, the examination of the doctor is now also comprised of a statistical component. This statistical component is added upon the observing gaze, in order to calculate the risks and chances of the diseased. In describing the constitution of the clinic, Foucault elaborately focuses on the importance of language. However, I will elucidate on the importance of language and semiotics in medicine extensively in the 2nd chapter.

Furthermore, another implication of the rise of the clinic was a new way of observing and assessing patients. Initially, doctors assessed patients through looking (what is wrong with you?), or gazing if I may, at patients, however two senses were added to the assessment, namely touch (now is added; where does it hurt?) and the ear. Taken together, this constitutes what Foucault calls the ‘sensorial triangulation’. The medical gaze of the doctor is expanded, or rather transformed, in such a manner that it doesn’t only look at the patient, but through touch and hearing starts to penetrate the invisible with which it localizes the disease of the patient. This development made the invention of the stethoscope by Laennec an understandable development at that time.

The gaze of the clinic, or the clinical gaze, revolves around the empiricism that is cardinal in the decision-making process of the doctors. This empiricism is based on the abovementioned statistical component, which functioned as a tool to deal with the inevitable uncertainties that one faces in the medical field. From this moment onwards, similarity of symptoms in diseases was no longer a necessary given, but the convergence of symptoms in similar diseases contributed to a greater body of knowledge, which was progressive in its essence. As Foucault puts it: “The simple dialectic of the pathological species and the sick individual, an enclosed space and an uncertain time, was, in principle, dislocated. Medicine no longer tried to see the
essential truth beneath the sensible individuality; it was faced by the task of perceiving, and to infinity, the events of an open domain. This was the clinic."  

The anatomo-clinical gaze

According to Foucault, the final stage at which medicine arrived in the 19th century is the way in which medicine is practiced at the time of Foucault’s publication, namely the anatomo-clinical method. This method relies upon pathological anatomy. Pathological anatomy is derived from the knowledge of the dissection of corpses. In describing this phase of the practice of medicine, Foucault mainly discusses the influences of Bichat on the formation of the pathological anatomy. Bichat himself had clear influences from classificatory medicine, as is displayed by his methodology, namely that of ordinal classification of human organs and not localization, which came about later. These influences shine through in his methodology.

The anatomo-clinical method is the method in which knowledge about symptoms and knowledge that has been brought about by pathological anatomy enjoins. The two-dimensional gaze in which the clinical gaze had been operating is now extended by a third dimension, namely the gaze that really enters the body. The internal body is now illuminated by the gaze of the doctor, through the brightness of death.

Disease is now not only characterized by a set of symptoms and statistics but is also described in terms of a geography within the body. It also provides the doctor the possibility to conduct a post-mortem discriminating analysis. Foucault quotes the following: "The feeling of suffocating, sudden palpitations, especially after physical effort, quick, difficult breathing, waking up with a start, cachectic pallor, a feeling of pressure and constriction in the precordial region and of heaviness and numbness in the left arm are overwhelming signs of heart diseases in which only anatomy can distinguish pericarditis (which affects the investing membrane), aneurism (affecting the muscular tissue), or contractions and hardening (in which the heart is affected in its tendinous or fibrous parts)." 6 This displays the wide variety of symptoms which can occur with different diseases and in which anatomy provides the solution. The

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5 Ibid., 98
6 Ibid., 138
anatomo-clinical gaze is thus a penetrating gaze which combines the localization, site and origin of the disease to unravel the spatio-temporal proliferation of the disease. The gaze penetrates in the sense that it localizes the disease in the body and thus seats the disease in the body, instead of classifying the disease as was done before.

**Critical reflection**

There are several critiques that can be provided on the epistemic analysis of Foucault. Foucault claims that the anatomo-clinical method is still the method that is being used in modern medicine and that the penetrating gaze associated with this method is the gaze that physicians still have. However, since every historical work is bound to time, the question arises whether this is still the case. There are two answers that can be presented to answer this question. The first is that the anatomo-clinical method/gaze is still the relevant method in 21st century medicine. New diagnostic/imaging techniques are no more than an extension of the existing method. The second is that new diagnostic/imaging techniques have constituted a new medical gaze in which the gaze does not penetrate the patient but externalizes the disease into e.g. a screen in the case of imaging techniques. I will illustrate these answers using an exemplary case of brain imaging.

Brain imaging techniques have enabled the medical profession to find specific diagnoses for neurological diseases. There are several techniques that classify as brain imaging, such as functional magnetic resonance imaging (fMRI) and computer assisted tomography (CAT). These techniques display pathological processes of the brain on a computer screen. On the basis of these images, symptoms and possibly other laboratory testing a diagnosis is made.

These brain imaging techniques allow the physician to shed light into the brain of the patient to find the actual diagnosis. This possibility makes the opening of the cranium to find the diagnosis redundant. In that sense, a pathological anatomist becomes also redundant to find the actual diagnosis. Through these images the physician’s gaze does not penetrate the patient but displays the pathological process through

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externalization of the disease on the screen. At this instance, the disease is diagnosed on the screen and not in the patient. From this one can argue that the disease, or at least awareness of the disease, does not reside in the patient, but on the screen. As discussed in the previous paragraph, the pathological anatomy is characterized by giving the disease a geographical location in the body. Through the use of brain imaging techniques, this process has become superfluous. Even a parallel can be drawn between this externalizing method/gaze and the nosological table of the hospital, implying a retrograde development of the medical field. The conclusion that we arrive at is that this method is not the same as the anatomo-clinical method, because it has made the pathological anatomy superfluous. Thus, 21st century medicine has abandoned parts of the anatomo-clinical method.

An opposite argument can also be presented regarding this matter, namely the argument that brain imaging is an extension of the anatomo-clinical method. In this case, imaging techniques function as a mediator to geographically locate the pathological process in the body. So, now the anatomo-clinical method does not only use symptoms, statistics and post-mortem discriminating analysis, but also an alive discriminating analysis of the pathological process. The real difference in this case, is that knowledge of the diagnosis does now not necessitate the death of a patient. However, this does not imply that in its essence the anatomo-clinical method has fundamentally changed, but it only implies that the methods to reach the goal have now been enriched in their mediators. This last argument is the most convincing argument, in light of the paradigmatic developments that have occurred regarding patient-centered care in medicine. This type of care is more holistic in its essence, which resonates more with the anatomo-clinical method and gaze, than it does with externalizing method mentioned in the previous indent. This is the case, because an externalizing method would localize a disease outside of the body and this does not concur with the paradigm of patient-centered care. Thus, the anatomo-clinical method resonates more with patient-centered care, because it takes all clinical aspects into consideration. However, there are clear differences with the anatomo-clinical method/gaze. A more extensive discussion of patient-centered care is covered in the 4th chapter of this thesis.
Chapter 2. The importance of language and use of semiology

In this chapter I will reflect on the role that language has played in transforming medicine into a modern medical science. In order to discuss this, I will firstly elucidate some terms that Foucault uses in his philosophical reflection of language. To do that I will discuss the semiotics of Saussure and the terms: symptoms, sign, signifier and signified. After that I will the discuss the transformation of language alongside the same timeline as the first chapter, namely alongside the hospital, clinic and the clinical/pathological anatomy. The proto-clinic will not be discussed as it is not distinctly discussed in terms of language and semiotics in the book.

Saussure, symptoms, signs, signifier and signified

Ferdinand de Saussure (1857) was a Swiss linguist who had a great influence in the field of linguistics and is seen as one of the founding fathers of semiology. Semiology is a subset of semiotics, which is the study of signs, sign processes, indication, designation, analogy and more. Semiology focusses on the function and pattern of language. The idea that De Saussure poses is that language structures us and how we communicate. Foucault uses specific terms of Saussure, especially the terms sign, signifier and signified and relates them to medicine through symptoms:

A *symptom* is the form in which the disease manifests itself.

The *sign* communicates the idea of the symptom without having to see the symptom itself. A non-medical example of this is: the word dog is a way to communicate the idea of a dog, without having to go and get a dog and show it to you.

The sign is comprised of two elements, namely the *signifier* and the *signified*. The signifier is the physical form, e.g. a word, that enables you to communicate what idea you are trying to get across. The signified is the idea, meaning or concept that is being communicated.  

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9 Daniel Chandler, *Semiotics for Beginners* (University of Wales, 2000).
The language of the hospital

In the language of the hospital the disease was observed in terms of symptoms and signs. Symptoms are the way in which the intangible disease is grasped and is the presentation of the disease; it is not the disease, but it is as close is it could be. Foucault describes that as follows: “Cough, fever, pain in the side, and difficulty in breathing are not pleurisy itself—the disease itself is never exposed to the senses, but ‘reveals itself only to reasoning’—but they form its ‘essential symptom’, since they make it possible to designate a pathological state (in contradistinction to health), a morbid essence (different, for example, from pneumonia), and an immediate cause (a discharge of serosity).”¹¹ The symptoms thus bring to the forefront, which was invisible at first. In this case, the symptom and the sign are the same thing. As Foucault puts it: “In its material reality, the sign is identified with the symptom itself; the symptom is the indispensable morphological support of the sign “The sign however manifests itself in three different ways: the prognostic sign, the diagnostic sign and the anamnestic sign.”¹² Foucault describes the following ways in how the signs announce: the prognostic sign announces what will happen, the diagnostic sign announces what process is occurring and the anamnestic sign aims at announcing what has happened. These signs allow the doctor to recognize what is hidden inside the patient.

The language of the clinic

In the language of the clinic the symptom and the signifier start taking a different form. The symptom doesn’t encompass a pathological essence anymore but the entire disease itself becomes the phenomenon that presents the phenomenon. All the symptoms combined is the phenomenon that constitutes the disease.

Whereas in the hospital the sign tried to display the symptom, Foucault argues that the symptom has now taken the form of a signifier. He argues this because previously symptoms were merely a display of the natural phenomenon, meaning that it designates a disease. A symptom now signifies a disease, because a disease in itself is taken as a whole, a collection of symptoms. Thus, in this case the disease has become the signified.

¹¹ Foucault, The Birth of the Clinic : An Archaeology of Medical Perception., 90
¹² Ibid., 90
As described in the first chapter, statistics and thus probabilistic medicine has found its way into clinical reasoning. This adds a new element to the certainty that signs provide in the diagnostic process. As mentioned above a set of signs constitute a disease. The multitude of these signs thus give certainty, rather than in the hospital, in which a sign itself was sufficient for the diagnosis of a disease.

The importance of language in medicine became increasingly important during the development of the clinic. Especially in this period of time, language functioned as a synthetic truth, as explained in the 1st chapter. However, according to Foucault, the 18th century clinic had failed to constitute a coherent grammar and medical practice at the time was not yet a scientific knowledge.

What also emerged was a relationship between seeing and saying. The doctor alternates between these two mediators to unravel the disease and reach the truth. The doctor sees the patient and through the clinical gaze observes the patient. Following this, a round of questions as to the nature of diseases is asked and is thus dominated by language. After this follows the exhaustive description of clinical examination, in which the language has to be as comprehensive as possible lest deviations occur. Thus, language has the function of elucidating the expressible. The crux of language is that it grasps the visible. Foucault quotes: “The art of describing facts is the supreme art in medicine: everything pales before it”\textsuperscript{13}. What follows from this extensive effort to create a well-made knowledge, by constituting its methods and scientific norms, is the myth of the pure Language; Foucault calls this the speaking eye: “This speaking eye would be the servant of things and master the truth”. Foucault sharply describes the connection between seeing and speaking as follows: “A hearing gaze and a speaking gaze: clinical experience represents a moment of balance between speech and spectacle. A precarious balance, for it rests on a formidable postulate: that all that is visible is expressible, and that it is wholly visible because it is wholly expressible. A postulate of such scope could permit a coherent science only if it was developed in a logic that was its rigorous outcome.”\textsuperscript{14}

\textsuperscript{13} Ibid., 114
\textsuperscript{14} Ibid., 115
The language of the clinical anatomy

The final stage that we arrive at according to Foucault is the language of the clinical anatomy. What now prevails is not the botany of symptoms, as Foucault puts it, but a grammar of signs; this grammar of signs makes the analysis of the pathological phenomenon possible. This grammar of signs is completed by the localization of the disease in the body, where the final signs for the disease are found through the pathological anatomy.

Critical reflection on modern day medicine

The basis of 21st century medicine still resides in pathological anatomy, even though imaging places the disease outside the body of the patient, it is still resided within the patient, as is discussed in the 1st chapter. In 20th and 21st century medicine blood testing, imaging and other diagnostic aids have been added to the wide pallet of diagnostics. These are additions to the pathological anatomical approach, as they made the opening of the body superfluous. This means, the way in which physicians try to find the signified has changed, meaning that the signifier of diseases also manifests itself in a different fashion. In that sense, the sign still remains as it was in the language of the clinical anatomy. This is the case because the sign that is sought after has not differed. The sign in this case is the disease, which is being communicated through the signifier and the signified. Blood tests and imaging aid in the diagnostic process and thus function as signifiers of the disease. The relationship between the signifier and the signified has thus not changed, but merely an extra signifying option is added. From this I can infer that the search for the sign hasn’t changed in 21st century medicine from the instance where Foucault’s analysis ended, in the 1960s. I will elucidate on this using the exemplary case as is used in the 1st chapter.

If a patient presents him or herself at the polyclinic with symptoms of a brain tumor, the physician decides to use brain imaging techniques like an fMRI or CAT-scan. The aim of these techniques is to obtain a diagnosis. In this case a tumor is the sign of the symptoms. As mentioned before, a sign is divided into a signifier and signified. The
signifier in this case is the imaging technique that is used. The signified is the tumor itself. In order to assess whether this differs, this has to be compared to the anatomo-clinical method that Foucault described. In this method the signifier would have been a post-mortem discrimination analysis. As argued in the first chapter, this new method is merely an extension of the tools of the anatomo-clinical method, rather than an entirely new externalizing method. This means that in this case only an extra signifying method has been added, but the sign has not changed in 21st century medicine.
Chapter 3. The changed stance towards death

Foucault dedicates a great deal of his book to man’s changed stance towards death. It is one of the most essential parts of his book. In this chapter I aim to provide a chronological timeline on how the stance towards death has changed. I will discuss the change of attitude towards death alongside the terms of pre-pathological anatomy and pathological anatomy.

Death in the pre-pathological anatomy and pathological anatomy

In the era of the pre-pathological anatomy, the 18th century, death was seen as the most inevitable truth and fact. Death was the endpoint of man; death was the endpoint of disease. Death was an absolute endpoint in which the gaze of the doctor did play no role and had no function in the contribution to the medical body of knowledge. Death was feared by doctors. However, during the development of pathological anatomy and thus clinical anatomy, death starts to play an instrumental role. When Foucault discusses death in the era of pathological anatomy, he mainly addresses Bichat and his view on death and on how his methodology has changed the medical profession’s view on death. It was due to pathological anatomy that death was no longer this evil ending, but a basis for knowledge. It made disease legible and visible, because through dissection light could be shed unto the body, from which knowledge of the disease could be extracted. At the instance that death is not being demonised and seen as a-natural, it starts to be seen as a truth that lives inside bodies, without per se being negative. I think the following is a good example of this embracement of the positivity towards death: it is possible to place your body at the disposal of a medical faculty. Through this, it is possible to educate medical students on anatomy and pathology. A fitting quote from Foucault is: “It will no doubt remain a decisive fact about our culture that its first scientific discourse concerning the individual had to pass through this stage of death. Western man could constitute himself in his own eyes as an object of science, he grasped himself within his language, and gave himself, in himself and by himself, a discursive existence, only in the opening created by his own elimination.”¹⁵

¹⁵ Ibid.
Also, death is not seen as an abrupt event, but an intrinsic characteristic of life, towards what you live. This if often made possible by disease, and in some cases by an accident. Disease is the glue between life and death, it is the facilitator of death. It is a constant factor which leads to death. Death is inevitable, but according to Bichat this implies that someone becomes diseased because they may die, and not the other way around. “Death is made possible in life”, “Deviation in life is of the order of life, but of a life that moves towards death.” 16

*Death left its old tragic heaven and became the lyrical core of man: his invisible truth, his visible secret.*17

So, what now has been constituted is a trinity between life, disease and death. These belong to each other in a technical and a conceptual sense. The oppositional tension between death and life has now disappeared, but both truths depend on each other and become intertwined peacefully. In pathological anatomy, this trinity is summited by death, because knowledge about life and disease is derived from life and death.

**Critical reflection**

As discussed above, the stance of the medical profession towards death as the direst place to be in has changed. It is now part of existence and a state of being through which knowledge can be acquired. In the pathological anatomy death has a positive meaning which sheds light into the body and localizes the cause of death within the organs of the body. However, an interesting concept that was not present in the time of the development of the anatomo-clinical method, is the concept of being brain dead. This is a protocol on the basis of which someone can be legally labelled dead, on the basis of absence of brain function.18 The inability to provide this type of death a geographical location within the body and the inability to learn from this death, infers the idea that the diagnosis of death using this protocol is not positive.

16 Ibid., 156
17 Ibid., 172
The diagnosis of brain death is unique in its kind, due to its residence in the medical discourse. It only exists in the protocol and as such is dependent of the medical experts who establish the protocol. This implies that being brain dead is dependent on the contemporary discourse of medical science in the region in which the deceased is localized. This is significantly different from the notion of death in the pathological anatomy as Foucault discusses in this book. In this case, the relation between life, death and disease is not centralized by autopsy, but by existing medical discourse.

A continuation of the internalization of death is seen in the current Dutch setting, in which control over death by people is being enlarged through euthanasia and end-of-life clinics, underlining the perception that in some circumstances being not-alive is better than being alive, and that, if possible, those circumstances should be prevented. Euthanasia is an internalisation of death due to the nature of its execution. Someone who regards his or her life as complete and has legitimate medical reasons can request euthanasia. The fact that someone regards their life as complete and thus decides to terminate their life, is the ultimate internalization of death, as now complete control over death is established. From this one can argue that the positive stance towards death has only increased and followed the trend set after the rise of pathological anatomy. This will be more extensively discussed in the 4th chapter of this thesis.
Chapter 4. The gaze, semiology and death in the 21st century

In this chapter I aim to provide a comparison of modern medicine as Foucault describes it and the current state of modern medicine as practiced in the West in the 21st century. I will do this along the lines of the material discussed in the first three chapters of this thesis. The translation towards the 21st century has already briefly been made in every chapter, but here the aim is to discuss these topics more extensively. Firstly, I discuss a new kind of patient-physician relationship and how that differs from the anatomo-clinical gaze Foucault has mentioned. Secondly, I will discuss the similarities between anatomo-clinical semiology and current modern medicine semiology. Lastly, I will discuss that the internalization of death has developed into the desire of control over death.

The anatomo-clinical method/gaze
As discussed in the first chapter, Foucault states that the anatomo-clinical method is the method which constitutes modern medicine. It is a method in which symptoms and knowledge of pathological anatomy make diagnosis possible. Characteristic of this method is thus the anatomo-clinical gaze, which needs to penetrate the patient to come to the true diagnosis. I have argued that this is still the case in 21st century medicine, but only the mediators of the anatomo-clinical method have been extended as has been illustrated by the exemplary case of brain imaging.

As argued above, historical analysis is also temporally bound. Foucault’s book is published in 1963, in which many of the current technological advances had not been made yet. New types of diagnostics that are used are DNA tests and imaging techniques such as a CAT-scan or MRI-scan. Through these diagnostics the exact diagnosis can be determined, or the probability of specific diagnoses can be increased or decreased. However, these types of diagnostics require prior suspicion of a range of diagnoses, because without a priori suspicion they do not provide sufficient information. In order to develop these types of diagnostics prior knowledge of the pathophysiological processes is necessary. Thus, these types of diagnostics depend on knowledge of pathological anatomy of the diagnoses and the symptoms of the
diagnoses that a doctor wishes to determine or rule out. In this sense it can be argued that the anatomo-clinical method is still upheld but has taken different forms.

However, as discussed in the introductory chapter, contemporary medical practice aims to provide patient-centered care, which takes into account patient preferences and also places focus on quality of care and the value of the care provided. As a consequence, the focus is not necessarily treating the disease of the patient, but to improve the quality of life and not only quality of health. Therefore, I want to argue that the gaze of the physician, as patient-centered care becomes more prevalent, is not only penetrating the body of the patient as Foucault describes, but that it is becoming a more holistic gaze.\textsuperscript{19} A holistic gaze that not penetrates the body to see the disease and treat it but sees the body and the mind aiming to improve quality of life. Thus, the doctor’s gaze now intends to penetrate the personal sphere and investigates how to improve this.

**Signifier-signified in current diagnostics**

As discussed above, advanced diagnostic techniques have been introduced in to the medical sphere. As mentioned in chapter 2 these techniques can be seen as an extension of the signifiers, but the relationship between the signifier and the signified has not necessarily changed.

However, one can also argue that as the signifiers have multiplied, the signified have grown as well. Not only do positive (or negative) tests infer a specific health state or a disease, they also have a certain impact on the quality of life. It can mean that someone cannot work as much anymore or cannot take care of the children anymore. As the paradigm within current Western medicine takes into account these aspects of treatments and diagnoses, the signified aspects of a disease have multiplied alongside the signifiers. They are not necessarily related to each other, because the aim of the multiplication is different in both cases. The aim of more diagnostic techniques is to be able to accurately establish diagnoses. The aim of patient-centered care is to provide care in a holistic sense in order to improve quality of life. In this sense, the aim of the

\textsuperscript{19} Ronald M. Epstein and Richard L. Street, Jr., "The Values and Value of Patient-Centered Care," *Annals of family medicine* 9, no. 2 (2011).
multiplication differs, but of course in the end the eventual aim is to provide better health care, albeit in a different sense.

If the signified changes, that implies that the sign changes as well. As the sign firstly portrayed a symptom, now a new sign is added. This new sign is logically the quality of life.

**Control over death**

The trend that Foucault describes is a more positive stance towards death as the pathological anatomy developed. Death is no longer the negation of life but is part of existence. Death has become even more internalised in our thoughts and practices in current medical and societal discourse in the Dutch (legal) setting. This is depicted by the current developments of rising euthanasia procedures, which also display the tendency to give people/patients control on how and when they want to die.\(^\text{20}\)

Euthanasia gives one the possibility to “opt-out” in circumstances where their suffering is unsalvageable. There is ongoing discussion on whether to extend the criteria in which euthanasia is possible and should be facilitated.\(^\text{21}\) This possibility of euthanasia doesn’t only display the internalisation of death, but it displays something even more profound. Death is so much so a part of our life, that control of death should be in the hands of the one who has to undergo it and should not be in the hands of faith. This can be seen as an extension of the historical tendency of the positivity towards death that Foucault describes.

Besides this control that patients in dire situations are given, the medical discourse towards control on death has also undergone transformation. Every patient who is being hospitalised, even a 20-year-old who is being hospitalised for e.g. a cosmetic intervention, is asked the following question: “If it is necessary, do you wish to be resuscitated?”\(^\text{22}\) The inevitability of death and its indissoluble kinship with life is thus continuously acknowledged and has become an essential part of the medical discourse between the doctor and the patient.

\(^{21}\) ANP/Redactie, "'Arts Moet Meer Openstaan Voor Euthanasie'," *de Volkskrant* 2011.
Conclusion

This paper focused on answering this thesis: Foucault has given a historical account of the birth of modern medicine and I will argue that the paradigmatic trend this birth has set, has continued up until 21st century medicine.

Throughout this paper I have discussed the matters of space, the gaze, language, semiology and death in a chronological order. I have laid out what Foucault has historically and philosophically analyzed about the birth of modern medicine during the 18th and 19th century.

Concerning space and the gaze, four periods have been described, namely the period of the hospital, of the proto-clinic, of the clinic and of the clinical anatomy. In the period of the hospital, spatialization of disease took place. This triangular spatialization eventually is followed by giving diseases specific names. Naming these diseases and the pursuit of naming a disease is characteristic to the period of the proto-clinic. Eventually, in order to make medicine a rational science, it became institutionalized. The endpoint of his analysis, modern medicine, is the period of the clinical anatomy. This period is characterized by the same medical methodology and gaze but is extended with pathological anatomy. At this moment the gaze penetrates the body of the patient, on which light has been shed through the knowledge obtained through the bodies of the dead. However, in 21st century medicine death is not a necessity for obtaining knowledge, as imaging techniques enable localization of pathological processes in the body, without having to open the body. This means that an extension of the anatomo-clinical method has been established.

In the second chapter, the role language has played in making medicine a medical science and the semiology of symptoms and diseases has been addressed. This has been discussed along the lines of the theory of semiology of Saussure and the way language and semiology changed in the time of the hospital, the clinic and the clinical anatomy. In the hospital the symptom encompasses the pathological essence of a disease, whilst in the clinic the symptom doesn’t represent a pathological essence, but a combination of symptoms represents the actual disease. In the period of the clinic language forms a synthetic truth. A truth in which with words, diseases can be labelled
and thus unraveled. Finally, in the period of the clinical anatomy a grammar of signs has been constituted, where the final signs of the disease are found through pathological anatomy.

In the third chapter, the third main topic of the book is discussed, namely death. This is divided into the stance towards death in the pre-pathological anatomy and post-pathological anatomy. This dichotomy is made due to the importance that Bichat plays in the analysis of death by Foucault. In the pre-pathological anatomy death is seen as the worst possible state of being and is perceived as the negation of life. At all moments it should be avoided, and medicine is responsible for preventing death. In the post-pathological anatomy death is perceived as something positive. It is the possibility to learn about diseases and shine light into the body, which has always been draped in darkness. The pathological-anatomist opens the body and finds the cause of death. Through this procedure medical knowledge is acquired. What Foucault describes that happens in this period is that death is becoming internalized and death is seen as something positive and a truthful promise given to a person when entering this world. A baby is born with death inside it. This is not per se the case when speaking of brain death, because this is dependent on contemporary medical discourse and because of that the state of being deceased lies not within the patient but within the established protocols of the medical profession.

In the final chapter, the aim was to answer the thesis that the anatomo-clinical paradigm is still present in 21st century medicine. From this analysis I have concluded that this is not necessarily the case. Concerning the gaze, the approach of patients and the gaze patients receive is one of a more holistic nature, taking into account not only healing a patient, but also improving quality of life. Therefore, the signs of the disease do not only encompass the symptoms, but also there are signs that signify quality of life. The trend towards a positive stance towards death has developed from the 19th century onwards. Death is seen as something equally natural as live and thus the control over death is internalized, especially in the Dutch setting.

The thesis I posed was as follows: Foucault has given a historical account of the birth of modern medicine and I will argue that the paradigmatic trend this birth has set, has
continued up until 21st century medicine, with slight modifications concerning the clinical methods used. The conception of how death is defined has changed in 21st century medicine.

This thesis is correct due to what I have shown in the critical reflections of each chapter. The anatomo-clinical paradigm remains the dominant paradigm in current medical discourse, only to be extended by imaging and diagnostic techniques. The conception of the positivity of death has followed the trend that had already been set in the era of the pathological anatomy. However, in the case of being brain dead, this is an entirely new concept which lays perpendicular on the positive conception of death, regarding obtaining knowledge from the deceased. The definition of brain dead now locates itself in medical discourse rather than in the body of the patient.
Bibliography

ANP/Redactie. "'Arts Moet Meer Openstaan Voor Euthanasie'." de Volkskrant, 2011.


Pickstone, JV. "A Brief History of Medical History."
https://www.history.ac.uk/makinghistory/resources/articles/history_of_medicine.html.