

Governing through Speech: The New State Administration of Bodies*

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*C*ONDITIONAL decriminalization is the most obvious common feature of the change in practices affecting the relationship between the individual and his or her body that has taken place over the last few decades. This is particularly true of corporal practices involving the beginning and end of life, which has seen the conditional decriminalization in France of the use of contraception in 1967, abortion in 1975, sex change in 1976, homosexuality in 1982,¹ and today, the insistent demand for the decriminalization of euthanasia. This withdrawal of authority has taken place by the *removal of the penalty* rather than by the proclamation of formal rights. In this area of civil law or public health law, as in criminal law analyzed by Michel Foucault, it is less a question today of “punishment” than of “surveillance.”

What type of supervision are we dealing with here? Does the shift of state control from punishment to supervision in France necessarily lead to a new deployment of state control in the direction of “disciplinary” control? Does it lead to the process of lining up bodies, gestures, and postures in rows that Michel Foucault described at length in reference to prisons and schools? Clearly not. Although 80 percent of the dying in France are found in hospitals today, these patients are not separated from the others but scattered among the various wards, and women who come to ask

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for contraceptives or an abortion, for example, are only briefly held captive by hospital departments. The control over their use of their own bodies obviously calls other procedures into play.

Financial Incitement

Although this control seems to be characterized by explicit withdrawal of legal authority, in reality it has been accompanied by what I would call “financial incitement” and control through “biographical compliance.” The authorization given to new corporal practices has taken concrete form in France, where we have seen: national health insurance coverage of (female) contraception in 1974, abortion in 1982, and soon thereafter artificial insemination, the RU 486 pill and in vitro fertilization. This financial coverage is tantamount to full social recognition. We have forgotten the bitter debates once sparked by these issues and how long it took for them to be granted coverage: seven years elapsed between legalization and coverage by national health insurance of both contraception (1967 to 1974) and abortion (1975 to 1982). Similarly, the condemnation of surrogate motherhood (“gestational carriers”), pronounced by the National Ethics Committee in its first opinion in 1984, took the form of proposing to refuse legal recognition of such a costly practice. Sterilization is another example of this system of “financial” supervision without punishment. Until 1994, no legal action was taken when it was practiced under the former criminal code nor was it covered by national health insurance.² Conversely, total insurance coverage of palliative “care” (which might, however, be categorized as simply maintaining a comfort level) and the creation of “special work leave to care for the dying,” which allows the dying to be assisted by a close family member for up to three months (Law of 9 July, 1999), indicate clearly that palliative care is the sole method of alternative treatment for the dying that is officially tolerated in France today.

The state's financial contribution in these areas reveals the increasing management of biological complications as a social and political concern. The increasing financial coverage of what has gradually developed into an unacceptable biological risk or misfortune is precisely what Michel Foucault defined as the advent of biopolitics (as opposed to disciplinary supervision). It desperately tries to preserve and "foster life" in the face of the threats and risks surrounding it. On the one hand, there is the "risk" of unwanted pregnancy (overcome by contraception, sterilization, prenatal diagnosis, abortion), and on the other, the "risk" arising from the obstacles of sterility, hypofertility, or declining fertility due to age (overcome by medically assisted procreation). Biological complications encountered in reproduction or in the process of dying are now considered legitimate concerns of society. They are put in the same category as misfortunes, which, although "natural," deserve to be covered by the national health insurance system just as other *physical* obstacles, including illness, accident, and aging, once were. Biological complications arising in the procreative process call for social and medical services. These are granted according to the principle of equal access to public service, thereby proving that management of biological "risk" is indeed one of the features of "biopolitics" today. Supervision ensured by providing or refusing financial coverage is typical of biopolitics today: a back-and-forth movement within what is commonly known as the welfare or social state. And this financial coverage is by no means an empty term: in 2002, the cost of an abortion was 902.16 French francs (137.53 euros), with maximum coverage of 1,212.16 French francs (184.79 euros) if general anesthesia was required; RU 486 costs 1,311.46 French francs (199.93 euros). We have come a long way from the penalties imposed on women who had abortions by the Vichy government to our "biopolitics" of today, from "punishment" to financial "supervision."

Biographical Compliance

Decriminalization and the provision of financial coverage were not granted without something in return. To benefit from both, patients must go through representatives of the state (doctors, nurses, midwives) and other agents associated with hospital procedures (family counselors). The trend is toward removing prohibitions or legal restrictions on these social practices. Today it is possible to do many things with one's body involving the beginning and end of life: make oneself temporarily or permanently sterile, engender a baby by artificial means, abort for various reasons, control high-risk sexual behavior after the event by taking a morning-after pill, and soon, perhaps, demand euthanasia. There remains, however, one condition for doing so throughout Europe: one must present oneself before a physician. And what does this physician ask the person? Almost nothing, apparently. Patients are merely told to sit down and talk about their reasons for being there. It is this "almost nothing" that will be central in this paper.

This "almost nothing" refers to a certain way of governing social behavior through speech. It involves stating, at the request of the physician, a few good reasons for the desired medical intervention. In other words, it involves presenting, in a consensual manner, arguments upon which the patient and physician can agree. The degree of consensus legally required is, in reality, extremely variable. In the case of abortion, the woman is the only one who can assess the reality and the degree of her "distress." This distress cannot be verified either by the doctor or by those she encounters during the mandatory "social" interview. The doctor she meets is *legally* required to inform her about the physical risks associated with an abortion, and the financial assistance available to her if she keeps the child. Something else is imposed on the person who has been duly enlightened through repeated dialogues with professionals: a waiting period considered favorable to the latency and reflection needed by this ultimately solitary individual.

The same phenomenon is beginning to occur for the dying. The proposals put forth by proponents of palliative care and activists in favor of euthanasia have one thing in common: a concern for listening to the patient rather than to medical authorities for an account of “rightful” death. Naturally, the procedure for obtaining the correct narrative of “rightful” death varies. It may take place orally in an ongoing, gradual manner at the patient’s bedside in a hospital ward. For members of the Association of the Right to Die with Dignity, it is a formal statement of the patient’s “will to die with dignity” made in writing on specific occasions, repeated over time. Of course, the expected legitimate account will not be the same for everyone. For activists in favor of euthanasia, it will mean ascertaining the patient’s determination to die. The purpose then is to make available the means to satisfy that decision. The “style” of death varies: dying with “dignity” means that life has not been physically diminished, which is consistent with the efforts of biopolitics to eliminate the misfortunes imposed by biology. Palliative care was originally intended to oppose this narrative of a good death by helping patients to go through the stages considered necessary to arrive at a “good” relationship with death. After the stages of “denial,” “anger,” “bargaining,” and “depression,” the patient finally arrives at “acceptance.” This narrative of a good death—more or less explicitly supported by scientific argument in the works of Elisabeth Kübler-Ross—has become the reference in palliative care units. For both groups of activists, a period of latency is set aside for the individual’s maturation: the renewal every five years of a written request for euthanasia is the counterpart to the slow, inner transformation fervently desired in palliative care.

The two groups share a common worry: the individual must be able to express his or her adherence to the specific version of a good death. The Right to Die Association “declaration” is only one version of the “final wishes of the dying” (hence the name “living will”). As for patients in palliative care, while they are indeed given “support,” they are the ones who must “follow the

path,” who must go through the “stages” of this desirable “process” (all these terms are constantly encountered in this domain). Those who offer support in these units often find themselves functionally in the same position—in relation to the patient—as the parade of people who interview women requesting an abortion: their role is to make the patient speak and elicit the final position that should, sensibly, prevail. Pain control, which is one of the strengths of palliative care, may thus seem to be the necessary counterpart to the requirement of biographical compliance: “it is impossible to talk serenely with a person who is suffering.”³ Right to Die Association members strive to “recognize a right to speak”, which is unusual for the dying, by allowing them to “express their wishes formally in writing” (Montandon-Binet, 1993). Similarly, the supporters of palliative care continually endeavor to make the dying “speak in order to understand more fully”⁴ and “learn how to die.”⁵

In short, the preferred method of social control surrounding the relationship between the individual and his or her own death involves eliciting from the dying person one of the competing edifying narratives: momentary heroism for the partisans of the “right to die with dignity,” heroism over time for proponents of palliative care. And the same opposing narratives are frequently encountered as soon as death is mentioned in semiscientific works.

A Shift in “Biopolitics” or in the “Process of Individuation”?

The approach by “disciplines” used by the “early Foucault” is thus seen to be insufficient to explain the evolution under way since the decade between 1965 and 1975. The discursive control surrounding such social practices obviously looks more like control through avowal and confession analyzed by Michel Foucault later on in his *History of Sexuality* (1976-1984) than “disciplinary” control. That is probably not an accident. The intellectual shifts undertaken by Foucault precisely during that period may indeed

express the refracted images in his work of a new type of social control that was being introduced at the time. In this new approach, Foucault abandons the arsenal of “disciplines” surrounding the human body (analyzed again in 1975 in *Discipline and Punish* (1975) in favor of the advent of a general “care of the self” and a well-balanced control of the “use of pleasure” (to borrow the titles of the last two works published by Michel Foucault in 1984, nine years after *Discipline and Punish*).⁶ But, oddly enough, Michel Foucault used this approach only for the analysis of ancient philosophy. Yet the ways of controlling the use of the body through financial incitement or biographical compliance that were being deployed at the time Michel Foucault was writing his last books had one thing in common: both delegated the “choice” of the desired treatment to the social actor as long as he or she passed stringent financial and discursive scrutiny. Between the “use of pleasure” and “care of the self,” the social actor became, as it were, the main depository of supervision of his or her own body while remaining duly surrounded by a halo of vague sanctions.

Similarly, the historical evolution that interests us here does not seem to fit entirely into the history of the transformations of “biopower” proposed by Foucault. *Biopolitics* is a set of “regulatory” mechanisms ensured by the state and that appeared in the second half of the eighteenth century. It “did not exclude disciplinary technique, but followed closely on its heels, incorporated it, partially modified it, and above all, was to use it. . . .” Its evolution was characterized by the fact that the “power of sovereignty” (using Foucault’s terms again), which once consisted in *making someone die* (or letting someone live), gave way to political action aimed essentially at “*making someone live*” (and “letting someone die”). At the time, Foucault was particularly concerned about describing the concern for enhancing “life” and eliminating, combating, or compensating for whatever impeded it (Foucault, 1997: 41). It is therefore up to us to interpret another order of phenomena, which no doubt was less clearly perceptible during

Foucault's lifetime: the apparent delegation to the citizen of the right to live or not, to "make someone die" and "let someone live" (or not = abortion), and to "let oneself die" (= palliative care) or "make oneself die" (= euthanasia).

Thus, we have turned to another author, Norbert Elias, for an interpretive framework that will enable us to understand what has been at work in this area for the last 30 years. One common feature of the relationship to birth and life is the ideal of control underlying both. "To have a child if I wish, when I wish" or to assert the right to die when one is ready means accepting the idea of the subject's control over his or her own bodily destiny. Terms such as birth "control," "planned parenthood," and "family planning" have become so commonplace that we have forgotten how strongly they convey the ideal of control in the area of procreation. The discrediting of abortion, and even more so, the argument that usually accompanies it, is a further sign of the evolution currently taking place: abortion, especially when repeated, indicates a failure of contraception, of the sensible control of the desire for a child; it is a poorly "controlled," poorly "planned" desire for a child. While the advent of procreative techniques is no doubt a sign of the growing triumph of the scientist's rational control over nature, our point here is that it is accompanied by a delegation of that rational control to the ordinary citizen. To put it more precisely, the citizen is asked to use his or her body "reasonably."

Above all, what is at work is not so much the advent of this ideal of control over practices as its institutional and state recognition. Procreative self-determination, first introduced through do-it-yourself operations in the privacy of the bedroom, has ensured the slow triumph of Malthusianism since the end of the eighteenth century. In the period between the wars, there were no birth control pills or IUDs available, yet fertility rates in Europe were so low that, if they had continued unchanged, demographic growth would have been negative (0.9 in France and 0.8 in Great Britain, for example). This was followed by public recognition of the legitimacy of such practices and the development of new contraceptive methods in the name of the right to control one's pro-

creation. One eloquent statistic: it has been estimated that in 1952, 1 percent of all the countries in the world officially practiced family planning, compared with 55 percent in 1974 and 96 percent in 1991. An analysis of the major international conferences devoted to this question (Bucharest 1982, Mexico 1984, Geneva 1993, Le Caire 1994) seems to confirm that what was once willingly done in the name of regulating the national population now tends increasingly to be justified in the name of individual control over one's own reproduction.⁷ "Self-determination" in procreation, legitimated by the state, which scarcely entered into Foucault's analysis, appears to be a widespread feature of contemporary biopolitics.

In a similar fashion, it is striking to note the increasing desire to control one's own death and the conditions under which it takes place. This form of euthanasia is, incidentally, eloquently described as "active" by its defenders, compared to "passive" euthanasia—that is, leaving to doctors the decision to pull the plug. To date, the regulatory proposals in favor of euthanasia vividly convey the idea of self-determination. Here again, the subject is held to be superior to his or her biological destiny, capable of making a sovereign judgment about the attributes of life ("I and I alone can judge my quality of life").⁸ The individual's superiority is based on consciousness: "In view of the fact that brain functioning determines the level of consciousness and the level of consciousness defines the human being. . . ."⁹

There is another sign that is likely to betray a similar development: the very perceptible increase in the rate of cremation (which has reached an average of 17 percent of all death since the beginning of the 1980s), as well as the practice of scattering the ashes in a natural setting or the landscaped setting of the "Memorial Gardens" adjacent to crematoriums. In addition to avoid subjecting family members to postmortem social constraints (that is, visits to cemeteries), the reasons put forth for cremation seem to indicate a concern about controlling the biological process of annihilation by preventing the slow decay of matter that accompanies it, which would be consistent with the simultaneous increase in embalming

that also appeared in France (1963) and was institutionalized (1976) during the decade mentioned earlier. The rapid construction of crematoriums since the beginning of the 1970s and the recognition of embalming practices in 1976 are both developments that have been given support by the state. This enterprise of self-determination in relation to death sometimes takes particularly eloquent forms outside France. A center has been set up in Great Britain to teach the dying, with the help of “nurse-midwives,” to “explore one’s own death” and “broaden one’s view” by contemplating it. The Natural Death Center also offers a practical burial handbook with instructions on how to make your own casket for about 850 French francs (129.58 euros) (Thomas, 1993: 13).

Self-Determination: Representation or Reality?

Instead of magnifying or lamenting the growing freedom of the individual and the cautious reserve of the state in these matters, we will examine more closely the new configuration that structures their relationship. This refers to delegating concerns about controlling “excess” through a process of duly supervised self-determination. The enormous increase in women’s social power over reproduction (under medical supervision, however) in the twentieth century—this “feminist victory”—can be reinterpreted by placing it back in the context of state-organized corporal self-determination, which delegates to the individual most directly concerned the task of using his or her body *sensibly*. What stands out is a phenomenon that is only seemingly paradoxical: the advent of a triumphant subject, curiously helped along by control mechanisms themselves.

This is consistent with Norbert Elias’s interpretation. In particular, the idea of the “sovereign subject” places us, above all, in the order of representations, even though they have real effects. Indeed, here we have to get beyond the simple opposition between the individual and the state. In *La société des individus* (1991), Elias presents the problem so that it is impossible to think the individual

outside his or her relation to the state. This approach brings out the historical moment in which social actors themselves, as well as representatives of the state, come to understand their autonomy and the “we-I relationship.” It is this representation that appears to refer to a certain stage of development of the State.¹⁰

The contemporary phase of the process of individuation thus appears to be a product of the modern state. It is a process whereby social actors interiorize the discourse of the state rather than undergo it in the form of legal punishment. They may, incidentally, content themselves with minimal, purely verbal acceptance, which allows them to reproduce this discourse at the proper time (for example, when requesting an abortion or artificial procreation). The only control that counts in this case is the one surrounding the discourse that the “I” produces about itself. Explicit regulations, accompanied by sanctions, tend to give way to self-regulation, provided it is accompanied by the expected arguments. *Policing the body turns into policing narratives*. This shift is congruent with a more general, twofold evolution since the end of the 1960s: what has been called the return of the narrative, of history, of biography and autobiography (and, within the social sciences, of the subject) (Pudal, 1994: 5ff), and the introduction of procedures of “self-discipline” and control over one’s own productivity in establishments such as schools and firms.

The trend toward control over one’s body, in whole or in part, would thus be merely a crystallization of the process of individuation, combined with increased individual self-determination. The latter requires special symbolic capabilities—those that make it possible to reproduce sensible, expected arguments. Thus, the analysis of the “late Foucault” (which scrutinized control through confession) can be encompassed by a version of Elias’s thesis. The historical increase of “self-determination” works through highly unusual avowal procedures: namely, the request made to social actors to subscribe solely to narratives that can be legitimated by the state.

A particularly well-developed form of this mode of control over the social uses of the human body is represented by “bioethics.”

First, “bioethical” regulation confirms the tendency to decriminalize the relationship to the body. Legal sanctions give way to “diffuse sanctions,” to borrow the famous distinction introduced by Émile Durkheim. Legal imperatives yield to moral prohibitions. Hence, the National Ethics Committee, France’s guardian institution of bioethics, can only deliver opinions. It insists on presenting itself as having only “moral”—and therefore neither political nor legal—authority. There is a corollary to this resistance to legal or political “authoritarianism.” “Self-control” is constantly being demanded of both subjects and health-care professionals on these burning issues. An ethical opinion constitutes an obligation to self-control. Unlike the law, “ethics” is presented as a method of regulation developed among professionals (regardless of whether it involves “corporate ethics” or “journalistic ethics”) striving to achieve self-control through rules upon which they have collectively agreed.

In short, *counseling*—that is, the enlightened discussion with a physician—is constantly promoted as a satisfactory and flexible way of regulating conduct in these matters, without diktat. For the National Ethics Committee, invoking “wisdom” and “prudence” may well be equivalent to the enlightened advice and careful listening offered to those who abort and those who are dying: they all are credited with being capable of self-determination. Bioethical reflection and the doctor-patient relationship would thus appear to indicate the same thing: a growing interiorization of rational control—or better still, of “reasonable conduct”—in social practices.

Conclusion

What we find here, concerning the uses of the body at the beginning and the end of life, is the advent of an increasingly sophisticated form of social “supervision” that requires more education and a higher cultural level, inasmuch as it relies on the more or less successful interiorization of the “right” narratives concerning

the practice involved. As for controlling the body through confession and producing legitimate narratives, it is not an entirely new phenomenon: it was once duly practiced by the Church. What is important here is that it has become secularized, with specialists of the body supplanting those of the soul. They have become “*les nouveaux clercs*” (Vincent et al., 1985) at a time when the former *clercs* have been increasingly discredited, especially because of their conservatism regarding these same issues. One counterpart of accelerated secular control of private conduct, which took place in the last century, may well be that the state has taken over the Church’s tried and true techniques for governing human beings. But this process has required the development of a new image of the patient as an individual capable of self-determination, reflexivity, and reasonable conduct concerning his or her own body—an individual capable of producing a sensible discourse and attitude when confronted with lay institutions.

Notes

¹More accurately, criminal discrimination linked to homosexuality was brought to an end at the initiative of Robert Badinter, the French Minister of Justice at the time.

²Even though it concerned more than 200,000 women and 10,000 men in 1982, and even though 50,000 requests for sterilization continued to be made each year. Cf. Arnoux (1994).

³Statements made by Mireille Noury and Michèle Salamagne in “Vers une nouvelle approche de la mort” (A New Approach to Dying), mimeo., September 21, 1998, La Maison des Arts de Créteil.

⁴Cf. “Parler pour mieux comprendre.” *Passage* 4 (Autumn 1997): 1.

⁵The title of a work edited by Ch. Montandon-Binet and A. Montandon (1993).

⁶The turning point occurred between 1975 and 1976, and was made clear in 1976 both by the publication of the first volume of *l’Histoire de la sexualité* and the course that took up the conclusion: “Il faut défendre la société” (the course was given at the Collège de France in 1975-1976 and published in 1997 by Gallimard/Le Seuil in Paris).

⁷Regardless of the handicap that this ideal may represent for demographic policies.

⁸French legislative bills “tending to legalize the declaration of the will to die with dignity,” introduced into the Senate and the National Assembly on May 18, 1989, and October 26, 1989, respectively.

⁹Proposed resolution concerning assistance to the dying, European Parliament, April 30, 1991. From this standpoint, the contemporary redefinition of death as “brain death” is quite consistent with this enhancement of “consciousness” up to the moment of death.

¹⁰To take up the summary presented by Roger Chartier in his preface to *La société des individus*, Norbert Elias asserts that “the conception of a separate, autonomous self that poses the social world as outside or even hostile to it, comes into being at a particular stage in the process of civilization, when greater severity in ‘the control of individual behavior’ is required, along with rigorous self-control in public conduct.” Conversely, he establishes that “interiorizing the mechanisms for regulating and censoring affect, drives and emotions creates in individuals a control system or authority which is designated as ‘consciousness’ or ‘reason.’ A fundamental duality is thereby introduced between the subject and the world, thought of as two separate individuals” (Elias, 1991: 17, 19).

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