

The Medical Gaze Between the Doctor, the Patient, and the State

Written by Zeynep Balcioğlu

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On March 3, 2011 the doctors from Haydarpaşa Numune Eğitim ve Araştırma Hastanesi in Turkey organized a manifestation on the street shouting “Let Super Mario to collect the point, not the doctors!” to protest against the new health policy. This is a policy that regulates and measures the working hours, environment, and performance of the doctors by assigning specific amounts of points to their actions. The doctors were accusing the “performance” system of disturbing the peaceful working environment.[1]

Medical knowledge and practice, though, is a form of discipline within modern societies. Knowledge and power co-produce each other at all times. A specific form of knowledge is privileged in different contexts to create a particular kind of hierarchy. It constructs organized relationships between subjects of the power. In this case, power can be seen as being projected in terms of the bodies of its subjects. The definition of health draws the boundaries of society by defining specific limits, which, when looking at Turkey, is done by encapsulating and ordering them through normalcy curves and time intervals. The process that Foucault calls “discipline”[2] is not so visual or material on its own. However, the discipline takes and shows its form by controlling the bodies of its subjects both directly and indirectly. Accordingly, the subject inherently becomes a part of the system set in place by adhering to and performing within the power’s imposed bodily practices.

Regarding the medical sector in Turkey instituted by AKP, it is possible to say that the patient and the doctor can both be considered as the aggrieved, even within the maintenance of the hierarchical organization of power through knowledge. Implementation of neoliberal policies in the health sector binds both the doctors and the patients to perform as homo-economicuses, strategically structuring their relationship, despite the fact that it is one where life or well-being are being considered. In this essay, I will argue that the application of the new medical policy by the AKP government relates to the academic concepts of mind-body dualism, medicalization, fragmentation and the ways of disciplining bodies by constraining them into time intervals I will analyze how the bodies of both doctors and patients are controlled and reconstructed relationally and separately through state policies in favor of particular political and economic discourses.

The dichotomy constructing the relationship between the body and mind goes back to Cartesian dualism. Descartes claims that the mind and body are separate, as two different classes of matter.[3] This binary formation between them results in the sublimation of the mind from the body. When this becomes considered as knowledge, it acts as a form of power that articulates the mind as constituting a hierarchy within and between different spheres of being. Thus, what is known as a white sphere, through the implementation of specified knowledge, is instituted[4] by exclusively allowing only certain people to have an access to that “knowledge”. As Kundera mentions, science can be considered as being the tunnel of specialized knowledge.[5] In terms of medicine, the doctors are the ones who are worthy of having and identifying with this knowledge.

The distinction between body and mind reflects itself as part of a project of modernity also in the difference between social and economic worth of manual and mental workers in the capitalist mode of production. A doctor is an agent who is deployed at the upper hierarchical levels of social construction. He/she has the knowledge of medicine, which can be considered as within the discourse of modernity and capitalism. The application of medicalization takes place

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as a means of control on bodies. Hence, the social is denied or disregarded by transforming it into something that is just biological. The process legitimizes itself through “scientific explanations”. The clash between social and biological is the product of embodying a materialistic way of thinking. As Nancy-Scheper Hughes exemplifies in her article “The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology”, the doctor searches for the “real” cause of the headache, ignoring the social and personal implications of the illnesses with which the patient deals. Thus, through the discourse of medicalization, the sickness emerges as “a form of communication- the language of the organs- through which nature, society and culture speak simultaneously.”[6]

When medicine becomes the only social language, the distinction between the doctor and the patient gets more explicit. Their perception of each other becomes hierarchical. In this relationship, the physician is the healthy, wise and authoritative one; whereas, the patient is perceived by the doctor as sick and powerless, even though the doctor may also get sick sometimes. This is what Foucault calls the “medical gaze”[7]. He says:

“Facilitated by the medical technologies that frame and focus the physicians’ optical grasp of the patient, the medical gaze abstracts the suffering person from her sociological context and reframes her as a “case” or a “condition”.” [8]

The “white” coat that the doctors wear can be considered as the symbol that differentiates the doctor from the patient, by constructing a “white” space for the doctor. When the patients lodge at the hospital, they are usually supposed to wear blue pajamas, which, arguably, can be interpreted as reminders for the distinction of white and blue collar workers in industry. However, whether calling it blue or white, they are either the workers or the subjects of power.

Analyzing the Turkish public health service, a regular doctor from the gynecology department has to see about 80 patients on average each day. They do not have a constant wage, but they gain points according to the number of medical examinations and surgeries they have with patients in a month. Regarding the points they acquire, their wage is determined by the state. Alongside that, they get a share from the circulating capital of the hospital where they work in, but only if they do not make the hospital spend more than the budget allocates it. The system is called one of “performance”.

Each doctor works 8 hours a day, and they have a total two hours of break. According to the calculation, they can only manage 4.5 minutes for each patient. However, they would want to go over the number of the patients because they gain more money by looking after more patients. Because of the limited time that each patient has with the doctor intimately, there is more of a pressure for test results coming from the laboratory to not to have any mistakes regarding the potential illnesses and treatments. “In so doing, the classificatory doctor’s gaze was,” as Foucault writes, “directed initially not towards that concrete body, that visible whole, that positive plenitude that faces him – the patient- but towards interval in nature, lacunae, distances.”[9]

There is no more an intimate and personal relationship between the doctor and the patient any more. Doctors do not identify the names or faces of their patients but, rather, recognize them from their test results. The patient is now composed of the numbers and curves in and out of the “normal” and “healthy” intervals of the scores. There is no completeness or wholeness to the body anymore. It is, rather, fragmented into pieces into the quantifiable roles of both the doctor and the patient. The body is dissolved into pieces, becoming “post-human”.

According to Wegenstein, this is a phenomenon about anatomical fragmentation of the body, a concept that goes back to fifteenth and sixteenth centuries.[10] The parts of the body become autonomous pieces as “self-sufficient biotopes”[11]. He adds that “...in the current discourse universe, even the body itself would no longer seem necessary; rather, what must be recognized is the insistence on “organs instead of bodies” – namely, organs that are configured as “inside out,” having lost their quality of being “in” the body.”[12]

The patients become faceless cases for the doctors, without having any bonding with their caregiver. A doctor from a public hospital cannot give any consultancy to their patients on the phone or out of the hospital because it is nearly impossible to identify who the patient is without the help of the computer based system in hospital that would remind them of the patients’ name and the relevant medical information regarding the illnesses. The medicalization and

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digitalization of the bodies are the hegemonic way of articulating the information and knowledge of the discourse itself. These are the very specific ways of embodiment that take place in the application of those practices.

However, it is important to note that there is also a dilemma for the doctors. Within the limited time interval, the doctor has to apply for the appropriate tests from the laboratory to prevent any possible mistakes for the treatment of the patient. In addition, there is also a limited budget given by the state for the application and utilization of the laboratory. According to the regulation, each patient's lab cost can be of 27 liras maximum if the doctor wants the state to compensate it. If the cost gets above this amount, the "excess" money spent is cut off from the wage of the doctor who demands the test result from the lab. Moreover, the patient has right to demand the test from the doctor. In such incidents, doctors of the public hospital prefer to direct their patients to "family doctors", who are in another public health institution of the state that resides in every neighborhood for free and basic health service, to apply for more test results. This presents an additive articulation and relation amongst doctors, where the doctors of the two different public health institutions are put in a position like workers of rival companies. Nonetheless, the patient still has the right to insist to use the lab of the hospital he or she is in, instead of that of the family doctor, so that he/she can get quicker results. If that happens, the doctor of the hospital must persuade his/her patient to not have more tests, especially when their total interaction is only 4.5 minutes on average, as it may not seem. Hence, the "performance" of the doctor is so limited by the social, biological and economic consequences of his/her acts that it is as constraining of a role as that of the patient.

Thus, here occurs the disciplining of the bodies by enforcing them indirectly into specific practices. Power structures are not revealed in totality, but they are fragmented, making it difficult to attack or to find an alternate. As Foucault mentions, the discipline works by prescribing a specific mechanism that operates by the "hierarchical observation"[13]. The power of the discourse- that is in the hands of the state- is materialized in institutions that regulate like controlling machines and operating as a "microscope of conduct"[14].

The working hours of the doctors are so restricted by the implementation of socio-economic regulation.[15] The commodification of time is understandable, even though it a public hospital is ideally supposed to sufficiently provide welfare services for the public. However, the economic aspect is so deeply embedded in the created neoliberal conceptualization of health. The doctors prefer to have medical examinations during the day, instead of dealing with surgeries, because the examination brings more points in less time. This causes too many referrals for the patients to private or university hospitals. The bodies of the patients are sent or made to wait until the proper hospital accommodating the socio-economic status of the patient is found. Scheper-Hughes calls this circulation of bodies a "new cannibalism"[16]. Bodies can circulate now by being considered no different than any other natural resource. The disciplining of time for both doctors and patients directly provides the control of patients' bodies and the doctor's interpretation of and agency in fulfilling his responsibilities. Therefore, it is possible to say that the distinction between employers' and employees' perception of time, as mentioned in the Thompson's article 'Time, Work-discipline and Industrial Capitalism,'[17] exists in the Turkish model of health by tripling itself. It is valid for the relationships between the doctor and the patient, the doctor and the state, and the patient and the state.

The vacuumed time interval within which the doctor and the patient are allowed to interact is also one of the reasons that the relationship between the doctor and the patient is so standardized. The 4.5 minutes on average for each patient necessitates that both sides act as if they are being fast-forwarded. The perception of the both towards each other cannot go beyond the "medical gaze" in that limited time period. The patient identifies the doctor as the white colored robot or piece of machinery who is talking in and translating the patient's words into an unknown language, that being the medical one. Simultaneously, the patient is also no more than a machine or a part of machinery who needs to be fixed by the doctor. He/she has to repair the patient in between the next and the previous patients. The working conditions of the doctor or the physician are no more different than those of a worker who is working in an assembly line. In such an analogy, the patient's body then becomes the end product of the assembly line, disregarding that the 'fixing' is their lives and that they are not products but humans. Consequently, the relation is constricted in such a mechanical way that it leaves the medical discourse as the only social language between the doctor and the patient. When it is asked to the doctor what they do when a patient wants more information about his/her illnesses, a doctor *must* claim that they will try to provide it as quickly as possible by keeping the patient in the examination room for longer, while, at the same time, they prepare the room for the next patient waiting.

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In addition, again looking at the gynecology department in public hospitals, it shows how there is an implication that a cesarean section, for example, for pregnant women is not really preferable for doctors because it causes cut off from their points, and, consequently, their wages. A kind of hierarchy develops around the different options available for delivering children one that is in terms of their prices. However, the formal explanation for this regulation is the claim that vaginal delivery is healthier than the cesarean section. Hence, the specific state institution defines the definition of what is “healthier”. The vaginal delivery is considered as the “normal” way of giving birth for women. Thus, the “normalizing function”[18] operates through bodies by locating and attributing a “natural” reference for itself. In contrast, there is no such regulation on the implementation of the cesarean section in private hospitals. Therefore, the doctors working in the public hospitals prefer to refer women who need or prefer to have a cesarean section to have it elsewhere. Thus, even a woman’s will to get the cesarean is determined and regulated by the state. However, there are several times or incidents that women urgently need to have cesarean sections in public hospitals. At this point, the doctor has to take in the women for the necessary surgery without considering his/her economic benefit from that very specific operation. The application, as such, brings the doctor and the patient in conflict by constructing a client-merchandise relationship between them, similar to the one in capitalist mode of production. One’s benefit turns into the other’s loss, with the process continuing to be directly linked to the both sides’ bodies. Thus, even “public” health is commercialized by engaging the bodies of the agents in certain practices, though making it seem as if they are really making a choice between the alternatives. Foucault says: “They did not receive directly the image of sovereign power; they only felt its effects – in replica, as it were – on their bodies, which had become precisely legible and docile.” [19]

Thus, the hegemonic discourse reveals itself in a fragmented way on the bodies of its subjects. It works itself all the way down to the microscopic, detailed level of appropriating conduct, so there is no space left for alternatives. While doing that, the discourse justifies itself through the utilization of a very specific language, constituting a particular type of gaze, that which has been illustrated in this essay. The medical gaze that the doctor and the patient direct towards each other is being embodied through their own bodies and in the time and space they share. The “performance” system that regulates the doctors’ working cycle, and their time and bodies, standardizing the measurement of doctors’ efficacy through a point scale matching the doctors’ actions. Therefore, it no longer seems that the patient is the only one whose position is constrained, that being through the intervals of the normalcy curves. It is also the doctor himself/herself who is restricted in identification by number, with points the form of measurement. All in all, the regulation of the “performance” between the doctor and the patient detains the bodies, spaces, and times by institutionalizing control in all social, biological and economical aspects.

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