

Beyond *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*: A Theoretical and Methodological Intervention into the Sociology of Brain Implant Surgery

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*Drawing on and extending the Foucaultian philosophical framework that Jeffrey Bishop develops in his masterful book, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying*, we undertake a sociological analysis of the neurological procedure—deep brain stimulation (DBS)—which implants electrodes in the brain, powered by a pacemaker-like device, for the treatment of movement disorders. Following Bishop’s work, we carry out this analysis through a two-fold strategy. First, we examine how a multidisciplinary team evaluates candidates for this implant at a major medical center. We present excerpts from an ethnographic study of the “case conference” where disease entities are presented, contested, ratified, and made objects for intervention with this technology. The case conference becomes the key site in the transition from “person-with-illness” to “person-with-brain-implant” as a team of health professionals determines a plan of action by interpreting both statistical and “quality of life” data regarding their patients. Second, this article explores these decision-making processes through Bishop’s conceptualization of evidence-based medicine, which relies on statistical approaches as the ultimate authority in knowledge production and medical decisions. We then reflect on Bishop’s critique of the social sciences and the methodological,*

analytical, and substantive ramifications that The Anticipatory Corpse can offer future sociological work.

Keywords: case conferences, deep brain stimulation, Foucault, sociology of medicine, The Anticipatory Corpse

We know that knowledge is power—the power to relieve the human estate. Yet we have not taken seriously Foucault’s point that power includes the power to define new knowledge and to create new functions that are better fitted to the function of a person within a functioning society—a body within the polis.

— Bishop, 2011, 251

I. INTRODUCTION

The Anticipatory Corpse: Medicine, Power, and the Care of the Dying provides critical social scientists with a useful way forward in Foucaultian-inspired studies of medical practice. As sociologists engaging a work in philosophy and biomedical ethics, we approach this book looking for empirical, methodological, and theoretical insights that Bishop’s work contributes to conversations with critical medical sociology. One of our aims is to establish a dialogue between sociologists, who are often empirically oriented and philosophically impoverished, and the more philosophically-oriented sophistication we take from Bishop’s work. Beyond a simple review or critique of the text, this essay extends Bishop’s framework into the realm of sociology to interrogate medicine and the social scientific study of medicine. In doing so, we draw on a specific medical case—the case of deep brain stimulation (DBS), a high-technology surgery for the treatment of movement disorders such as Parkinson’s Disease, essential tremor, and dystonia—which demonstrates the contributions of Bishop’s work across academic disciplines. DBS surgeries implant electrodes into the brain’s motor system, which emit pulses of electricity into this structure and, ideally, eliminate symptoms of these illnesses. Our essay analyzes this practice of DBS through a grid comprised of five central components from Bishop’s *The Anticipatory Corpse*: (1) the “dead body” as the foundation of medical knowledge, (2) the disciplinary power of medical authority, (3) the medical gaze of power/knowledge, (4) the subjectification/objectification of the patient as object of medical knowledge, and (5) the political space of the clinic. As a result, our work is an empirical demonstration of Bishop’s thesis by applying it to a novel case study using ethnographic research. We think that Bishop’s five-part analytic strategy can reinvigorate sociological studies of medical knowledge and practice, and that his work should be taken up to guide the empirical research of critical social scientists such as ourselves.

We take as the focus of our analysis the practice of the multidisciplinary case conference where health professionals evaluate patients for DBS

surgery. First, we describe the case conference as a decision-making venue and discuss how the medical gaze “sees through” the patient to his or her symptoms, freezing time and rendering the patient static, or in Bishop’s terms, a “dead body.” Second, we describe the forms of power/knowledge that infuse the case conference, as surgeons and neurologists engage in a “politics of truth” through the exercise of the medical gaze. Next, we reflect on the production of knowledge in this context, where statistical forms of evidence influence decisions and determine closure. Furthermore, we discuss doctors’s reliance on statistics and the disciplinary power of these socially produced facts to shape possibilities for both doctors and patients. Finally, following Bishop, our study interrogates the power of medical decisions to regulate social life and demonstrates how his insights can be applied well beyond the end of life.

The Dead Body as Empirical Ground for Medical Knowledge

In *The Anticipatory Corpse*, Bishop’s analysis begins with a theorization of the “the dead body” as foundational to modern medicine. It is the dead body, rather than the living body, which becomes “an ideal-type, a representation laid over the living body” (2011, 24) whereby “medicine has pulled the dead body out of community, stripped it of its communal significance, and found the ground of its knowledge in the dead, decontextualized, and ahistorical body” (2011, 27). By theorizing the dead body as the foundation for medical knowledge and diffused throughout contemporary medical care, Bishop extends Foucault’s discussion of the medical gaze into the contemporary world. Thinking about the dead body as the point of entry provides leverage in discussing how living bodies are treated in discourse and practice. In his analysis, Bishop develops his theory around three practices: evidence-based medicine, statistical approaches, and measurable treatment, which are all apparent in DBS treatment. When statistical approaches are applied, a biopolitics of risk/reward becomes the dominant logic through which doctors and surgeons determine which bodies are important to work with and which ones are not. Through Bishop’s framing, medicine itself dictates the parameters that are used to make life-or-death decisions—decisions that do not fully account for the living body nor the full humanity of the person. For Bishop, scientific and technological thinking leads medicine to manipulate bodies in order to reach the effects it desires. Here, bodies are reduced to the malleable material that needs to be brought into alignment with medical standards, evaluations, and prescriptions (Bishop, 2011, 21). The body is without intrinsic meaning, as it is a “thing” which must be manipulated towards some measurable outcome (Bishop, 2011, 21). As Bishop argues:

Medicine’s epistemology already holds the world and bodies to be objects that are primarily measureable, even before the measuring. The dead body is the measure of medicine, creating the sense that life is primarily matter ordered to efficiently move

within space, both within the space of the body itself but also within the space of the body politic. The dead body as the normative body in medicine creates the conditions for the possibility of the deployment of a metaphysics of efficient causation, a metaphysics of power and control of bodies and psyches. (2011, 21–22)

Treating the body as an object of analysis, as an object to be measured, is not the outcome of medicine for Bishop, rather it is the starting point of all medical intervention. As a result, what we think of as “life” or the “living-being” of the person is reduced to the embodied object, severing it from anything other than its physical, treatable matter. Here, and for society more generally, medicine treats the world in terms of cold, rational effects and causes, with the aim of controlling both, in the eventual end-goal of mastering both, as much as possible. For Bishop, this leads medicine into the realm of “thoughtlessness,” insofar as it neglects the living. A parallel between the case conference and Bishop’s work on the ICU illustrates these points with regard to the dominance of medical technology:

The ICU is a space where, despite the best efforts of the caregivers to humanize it, patients and families continue to come away feeling abused. The technological stance cannot but dominate. . . . Patient life is reduced to physiological function. Thus, both disease and patient disappear in the space of the ICU for the sake of mere vital function. (2011, 113)

The DBS Case Conference, the Medical Gaze, and the Dead, Static Body

Similarly, the case conference is a space where the medical gaze, that quantifying, objectivizing, and statistics-laden place, simultaneously puts the patient on display and yet, paradoxically, disappears it in the process. The fleshy, suffering, declining body is replaced both metaphorically and quite literally by the static, dead body defined by symptom inventories and psychometric test results. The person with a movement disorder disappears, and a pristine disease entity that is a calculable, manipulated, and fully knowable object for power/knowledge appears before doctors and surgeons.

Accordingly, the world of DBS treatment, as seen in the ethnography of the case conference below, must be measurable, quantifiable, in order to judge whether or not a treatment is worthwhile and efficacious. From the perspective of the dead body, and the concern with evidence-based outcomes, living human conditions and quality of life are obscured. Bishop’s framework enables us to draw out the epistemological and ontological investments that medicine has, as well as the sacrifices those particular commitments produce. As is seen in the empirical study of DBS, mastery of life and death result in the prioritizing of the latter without concern for the former (Bishop, 2011, 22).

II. PRACTICING POWER/KNOWLEDGE IN THE CASE CONFERENCE

In this section, we draw on Bishop’s expansion of Foucault’s power/knowledge nexus in relation to medicine to provide an ethnographic account of the

complex and intersecting viewpoints that go into understanding the patient within the case conference. The case conference is best understood as a formalized space for information exchange, where doctors, physical therapists, and others share perspectives on the “facts” of the case; it is the “facts” that are the subject of sharp, but professional debate. As Bishop defines the relationship between disciplinary power and knowledge: “each discipline—medicine, psychology, social work, and chaplaincy—also defines its expertise, constituting itself in its own processes” (2011, 252). Modern medicine has emerged as a comprehensive, totalizing force he labels biopsychosocial-spiritual medicine:

It is holistic, covering the whole of human thriving. It is about total care, and in this sense it is totalizing. In the processes from conceptualization to intervention, not only do we achieve total patient care, but each discipline—medicine, psychology, social work, and chaplaincy—also defines its expertise, constituting itself in its own processes. (2011, 251–252)

Drawing on Bishop’s connection between medicine’s knowledge and its self-justificatory mechanisms, we are forced to take up the debate and discussion that constitute the case conference with a more skeptical eye. Here, Bishop’s engagement with Foucault demands that medical sociologists and others more critically interrogate the all-too-often taken-for-granted analytic categories that medical professionals employ.

The case conference—a regularly scheduled meeting where health professionals gather in order to discuss the patients and health problems that constitute a portion of their workload—is a relatively recent invention.¹ Instead of a doctor–nurse team treating patients in clinics, or teams of doctors on rounds in hospital wards, the case conference requires an interdisciplinary medical team. Scheduling a recurring meeting of 20 people—six neurologists, two neurosurgeons, one physical therapist, one neuropsychologist, one technologist, one surgery coordinator, two patient care coordinators, a neurosurgery nurse, three neurosurgery interns, two medical students, and one device maker representative—requires a serious commitment of both time and resources to review about 10 cases per month.

We can interpret the case conference and its complex workings in several ways. The conference is a space for the construction and deployment of medical knowledge. The conference is also a site of “claims-making” and rhetorical performances as medical professionals offer, react to, reject, and affirm the judgments of others. Furthermore, the conference is a space for boundary construction and maintenance of professional authority, scientific practices, and social reputations. Finally, the case conference includes medical personnel, symptom scale scores and statistics, professional opinions and judgments, while it simultaneously excludes knowledge and concern over patients’s bodies and lives.

The conference is a particular type of claims-making venue in which the presentation of each “case”—medical history, symptom severity, and all

other aspects of representation—cannot be challenged or supplemented by the patient himself or herself; in short, “their” case is beyond “their” control. The case conference is the place where disease entities are presented, contested, ratified, and made objects for intervention. Given the costs associated with cutting edge technologies such as DBS implants and the uncertainties of prognosis, the case conference serves as an obligatory trial through which each “case” and the conferees themselves must produce the “truth” of the case. Such investments of time, resources, and hope are now subject to group discussion and analysis. The case conference is thus a key site in the process of illness and treatment, as it is the vehicle through which the patient is reclassified from person-with-illness to person-with-brain-implant. It is here where actors beyond the patient’s primary neurologist are enrolled, transforming the patient’s experiences of illness and treatment into a temporarily stable disease entity subject to medical inquiry and potential remediation. This is where the discursive, and collective, work of objectifying the patient as medical object/object of intervention occurs.

Members of the case conference deploy the medical gaze when they collectively enact and construct their understanding of the disease entity, looking through the patient’s symptoms to the underlying signs of disease process. They do this most often in the absence of a textured understanding of patient experience. This absence becomes a space to fill in with individual and collective medical imagination, as surgeons and doctors offer each other stories from past experiences and from previous patients with disease presentations that seem similar. In doing so, they rely on the disciplinary power/knowledge of medicine to fill in significant gaps in the patient’s story.

The task of representing the patient and his or her condition is reserved for medical professionals. Patients are not invited to participate beyond their symptom testing, limiting any significant level of control or influence over this presentation. Neurologists often report that patients strongly desire DBS surgery to control increasingly uncontrollable motor symptoms, such as tremors in their hands, legs, and feet. Any attempts that patients undertake to highlight their symptoms or exaggerate their severity during standard tests of movement disorder severity are taken as forms of deception and, at the extreme, signs of mental instability.

Doctors face the challenge of discerning the difference between exaggerated and “real” symptoms in their interactions with patients that are objective and quantifiable. The issue of stability in symptoms is a core feature of DBS conference work. For most patients, symptoms are expressed more or less severely on a daily, even hourly basis. These fluctuations are often due to medications losing their effectiveness. Symptoms may also vary according to patient diet, physical activity, and exposure to stress. Controversies over what symptoms really are, and how the reality of each patient’s experience is represented, are repeated again and again. Throughout this process, doctors struggle to articulate and defend their positions, marshaling both

evidence and support for their interpretations of available evidence. This evidence includes standardized symptom scale scores and clinical (never “anecdotal”) patient self-reports. These kinds of knowledge have varying truth-values, with statistical scale scores and clinical judgment ranking higher than patient self-reports. These decisions doctors make over the medical record ultimately place people into one of three categories: “surgery,” “not a candidate,” and “re-evaluate.”

Observing the case conference allows us to investigate how a *collective/social* kind of medical gaze is practiced and collectively constructed in the course of everyday work practices. These practices share the central features of Bishop’s analysis of the dead body and the medical gaze, grounded in both putatively stable dead bodies and social constructed stabilities—statistics. In both doctors’s discussions and decision-making, the medical gaze constructs the patient as object, capturing him or her as if frozen in time, creating a dead body subject to medical power, authority, and manipulation.

Medical Vision and Patient Representation: Videographic Displays of the Diseased Body

The case conference is a discursive, textual, and visual feast, with case discussions, videos of patients with and without maximally effective medications, as well as projected images of each patient’s electronic medical record. The neurologists, surgeons, patient care coordinators, technologists, and students are asked to attend to the neurologist making the case presentation, the questions asked and answered, and the images of patients in the videos. While a neurologist presents each patient as a case, another neurologist often runs the computers and video equipment, syncing together videos of patients with and without medications with the goal of allowing viewers to assess the differences in well-treated and untreated symptoms. The video comparison is intended to illustrate the likely benefits of DBS treatment, because the electrical stimulation is meant to mimic the effects of maximally controlled symptoms. Neurologists may pause during their case presentation verbally to interpret the symptoms visualized on the screen, solicit questions, and respond to feedback from colleagues. However, it is the video—as unassailable proof—itself the very product of medical technology/knowledge that is used as the ultimate object of reference.

Bishop’s five-part analytic structure helps us to understand these symptom inventory exercises as simulations of “everyday life”—approximations of routine tasks under specific and standardized conditions. Short of observing each patient in his or her home, it is difficult for participants to ascertain how a patient’s environment and illness interact. These difficulties problematize instrument choice, evaluative criteria, and a number of other factors that combine to create the assessment and shape its interpretation. The images of patients can be helpful to doctors, but when combined with scores, they may be a somewhat misleading form of reality. What is given in standardization is then taken

away in specificity and context for the particular patient under inspection. It is just this type of truth construction that the conference has as its goal.

Quantified Evidence in Medicine

Following Bishop, we think that the case conference exemplifies medicine's current hyper-focus on quantitative measures, exemplified by evidence-based medicine. The structural features of health care often shape medical decisions for doctors and patients in unseen ways. These features have their own internal logic and often work below the level of conscious awareness. That is, they take reflective and philosophically oriented work to recognize and evaluate. These unseen logics constitute an epistemology and create epistemic closure around what is possible and knowable—the epistemological horizons that both enable and constrain both knowledge and action.

The case conference, as does all of modern medicine, shares the assumption that life is defined as matter in motion that resists death (Bishop, 2011, 67). As we see in *The Anticipatory Corpse*, this negative, mechanistic approach to death and efforts to stave off the most consequential movement disorder symptoms is the focus as conference members consider each patient's situation. Bishop's approach in *The Anticipatory Corpse* both highlights the taken-for-granted goal of medical knowledge as well as dramatizes the inverted priority of death over life, treatment of static and diseased bodies over promotion of human flourishing within community. As a result, the very notion of health/medical "care" is called into question. As Bishop explains:

There is indeed something rather odd about the fact that those who study human life in depth in its biological, social, and psychological aspects should become the ones who come very close to the zone of indistinction, when decisions about life and death are confused and the social apparatus of medicine comes to look as if it is promoting death. . . . Yet the oddness is perhaps even more acute when doctors take away a life that is perceived to be abnormal, or when it is perceived to have abnormal amounts of suffering, or when the patient's predicament is outside the norm of human comforts. (2011, 13)

By viewing the patient's case through Bishop's lens, we see how those who are in the very position of administering care are simultaneously engaging in a death-centered logic that does violence to the living, active, and dynamic embodied person. The tension between these states, as Bishop highlights, often gets conflated when decisions are made that more often look like they are "promoting death" instead of life. The more objectified the patient becomes, the more arbitrary the decisions about his or her medical treatment become. What is important to note in Bishop's analysis is the object of critique; when the knowledge that medicine generates is founded on the "dead body" and more focused on death and fending off death, it functions to "anticipate" death, rather than on enhancing quality of life and better practices of living. If Bishop's argument is constructive, it is so in this

sense: for him, medical practices should be oriented towards the flourishing of the embodied human person, always already situated within a particular community.

Ethnographic Reconstruction of a Patient's History

Through an ethnographic reconstruction of a patient's history, we illuminate how opening a case for DBS surgery is always a complex act of storytelling. Since there are usually three to five neurologists in the room, and at most two neurosurgeons, casework takes on the character of "presenting" a patient's history, test scores, and neuropsychological results to the surgeons and other neurologists for evaluation. With about 10 patients to discuss and evaluate for each conference, and each conference scheduled for 105 min, minus introductory and concluding remarks from members of the team, each patient receives roughly 10 min of discussion. Most often, case presentations have standard "openings" and "closings" with analysis of the patient's neuropsychological testing and its interpretation in between these tropes. Below, we enter the ethnographic scene of the case conference and describe the general structure of case presentations. We re-present Ms. Aleander,² a middle-aged woman suffering from essential tremor. Here, Dr. Philos, a neurologist, Dr. Clark, a neurosurgeon, and other members of the case conference are gathered:

Dr. Philos begins her discussion of a patient diagnosed with essential tremor:

Ms. Aleander is a 50-year-old woman with tremor since childhood. She is having difficulty with her ADLs [Activities of Daily Living]. Her neck dystonia does not bother her. The question here is not whether or not to do the surgery, but rather what type of surgery to do.

Dr. Philos starts her discussion of Ms. Aleander by reviewing features of the case that should be familiar to conference members. A few days before each conference, one of the surgery coordinators emails a copy of the conference agenda to the team. Features on the agenda include the patient's record number, name, age, diagnosis, the names of his or her doctors, and the dates of the patient's visits for neuropsychological and motor symptoms testing. Outcomes of these tests are generally not widely known until each patient is presented during the conference. The agenda provides members with a sense of the "case load" for the month and an outline of which neurologist will present each case.

Dr. Philos highlights the long duration of Ms. Aleander's illness and her major complaint: difficulty with ADLs. ADLs stand in for a great number of practical actions that constitute a person's routine. The contents of Ms. Aleander's routine are left unspecified, yet taken for granted as meaningful for her and for the team's evaluation of her candidacy for surgery. A restriction in the ability to perform ADLs often leads to a discussion, or at least the evocation, of "quality of life" as a key consideration in deciding whether or not a patient will be offered DBS surgery.

This particular patient's cluster of symptoms is somewhat problematic, since an essential tremor is accompanied by dystonia—an often painful condition that often involves contractions in one or more muscle groups—in this case in her neck. Dr. Philo minimizes this potential problem by reporting that Ms. Aleander is not bothered by her neck dystonia, and thus treatment for that condition is thought to be unnecessary at this time. Unsatisfied, the senior neurosurgeon, Dr. Clark, seems to ignore Dr. Philo's report that only one surgery is required. He offers a solution to the choice between surgeries: the team needs to tackle the essential tremor first, then go to the dystonia after about a year. Further, he says that they usually estimate regained function as somewhere between 85% and 90%, but that in this case they should say 60%. Taking into account Ms. Aleander's co-occurring dystonia, Clark hedges his estimate of success, lowering it between 25% and 30%. Here, Clark narrows his definition of the problem and the likelihood of success, perhaps indicating that Dr. Philo should prepare her patient for less benefit than she might otherwise expect (Morrison, 2012).

Widening the scope of the conversation, and showing his own command of the neurological literature, neurologist Dr. Davenport suggests that many other centers are dealing with patients who show signs of both essential tremor and dystonia. Passing over this comment and responding to Dr. Clark, Dr. Philo responds that it is hard to capture tremor in these circumstances. Here, "capture tremor" means to relieve, or reduce, symptoms of essential tremor and dystonia using DBS. Once the case conference is opened, it then proceeds by the presentation of patient records, scales, and scores.

Entering the Statistical Grid

The middle of case presentations is usually marked with a "call for scores" and a brief analysis of neuropsychological testing. A member of the team, often, but not always, a neurosurgeon, calls on the physical therapist, Ms. Steele, to report on the assessment of motor functioning she conducted with the patient. Neurosurgeons are often "in" the chart, altering the conference notes as it goes on, keeping a minimal record of the group's discussions and findings. These reports are then used as the basis for future action, and their construction is often constrained by factors that some may consider external to patient care. Someone calls for scores. Ms. Steele reports the patient's Washington Heights-Inwood Genetic Study of Essential Tremor (WHIGET) scores, 15 on her right, 11 on her left. The conference team relies on standardized scales and thus let the statistical scores speak for themselves.

The tests that Ms. Steele, the physical therapist, conducts with patients are intended to assess and record several types of movement, each one meant to simulate a task of daily life. For each disease, at least one motor test is available. For Parkinson's, this group uses the Unified Parkinson's Disease Rating Scale (UPDRS). For Essential Tremor, it is the WHIGET, and for Dystonia, it is the Toronto

Western Spasmodic Torticollis Rating Scale (TWSTRS). Ms. Steele conducts these tests at a privately run clinic, and she is in each “on” and “off” patient video, leading patients through a series of activities that are then used to measure motor function.

The importance of scores varies across disease entity. For Parkinson’s Disease, the case conference group likes to see at least a 30% difference in a patient’s “on” versus “off” score. For essential tremor, the standards are less specific. In part, this is due to the fact that the difference is that scores for Parkinson’s patients are essentially an index of how well medications work for patients, whereas essential tremor symptoms often do not respond even slightly to medications. For Parkinson’s patients, better medication response seems to lead to better DBS response. Since very few, if any, drugs work for essential tremor patients, there are no “on” or “off” scores for them, and thus the WHIGET scores are simply an index of severity. Scores are also used in dystonia cases, but they are also less prohibitive when compared to the use of scores in Parkinson’s. The team relies on these standard symptom inventories, having selected them from the many such scales and rating systems that are available. Having been discussed and evaluated, the case in question must have a final decision.

The Official Medical Decision

If a patient’s scores are acceptable, (or if they have been made suspect through claims-making within the conference) and neuropsychological testing is “passed,” the conference moves on to consider what type of surgery that is warranted. This can happen very quickly. In Ms. Aleander’s case, once the scores are read Dr. Clark says that they will do DBS mapping for VIM implantation, then future planning for possible additional surgeries. Dr. Clark dismisses the patient’s judgment that her essential tremor is livable without DBS intervention. Clark’s experience seems to “trump” Ms. Aleander’s expressed wishes, her desire to live without the device for treatment of her dystonia. Here, the doctor seems to insist on overtreatment. Several quick moves are made here. First, the senior neurosurgeon follows up on his previous commitment to treating Ms. Aleander’s essential tremor as the primary concern. Second, he outlines a technical procedure: DBS mapping, a system that combines brain images to model a person’s brain in three dimensions. This program, called Atlas, helps Clark determine exactly where to place the DBS electrodes within the patient’s brain. Atlas is accurate to about 1 cubic millimeter. Finally, Clark leaves the possibility of reconsidering Ms. Aleander for more interventions should she wish to be treated for the neck dystonia that Dr. Philos said was not a current concern. It is assumed that Dr. Philos will report this decision to Ms. Aleander. As the decision is made, this decision now has both authority and power to authorize future courses of actions, including resource allocation.

III. DISCUSSION

The preceding brief review of a case conference allows us to consider four major outcomes of modern medicine for Bishop: (1) medicine's metaphysical nature, (2) the function of medicine to regulate social life, (3) the limits of medical progress and the costs of those limitations, and (4) the issue of the "quality of life" as continually overlooked.

Medicine's Metaphysical Nature

The case conference as a space for medical decision-making is exemplified in Bishop's critique of medicine's metaphysics:

Foucault claims that the result of this kind of nominalism in medicine is also a shift in metaphysics: medicine precludes formal and final causation from its understanding of the body and elevates material and efficient causation. The great accomplishment of this epistemology of death is that the resulting metaphysics of efficient causation allows mastery over the living body as machine, as dead matter in motion. . . . In addition, this medical nominalism allows not only for an exhaustive description of the body in motion but also for an exhaustive description of the body politic. (2011, 60)

Through this ethnographic investigation of collective, institutionalized medical work, we come to understand how health professionals screen out ultimate questions of meaning in their quest for certainty in diagnosis, evaluation, quantification, and treatment. Focused as they are with issues of efficiency and effectiveness in their treatments and in quantifiable results for the calculation of statistics, doctors and others both narrow the scope of their concern while paradoxically including more and more into their purview. The medical nominalism that Bishop discusses not only allows for an exhaustive description of the body in motion but also for an exhaustive description of the body politic; here medicine and the state become intertwined. Describing this problematic, Bishop writes:

"Why" questions, questions of purpose and final causation, emerge out of an overly speculative mind, a mind not focused by science on immediate prior causes. "Why" questions are out of order for the experimentalist. Physiology is not about purpose but about function. . . . Moreover, the purpose of knowledge is power over the phenomena. This is the typical framing of inquiry in scientific medicine: figure out the causes, and then manage the causes to bring about the effects one desires. (2011, 71)

The "why?" question Bishop addresses are those which are continually bracketed as outside the purview of medicine; medicine is now a matter of function rather than one of meaning. Knowledge circulates not to inform how one should live or the type of life that is valued, but for the implementation of correction and adjustment of the body to its "normative" functioning in society. When patients "pass" their presentation at a case conference and are scheduled for surgery, they are subject to another aspect of medicine's

metaphysics, and it is here that Bishop's discussion of medicine's grounding in the dead body meets DBS surgery. Just as the DBS device aims to modify or enhance previously typical functions of the brain in order to restore movement, Bishop describes how a nonliving machine may replace nonfunctioning organs, under medicine's metaphysics. He writes:

With the rise of physiology, it requires very little imagination to realize that a dead, nonfunctioning organ can be replaced by another dead, nonliving machine. A mechanical heart can replace the dead heart of the patient. A mechanical lung can resume respiration and ventilation for the dead lung. . . . The function of the body-machine is lifted out of the messiness of human purpose and meaning; meaning and purpose become part of the cultural attribution placed on the mechanism. Meaning and purpose are post hoc additions to the mechanism. (2011, 91)

Taken together, Bishop's description of medicine's metaphysics and his analysis of contemporary practices as critiques of medical progress highlight medicine's narrative of progress, whether scientific, technical, and/or psychosocial. He reveals that this narrative is grounded in the production of the power/knowledge nexus of the dead body. Bishop helps us illuminate the mechanisms by which the disciplinary power of medical practice shapes the entire case conference from beginning to end, from initial interview to final decision. As patients enter into the statistical grid of the case conference, medical professionals invoke the power of statistical reasoning to examine the functioning body alone in order to preserve the life of the patient. In doing so, medicine necessarily brackets out the full social and interpersonal contexts, life projects, and purposes of the patient. As a result, patients may not be able to pursue their own project and end up "living lives worse than death" (2011, 25).

The Social Function of Medicine

For Bishop, medical practices serve the needs of the state in multiple ways. In his reading, doctors and others in the healing and caring professions tend to serve the needs of the political place and time, all while espousing a rhetoric of patient choice and autonomy. Building on the work of Foucault, Bishop writes:

The defining of normal behaviors, the categorizing of behaviors according to normative (*norm* meaning "law-like") psychological or social science, is no less violent an act than the definition of abnormal behaviors. The psychologist or social worker has to probe deeply to capture one's deepest memories or the hidden truths of the psyche. If a patient resists this probing, he is defined as being in denial about his depression or psychological traumas; and his resistance and denial are more evidence of his psychological ill health. "He must be hiding something from himself." The health professional's role is to help him to find it. Even if there are standardized criteria for naming some set of behaviors as disordered or diseased, some subject must pronounce that this particular and idiosyncratic object is of such a kind, and then this particular object's place in society, in the polis, is changed forever. The old particular and idiosyncratic person is put to death and a new defective object is

born. . . . It is here, then, that medicine is a social practice. Bodily function, biological function, is ordered toward social function. (2011, 93)

Bishop illuminates how medicine is a social practice engaged in a struggle against death and oriented towards the productive functioning of the individual insofar as that person is a member of the state. This implies that those defined outside the polis are unworthy of, or unqualified for, society's protection and medicine's efforts to care and to heal. The practice of medicine is at once oriented toward dividing the normal from the pathological, labeling behaviors and subjects as diseased or disordered, and reframing the "patient's" relationship to society more broadly. As a result, we can see that medicine does not simply classify and treat individuals; its disciplinary power forges categories of social life (of normality and abnormality) more generally. Medicine is not isolated to treatment sites (hospitals, doctor's offices, emergency care, clinics, etc.); it permeates social life more generally.

Furthermore, we can see how medicine operates over and above its treatment of individuals. For Bishop, the rise of statistical theory within the political arena becomes the legitimating force for medicine to become a regulating force of social life. This scientific regulation of the social, the politics of the state itself, is one that is intimately wrapped up in the health of every individual. Today, "science must penetrate the body in order to know how to manipulate body and psyche, for their own good, no doubt, but also for the good of the body politic" (2011, 24). As a result, the medical regulation of social life infuses itself into other bodies of knowledge, from the social sciences to theology, becoming constitutive of the social structures of society:

In the social sciences, power is dispersed away from the government and moved into extragovernmental structures of governance. It is placed in the hands of the doctor, the psychologist, the social worker, or the spiritual experts who provide for the care of bodies and souls. Thus, the governance of the body and soul becomes more subtle; it is almost unrecognizable as power because it has been internalized. This power resides in the hands of those helping professions, those whose disciplines are to help care for people, body and soul. Or, as Foucault might say, these professions exert disciplinary power; they discipline the body and soul. (2011, 251)

Bishop's analysis highlights medicine's social function in the governance of bodies within the body politic as a whole. His critique goes beyond the healing professions to the social sciences and spiritual disciplines, each with their technologies, strategies, typologies, and courses of treatment. Whether biological, sociological, psychological, or spiritual, all of these disciplines converge and wrap the patient as person in a subtle, yet powerful set of disciplining practices. In doing so, the regulation of both individual bodies and the body of the population becomes more and more subtly disciplined as the "helping" professions, furthering medicine's logic by conditioning bodies externally and internally to be more compliant with the demands of the state.

The Critique of Medical Progress

Bishop argues that contemporary medicine understands the body as a “perpetual motion machine, potentially living forever, as long as its parts are replaced” (2011, 97). As a result, patients become machines who, when parts become diseased or fail, become vehicles in need of repair (organ transplants or, in the ethnographic study presented here, a DBS device). This critique of medical progress and the metaphysics of motion and efficient causation leads us, paradoxically, to humility instead of biopsychosocial hubris that often defines medical practices. Bishop writes:

These developments also have unintended consequences. People become caught in the dream that medicine can sustain mechanical life indefinitely. A metaphysics of efficient causation and an epistemology of stasis always result in a kind of violence, for one merely has to exert a greater force over the dying body in order to keep its matter in motion. . . . The automatic function of the machine resists death. (2011, 97)

Using the infamous Schiavo and Englaro cases, Bishop argues that recognizing a space for life outside of the political, the *bios politicos*, is essential for a type of caring that is fully human, transcending doctor–patient relations. Characterizing such a relationship must avoid the trap of being totalizing in its effects while simultaneously providing guidance to healthcare professionals who aim to authentically care for and with patients. Understanding the limits of the doctor–patient relationship and resisting the violence that results in an over-reliance on the metaphysics of efficient causation can be a way forward into companionship with the suffering other.

As humanistic and social scientific disciplines become overly technical in their approaches to medical care, doctors and others have described the biopsychosocialspiritual model of care as another kind of treatment for what ails medicine. This inherently interdisciplinary model aims to humanize medical treatment by encompassing patients in a total and, for Bishop, totalizing care model. Bishop argues that this model merely reinforces the dominant and dominating metaphysics of efficient causation, obscuring the realities associated with death and further objectifying the patient. He writes:

The patient as object is subjected to medical categories. . . . The individuality of the object must fade away so that I can know what is true about all objects within a class of objects, not just this particular object in front of me. . . . The idiosyncrasies of a particular object are lost, are put aside, and are put to death, so that the object can be truly known. . . . On the medico-scientific view, objects that have been categorized are exhausted, without remainder. Knowing, then, is a violent act; it is intimately tied to power and, as such, is a political act. Knowledge is the power to subject one’s object to one’s categories, and it is the power to control, to bring about the effects one desires in the world. (2011, 92)

By extending the critique of medicine to the social and psychological sciences, Bishop argues, “The so-called human sciences such as sociology or

psychology apply their discipline to the patient; one might say that they also ‘discipline’ their objects” (Bishop, 2011, 92). The qualitative social sciences may also discipline their objects through rigid typologies, deterministic quantitative and statistical models, distorting the people and communities they study while creating the power/knowledge that Bishop critiques. Indeed, the power to categorize concerns critical social scientists and philosophers alike. Both see the ensuing consequences of this epistemology as medicine becomes its own form of politics:

Biopsychosociospiritual medicine is a politics, not in the sense of governmental control through duly constituted means of defining, executing, and interpreting law, but in the defining (through conceptualization and operationalization), in the executing (through the deployment of various inventories of assessment and interventions), and in the judging (through reflexive assessment) of the lives of patients. (2011, 251)

Each profession, including spiritual caregivers such as chaplains, comes under Bishop’s critique. Inasmuch as any professional group, and individual professionals like chaplains, aims to standardize their treatment of the hospitalized and dying, their efforts can be totalizing, creating objects for care rather than human beings in need of caring relationships. Medical categories abstract out from the particularities of individuals’s life histories, lifting those individuals out of their embedded contexts of social life. These abstractions serve to create ideal types to compare and contrast, which decontextualize as well as dehumanize as they become standardized “types” that people must fit in order to be rendered intelligible. The process of category formation itself must be considered a form of politics, as well as the investments and values embedded in those categories, having consequences for the ways medical practices are deployed throughout society. Here, the power–knowledge nexus that Bishop points to serves as a regressive mechanism of control rather than advancing our understanding and treatment of the living.

The empirical material presented above in the example of the case conference illustrates one of Bishop’s sharpest critiques of medicine as social practice: even when medicine succeeds in restoring function, it nevertheless fails to understand that loss is never merely functional. Rather, the losses of illness, and certainly the losses that accompany dying, are deeper, richer, and beyond that which can be restored functionally. Just as the doctors in the case conference narrow the scope of their considerations while relying on “quality of life” to account for their judgments, the logic behind those judgments masks its own inherent violence. For Bishop, these practices are exactly what ail medicine (2011, 294–295).

Quality of Life

What remains overlooked in modern medicine’s approach to life and death is the fullness of meaning and purpose that characterizes human life. As Bishop argues, all systems of knowledge are necessarily incomplete and do violence to their object of study through their interpretive schemata. While

the public perception of medicine is one that serves to promote quality of life, Bishop sees a growing demand for technological cures. This misdirected faith in technology, as an end-all “cure” or “fix” to illness, obscures more important fundamental questions (2011, 16). Bishop argues:

And for those who would embrace death, due to a poor quality of life, is it not equally odd to think that death might be the proper means to achieve a quality of life, in ending it, or that the quality of a life might be so bad that the quality of death might be its counterpoint? In what sense can death be said to be better than a certain quality of life? And if we, as a culture of medicine and more broadly as a society, are so bent on improving the quality of life, why is it that patients still find themselves in intensive care units enduring lives worse than death, just as they did in the 1970s? (2011, 16)

In its expanding dominance of biological, psychological, social and spiritual matters, doctors and their allied professionals join their patients in a series of paradoxes brought on by the metaphysics of efficient causation. “Quality of life” understood as the capacious and expanding realm of human experience, relationship, and purpose exceeds its biopsychosocialspiritual corral.

Placing death ahead of life leads to unresolved paradoxes in medical care, including some overtreatment that simultaneously neglects the fundamental aspects of human existence within a caring community. As society becomes a “culture of medicine,” totalizing standards of care are diffused throughout social life, with ominous implications for human relationship, connection, and flourishing.

IV. CONCLUSION

Having demonstrated the utility of Bishop’s framework for the consequences and outcomes of the ethnographic DBS case, we now focus on Bishop’s critique of the social sciences and reflect on what the five central components of the *The Anticipatory Corpse* can offer for future sociological work. First, we discuss the need to critically interrogate the disciplinary power of institutional practices. Second, we consider how social scientific work can centralize both the importance of living in the present and in maximizing human flourishing today.

The Disciplinary Power of Institutional Practices

Sociology must focus on the unveiling of disciplinary mechanisms of power, domination, subjugation, and marginalization within medical knowledge, medical care, medical institutions, medical training, and medical practices, so as to better understand caring for the living. The issues of over-medicalization and overtreatment have been increasing at an alarming rate. DBS exemplifies an intensifying medicalization that

is also evident in pharmaceutical advertising. The dominance of medical knowledge over the significance of human lives and how living is given significance within a particular community has been increasingly well documented. A recent spate of academic and trade books has documented this medical oversaturation: [Brownlee's \(2007\) *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer*](#); Welch, Schwartz, and [Woloshin's \(2011\) *Overdiagnosed: Making People Sick in the Pursuit of Health*](#); [Hadler's \(2012\) *Worried Sick: A Prescription for Health in an Overtreated America*](#); [Abramson's \(2008\) *Overdosed America: The Broken Promise of American Medicine*](#); and [Cassels's \(2012\) *Seeking Sickness: Medical Screening and the Misguided Hunt for Disease*](#). As more and more emphasis is placed on patients to self-monitor for symptoms and ailments, we must consider how overtreatment is sold to patients.

Direct-to-consumer advertisements could play a key role in overtreatment. Generating demand for new and often expensive drugs, these advertisements fit into an array of sales practices for hospitals, HMOs, clinics, doctors, academic medical centers, and other centers of care. Often, disease-awareness campaigns are more than public service announcements. They are paid placements. Indeed, as [Welch, Schwartz, and Woloshin \(2011\)](#) write, "Instead of promoting healthy lifestyles, the campaigns are pushing the early detection of disease, encouraging you to get checked for any one of a number of health concerns" (2011, 159). In addition, marketing of pharmaceuticals now involves help from the press as a "third-party strategy." Here, the result is getting a message channeled through a seemingly independent and credible source rather than the pharmaceutical companies, in that the media are constantly given press releases about new drug studies and drug developments ([Brownlee, 2007](#), 189). These developments have led Hancock to conclude:

This interconnected state of affairs as being all part of "an epidemic of diagnosis" in which the apparent constant screening for something to be wrong has in turn created an unforeseen danger, that of "overdiagnosis," whereby we are in constant pursuit of detection of abnormalities that have no medical consequences ([Welch, Schwartz, and Woloshin, 2011](#), xii). Medicalization has created an oversaturated social space where we have an indeterminacy of sources. In this blur, we are left unable to narrow down the precise mechanism of socialization. ([Hancock, forthcoming](#))

Sociological work that draws on these strategies may provide us with an understanding of caring for the living. As Bishop forcefully argues, medical practices are currently ordered toward staving off death and thus are by definition reactionary. Yet, it is also the case that medicine is a disciplinary practice, shaping behavior before problems arise. Such a focus on disciplinary power and domination could help sociologists and other social scientists reflect on the power of our own practices to discipline and dominate. Reflective practices like these could lead researchers to humility and reverence when approaching the deep complexity of human experience.

Sociology's Emphasis on Vitality and the Living

Sociologists might also be helpful in the service of maximizing vitality, embodiment, and well-being in the here and now of life, not focusing on death as the endpoint, but rather centering ourselves on and in the present. Rather than thinking about predictions and statistics, how might we maximize the meaning and enjoyment of life now? Therefore, we need to think about living as the endpoint of our lives, displacing death. Such reflection leads to an understanding of our existential place in the world and what is most important within the world. How do we maximize life and living? With these considerations in mind, sociologists might advocate rethinking exercise. Instead of thinking "I need to exercise more so that I can live longer," I can think, "I need to exercise more because it helps me live better today." Sociologists could use this perspective to study communal practices of health in disadvantaged communities instead of merely cataloging health statistics and lamenting rates of chronic illness that exceed those of more affluent communities. How is health a practice instead of a state of being for those in disadvantaged circumstances?

As we see in the ethnographic study reported here, sociologists have tried to insert themselves into medical care in order to improve our understanding of patient care, decision-making, treatment, the power/authority of doctors, what medicine conceals from us, and our blind faith in biotechnology. In this case study, we see that sociologists and sociological workers have indeed tried to insert themselves into the study of medical care in order to improve patient care. As a result, perhaps the intellectual project outlined in *The Anticipatory Corpse* and critically engaged medical sociologists are not so far apart. However, much work is still needed to grapple with the embodied wholeness of the people whom sociologists and others study. What we need is continued dialogue. We hope this engagement with Bishop's work both provokes and suggests as possible a rich, respectful, and ongoing dialogue. Bishop's *Anticipatory Corpse* provides a springboard to ask a host of sociological questions to be carried out in future research: What does sociology contribute to the study of the corpse/body? What questions does sociology ask and not ask that may obscure essential features of medical practices and the practice of medicine? Without a vigilant reflexivity, how are sociologists themselves caught up in the very knowledge production they claim to make? We look forward to such a dialogue with Bishop and others as we work to think, write, and practice with care.

NOTES

1. Morrison gathered this ethnographic data through unobtrusive participant observation during 30 monthly meetings at a major medical center in the Southeastern United States from 2009 to 2012. Meetings were held to less than 2h and included a core group of neurologists, neurosurgeons, and technicians. See Morrison and Bliton (2011), and Morrison (2012).

2. All proper names have been changed according to standard sociological methodology for the protection of human subjects.

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