

# Michel Foucault and the Problematics of Power: Theorizing DTCA and Medicalized Subjectivity

BLACK HAWK HANCOCK\*

*De Paul University, Chicago, Illinois, USA*

\*Address correspondence to: Black Hawk Hancock, PhD, Department of Sociology, DePaul University, 990 W. Fullerton Ave, Chicago, IL, USA. E-mail: [bhancock@depaul.edu](mailto:bhancock@depaul.edu)

*This article explores Foucault's two different notions of power: one where the subject is constituted by power–knowledge relations and another that emphasizes how power is a central feature of human action. By drawing out these two conceptualizations of power, Foucault's work contributes three critical points to the formation of medicalized subjectivities: (1) the issue of medicalization needs to be discussed both in terms of both specific practices and holistically (within the carceral archipelago); (2) we need to think how we as human beings are “disciplined” and “subjectivated” through medicalization, as discourses, practices, and institutions are all crystallizations of power relations; and (3) we need to reflect on how we can “resist” this process of subjectification, since “power comes from below” and patients shape themselves through “technologies of the self.” Ultimately, Foucault's work does not merely assist us in refining our analysis; rather, it is essential for conceptualizing medicalization in contemporary society.*

**Keywords:** *carceral archipelago, Foucault, gaze, medicalization, technology of the self*

## I. INTRODUCTION

Direct-to-consumer advertising (DTCA), the advertisement of medical and pharmaceutical products directly to patients through multiple media, has only been legal in the United States since 1997. This development has garnered considerable attention from researchers in many disciplines, including medical sociology and biomedical ethics. These scholars tracked how DTCA

has changed the practices of prescribing medications by healthcare professionals and generated consumer demands for such medications in clinical encounters, as well as reoriented the understanding of health and healthcare decisions/treatments in general (Donohue, Cevasco, and Rosenthal, 2007). For us to understand the social implications of DTCA, we must theorize it as a normalizing system of power/knowledge that judges the normality/abnormality of people and as constitutive of the formation of a medicalized subjectivity.

This article utilizes Foucault's two notions of power: one where the subject is constituted by power-knowledge relations and another that emphasizes how power is a central feature of human action (Sluga, 2011). By drawing out these conceptualizations of power, Foucault's work contributes three critical points to the formation of medicalized subjectivities: (1) the issue of medicalization needs to be discussed both in terms of both specific practices and holistically (in terms of the carceral archipelago); (2) we need to think about how we as human beings are "disciplined" and "subjectivated" through medicalization, as discourses, practices, and institutions are all crystallizations of power relations; and (3) we need to reflect on how we can "resist" this process of subjectification, as "power comes from below" (Foucault, 1978, 94) and patients shape themselves through practices and "technologies of the self" (Foucault, 1988). Ultimately, Foucault's work does not merely assist us in refining our analysis; rather, it is essential for conceptualizing the broad processes of medicalization in contemporary society.

## II. PRELIMINARIES

Despite Michel Foucault's extensive scholarship on the topics of medicine and psychiatry, very little analysis has been devoted to showing how his concepts can be brought into dialog with and illuminate aspects of contemporary medical practices (Bishop, 2009a). Of particular interest here is what Foucault's work, when extended to DTCA, can provide to further our understanding of medicalization and medicalized subjectivities. Although several scholars have established links between Foucault and medicalization from a number of different disciplines, including anthropology (Frykman and Lofgren, 1987), history, (Mort, 1987), philosophy (Lupton, 1997), and sociology (Conrad 1992, 2005, 2007, 2013; Turner 1995; Clarke et al., 2010), it is in the field of sociology that this connection has been most recently reexamined and that I critique and extend here (Conrad 2007, 2013). Referring to Foucault's *Birth of the Clinic*, Conrad argues that the medicalization thesis as it is constituted today—through which a human condition or state becomes defined as a problem in medical terms and requires medical intervention to treat—has a dual emphasis on both medical professionals/medical knowledge and the subjectivity of the population:

Medicalization . . . examines how medicine and the emerging engines of medicalization develop and apply medical categories, and to a lesser degree it focuses on how the populace has internalized medical and therapeutic perspectives as a taken-for-granted subjectivity. (Conrad, 2007, 14)

As a result, Conrad argues that more and more spheres of life have become medicalized, such that an ever-expanding range of medical treatments is applied to human conditions. Medicalization is now a common part of professional, consumer, and market cultures (Conrad, 2007, 14). Conrad's work emphasizes the role of consumer and corporate interactions: the production, consumption, availability, and accessibility of medical products, treatments, and solutions, as fundamental in explaining the advance of medicalization.

Extending medicalization to marketing schemes, target audiences, types of advertisement (such as product-specific education and brand promotion), content (including representations, themes, points of view or perspectives), or in terms of the impact on consumers, physicians, and health care as a whole, demonstrates that DTCA has become a well-researched terrain: see, for example, the work of Donohue (2006), Donohue and Berndt (2004), Fox, Ward and O'Rourke, (2006), Frosch et al. (2011), Kaphingst (2004), Metz (2004), and Wilkes, Bell and Kravitz (2000). Sociologists, such as Conrad, have linked medicalization to DTCA in terms of the ways in which "the pharmaceutical industry and consumers are becoming increasingly important players in medicalization and that DTCA facilitates this shift" (Conrad and Leiter, 2008, 836).

Conrad's identification of the pharmaceutical industry and DTCA as new "engines" of medicalization shows how "the engines of medicalization have proliferated and are now driven more by commercial and market interests than by professional claims-makers" and opens up a particularly compelling way to theorize those interests, the advertisements, and the consumers/medicalized subjectivities embedded within those arenas (Conrad, 2005, 3). The constant development of new drugs, technologies, and treatments sparks consumer demand in both mediated and private markets. In mediated markets, there is an indirect relationship between consumers and producers, with a third-party intervention (typically private or public insurance) deciding what is medically necessary and paying only for those services deemed necessary. In private markets, the relationship between consumer and provider is direct, where a consumer can obtain any health service or product they desire, as long as they have the resources to pay (Conrad, 2005, 11). DTCA, through various techniques and strategies, has helped to expand both mediated and private markets, while simultaneously expanding the medicalization of human problems. Although advertisements often appear to clarify and educate, they purposefully confuse, causing people to redefine normal aspects of their lives in medical terms, which in turn creates greater demand for a medical product (Conrad and Leiter, 2004, 823; Conrad,

2007, 162). As a result, medical products “create” their own markets through convincing consumers to seek medical treatments that actually might not be needed, with medicalized subjectivity as the by-product.

As a result, Conrad and others have overlooked the ways that medicalization/DTCA not only redefines human conditions in new medical terms, but also redefines human subjectivity. Thus, the field remains undertheorized in terms of the ways that DTCA relates to medicalized subjectivities. Current conceptual models leave out what Foucault refers to as the “normalizing gaze,” which when internalized becomes a mode of power for social control and imposes self-regulation (Foucault, 1977, 184). This provides solid ground to explore Foucaultian concepts, as medicalization does not simply redefine human problems; rather, it redefines human beings themselves as problematic. Without such an approach, we leave out internalization and subjectivity, which are, perhaps, Foucault’s most important theoretical contributions to medicalization. Although most research has not focused on subjectivities, Foucault’s ideas help us to further theorize the relationship.

Theorizing medical subjectivity along these lines shows us how there are multiple social forces at play. We can see that medicine and medical practitioners are not the only mechanisms for the over-medicalization of society. DTCA becomes a new “normalizing” medium through which individuals are constituted and constitute themselves. This highlights the ways patients are responsible as they freely participate and become complicit in the processes of medicalization. By bringing together several facets of Foucault’s thought, we can open up an alternative way of theorizing the social forces of medicalization and the medicalized subjectivities of social agents.

The first section of the paper moves beyond Foucault’s much discussed concept of the “medical gaze” by drawing on Foucault’s metaphor of power relations as a “carceral archipelago.” Foucault uses this metaphor of a group of interrelated islands to represent “the way in which a form of punitive system is physically dispersed yet at the same time covers the entirety of society” (Foucault, 1980b, 68). This geographic metaphor provides a more fruitful approach to conceptualize medicalized subjectivity illuminating the multiple points from which the power of medical knowledge and expertise are exercised. These forms of power are also internalized in the process of the constitution of the self, as well as circulating throughout the social landscape. The second section of the paper draws on a number of Foucault’s rarely cited writings on medicine to discuss how medicalization judges not simply our health, but produces our understandings of normality/abnormality as well. Finally, the third section of the paper examines Foucault’s later view of power in the “technology of the self,” where agency becomes paramount. This shift in focus allows us to understand both the give and take of medical power, as patients become more and more active and involved in

their healthcare decisions and to open the possibility of forging new health/medical subjectivities and self-understandings within the constraints of a medicalized society.

### III. FOUCAULT AND THE MEDICAL GAZE

In the context of medicalizing deviance, [Conrad \(1979\)](#) distinguished three types of medical social control: medical ideology, collaboration, and technology. Conrad argued that:

To these categories, we can add a fourth—medical surveillance. Based on the work of [Foucault \(1973, 1977\)](#), this form of medical social control suggests that certain conditions or behaviors become perceived through a “medical gaze” and that physicians may legitimately lay claim to all activities concerning the condition. ([Conrad, 1992, 216](#))

Although Conrad’s interpretation focused on social control, the emphasis here is to understand the gaze itself, in terms of how it is constituted and how it operates. In *The Birth of the Clinic*, [Foucault \(1973\)](#) chronicles the rise of the medical industry in the eighteenth and nineteenth centuries, linking its growth directly to the expansion of medical knowledge. The economics of medicine were co-emergent with the political side of medicine—to defend the population’s health. This economic–political nexus led to the expansion and dominance of the medical field over the next few centuries. Central to the accumulation of medical knowledge was what Foucault referred to as “the medical gaze,” the medical separation between a patient’s body and his identity ([Foucault 1973, 89](#)). This detachment or dehumanization of the body into an object of analysis, to be isolated, probed, analyzed, examined, and classified, became the basis on which medical knowledge was developed. The gaze is just as constitutive of the object as it is of the observer; the gaze defines both the object of knowledge and the subject knowing that object ([Foucault, 1973, 165](#)).

For Foucault, modern medicine emerged with the rejection of medieval superstitions. However, this did not mean that modern conceptualizations were without their own unquestioned mythologies. Modern medicine deployed a specific way of seeing, a “medical gaze” which could penetrate illusion and see the hidden reality, the hidden truth of the body that could only be understood by the medical expert. Although the authority of the physician was not new, the theoretical underpinnings and justifications for that authority in modernity were, as they shifted from abstract to practical knowledge and examination, based in the wisdom of the doctor ([Foucault, 1973, 54–57](#)). For Foucault, the gaze is defined as follows:

The observing gaze refrains from intervening; it is silent and gestureless. Observation leaves things as they are; there is nothing hidden to it in what is given. The correlative of observation is never the invisible, but always the immediately visible, once

one has removed the obstacles erected to reason by theories and to the senses by the imagination. In the clinician's catalogue, the purity of the gaze is bound up with a certain silence that enables him to listen. The prolix discourses of systems must be interrupted: "All theory is always silent or vanishes at the patient's bedside." (Foucault, 1973, 107)

For Foucault, the gaze is not an abstraction seeking hidden essences, but rather is practical and a concrete examining of the object before it. The gaze operates through a successive order of reading, it "records and totalizes" all information within its purview. The gaze, through which knowledge is produced, is able to penetrate the body, ascertain its true meanings, master its secrets, diagnose, and prescribe treatment. This is not limited to physical ailments, but to anything that falls under the physician's gaze. In turn, new tests were established and rules were invented that allowed the patient to be touched and prodded in the name of our culture's belief in the physicians' diagnostic wisdom. The invention of the medical gaze brought about a shift in understanding: what was once concealed became revealed through the illuminating power of the gaze and, in so doing, medical knowledge was considered free from distortion as it brought unprejudiced truth to light (Foucault, 1973, 164–5).

#### Theorizing the Gaze in Relation to Medicalization

It was while I was studying the origins of clinical medicine. I had been planning a study of hospital architecture in the second half of the eighteenth century, when the great movement for the reform of medical institutions was getting under way. I wanted to find out how the medical gaze was institutionalized, how it was effectively inscribed in social space, how the new form of the hospital was at once the effect and the support of a new type of gaze. (Foucault, 1980a, 146)

Several scholars have extended Foucault's concept of the gaze into a number of different areas and aspects of health and medicine by showing how, for Foucault, the gaze was not something that remained among physicians alone, as it became socialized into our very subjectivity (Conrad 1979, 1992, 2007; Waitzkin, 1991; Armstrong, 1995; Heaton, 1999; Rose, 2003, 2006; Abi-Rached and Rose, 2010; Clarke et al., 2010). These analyses document how the gaze is constitutive of our subjectivity, as we become self-diagnosing, self-scrutinizing, and self-analyzing subjects. This article now turns to consider one of the ways in which the gaze—and by extension medicalization—operates as a socializing force which inscribes itself simultaneously in both viewer and viewed.

In doing so, however, as Lupton has argued in her now foundational essay on Foucault and medicalization, one of the major tendencies with Foucault and with other scholars who have drawn on his work is to:

neglect hegemonic ways that medical discourses and practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximize their health status and avoid physical distress and pain. It is here that a Foucauldian perspective has had little to offer hitherto. (Lupton, 1997, 94–5)

In addition, Lupton points out a second problematic aspect of Foucault's followers, that of the deterministic nature of their arguments, where discourses are represented as simply subjugating, especially in terms of the "docile body" and the "clinical gaze." With the inability of the patient to return that gaze, this results in viewing medical power as solely coercive and confining, despite Foucault's own insistence on the productive rather than the repressive nature of power. As a result, there has been little scholarship undertaken on the ways that power is mediated through social categories such as race, gender, class, or by occupational or institutional constraints (Nye, 2003, 120).

Smirnova's (2012) recent content and discourse analysis of DTCA in relation to the "cosmeceutical industry" provides a useful case study to highlight Lupton and Nye's critiques. Smirnova's overview of the multiple intersecting literatures through which gender norms and ideals come to play in female aesthetics is extensive and the empirical data of the study (124 advertisements) are substantial. Her argument—that the ways that the body can be reshaped and remade to reach a closer approximation of the Western ideal through the cultural representation advertisements provide—illuminates the ways that advertisements have "changed the structure of the 'truth' about age, gender, race and sexuality" (Smirnova, 2012, 1239–42). However, though she invokes Foucault's theory of "the gaze" in which women learn who they should be, there is no substantive explanation of how this gaze works, how it affects the individual, or how the medical gaze becomes internalized through advertising. By failing to do so, her analysis ends up reaffirming the monolithic, dominating effects of advertising on the agentless bodies that absorb and abide by this propaganda. As a result, we can come to see "the gaze" as fundamentally inadequate for fully addressing medicalization in our consumer-based technological society.

Despite its limitations, we can still draw on Smirnova's work as an impetus to broaden our understanding of medicalization in four important ways: (1) the fact that it is not advertising alone which needs to be addressed, since we cannot just look at medical ads or products alone (as in Smirnova), or limit our scope to medical practitioners alone (as in both Davis and Conrad); rather, we must take into account the myriad of agents and institutions that circulate medical knowledge. These include: pharmaceutical companies, medical regulators, drug regulators, advocacy groups, advertising agencies, media companies, biotech firms, etc. (2) Since DTCA is a relatively recent phenomenon, having only been in effect since 1997, scholars are still grappling with how best to understand it. Also, though "the gaze" may be a constitutive factor in forming our subjectivity, by itself, it is no longer a viable

theoretical paradigm in terms of the expansive rise of pharmaceuticals and the reality of how we engage in medical knowledge in everyday life. Finally, understanding how DTCA illustrates the ways in which larger systems of power, including not only medical power, exert effects at both the individual and collective levels of society necessitates further engagement with the work of Foucault.

#### IV. TURNING TO THE CARCERAL ARCHIPELAGO

In order to best understand medicalization in contemporary society, we must not conceptualize this as a monolithic, static system or a preestablished set of relations, but instead holistically as a diffused set of crisscrossing matrix of social relations in which we, as human beings, are both “disciplined” and “subjectivated.” Therefore, we must move beyond theorizing medicalization in terms of the gaze towards the carceral archipelago, a more fruitful and generative metaphor. In order to understand that move, this section begins with panopticism to show how the individual internalizes the medical gaze in the process of the constitution of the self, through which norms and regulations are deployed against individuals. In addition, I address Foucault’s concepts of normal/abnormal to draw out how the medical gaze judges the normality of individuals. This section suggests Foucault’s notion of the carceral archipelago as a way of theorizing power and then turns to extend this to medicine and DTCA as an important source of medicalization today.

##### Panopticism, Internalization, and Regulation

In moving from the medical gaze to the carceral archipelago, a brief overview of the ways Foucault theorized relations of power is needed. Foucault drew on the metaphor of the panopticon, a prison proposed by Jeremy Bentham, the utilitarian philosopher, as an image of modern society. In the panopticon, the prisoners are locked in individual cells, arranged in tiers of a circular structure, which is observed from a central vantage point. The prisoners can be seen at all times by the guards and the knowledge of their visibility eventually induces them to monitor and regulate their own actions. As the gaze of surveillance is turned upon oneself, self-scrutiny becomes the most pervasive and effective form of social control. Foucault conceptualized the panopticon as a template for all forms of social control in modern society; for Foucault, society was increasingly becoming a carceral system. Modern social life is a world in which surveillance, self-surveillance, and social regulation are diffused throughout all institutions of society. As a result, power in the modern era must be considered a “physics of power represented by panopticism . . . which has its maximum intensity not in the person of the king, but in the bodies that can be individualized by these relations” (Foucault, 1977, 208). For Foucault, the body is the locus where the



minutest social practices link up, intertwine, and connect to larger organizations of power, as power circulates through “the whole social body down to its smallest particles” (Foucault, 1980a, 156). Foucault’s notion of panopticism highlights the systematic ordering, controlling, recording, differentiating, and comparing of an entire society through both visible and invisible forces. These forces are deployed to control, modify, torture, mark, and train bodies to perform, carry out tasks, and behave in particular ways without the need for overt coercive measures (Foucault, 1977, 25–6). For Foucault, power is pervasive and polyvalent throughout society:

it serves to reform prisoners, but also to treat patients, to instruct schoolchildren, to confine the insane, to supervise workers, to put beggars and idlers to work. It is a type of location of bodies in space, of distribution of individuals in relation to one another, of hierarchical organization, of disposition of centres and channels of power, of definition of the instruments and modes of intervention of power, which can be implemented in hospitals, workshops, schools, prisons. Whenever one is dealing with a multiplicity of individuals on whom a task or a particular form of behaviour must be imposed, the panoptic schema may be used. (Foucault, 1977, 206)

Panopticism provides a framework to theorize the ways that a constant surveillance over all areas of life by which all individuals are made visible, their conduct shaped, and their behavior determined. Through panopticism, society is spatially organized and temporally ordered; social groups and individuals are categorized and classified and understood. For Foucault, the surveilling gaze of society is internalized into individuals and constitutes them through power relations. As Foucault argues:

the individual is carefully fabricated in it, according to a whole technique of forces and bodies. We are much less Greeks than we believe. We are neither in the amphitheater, nor on the stage, but in the panoptic machine, invested by its effects of power, which we bring to ourselves since we are part of its mechanism. (Foucault, 1977, 217)

Power here operates like the sociological term “socialization” in that “the individual, with his identity and characteristics, is the product of a relation of power exercised over bodies, multiplicities, movements, desires, forces” (Foucault, 1980b, 74). The workings of power are articulated on and through bodies—inscribed on them—where dispositions, attitudes, orientations, and understandings of the world are variously cultivated. Foucault writes:

He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection. (Foucault, 1977, 202–3)

Here, “the gaze which is inscribed in the very structure of the disciplinary institution is internalized by the inmate,” transforming the individual into

a “self policing subject, a self committed to a relentless self-surveillance” (Bartky, 1990, 80).<sup>1</sup> As a result, we can see the distinction between panopticism and the gaze as individuals enmeshed in power relations become self-disciplining and self-regulating without need for the constant surveillance and intervention of authorities in every aspect of their lives.

The effect of power relations is the way in which norms, rules, laws, and regulations are deployed against people. People are constantly being critiqued and evaluated in all aspects of life.

The judges of normality are present everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the “social-worker”-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behaviors, his aptitudes, his achievements. The carceral network, in its compact or disseminated forms, with its system of insertion, distribution, surveillance, observation, has been the greatest support, in modern society, of the normalizing power. (Foucault, 1977, 304)

Power operates on the body as a form of social regulation. Although power may be coercive in terms of discipline and punishment, it is more often than not regulatory and order maintaining in terms of norms, codes, and rules through which the social organization is produced and reproduced. This “normalizing gaze” is constantly operating, whether by others or one’s own self-normalization, in a never-ending evaluation of one’s conformity.

### The Carceral Archipelago

In turning to the carceral archipelago metaphor, it should be noted that this concept is not tied to the academic practice of geography, nor to the ways in which Foucault’s own historiographic methods (archaeology and genealogy) relate to geographic methods. Highlighting the metaphor here provides a concrete example to theorize how power is constantly circulating, not as an all-seeing eye or unified field of vision imposing itself, but through a multiplicity of sites and conduits in the constantly changing field of forces of social life (cultural, social, political, economic). These forces are simultaneously individualizing and totalizing in the production of both a medicalized population and individuated medicalized subjectivity. By moving past the gaze to the archipelago, we can develop our theoretical apparatus as fluid and mobile and, therefore, better understand how medicalization is embedded in and constitutive of contemporary social relations.

In an interview, while discussing the relationship between geography and power, Foucault emphasized a particular geographical point:

There is only one notion here that is truly geographical, that of an *archipelago*. I used it only once, and that was to designate, via the title of Solzhenitsyn’s work, the carceral archipelago: the way in which a form of punitive system is physically dispersed yet at the same time covers the entirety of a society. (Foucault, 1980b, 68)

This reference to the “carceral archipelago” (and the geographical description of a cluster of islands to which it refers) is used by Foucault as a metaphor for how power relations operate in modern societies as simultaneously multiple and dispersed and yet form a complex system.<sup>2</sup> While having connotations to the criminal justice system, Foucault’s concern is geographical, as is clarified in the interview “Questions of Geography,” where he specifies its use to avoid the reductionism of other geographical metaphors (territory as reduced to juridico-political, field as economic-juridico, and domain as juridico-political; [Foucault, 1980b](#), 68).

Following Foucault’s metaphor for its geographical usefulness, one can conceptualize the carceral archipelago as the way that the body is always ensnared in a plurality of social relations, which are constantly surveilling, observing, conditioning, regulating, and normalizing it within the workings of everyday life. In addition, the carceral archipelago provides an ideal visual image through which to conceptualize the ways that “power relations” operate for Foucault, in that it highlights the decentralized multiplicity of forms and dynamics of power ([Foucault, 1982](#), 779). By being both dispersed and running through the entirety of a society, power relations are not a merely unidirectional “gaze”; rather, they are the intersecting and crisscrossing lines of socialization within which we are embedded. In drawing out these aspects of power, we can turn to extend its usefulness to the ways medicalization (medical advertising/knowledge) operates and circulates in society unpredictably, as well as how we experience and incorporate medicalization in a consumer-oriented, technological society (through technologies of the self).

In the conclusion to the interview “Questions on Geography,” Foucault provides further insight into the ways that geography factors into the way he conceptualizes power:

Geography acted as the support, the condition of possibility for the passage between a series of factors I tried to relate. Where geography itself was concerned, I either left the question hanging or established a series of arbitrary connections. The longer I continue, the more it seems to me that the formation of discourses and the genealogy of knowledge need to be analyzed, not in terms of types of consciousness, modes of perception and forms of ideology, but in terms of tactics and strategies of power. Tactics and strategies deployed through implantations, distributions, demarcations, control of territories and organizations of domains which could well make up a sort of geopolitics where my preoccupations would link up with your methods. ([Foucault, 1980b](#), 77)

For Foucault, power is not reducible to the State, nor any one authority, set of laws, or centralized institution. Power is not restricted to political institutions nor is it reducible to them, where one class can dominate over another, or where power is simply the reproduction of the relations of production. Therefore, power cannot be understood as a false-consciousness produced by ideology or propaganda; rather, power is constitutive of all social relations,

norms, and practices, working on the dominant as well as the dominated. Like an archipelago, power operates through a plurality of positions, from the top-down, in both institutions and authorities, as well as from the bottom-up and laterally, because individuals themselves serve as vehicles for the transmission of power. By viewing power as multi-dimensional, power is not something one has or wields over others, as if power were a position or an object, because those who exercise power are just as much as those over whom power is exercised and, therefore, power circulates in a web of relations in which we are all enmeshed (Foucault, 1980a, 156).

Finally, in focusing on the cartographic aspect of the archipelago, we can understand what Foucault means when he differentiates power from a uniform or totalizing process such as rationalization:

It may be wise not to take as a whole the rationalization of society or of culture but to analyze such a process in several fields, each with reference to a fundamental experience: madness, illness, death, crime, sexuality, and so forth. I think that the word “rationalization” is dangerous. What we have to do is analyze specific rationalities rather than always invoke the progress of rationalization in general. (Foucault, 1982, 779–80)

The archipelago of power provides a way of mapping out the diverse and intersecting dynamics of socialization, which form their own internal logic of organization. The archipelago functions as a field of forces circulating through the state, the law, and other hegemonies, forming an interrelated system of relations in which all discourses, practices, and institutions crystallize. As a result, we can view DTCA not as a monolithic social formation that imposes itself uniformly on consumers in terms of the gaze, but can conceptualize the ways in which DTCA forms a plurality of points of view and perspectives that overlap and reinforce each other. As such, we can see how DTCA forms a mechanism of socialization that is consistent with Foucault’s notion that power “circulates” as it works in, on, and through bodies.

#### From the Archipelago to DTCA

Theorizing DTCA through the medical gaze, as Smirnova did for beauty ideals, simply reifies medicalization, rather than drawing out the dynamics through which medicalization circulates. Medical knowledge is no longer only dispensed by physicians, but is disseminated through a myriad of mediums: magazines, TV, internet, billboards, popular culture, as well as through social relations of family, friends, co-workers, and others. The medical gaze is no longer appropriate for understanding our medical culture today because it ignores the way that we experience medical knowledge in our consumer-oriented, technology-driven society. Rather than assuming that all people are shaped the same way through the imposition of the medical gaze, we must focus on the individual as an active discerning subject

who finds different types of utility in DTCA and the different behaviors that the practice encourages. Individuals may seek medical care/contact a physician, may establish dialogue with healthcare providers, which in turn may reduce underdiagnosis, undertreatment, and underreporting of conditions and illness, as well as remove the stigma associated with certain conditions, or they may seek out further information on their own or even self-evaluate to raise health awareness (Bell, Kravitz, and Wilkes, 1999). No longer relying on the medical gaze, we must turn to an alternative model, extending the carceral archipelago metaphor to a medical archipelago, in order to conceptualize the dynamism of medicalization in society today. Through the medical archipelago, we can theorize DTCA as a series of nodes and conduits, both as points where medicalization is crystalized and as vehicles through which medicalization flows, as it socializes us into the way in which we understand ourselves and the world around us. The medical archipelago provides an analytical framework to analyze multiple spheres (both micro and macro applications) of medicalization simultaneously. DTCA in isolation is just one island among others. We can analyze an individual caught in a series of advertisements. In addition, we can consider an individual within the nexus of institutions and media outlets that promote DTCA, or physicians, medical practitioners, and clinics and hospitals that would constitute another archipelago.

#### Foucault, the Historical Development of Medicine, and Medicalization

Extending the metaphor of the “medical archipelago” to DTCA provides a way to theorize how advertisements serve as nodes and conduits in the constantly circulating field of forces of social life (cultural, social, political, economic), which simultaneously individualize and totalize the population as medicalized subjects. Just as individuals are socialized through institutions and other individuals, they are also socialized through forms of media such as DTCA. Although DTCA is but one segment of this saturation of the social landscape, it has become the primary way individuals receive medical information (Frosch et al., 2011). By conceptualizing the crisscrossing field of advertisements as constitutive of a medical archipelago, whereby bodies become complicit in this social order as fully functioning participants in the normative order of everyday life, we can further our understanding of how medicalization is embedded in and constitutive of social relations. In this connection, in his 1974 lecture, “The Birth of Social Medicine,” Foucault clarified his own investment in medicalization and described it as follows:

Medicalization—that is, the fact that starting in the eighteenth century human existence, human behavior, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape. (Foucault, 2001, 135)

Foucault's concern with medicalization is a thread that runs throughout a number of his writings. This concern is intertwined with "Biohistory—that is, the effect of medical intervention at the biological level" and the "economy of health—that is, the integration and improvement of health, health services, and health consumption in the economic development of privileged societies" as three distinct historical developments that emerged. Although distinct in their contextual emergence, these developments converged in different ways to form modern social medicine (Foucault, 2001, 135).

Extending the medical archipelago to DTCA, as a major conduit through which power relations flow, can be seen in relation to Foucault's (1980c) essay "The Politics of Health in the Eighteenth Century." Here, Foucault argues that the development of the medical market in the form of private practice, the expansion of medical professions, the growing demand for health care, and individual examination and treatment emerged concomitantly, forging the "great medical edifice of the nineteenth century" (Foucault, 1980c, 166). However, as Foucault is careful to point out, these developments in the areas of health and medicine were tethered to considerations of disease as a political and economic problem for social collectivities. As a result, new rules, practices, and analyses emerged simultaneously as "the age is entered not so much of social medicine as of a considered *noso-politics*" (Foucault, 1980c, 167). Through his emphasis on "*noso-politics*"—the establishment of disease classifications and treatment protocols (in reference to a new regime of social sanitation)—Foucault articulates a number of important points that serve as a springboard for developing his thought today. First, Foucault emphasizes the emergence of markets for medical services, the innovation of new medical technologies, the professionalization of medical experts, and the intertwined notion of the development of medicine with political and economic considerations. Second, Foucault emphasizes the multiplicity of sites in the social body of health and disease; rather than being a top-down initiative, it "figures as a problem with a number of different origins and orientations, being the problem of the health of all as a priority for all, the state of health of a population as a general objective of policy" (Foucault, 1980c, 168). By taking these foundations of medical development as being multi-faceted, as having multiple origins and orientations, and coming from a multitude of sites—as multiple, dispersed, and having no center—Foucault theorizes an archipelago of power relations. In linking this conceptualization of multiple nodes of power to a *noso-politics* of medical classifications and treatments, DTCA can be understood as a natural extension of creating and responding to new medical markets.

However, in order to draw out the full import of Foucault's ideas, it is necessary to revisit some critiques of the medicalization thesis. Although these critiques are not of Foucault, understanding these critiques will better enable us to see why Foucault's work provides such a powerful addition to our theoretical framework. Scholars such as Davis (2006) have criticized the

medicalization thesis as having become analytically empty by encompassing everything:

The concept of medicalization has become a complete muddle. It once referred to a specific social process—the expansion of the jurisdiction of the medical profession that followed from the successful redefinition of forms of deviance, natural life processes, and problems of living as illnesses requiring medical intervention. Medicalization by this definition was similar to other terms about institutional categories and jurisdiction, such as criminalization. But, theorists decoupled medicalization from the institution of medicine some years ago in an effort, apparently, to give the concept greater generalizability. Now medicalization refers to any definition or description of a problem in “medical” terms or its treatment by a “medical” intervention—no matter who is doing the defining or intervening or how idiosyncratic or analogical their use of the language. This medicalization without medicine is wrongheaded and untenable. (Davis, 2006, 51)

For Davis, the issue of what is defined through medicalization has been decoupled from and is “no longer limited to those defined and used by the medical profession.” As a result, he concludes that, “outside the sphere of medicine, we have no way to determine what constitutes a ‘medical’ term or framework.” For Davis, only by restoring “medical jurisdiction” can the definition of medicalization have legitimacy. Without such authority, “[u]sing a medicalization framework . . . is likely to hinder rather than help us make sense of this language because it will direct our attention to the wrong phenomenon” (e.g., pharmaceutical manufacturers, biotechnology companies, patient advocacy groups, and consumers). Therefore, for Davis, though “undeniably important in the ongoing social transformation of medicine” which “changes the subject,” a generalized medicalization diverts attention away from the correct focus on the medical profession. In short, Davis surmises that “restoring medical jurisdiction would sharpen the thesis by concentrating attention on the right institution,” whereby adjudication can be correctly made—“some troubles are the doctor’s business and some . . . are not” (Davis, 2006, 54–56). In drawing on DTCA, Davis’s full critique of medicalization becomes clear:

For example, recent critiques of the overselling of prescription medications (conceived as increased medicalization under the broad definition) focus on the aggressive advertising of the pharmaceutical companies. What they miss or badly underemphasize is that none of this overselling would be possible without physician support and acquiescence. The action or inaction of the profession, including its collusion with industry, needs to be the target of critical analysis. Otherwise, we end up, as in this case, with a vacuous criticism of Big Pharma for marketing its products so cleverly and, implicitly, an elitist criticism of people for being such nitwits to fall for it. (Davis, 2006, 56)

The argument that none of this would occur without physicians is clear. However, Davis’s argument about “the target of critical analysis” is where the entire project collapses. Simply putting the physicians of “the profession”

on trial for their guilt or innocence in collaborating with the pharmaceutical industry is not only reductionist, it fuels the misguided notion that medicalization is simply and straightforwardly a “medical” issue and distorts the positions of those who have tried to advance the medicalization thesis.

Sociologists such as Conrad document how the expansion of medicalization has come through social forces both inside and outside of medicine. By doing so, he highlights the role of medical norms in shaping social norms in terms of what is “normal, expected and acceptable in society,” as well as the focus on the ways that “the clinical gaze or the clinical medical model focuses on the individual rather than the social context” (Conrad, 2007, 152). As a result, Conrad concludes that:

In a culture in which health has become a high-value asset, it should not be surprising that life problems have become medical pathologies. One of the ironies of our culture is that no matter how much health is improved (as evidenced by decreased mortality rates, increased life expectancy, and improved health care), the reporting of health problems continues to rise. (Conrad, 2007, 149)

By bringing back in the notions of the social and cultural into his overall analysis of medicalization, medical sociologists such as Conrad appropriately raise, but do not fully develop, their own positions. Turning to Foucault again, we can see Conrad’s insight into the “inside and outside of medicine” come to its full realization:

Actually, one must not think that medicine up until now has remained an individual or contractual type of activity that takes place between patient and doctor, and which has only recently taken social tasks on board. On the contrary, I shall try to demonstrate that medicine has been a social activity since the eighteenth century. In a certain sense, “social medicine” does not exist because all medicine is already social. Medicine has always been a social practice. What does not exist is non-social medicine, clinical individualizing medicine, medicine of the singular relation. All this is a myth that defended and justified a certain form of social practice of medicine: private professional practice. Thus, if in reality medicine is social, at least since its great rise in the eighteenth century, the present crisis is not really new, and its historical roots must be sought in the social practice of medicine. (Foucault, 2004, 8)

For Foucault (2004), as argued in his essay “The Crisis of Medicine or Anti-Medicine,” medicine is inherently social, political, and constituted in power relations. To conceptualize it as individualistic or in terms of doctor–patient relationships misses the crucial social contexts within which the field of medicine exists. Just as Foucault documented the medical gaze as something that emerged out of particular historical conditions, coupled with the new regime of medical authority, which provided it with justification, medicine itself must always be understood within the social contexts that make it possible. Without doing so, we tautologize medicine and the physicians as being the discipline of knowledge under the purview of medical professionals.



Furthermore, we mistakenly theorize medicine as objective, neutral, and without investment in securing its own authority and legitimation.

This concern with medical authority and its power to control and define the health of an individual is a subject that Foucault dealt with extensively. In Foucault's *Abnormal* lectures, he discusses the ways that the "abnormal" individual arises within the contemporary medical-legal system through the ever-expanding power of normalization and how those forms of abnormality become the inexhaustible arena of medical inquiry (Foucault, 2003, 26).<sup>3</sup> He would go on to develop this division between normality/abnormality in *Discipline and Punish*:

The constant division between the normal and the abnormal, to which every individual is subjected, brings us back to our own time, by applying the binary branding and exile of the leper to quite different objects; the existence of a whole set of techniques and institutions for measuring, supervising and correcting the abnormal brings into play the disciplinary mechanisms to which the fear of the plague gave rise. All the mechanisms of power which, even today, are disposed around the abnormal individual, to brand him and to alter him, are composed of those two forms from which they distantly derive. (Foucault, 1977, 199–200)

As the disciplinary and normalizing techniques that go into correcting the abnormal permeate society, everyone is constantly evaluated and becomes self-evaluating. In the case of health, one then has to ask, "what is a normal health?" Through DTCA, health is depicted as precarious and able to be improved through the latest fashionable drugs. As we become more and more scrutinizing of ourselves for conditions and maladies that may make us "abnormal" and desirous for the proper pills to correct for that, we become more and more complicit in a system that constitutes medicalized subjectivity. By drawing on Foucault, we can call the apparently self-evidently progressive development of medicine that DTCA portrays into question. As a result, Foucault's concepts of normal/abnormal can be explored to draw out how, in addition to health, the medical gaze also judges the normality of individuals.

Extending Foucault's concepts to the analysis of medicalization supplements sociological studies of medical trends by making sense of the "social" and "cultural" fields within which they unfold. This approach is not meant to be a definitive analysis of medicalization; rather, it provides a way into asking questions and conceptualizing aspects of those social processes. Exploring the forces and agents shaping the medicalization of social life—from biotechnology, to physicians, to consumers, to insurers, to developments in technology and treatment, to the expansion of markets, and the desire for medical products—deepens our understanding of medicalization, rather than obscures it. For Foucault, the examination of the history of medicine provides a way of acquiring better knowledge of how medicine developed and, by doing so, understanding the ways of changing it. As he argued:

medicine should not be rejected or adopted as such; . . . medicine forms part of an historical system. It is not a pure science, but is part of an economic system and of a system of power. It is necessary to determine what the links are between medicine, economics, power and society in order to see to what extent the model might be rectified or applied. (Foucault, 2004, 19)

By bringing to light the fact that medicine is a product of society and not something that stands independent of it, we must necessarily confront the ways that medicine always intersects with economics, power, and social life, elements that are always constitutive of one another. By doing so, Foucault opens up a way to approach problems of health and illness as contextually situated dynamics that can never be separated from the larger social–structural dynamics which give rise to them.

In the archipelago, in the context of social life, the nexus of relations of power operate on, in, and through both individuals and the collective, because it is both individuating and totalizing. Each individual is analyzing himself and others, as others do the same in an endless circulation of evaluations. For Foucault, there is no primary or fundamental principle of power which defines all aspects of society, but because of the never-ending scrutinizing of self and others:

taking as point of departure the possibility of action upon the action of others (which is coextensive with every social relationship), multiple forms of individual disparity, of objectives, of the given application of power over ourselves or others, of, in varying degrees, partial or universal institutionalization, of more or less deliberate organization, one can define different forms of power. (Foucault, 1982, 793)

Extending this to medicalization and DTCA, we can see advertisements forming a network of interconnected signs, symbols, and points of socialization. They configure their own constellation of power relations—each contributes to the whole and the whole is reflected in each specific instance as a conduit for medicalization. In this way, not one advertisement must have an “effect,” nor must one be critically conscious of all the ads he encounters—because some DTCA (as nodes and conduits) affect different individuals differently at different times, while still operating within an internally consistent expanding logic of medicalization. To further elaborate the archipelago of power relations, a return to DTCA as a hall of mirrors may be appropriate to capture the never-ending barrage of images within which one is caught, where one is always in the interstices of a multiplicity of crisscrossing images. DTCA is not detached from, but rather embedded in, the social relations that go to make up everyday life. As [Brownlee \(2007\)](#) documents, DTCA has become “so ubiquitous you cannot walk past more than a few feet of airport hallway, watch network television for more than a few minutes or turn more than a few pages of a magazine without seeing an ad.” As a result, she concludes that advertising is becoming increasingly specialized and sophisticated in discovering ways to get “consumers to think of drugs as

the solution to a wider and wider array of ailments” (Brownlee, 2007, 186). Complementing Brownlee’s findings, a recent study published in the *Annals of Family Medicine* under the title “Creating Demand for Prescription Drugs” determined that Americans watch 16 h a year of televised pharmaceutical ads, whereas Nielsen now estimates that on any given day, on average 80 DTCA air per hour (Frosch et al., 2007). Although DTCA serves as the primary focus here, it is noteworthy to consider how these advertisements themselves fit into an even greater array of advertisements for hospitals, healthcare organizations, care centers, clinics, physical therapy institutes and outpatient clinics, doctors, freestanding diagnostic centers, and academic medical centers, all of which advertise treatments and services that can solve health problems. Moreover, disease-awareness campaigns have become a special form of advertising. Where once they were public service announcements, now they involve paid advertising; where “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” (Welch, Schwartz, and Woloshin, 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 through 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 Brownlee to conclude:

perhaps what’s most important about drug advertising is how sophisticated it has become, how each part of a marketing campaign fits neatly together with the others to mold the way we think not only about a drug but also about what it means to be healthy. (Brownlee, 2007, 187)

The effect is a molding of our dispositions and orientations toward pharmaceuticals, not just in terms of the drugs themselves, but about health and illness in general. From this general predisposition, comes a variety of ways that people now think in terms of “simplified check lists” that incite people to go to their physicians for symptoms that they previously had not recognized or thought could be treated. This has led to “medical care by advertisement instead of medical care by doctors and nurses.” Furthermore, this nexus of advertisements has induced an “enthusiasm for diagnosis” where Americans have been “trained to be concerned about their health,” as possible conditions or abnormalities may exist that should be discovered and treated (Dumit, 2012, 10). This has led some to consider 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.

Theorizing DTCA as an archipelago of power relations furthers our understanding of how medicalized subjectivity is cultivated within more generalized medicalized social relations. By thinking in terms of power relations, we can see how DTCA serves as a mirror to the individual who self-evaluates and self-analyzes her individual body in terms of the definitions of health and illness that DTCA outlets project. Although DTCA does not determine subjectivity, it serves to inculcate and refract the power of medicalization onto individuals, as well as expand how we understand ourselves as normal/abnormal objects of analysis for medical diagnoses and medical treatments. In this way, DTCA is understood in its multiple social-media outlets which interconnect and reinforce the medicalization of social life. This simultaneously totalizes us as a medicalized population and individuates us as medicalized subjects.

## V. ENTER THE TECHNOLOGIES OF THE SELF

With the shift to the concept of the archipelago, we can further develop our theorizing of medicalization in our consumer-oriented society by turning to Foucault's "technologies of the self" to open up possibilities for resisting the processes of discipline and subjectification circulating through medicalization and DTCA. Drawing this out affords us the opportunity to forge new health/medical subjectivities and self-understandings and establish new modes of social relations, out of which we form ourselves and the world around us. By turning to this conceptualization of "the way in which the subject constitutes himself in an active fashion, by the practices of the self," we can see that consumers have agency in terms of what they consume even in conditions not of their own design (Foucault, 1997, 291). Although the technologies of the self allow one to actively construct oneself, they are not freely chosen. These practices of the self are "not something invented by the individual himself. They are models that he finds in his culture" (Foucault, 1997, 291). By theorizing medicalized subjectivity in this way, we see that it is not an automatic or direct process. Rather, we can examine the synergistic way that medicalization circulates and the multiple possibilities of self-constitution in relation to it that are opened up through this theoretical intervention.

It is not just medical producers, institutions, and regulators that dictate from above (the gaze) what people should be and what they should understand. Today individuals have developed an intimate awareness of their own health conditions and developed expectations about possibilities of treatments. In doing so, they have become active participants in assessing the risks and benefits of medical procedures and products (Aikin, Swasy,

and Braman, 2004). This new understanding has led to a self-monitoring and self-diagnosing of conditions and symptoms that could easily be used to characterize a gamut of everyday emotions and symptoms. As Rose (2003) has pointed out, this can take place across a gamut of human experiences: worries as anxiety, sadness as depression, inattentiveness as ADHD, or emotional lability as premenstrual dysphoric disorder, all which turn us into “neurochemical selves” (Rose, 2003). As Williams et al. (2009) have documented, people viewing “sleepiness as narcolepsy” is just one of the several conditions that confronts them in terms of their pharmaceutical “lifestyle” or as a “pharmaceutical person” (Martin, 2006). Other scholars have defined this development in terms of the “pharmaceutical self” (Dumit, 2003, 2004), the “neurochemical self” (Rose, 2006, 22) or the “psychopharmaceutical self” (Jenkins, 2011). With the growing intensification of medicalization, and the ever-expanding private health-insurance industry, individuals are forced to become more and more obligated to monitor and manage their own health as “every citizen must now become an active partner in the drive for health, accepting their responsibility for securing their own well-being,” as people become more and more willing to reshape themselves and embody new definitions of health and wellness (fitness, prenatal screening, dietary restrictions, medications, etc.; Rose, 2001, 6). In medicalizing these conditions, health and illness become ontological concerns and the body becomes the empirical focal point of these concerns. In thinking about the medical archipelago as a field of constantly circulating gazes, upon oneself and upon others in terms of health and illness, in terms of normality and abnormality, we must simultaneously think about the technologies of the self that may alter those conditions, since we are now concerned with “the politics of life itself” (Rose, 2001).

In doing so, we must ask a series of questions. While we are socialized into and formed by the world, how can we alter ourselves and our surroundings? How does our constitution become an issue for ourselves? How does this process become political in that medicalization is called into question by that constituted self? How can the politics of our “self” and the politics of our “health” become co-constitutive issues? In order to answer these questions, we turn to Foucault’s (1988) “Technologies of the Self.” Here, Foucault argues that his objective has been to sketch out a history of the different ways that humans develop knowledge about themselves (economics, biology, psychiatry, medicine, etc.) and analyze these sciences as related to specific techniques that human beings use to understand themselves (Foucault, 1988, 17–18). Foucault argues:

As a context, we must understand that there are four major types of these “technologies,” each a matrix of practical reason: (1) technologies of production, which permit us to produce, transform, or manipulate things; (2) technologies of sign systems, which permit us to use signs, meanings, symbols, or signification; (3) technologies

of power, which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject; (4) technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality. (Foucault, 1988, 18)

Foucault goes on to argue that these four technologies rarely function separately, and each one of them is associated with a certain type of domination (certain modes of training and modification of individuals, of acquiring certain skills and attitudes). Foucault argues that he has insisted too much on the technology of domination and power in the past and is now more interested in pursuing the technologies of individual domination or how the individual acts upon himself (Foucault, 1988, 19). For Foucault, these “technologies of the self” provide crucial insight into understanding how we come to be specific types of subjects in specific historical periods. Foucault elaborates this project more explicitly in his essay “Subjectivity and Truth”:

The guiding thread that seems the most useful for this inquiry is constituted by what one might call the “techniques of the self,” which is to say, the procedures, which no doubt exist in every civilization; suggested or prescribed to individuals in order to determine their identity, maintain it, or transform it in terms of a certain number of ends, through relations of self-mastery or self-knowledge. In short, it is a matter of placing the imperative to “know oneself”—which to us appears so characteristic of our civilization—back in the much broader interrogation that serves as its explicit or implicit context: What should one do with oneself? What work should be carried out on the self? How should one “govern oneself” by performing actions in which one is oneself the objective of those actions, the domain in which they are brought to bear, the instrument they employ, and the subject that acts? (Foucault, 1997, 87)

For Foucault, the self is never predetermined or natural; rather, it is always political in that it is constituted by power relations, by the technologies built into our history. The capacity for self-transformation, of operating on one’s own body, and the ability to critically reflect on oneself and the power-knowledge relations that have constituted one’s subjectivity are paramount for Foucault. As Bishop has argued, we find that:

the self either accepts or resists the power structures into which she is thrown, and it is this self-creating that defines authentic subjectivity for Foucault. It is here between the lightness and heaviness of being that Foucault tries to carve out a space of freedom for self-creation, the freedom of becoming. Yet, those spaces of freedom are only carved out of the forces that shape and mold the uses of the body and the forces that shape and mold psyches. That is to say, those forces, those powers, are not merely social or political powers instantiated in the state but also the powers that shape the forms of life itself, such as medicine, psychiatry, and other of the human sciences. (Bishop, 2008, 339)

For Foucault, the self is doubly a product of power relations in that it is both a product of those relations and simultaneously self-determining on the basis of those very relations. It is this aspect of Foucault's thought, having moved past the medical gaze, where we can highlight the active self, engaged in practices of the self that promote well-being, health, and "the politics of life itself" (Rose, 2001, 2006). Following Bishop, we can see how Foucault's project traverses back and forth in terms of concerns for subjects (and objects) and the prior conditions of possibility within which those subjects (and objects) are constituted, creating a space for self-constitution, somewhere between the determining and determined subject (Bishop, 2009b, 337). By drawing on Foucault's Technologies of the self, we can approach the issue of medicalization in terms of subjectivity, as interconnected to the ways in which we are semi-autonomous subjects with purposiveness and agency.<sup>4</sup>

This approach offers an alternative way of theorizing medicalization and subjectivity because it opens up a way to consider our current conditions of susceptibility and preconditions, our capacity for self-determination, and our potential for enhancement, as well as the very notion of self-determination. As we can see, via Foucault's conceptualization, each individual acts on his/her own body and conduct, in order to modify and enhance the self (in a positive way). There is no one course of action nor prescription that all must follow. Although the studies cited here show how individuals take up a diverse set of dispositions towards medicalization and DTCA, the differences of these positions obscure the underlying unity in their plurality. Although different in orientation, all these positions are grounded in how one forges oneself as a subject in relation to medicalization/pharmaceuticalization/DTCA. It is this issue of subjectivity and the ways one fashions oneself as a subject out of these medical conditions, that Foucault's technologies of the self help us to theorize.

By turning to Foucault's technologies of the self, we can see how this conceptualization provides a way of systematizing a number of studies that have explored issues around DTCA such as the different types of "identities," "positions," and "dispositions" that one takes in relation to medical information and medical consumption. Sulik and Eich-Krohm argue that:

American society has created a health care market where people see themselves first as consumers, and then as patients. The qualities of the medical consumer now function as a common sense way of dealing with health and illness. Focusing on *personal responsibility*, *proactive and prevention-conscious behavior*, *rationality*, and *choice*, the medical consumer role suggests an active orientation to health decisions and services. (Sulik and Eich-Krohm, 2008, 22)

However empowering this may appear, their three main findings suggest a much less optimistic state of affairs. First, they argue that the "medical consumer" is an individualized role, who bears all responsibility for gathering information, making decisions based on that information, and accountability

for the outcomes. Second, they find that as medical information proliferates, people are left on their own to evaluate and put it into practice. In this case, issues of interpretation, competency, and expertise, as well as type and quality of information, were all thrown into relief. Third, the individualized focus of the medical consumer making informed consent for procedures and treatments absolves the system of health and medicine from responsibility as we develop “technoscientific illness identities” (Sulik, 2011).

Similarly, Henwood et al.’s (2003) study explores the factors facilitating or inhibiting the emergence of the “informed patient” and its sociological equivalent, the “reflexive patient” or “reflexive consumer.” In doing so, they document the tension between the emphases on the availability of information for lay people and how that conflicts with expert-medical knowledge in the clinical encounter. Along similar lines, Fox and Ward (2009, 51) examine a range of “health identities” from the “expert patient” who adopts the dominant model of health and illness, to the “resisting consumer,” as an alternative model of health. In addition, Fox, Ward, and O’Rourke’s (2005) study of the “expert patient” draws on Foucault’s “technology of the self” as a form of self-governance, integrating itself into the dominant biomedical discourses; their alternative to Foucault in the “informed patient” resists the biomedical formulation of health through developing empowering “communities of expertise.” This consideration of biomedicalization resonates with the works of Clarke et al. (2010), which highlight how the medical gaze has shifted from the medical professional to the “patient-consumer-user” to reveal more complex and dispersed locations of agency and empowerment, as well as confusion and docility at the level of everydayness. Finally, Andreassen and Trondsen (2010) take a less optimistic view of the “empowered patient,” in considering the ways that the actual outcome of health promotion strategies that aim to empower patients might, instead, expand the medical gaze into individuals’ daily life, disempowering them, or leading to greater medicalization.

The issue of connecting patients/consumers to communities of expertise and the notion of resistance to medicalization has been a long-standing concern. Echoing Foucault’s archipelago metaphor, Conrad’s summation of resistance in relation to medicalization is quite telling:

What does this review of resistance tell us? In the sea of medicalization, there are some islands of resistance. The most successful examples of resistance, such as homosexuality and disability, politicize the issue and make it part of the agenda of a social movement . . . Some individuals resist medicalization of their own problems and have the resolve to seek alternative strategies for managing life difficulties . . . although medicalization is not destined, it is a ubiquitous and powerful force in defining human problems. (Conrad, 2007, 161)

Although Conrad points to historical examples that he considers success stories, he hedges the notion of resistance to medicalization, given its ubiquity



and power. However, more and more subject positions have emerged, where different individuals and groups claim “expertise” and challenge the lay/expert divide (Kerr, Cunningham-Burley, and Tutton, 2007). Becoming an “expert patient,” or in Foucault’s terms, learning to care for oneself, can connect individuals together and culminate in collective practices and alliance formation into communities of expertise. Here, the resistance or contestation over medicine is reworked into the service of self-determination and self-formation. The development of patient advocacy communities, such as Citizen Science, have created their own databases, which allows them to disseminate information, to interact, to validate, and to create a wider sense of participation and exert a form of agency in relation to larger narratives of power.

Epstein’s (1996) work serves as a particularly powerful illustration of how resistance communities of expertise and informed consumers converge in the discussion of medical knowledge (Epstein, 1996). Epstein draws out a case whereby the boundaries between expert scientist insiders and lay outsiders clashed in terms of “credibility struggles” around AIDS research and the flow of scientific information. Epstein documents how nonscientist AIDS activists transformed themselves from a “disease constituency” to an “alternative basis of expertise” as self-educated experts who could critique the medical establishment. In doing so, they acquired enough of a voice in the scientific world to shape NIH-sponsored research in terms of clinical studies and the way pharmaceutical companies manufacture drugs, as well as the way the FDA approval process works to approve drugs. Along these lines, one could also look to the work of ACTUP (AIDS Coalition to Unleash Power), the political group that sought to bring HIV/AIDS discrimination into the national discourse at a time of moral and medical panic. Both examples show how, through communities of expertise, individuals can come together and play a role in their own health concerns by changing the terms of who and what count as medical knowledge.

By understanding how we are constituted by those forces and relations of medicalization within our current historical and political circumstances (of which DTCA becomes an ever growing factor), we can see how, in Foucault’s terms, these conditions provide the possibilities for:

new freedoms and vitalities, in short to achieve the good life . . . Through a medicine linked to and governed by the state, the political apparatus comes to wield power over life, but now an enabling power that is not just repressive, creating instead the conditions for new capacities. (Bishop, 2008, 540)

As a result, we can see Foucault’s technology of the self as opening up our own individual self-health, as a question of politics, not of how to govern others, but how to govern and address ourselves as medicalized subjects. Although the earlier conceptualizations of power as the medical gaze appeared as superimposed, totalizing, determining, and dominating

over us, here through the technologies of the self, we see power in terms of the subject who acts and is able to transform himself in relation to existing dynamics of power. The subject is always “faced with a relationship of power,” so that “a whole field of responses, reactions, results, and possible inventions may open up” (Foucault, 1982, 789). Furthermore, for Foucault, although power–knowledge formations set limits within which one exists, they do not over-determine the individual, nor do they prescribe specific contents of particular thoughts or actions. In the case of medicalization, and DTCA as one of its newest extensions, we must not give in to an either/or of domination or liberation, but, instead, see a complex negotiation of a politics of self-constitution and self-transformation within the historical–contextual power relations in which we are always embedded. As Foucault argues, “the struggle against the forms of subjection—against the submission of subjectivity—is becoming more and more important, even though the struggles against forms of domination and exploitation have not disappeared. Quite the contrary” (Foucault, 1982, 782). As individuals become more involved with their health and health care, the once unilateral decision has become a collective one where patients question their physicians, request or pressure their physicians to prescribe medications they have researched, and call into question the previously sacrosanct medical authority (Aikin, Swasy, and Braman, 2004). Rather than fall into the sociological pitfall of theorizing an “over-socialized” concept of man who is simply the internalization of social norms and processes, we can see through Foucault’s categories that the multiple and differing responses to medicalization are not just responses to conditions, symptoms, or aspects of our health, but are responses to the very constitution of our subjectivity itself.

By drawing together some of Foucault’s ideas in relation to medicalization and DTCA, this paper has sought to open new possibilities for theorizing medicalization. Moving beyond Foucault’s concept of the “medical gaze” to the “medical archipelago” in the realm of pharmaceutical DTCA in a holistic way, we can deepen our understanding of how the engines of medicalization operate. The metaphor of the “archipelago” offers a way to conceptualize how advertisements serve as nodes and conduits in the social arena and how systematic relations form an interconnected, constantly circulating field of socializing forces (cultural, social, political, economic) that define the development of social medicine. This notion of “archipelago” in turn allows us to see how we are both disciplined and subjectivated through these processes of medicalization. As we internalize the norms disseminated through DTCA/media outlets, through which we as patients participate freely, we become complicit in these normalizing processes. This is not a straightforward internalization of social forces; rather, it represents the convergence of medicine, DTCA, and patients together in the process of medicalization. Finally, turning to Foucault’s technologies of the self opens

the possibility of resisting the processes of discipline and subjectification through medicalization and DTCA and of forging new or alternative health/medical subjectivities and self-understandings. Foucault's concepts, as well as their generative capacity, provide ways to supplement and enhance our understanding of medicalization as a set of social dynamics through which we not only understand ourselves, but out of which we form ourselves and the world around us.

## NOTES

1. For a discussion of the distinction between the concepts of the medical gaze and panopticism, see Bartky (1990).

2. In fact, Foucault uses the "carceral archipelago" metaphor, as applied to the entire social body, twice in *Discipline and Punish*. In the first, he writes: "We have seen that, in penal justice, the prison transformed the punitive procedure into a penitentiary technique: the carceral archipelago transported this technique from the penal institution to the entire social body" (Foucault, 1977, 298). In the second, he notes: "In short, the carceral archipelago assures, the depths of the social body, the formation of delinquency on the basis of subtle illegalities, the overlapping of the latter by the former establishing of a specified criminality" (Foucault, 1977, 301). Throughout this section of the book, Foucault utilizes numerous "carceral" metaphors in relation to power dynamics and bodies: carceral continuum, carceral net (Foucault, 1977, 297), carceral network (Foucault, 1977, 298), carceral archipelago (Foucault, 1977, 298, 301), and carceral system (Foucault, 1977, 301).

3. For a discussion of Canguilhem's distinction of normal/abnormal, see Trnka (2003) and for a comparison between Canguilhem and Foucault, see Spicker (1987).

4. It is Foucault's later works, specifically his essay "The Subject and Power," where he declares that it is not power, but the subject, that is the guiding theme of his research (Foucault, 1982).

## REFERENCES

- Abi-Rached, J. and N. Rose. 2010. The birth of the neuromolecular gaze. *History of the Human Sciences* 23(1):11–36.
- Aikin, K. J., J. L. Swasy, and A. C. Braman. 2004. *Patient and Physician Attitudes and Behaviors Associated with DTC Promotion of Prescription Drugs — Summary of FDA Survey Research Results*. U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research [On-line]. <https://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ucm151498.htm> (accessed May 2, 2018).
- Andreassen, H. K. and M. Trondsen. 2010. The empowered patient and the sociologist. *Social Theory & Health* 8(3):280–87.
- Armstrong, D. 1995. The rise of surveillance medicine. *Sociology of Health and Illness* 17(3):393–404.
- Bartky, S. 1990. Foucault, femininity, and the modernization of patriarchal power. In *Femininity and Domination: Studies in the Phenomenology of Oppression*, ed. S. Bartky, 63–82. New York: Routledge.
- Bell, R. A., R. L. Kravitz, and M. S. Wilkes. 1999. Direct-to-consumer prescription drug advertising and the public. *Journal of General Internal Medicine* 14(11):651–57.
- Bishop, J. 2008. Biopolitics, Terri Schiavo, and the sovereign subject of death. *Journal of Medicine and Philosophy* 33(6):538–57.

- . 2009a. Revisiting Foucault. *Journal of Medicine and Philosophy* 34(4):323–27.
- . 2009b. Foucauldian diagnostics: Space, time, and the metaphysics of medicine. *Journal of Medicine and Philosophy* 34(4):328–49.
- Brownlee, S. 2007. *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer*. New York: Bloomsbury.
- Clarke, A. E., J. K. Shim, L. Mamo, J. Fosket, and J. R. Fishman. 2010. *Biomedicalization: Technoscience and Transformations of Health and Illness in the United States*. Durham, NC: Duke University Press.
- Conrad, P. 1979. Types of medical social control. *Sociology of Health and Illness* 1(1):1–11.
- . 1992. Medicalization and social control. *Annual Review of Sociology* 18(1):209–32.
- . 2005. The shifting engines of medicalization. *Journal of Health and Social Behavior* 46(1):3–14.
- . 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press.
- . 2013. Medicalization: Changing contours, characteristics, and contexts. In *Medical Sociology on the Move: New Directions in Theory*, ed. W.C. Cockerman, 195–214. Dordrecht, The Netherlands: Springer.
- Conrad, P. and V. Leiter. 2004. Medicalization, markets and consumers. *Journal of Health and Social Behavior* 45(Supplement):158–76.
- . 2008. From Lydia Pinkham to queen Levitra: Direct-to-consumer advertising and medicalisation. *Sociology of Health & Illness* 30(6):825–38.
- Davis, J. 2006. How medicalization lost its way. *Society* 43(6):51–56.
- Donohue, J. 2006. A history of drug advertising: The evolving roles of consumers and consumer protection. *The Milbank Quarterly* 84(4):659–99.
- Donohue, J. and E. Berndt. 2004. Effects of direct-to-consumer advertising on medication choice: The case of antidepressants. *Journal of Public Policy & Marketing* 23(2):115–27.
- Donohue, J. M., M. Cevasco, and M. B. Rosenthal. 2007. A decade of direct-to-consumer advertising of prescription drugs. *New England Journal of Medicine* 357(7):673–81.
- Dumit, J. 2003. Is it me or my brain? Depression and neuroscientific facts. *Journal of Medical Humanities* 24(1–2):35–48.
- . 2004. *Picturing Personhood: Brain Scans and Biomedical Identity*. Princeton, NJ: Princeton University Press.
- . 2012. *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Durham, NC: Duke University Press.
- Epstein, S. 1996. *Impure Science: AIDS, Activism, and the Politics of Knowledge*. Berkeley: University of California Press.
- Foucault, M. 1973. *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Random House.
- . 1977. *Discipline and Punish: The Birth of the Prison*. New York: Random House.
- . 1978. *The History of Sexuality, Vol. 1: An Introduction*. New York: Vintage Books.
- . 1980a. The eye of power. In *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*, ed. C. Gordon, 146–65. New York: Vintage Books.
- . 1980b. Questions on geography. In *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*, ed. C. Gordon, 63–77. New York: Pantheon Books.
- . 1980c. The politics of health in the eighteenth century. In *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*, ed. C. Gordon, 166–82. New York: Vintage Books.

- . 1982. The subject and power. *Critical Inquiry* 8(4):777–95.
- . 1988. *Technologies of the Self: A Seminar with Michel Foucault*. Amherst: University of Massachusetts Press.
- . 1997. Subjectivity and truth. In *The Essential Works of Michel Foucault 1954–1984. Ethics, Subjectivity, and Truth. Vol. 1*, ed. P. Rabinow, 87–92. New York: The New Press.
- . 2001. The birth of social medicine. In *The Essential Works of Michel Foucault 1954–1984. Power. Vol. 3*, ed. P. Rabinow, 134–56. New York: The New Press.
- . 2003. *Abnormal: Lectures at the Collège de France, 1974–1975*. New York: Picador.
- . 2004. The crisis of medicine or the crisis of antimedicine? *Foucault Studies* 1(1):5–19.
- Fox, N. and K. Ward. 2009. Pharma in the bedroom . . . and the kitchen . . . The pharmaceuticalisation of daily life. In *Pharmaceuticals and Society*, eds. S. J. Williams, J. Gabe, and P. Davis, 41–53. Chichester, United Kingdom: Wiley-Blackwell.
- Fox, N., K. Ward, and A. O'Rourke. 2005. The 'expert patient': Empowerment or medical dominance? The case of weight loss, pharmaceutical drugs and the internet. *Social Science & Medicine* 60:1299–309
- . 2006. A sociology of technology governance for the information age: The case of pharmaceuticals, consumer advertising and the internet. *Sociology* 40(2):315–34
- Frosch, D., P. Krueger, R. Hornik, P. Cronholm, and F. Barg. 2007. Creating demand for prescription drugs: A content analysis of television direct-to-consumer advertising. *Annals of Family Medicine* 5(1):6–13.
- Frosch, D., G. May, C. Tietbohl, and J. Pagan. 2011. Living in the “land of no”? Consumer perceptions of healthy lifestyle portrayals in direct-to-consumer advertisements of prescription drugs. *Social Science & Medicine* 73(7):995–1002.
- Frykman, J. and O. Lofgren. 1987. *Culture Builders: A Historical Anthropology of Middle-Class Life*. New Brunswick, NJ: Rutgers University Press.
- Heaton, J. 1999. The gaze and visibility of the career: A Foucauldian analysis of the discourse of informal care. *Sociology of Health and Illness* 21(6):759–77.
- Henwood, F., S. Wyatt, A. Hart, and J. Smith. 2003. 'Ignorance is bliss sometimes': Constraints on the emergence of the 'informed patient' in the changing landscapes of health information. *Sociology of Health & Illness* 25(6):589–607
- Jenkins, J., ed. 2011. *Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology*. New York: SAR Press.
- Kaphingst, K. 2004. A content analysis of direct-to-consumer television prescription drug advertisements. *Journal of Health Communication* 9(6):515–28.
- Kerr, A., S. Cunningham-Burley, and R. Tutton. 2007. Shifting subject positions. *Social Studies of Science* 37:385–411.
- Lupton, D. 1997. Foucault and the medicalisation critique. In *Foucault, Health and Medicine*, eds. A. Petersen and R. Bunton, 94–110. New York: Routledge.
- Martin, E. 2006. The pharmaceutical person. *BioSocieties* 1(3):273–87.
- Metzl, J. 2004. The pharmaceutical gaze: Psychiatry, scopophilia, and psychotropic medication advertising, 1964–1985. In *Cultural Studies: Medicine and Media*, ed. L. Friedman, 15–35. Durham, NC: Duke University Press.
- Mort, F. 1987. *Dangerous Sexualities: Medico-moral Politics in England Since 1830*. London, United Kingdom: Routledge.
- Nye, R. 2003. The evolution of the concept of medicalization in the late twentieth century. *Journal of History of the Behavioral Sciences* 39(2):115–29.
- Rose, N. 2001. The politics of life itself. *Theory, Culture & Society* 18(6):1–30.

- . 2003. Neurochemical selves. *Society* 41(Nov/Dec):46–59.
- . 2006. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, NJ: Princeton University Press.
- Sluga, H. 2011. Could you define the sense you give the word “political”? Michel Foucault as a political philosopher. *History of the Human Sciences* 24(4):69–79.
- Smirnova, M. 2012. A will to youth: The woman’s anti-aging elixir. *Social Science & Medicine* 75(7):1236–243.
- Spicker, S. 1987. An introduction to the medical epistemology of Georges Canguilhem: Moving beyond Foucault. *The Journal of Medicine and Philosophy* 12(4):397–411.
- Sulik, G. 2011. ‘Our diagnosis, our selves.’ The rise of the technoscientific illness identity. *Sociology Compass* 5(6):463–77.
- Sulik, G. A. and A. Eich-Krohm. 2008. No longer a patient: The social construction of the medical consumer. In *Advances in Medical Sociology: Patients, Consumers and Civil Society*, vol. 10, eds. S. M. Chambré and M. Goldner, 3–28. Bingley, United Kingdom: Emerald Group Publishing Limited.
- Trnka, P. 2003. Subjectivity and values in medicine: The case of Canguilhem. *The Journal of Medicine and Philosophy* 28(4):427–46.
- Turner, B. 1995. *Medical Power and Social Knowledge*. London, United Kingdom: Sage.
- Waitzkin, H. 1991. *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems*. New Haven, CT: Yale University Press.
- Welch, G., L. Schwartz, and S. Woloshin. 2011. *Overdiagnosed: Making People Sick in the Pursuit of Health*. New York: Beacon Press.
- Wilkes, M., R. Bell, and R. Kravitz. 2000. Direct-to-consumer Prescription drug advertising: Trends, impact, and implications. *Health Affairs* 19(2):110–28.
- Williams, S. J., J. Gabe, and P. Davis, ed. 2009. *Pharmaceuticals and Society: Critical Discourses and Debates*. London, United Kingdom: Wiley Blackwell.