FROM MODERN TO POSTMODERN MEDICINE: THE CASE OF ORGAN TRANSPLANTS

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ABSTRACT

FROM MODERN TO POSTMODERN MEDICINE: THE CASE OF ORGAN TRANSPLANTS

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This thesis investigates the constituent tendencies of postmodern medicine, concentrating upon the organ transplantation therapy. Adopting a genealogical perspective, as a methodological tool, for reading the current history of medicine, it develops its theoretical framework through Michel Foucault's discussions on biopolitics and Nikolas Rose's discussions on molecular biopolitics. This study is based on the assumption that medical knowledges of body, vitality and death are historically fluid and context bounded. Therefore, the medical configuration of recent times operate under the conditions of postmodernity. This thesis explores the medicine peculiar to postmodern times, and presents the unique characteristics of current medicine through by focusing on organ transplantation as a postmodern medical case.

As a result, it is argued in this thesis that, there are four prominent ruptures in the field of medicine in the postmodern times. Firstly, postmodern medicine does not

imagine the body as something biologically given, contrarily it sees the body as something remouldable. Secondly, postmodern medicine transforms death into an event that is able to be experienced by individuals piece by piece. Thirdly, through operating in the conditions of current global capitalism, postmodern medicine transforms vitality parts into commodities. Fourthly, postmodern medicine gives new lives to the organs circulating without bodies.

Keywords: Sociology of Health and Illness, Sociology of Body, Biopolitics, Postmodernity, Organ Transplants

ÖZ

MODERN TIPTAN POSTMODERN TIBBA: ORGAN NAKİLLERİ ÖRNEĞİ

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Bu tez, organ nakli tedavisine odaklanarak, postmodern tıbbın kurucu eğilimlerini araştırıyor. Tıbbın günümüz tarihini okumak için, jeneolojik yaklaşımı metodolojik bir araç olarak benimsiyor. Teorik çerçevesini Michel Foucault'nun biyopolitika tartışmaları ve Nikolas Rose'un moleküler biyopolitika tartışmaları aracılığıyla geliştiriyor. Bu çalışmanın yaslandığı varsayım bedenin, canlılığın ve ölümün tıbbi bilgilerinin tarihsel olarak akışkan ve bağlamsal olduğudur. Bu yüzden, son zamanlara özgü tıbbi biçimleniş postmodern koşulların etkisi altındadır. Bu tez, postmodern tıbba ait bir vaka olarak organ nakli tedavisine odaklanarak, postmodern zamanlara özgü tıbbı inceliyor ve bugünün tıbbının biricik özelliklerini ortaya koyuyor.

Sonuçta, bu çalışmada, postmodern zamanlarda tıp alanında dört önemli kopuşun gerçekleştiği tartışılıyor. İlkin, postmodern tıp bedeni biyolojik anlamda verili bir şey olarak tahayyül etmez, aksine, bedeni yeniden kalıba dökülebilir bir şey

olarak görür. İkinci olarak, postmodern tıp ölümü parça parça deneyimlenebilen bir olaya dönüştürür. Üçüncü olarak, postmodern tıp hâlihazırdaki küresel kapitalizm koşulları içinde işleyerek, canlılık parçalarını metalara dönüştürür. Dördüncü olarak, postmodern tıp bedensiz dolaşan organlara yeni yaşamlar verir.

Anahtar Kelimeler: Sağlık ve Hastalık Sosyolojisi, Beden Sosyolojisi, Biyopolitika, Postmodernite, Organ Nakilleri

to Mehmet…

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TABLE OF CONTENTS

PLAGIARISM iii
ABSTRACT iv
ÖZ vi
DEDICATION viii
ACKNOWLEDGEMENTS ix
TABLE OF CONTENTS x
CHAPTER
I INTRODUCTION 1
II THE SLIPPERY KNOWLEDGE OF MEDICINE 12
2.1 Unstable, Time and Context Dependent Knowledges of Health and Illness. 15
2.1.1 Accumulation Patterns of Medical Knowledge 16
2.1.2 "Changeable Social" versus "Fixed Biology" 22
2.2 Methodological Concerns: "How Should the History of Contemporary Medical Subject Be Made?" 24
2.2.1 "The History of the Present" and the "Cartography of the Present": Genealogy as a Methodology 25
2.2.2 Power: A Genealogical Axis 28
2.2.3 Knowledge: A Genealogical Axis 36
2.2.4 Body: A Genealogical Axis 41
III FROM MODERN MEDICINE TO POSTMODERN MEDICINE 50
3.1 Modernity and Its Imagination of Medical Subject 52
3.2 Postmodern Turn and Its Reflections on Medicine 66
3.3 Constituent Tendencies of Medicine in Postmodern Times: First Steps towards a Sociological Analysis of Organ Transplants as a Postmodern Medical Case 87
IV POSTMODERN MEDICINE, ORGAN TRANSPLANTS, AND THE BODY 95

4.1. Molecular Body as a Network: New Spatialization 98
4.2 A Comparison between Molar Body and Molecular Body 104
4.3 Plasticity and Softness of the Body 112
4.4 Organs Jettisoned Out of the Body: From "Abject" Elements to Biovaluable Things 116
4.5 Concluding Remarks: The Piecemeal Body 122
V POSTMODERN MEDICINE, ORGAN TRANSPLANTS, AND THE DEATH 125
5.1 Reconfiguration of the Death: Delayed and Partial Deaths 128
5.2 Death in the Modern Context of Medicine 132
5.3 Partial Deaths in the Postmodern Context of Medicine: The Notion of Brain Death 135
5.4 Creating Partial Deaths in the Living Body: Immunosuppressants 144
5.5 Concluding Remarks: Blurred Deaths 148
VI POSTMODERN MEDICINE, ORGAN TRANSPLANTS, AND COMMODIFICATION 150
6.1 Exchanging Organs: Organs as Commodities without Bodies 152
6.2 What Kind of Commodity is an Organ? 156
6.3 "Complex Connectivities" of the Dirty Organ Market 162
6.4 Human Stories Embedded into the Organ Market 167
6.5 Concluding Remarks: Vital and/or Fatal Contradictions of Postmodern Medical "Progress" 173
VII CONCLUSION: LIFE AND DEATH IN THE GRIPPER OF MEDICINE… 177
REFERENCES 190
APPENDICES 203
A FIGURES 203
B CURRICULUM VITAE 212
C TÜRKÇE ÖZET 219
D TEZ FOTOKOPİSİ İZİN FORMU 240

CHAPTER I

INTRODUCTION

"Ve bizim en güzel öldüğümüzdür
bu: yaşamak"[1]
Edip Cansever, Umutsuzlar Parkı

Current history of medicine is neither a beginning nor an end. A history of something is always somewhere in the middle. Current history of medicine is merely the current stage of medicine, and so, it is meaningful in its own context. Current medical implementations, current medical technologies, or current style of medical imagining are able to operate in today's historically specific social and economic conditions. Otherwise, they melt away in the pots of unconditioned "scientific progress" discourse, and daily verbiage on medicine.

Today, we may talk about two main images which are related to medicine. The first one is a kind of dispersion which might be considered specific to postmodern

[1] "and this is how we die most beatifully: to live"

times. While considering this dispersion, we may imagine a pomegranate which ripens, dehisces, and then scatters around. Like this pomegranate, medicine disperses to all areas of life and paints the areas that it touches to its own colors. Second image is about the emphasis of "scientific progress". This emphasis on the "scientific progress" has wandered in the field of medicine like a ghost since the birth of modern medicine. It always implies that the medicine is getting better. These two images are not a dichotomy. One does not exclude the other. Both are closely related to the transformations of life, body and death that the medicine of postmodern times brings.

What we see when we focus on the first image is as follows: currently, the field of medicine has expanded as much as including almost everything. It has transformed into a "spongy referent"[2]. Today, health-related duties and wishes tend to roam around: "be healthy", "seek the right treatment for your disease", "learn to manage your stress", "choose healthy food", "get informed of new drugs and treatments", "look at yourself", "adopt a healthy lifestyle", "eat this", "don't eat this"… these are invading all areas of life. They are not imperatives. Rather, they say to us that in order to have a "good life" we need to be healthy. However, such a "good life" promise includes interventions to our very biological existences. The necessity of having a healthy life, in order to reach a "good life", may be read as a recently specific governmentality tactic, which tends towards to govern our bodies and souls through the medicalized principles of healthy life.

In addition to that, there are many recommendations and wishes, for teaching what is right and what is wrong for our health. Each recommendation on health affirms itself and each recommendation undermines the other. Our thoughts on our body, soul, wellbeing and diseases are becoming increasingly delivered to a

[2] This noun phrase employed by Jean Baudrillard in order to describe the current situation of social which has already come to an end for him (1983, p. 1).

chaos. The result is a complete confusion. In this confusion, our understandings concerning life, death, health, body, kin, progress, hope, sex, capital, lifestyle and cure are being reshaped. Medicine, as a continuously expanding category, loses its specificity, because it is absorbed by the other categories which it is in contact with. In such a coverage map of medicine, to find distinctive principles and constitutive tendencies of current medicine become harder day by day. When everything starts to be defined as medical, then nothing is left to be defined as medical.

What we see when we focus on the second image is as follows: contrary to the overexpansion of daily verbiage, medicine is the scene of overspecialization, "scientific progress" and advanced technological developments, all of which are able to remould human life, body and death. In this case, through scientific developments, specialization and advanced technologies medicine functions in a way previously unseen. Today, the inside of the body can be visually scoped more deeply. The power of *homo videns*[3] goes beyond the envelope of the skin and takes roots to the inner space of the body. Then, the recently specific superiority of visual occupies the inner body. Today's medicine sees the body in a way that had not been experienced earlier; it sees the unseen. In this way, it is able to intervene which has not shape yet. For instance, it is able to change the sex of an unborn or to stop the expansion of a potential tumor.

Another novelty is about replacements. Today's medicine is the specialist of replacements. For instance, today, people can give to each other or take from each other blood, kidney, a piece of lung, eggs, hair or tissues. Sperm and egg can be fertilized in the laboratory. A woman can carry in her womb the baby of another woman. Through these exchanges and medical interventions, the borders between

[3] *Homo videns* is the human who is seeing. Giovanni Sartori uses this term in order to discuss the power of seeing that established in the recent times' tele-directed society. For him, the human who symbolizes the current age is this *homo videns* (Sartori, 2006, p. 11).

bodies become more permeable. Recently, artificial limbs placed in the body multiply wildly. Using hearing aids, cardiac pacemakers, dental implants or prosthesis arms in medical therapies are now very common, but also medical specialistic works. Thus, the distinctions between mechanics, synthetic and organic disappear. The science of genetic translates individuality into numbers that cannot be found in any other individual. In this way, we gain individualities which are hyper subjective, but which are also represented in the abstract level of numbers. Moreover, plans and experiments are made and dreams are built, in order to reproduce the whole vitality of human. The copy sheep Dolly signals that copying a human is imminent. We are living in an age in which a part of vitality can be printed, similar to printing a text. Through the bio-printing technology, human tissues can be produced with 3D printers. Thus, the distinctions between born and made, between natural and artifactual vanish.

In addition to these, medicine does not see the symptoms of the diseases as the signs of holistic body. On the contrary, medicine wants to reach the smallest part of the body from where the symptom originates. For instance, newborn's umbilical cord stem cells are banked in the life banks for the treatment of possible future diseases of the baby. In this way, a specific kind of vitality which is unique to individual can be stored. Medicine searches for the micro level representative of the body. For the present, this smallest agent which represents the whole vitality is gene. Medicine searches the formulas of the body, life, death, disease and health in these genes. Someday in the future, when the disease knock the body's door, medicine would probably answer as such: There is no "body" here.

When these two images that I present here are considered together, it can be said that, on the one hand the boundaries of medicine are blurring today. On the other hand, not only the medical practice, but also the bodies, lives and deaths that medicine touches are resolving. What is critical here is that, the configuration which medicine received today is not a contingent nascency. It is something

contextual. The transformations that I present here are not merely medical or biological; rather, they are also causes and results of sociological, political, historical and economical fluctuations which postmodern times witness. There is a range of shifts underlying the newly developed configuration of medicine.

First of all, the shift from modernity to postmodernity open the way of rearrangement of medical field. In this way, the medical practice of modern times is dethroned by postmodern medical practices. Indeed, modernity created a series of crucial transformations in the field of medicine. Modern medicine described the medicine as an evidence-based scientific field. It medicalized the body, life and death of human. It rationalized not only the medical practice, but also the body, disease and death of individual. By exploring death scientifically, modern medicine detached the ties between metaphysics, death and fate. Modern medicine transformed the social construction of disease categories. There occurred a shift from "sin to sickness"[4]. Descriptions of ill, sinful, deviant, normal and abnormal are rearranged in the modern times, by reference to the secularization movement of medicine.

The novelties that modernity brought to the field of medicine is a great legacy for the postmodern medicine. The roots of the present condition of medical practice, first began to shape with modernity. However, I argue that the originality of postmodern medicine lies in its breaks from modern medicine. In other words, what gives the character of postmodern medicine, is not its continuities, rather its dissimilarities. The postmodern theory is full of conceptual shifts: a shift from historical progress to deconstruction, from epistemic certainty to hyperreality, from univocity of meaning to difference, from corporal unity to flowing corporal. These ways of seeing and thinking specific to postmodern times have got a strong

[4] "Sin to sickness" in a conceptualization developed by Bryan S. Turner in order to discuss the collapse of the hegemony of Judeo-Christian tradition and the rise of hegemony of the principles of rationality, in the field of medicine, in the modern times (Turner, 1987, p.18).

impact on the comprehensions of current medicine. Current medicine no longer sees the life, death and body of individual as rivers flow in their beds instinctively, conventionally and resignedly. In the view of today's medicine the life, disease, death and body do not *ipso facto* pursue inevitably a predetermined path. The biotechnological medical gaze sees all of these as something which are open to intervention, change and reconstruction. Postmodern medicine does not tend to accept the existing capacity of the body, rather it is disposed to change the body. Postmodern medicine does not comprehend the life and death as an entire courses. And so, medicine functions by deconstructing the structures of life body and death.

The shift from modernity to postmodernity overlaps with another shift which has a strong ties with the transformation of medicine and also with the medicine's capacity of transformation. This is the shift from biopolitics to molecular biopolitics. As we know from the oeuvre of Foucault, all living matters have fallen under the rational calculation of power since the modern times, especially since eighteenth century. With the birth of biopolitics, the vital character of human has become important in her/his construction as a governable political subject. Thus, birth, death, aging, illness, health, disability, abnormalities, mental illnesses and many other bodily and biological matters have become important issues in the determination of the tactics of power. Disciplining the body, controlling its forces and energies, making it productive and reproductive have become the main aims of power. In the formation of docile bodies, medicine has got a privileged role because it is one of the important institutions that produce knowledge about the body (Foucault, 2003; 1995; 1990).

However, it can be argued that, at the turn of twenty first century the biological truths and knowledges have changed. Accordingly, the answer of the question of "what is an embodied subject?" is also has changed. Nikolas Rose, one of the post-Foucauldian theoreticians, conceptualizes this turn as the rise of molecular

biopolitics. For him, since 1960s, the biocapital of human has undergone a series of changes through the sciences of micro biology, genetics and the novel medical implementations which are endowed with technology, sophisticated diagnostic and therapeutic equipment (Rose, 2007a). In the age of molecular biopolitics, the meaning attributed to the biological has been transforming. Indeed, thinking human with reference to her/his biological features has got a bad legacy inherited from modern times such as, gender discrimination, race discrimination of eugenics. However, today, the medicine plasticizes the human biology (Rose, 2012). It considers the biology not as an inevitability, but as a set of potentials. Notwithstanding, these conversions do not indicate that molecular biopolitics is something more beneficial than biopolitics. The conversions of molecular biopolitics requires a critical reading, because at that time our changing biology has become the target of political tactics and calculations which are different from modern times. Molecular biopolitics has brought control, intervention and governmentality which are functioning at the molecular level.

In this study by concentrating upon the shifts from modernity to postmodernity and from biopolitics to molecular biopolitics, I attempt to discuss the unique characteristics of current medicine. I concentrate upon the question what makes today's medicine dissimilar. Here, in order to contextualize current medicine and see its ruptures from previous medical models, I am going to explore the therapy of organ transplantation as a postmodern medical case. Today's medicine interknits the bodies, deaths and lives of humans. The investigation of organ transplantation therapy provides a potential for seeing the main motives and patterns of this knitting. Some machines, technologies, artificial devices or a part of vitality which is remained from a death, become a lifesaving comrade for a failing and suffering body, through the implementations of current medicine. Through the organ transplantation therapy, current medicine complements the shortcomings of a body through another body, by the help of technology. It

derives vitality parts from the death of an individual and it distributes these vitality parts to other suffering individuals as a second chance of life. It is possible to transform the death of an individual into a life for of another individual, through organ transplants. In this context, it can be asserted that organ transplants become possible in the current body, life and death understandings of the medicine. Thus, organ transplant therapy has the potential of demonstrating the characteristics of the medical context in which they developed.

I am going to adopt genealogy as a method for reading the current history of medicine through organ transplant therapy in this thesis. Genealogy is a specific way of reading the history of "now". Through genealogy one becomes able to historicize the present. Although making a conventional history of *something* necessitates searching for continuities between this *something's* present and past, genealogy does not seek for such continuities. It requires to concentrate on the ruptures. In this context, although this thesis has certain historical concerns and a kind of historical perspective, it attempts to keep away from the conventional logic of reading history. Thus, the target of this thesis is not presenting a detailed analysis of a certain period in the history of medicine or speaking on the history of medicine. It does not search for the history of postmodern medicine or the philosophy behind the foundation of postmodern medicine, either. On the other hand, it does not seek a certain technological novelty or a pioneer medical figure that opened the era of postmodern medicine and shaped it today as well. Rather, this thesis aims to construct a historical context in which contemporary medical practice could be embedded and comprehended. Through a genealogical reading of the present, this study seeks for the discontinuities and ruptures which paved the way of current medical regime and differentiate it from older medical models.

Then, the aims of this thesis may be summarized as follows: *(i)* to debate the current medical configuration by historicizing it and emphasizing the interplays between the categories of medical, social, biological and historical. *(ii)* to explore

organ transplantation therapy as a postmodern medical case, for exposing the recently specific acts of medicine which are cutting into pieces, recombining and plasticizing. *(iii)* to present the ruptures, developments and challenges of postmodern medicine, which open the way of reconstructing and repatterning of the lives, bodies and deaths of individuals.

This thesis is composed of seven chapters. In the second chapter of this thesis, I am going to discuss the epistemological character of medical knowledge. This chapter includes discussions on the theoretical roots and methodological directions of this study. I am going to begin with a discussion on the historically bounded and context dependent features of medical knowledge. Afterwards, I propose through this discussion that medical knowledge does not ground on the principle of 'unchangeable biology'; rather the continuous change of the social plays an important role in the production of medical knowledge. Thus, I shall put that there is not a continuous progress about medicine; rather, the history of medicine is full of ruptures and discontinuities. Afterwards, I am going to introduce genealogy as a method, which enables to see the positioning of current medicine within the full of ruptures history of medicine. In this part, I shall discuss three genealogical axes, which are power, body and knowledge, by focusing on Michel Foucault's conceptualization of "history of present" and Nikolas Rose's conceptualization of "cartography of present". The discussion on the theories of Foucault and Rose shall provide a ground for reading the shifts from biopolitics to molecular biopolitics, from modern medicine to postmodern medicine. I am going to investigate unique characteristics of postmodern medicine by considering these shifts as a theoretical base, in the later parts of this thesis.

The third chapter of this thesis attempts to make a periodization by concentrating on the differences between modern and postmodern medicine. In the first part of this chapter, I am going to discuss the modern medicine. I am going to concentrate

on the birth of medicine as a positive science in the context of modernity. Then, in the second part of his chapter I am going to discuss the postmodern medicine by presenting its differences from modern medicine. I shall focus on ever-expanding medical interventions in everyday life and plasticization of individual's biology, body, life and death. I am going to consider the roles of the discourses on risk, consumption and happiness in the formation of postmodern medical subject. Afterwards, in the third part of this chapter, I am going to introduce the case study of this thesis, namely the organ transplantation therapy. I present that why the organ transplantation case, as a postmodern medical example, is a ground with full of potentials in seeing differences between modern medicine and postmodern medicine.

In the following four chapters (fourth, fifth, sixth and seventh), I am going to present and discuss the organ transplantation therapy as a postmodern medical case. Through focusing on organ transplantation therapy, I am aiming to trace the main foundations of postmodern medicine and the ruptures that postmodern medicine creates. In the fourth chapter, I am going to discuss the molecular, borderless, plastic, body understanding of postmodern medicine through focusing organ transplantation case. In this chapter I argue that organ transplants bring new set of social relations by opening the bodies into a new kind of dialogue and the bodily borders between the categories of *me* and *other* blur. This indicates the resolve of the introvert, molar and well defined body of modern medicine and the rise of new medical subject. The bodily components of this medical subject, who is specific to postmodern medical configuration, are mobile and meaningful in themselves.

In the fifth chapter, I am going to discuss the unique death understanding of postmodern medicine, by concentrating on organ transplantations. In this chapter I argue that postmodern medicine has got a partial and fragmentary comprehension of death. In this chapter, firstly, I am going to discuss the newly conceptualized

notion of “brain death”. The conceptualization of brain death is a cornerstone event in the short history of organ transplants and it invalidates the long-established death understandings which see the death as an instant and single piece event. In this way, neither alive nor dead bodies occur. First time in the history of medicine, life and death dwell in the same body, at the same time, through the acceptance of the notion of brain death. Secondly, I am going to consider immunosuppressants which are drugs creating partial deaths in the recipient’s body in order to overcome foreign organ rejection. By pausing immune system of recipient’s body, immunosuppressants create small-scale deaths in a living body.

In the following chapter, chapter six, I am going to discuss the commodification of organs which is peculiar to postmodern medicine. First of all, I am going to concentrate on the question of “what kind of commodity is an organ” by taking into account Marx’s original discussions on the process of commodification in the age of capitalism. I present that commodification of the organs can be considered as one of the results of the newly established alliances between capitalist market and medicine. When a part of vitality is used as a treatment material, it transforms into something which can be bought and sold like other armamentarium of treatments circulating in the market. In the second part of this chapter, I will concentrate on the black organ markets, in which disadvantaged people sell their organs. By concentrating on black organ markets, I present the Janus-faced view of the organ transplant therapy. When this therapy is realized through the medium of black organ markets, some bodies getting closer to death by lessening and other some bodies attaining the second life chance by completing. This thesis ends with the conclusion chapter.

CHAPTER II

THE SLIPPERY KNOWLEDGE OF MEDICINE

Today, in the field of sociology of medicine the health related matters, diseases and medicine itself are being discussed in relation to a wide range of notions from risk to engineered vitality, from consumption to medicalization, from pharmaceuticalisation to medical subjects, from reflexivity to biographical medicine and so on. As Bryan Turner underlines "the sociology of medicine, like sociology of religion or the sociology of law, is primarily a study in sociology, not a study in medicine" (1987, p. 1).

There are two main pivots concerning the relations between health, illness and sociology (Bury, 1997). First pivot, which can be described as the *sociology in the medicine*, deals with the social distribution of health and illness, institutions that provide health services and institutional arrangements. This perspective keeps in touch with the clinic medicine, epidemics, nursing services, public health and psychological services. It aims to contribute examination of health and illness and protection and improvement of health. On the other hand, second pivot, which can be described as the *sociology of medicine*, focuses more general social processes. The studies that adopted this perspective embrace the issues of the experiences of health and illness, social patterns of health and illness, the networks composed

from illness, health and individual and the relations between medicine and power (pp- 3-4). This thesis, by aiming to make the genealogy of current medical knowledge and practice, through exploring organ transplantation therapy, is located within the second perspective.

The sociological debates on medicine not only comment on the social aspects of health and illness, but also they produce or reflect certain contextual assumptions on the meanings of life and death, in an open and/or tacit manner. Each comment about explanations, causes, patterns and preconditions of health and illness conveys value judgments, assumptions on right and wrong, and perceptions of good life. Moreover, the expressions on health and illness are encumbered with certain blamings, responsibilities and moral acceptances which place the individuals' whole lives into a medical scale.

All of the words that are produced concerning health and illness are context dependent. They are not ahistorical, immemorial and context free. Thus, it is impossible to read the words on health, illness and medicine, as they are merely statements of opinions on the physical condition of the biological body. In other words, health and illness are not merely biological matters. Moreover, today, biology itself is not considered as a fate to where individual is confined, and from where it is impossible for individual to escape. Thus, for the last few years, novel interactions between the realms of 'the social' and 'the biological' have occurred. Today the disciplines of sociology and biology are questioning each other's premises and implicit prejudices (Meloni, 2014, p. 593).

In this context, current sociological discussions on medicine, especially the ones adopting the perspective of social constructionism, corrode the *rational* and *modernist* view of medicine "which sees disease as being located in the body as a physical object of physical state that can be objectively identified and treated as a physiological condition by scientific medical knowledge" (Good as cited in

Lupton, 2000, p. 50). This statement presents that a medical approach, which is valid for a specific period, may expire in another era. Thus, it is possible to say that every historical period has its unique medical configuration, in its specific conditions. Because medical configurations are not merely built on the biological assumptions, contrarily, they always contain affects from the social conditions of their periods. This is true for today too, therefore, it is possible to speak on a medical configuration which is only specific to this day. And this configuration exists with today's unique historical circumstances.

In this chapter, I am concentrating on the socially constructed knowledge of medicine. I am inquiring the characteristics of the medical knowledge. I am proposing here that, the medical knowledge does not accumulate in a progressive manner. Rather, the history of medical knowledge full of paradigm shifts. Paradigm shifts result with the expiration of the assembly of knowledge that is specific to a certain historical period, in the following periods. Thus, epistemologically, the temporariness of knowledge is not something merely peculiar to postmodernity which carries each kind of knowledge to a slippery slope. However, the difference of postmodernity is that, the producers of medical knowledge in this period are now aware that they are acting on a slippery surface. Perhaps, the ones producing medical knowledge in the medieval or modern ages, believed the permanence of the knowledge which they produced, with all their heart and soul. Nonetheless, their beliefs failed to prevent the transformation of the knowledge, which they produced, into something invalid for the peoples of another period.

What makes the medical knowledge such a volatile thing is that, it does not built upon the idea of "unchangeable biology"; rather, the 'changeable social' plays a crucial role in the production of medical knowledge. In line with this, there is an interplay between "unsteady biology" and "changeable social", in the process of

medical knowledge production. Under these conditions, in order to understand the current picture of medicine, it is not enough to inquire the physical conditions, illness and health of the body. Rather it is necessary to elaborate the social meanings of them. Moreover, it is necessary to elaborate the power-knowledge relations circulating in the field of medicine. Here, I propose to employ 'genealogy' as a method in order to read/understand how the medicine device is constructed differently in different epochs. Thus, below, I discuss genealogical understanding of history, by focusing on Foucault's and Rose's works, in order to establish a ground for making the contemporary history of current medicine. In the next chapters of this study, I employ the genealogical method that I discuss in this chapter, in order to read the current medicine via the case organ transplants.

2.1 Unstable, Time and Context Dependent Knowledges of Health and Illness

It is impossible to separate the body and its pathology off their knowledge. Although health, illness, wellbeing, and disease are physical realities, they cannot be understood apart from their constructed representations. Medical trainings, clinical practices, hierarchy among lay and expert medical discourses, medical principles, medical beliefs, daily manifestations of health and illness and many other issues concerning health and illness are always open to change. Moreover, the relations between life and death are not given, stable and fixed, rather they are ultimately changeable. The politics of death and birth are context-bounded. And the borders built between nature and culture are mobile. The relations between the sciences are subject to diversifications. In a nutshell, it is difficult to find ahistorical and universal rules that organize medical knowledge and experiences into compact systems.

Thus, in this subtitle I attempt to circumscribe the leading accumulation patterns of medical knowledge. Here, I argue that the medical knowledge is in a constant state of flux. In this regard, I propose to consider the ground of reading the history of medicine by reference to historicized contexts, rather than considering it as a whole shaped by a linear historical tendency. In order to capture the fluxes of medical knowledge, I develop four discussion pivots. First of all, medical knowledge does not accumulate regularly by following a progressive aim. Secondly, the medical categories, such as "ill", "patient", "healthy" and the like, are not given, fixed and context-free. Thirdly, the individual, who is at the target of medicine, is comprehended in different ways at different times, by the medicine. Finally, individual's positioning of her/his self in relation to medicine varies according to the different historical contexts.

These pivots indicate the changeable nature of medical knowledge. And they present the categorizations of medical subject which may vary historically. Here, I develop these four points by feeding from the approach of social constructivism in medical sociology. This approach carries the basic message which emphasizes that, "medical *knowledge* no less than medical practice is socially constructed" (Bury, 1986, p.137). Moreover, this approach adopts the position which points that "the objects of medical science are not what they appear to be; the stable realities of the human body and disease are in fact 'fabrications', or 'inventions' rather than discoveries" (p. 137). In this regard, I discuss these four points, which I derived them via the help of the approach of social constructivism below.

2.1.1 Accumulation Patterns of Medical Knowledge

Firstly, the medical knowledge does not accumulate through supplementation of new statements to the old ones. By referencing Foucault, Hall underlines that

knowledge is not something that operates in a void. Rather, knowledge works "through certain technologies and strategies of application, in specific situations, historical contexts and institutional regimes" (Hall, 2001, p. 76). In line with this, it can be asserted that medical knowledge is context-bounded. For instance, it is obvious that, Galen's medical principles, which are based upon four bodily fluids or medieval medicine's explanations on diseases in which mundane and spiritual were amalgamated are not credible today. In fact, it is not necessary to bring examples which belong to a distant past, since recent past also contains this kind of expired solutions, notions and explanations. For example, in the second half of the twentieth century "stress has replaced the germ as the major explanation of modern illness; the concept of cure will be increasingly replaced by concepts of rehabilitation and care" (Turner, 1987, p. 8). Briefly stated, there are a lot of outmoded techniques, remedies, solutions, beliefs and feelings in the history of medicine. Thus, medical knowledge does not accumulate as putting up a wall by arranging the sticks in a row; rather, a new born knowledge aggregation or a novel style of knowing can invalidate the already existing ones. For this very reason, the history of medical knowledge is full of the ruptures, discontinuities and the paradigm shifts.

Secondly, the descriptions of "healthy", "ill", "patient", "unwell" and "fit" are not fixed, constant and ahistorical. Rather, specific discourses of particular medical configurations have their own meaningful medical categories and vocabularies. The relation between the sciences which present these certain vocabularies, for instance the relation between sociology and biology, are also cyclical.[5] Thus,

[5] In the early times of the birth of the sociology, the relation between sociology and biology was constructed upon a dualism whose one side attempted to distinguish sociology from biology and the other side took biology as a model in understanding society. Emile Durkheim and Herbert Spencer can be indicated as two leading figures that represent these two stands. Emile Durkheim, who attempted to establish sociology as a *positivist social science*, in his work titled *The Rules of Sociological Method* (1895), draw attention to the necessity of distinguishing biological explanations from the examinations of the social facts. On the other hand, in his work titled *The Principles of Sociology* (1898), Herbert Spencer, employed the term of *social organism* by feeding

certain areas of human life and certain conditions or parts of human body can fall under the considerations of medical gaze according to the existing particular historical circumstances. Along with the other relations, the phrase of particular historical circumstances indicates here "all those relationships which existed between the various sectors of science" (Foucault, 1989, p. 76). Moreover, the medical categories are not constantly determined from a fixed focus. For example, "it makes nonsense to talk of the 'hysterical woman' outside of nineteenth-century view of hysteria as a very widespread female malady" (Hall, 2001, p. 74). In a similar vein with the historicity of hysteria, Baudrillard discusses obesity, as an epidemic peculiar to today. For him, it is a malady that reflects the obesity of the whole current system and the obscenity of the whole existing culture. He puts that obese people display the empty inflation of the current system and they are the nihilist expression of the general incoherence of signs, morphologies, and forms of alimentation. (Baudrillard, 2008, p. 48).

These examples demonstrate that each medical context and gaze produce, describe, cure and present its own specific diseases. In addition to that, a bodily condition or a behaviour, which was not used to be considered as an illness or disease in a specific medical configuration would be categorized as a certain disease or illness under the gaze of another medical configuration. In other words, new illnesses can be added to the catalogue of medical literature or some illnesses started not to be defined as illnesses anymore. For instance, there may always have been attitudes or behaviours which resemble or equal to the homosexual forms of behaviour. However, medicalization and psychologisation of

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from biological analogy which identified the functioning system of the society with the functioning system of an organism. As I am going to discuss in the following chapters, the relation between sociology and biology is totally different today. Today the knowledge of these two disciplines is cross sectional as it has never been before.

homosexuality occurred within the perversity theory of late nineteenth century's moral, legal, medical and psychiatric discourses, practices and institutional apparatuses (Weeks, 1985, pp. 149-156). However, in the contemporary medical gaze, homosexuality is not seen as an illness anymore. Another important point here is that, changes in the nature of diseases would emerge. While the leading causes of death at the beginning years of nineteenth century in USA were influenza, pneumonia, tuberculosis and gastroenteritis; in 1980s the principal causes of death were the diseases of the heart, malignant neoplasm, cancers, vascular lesions of the central nervous system and accidents (Turner, 1987, p. 8). Thus, illnesses are not fixed. The definitions of the illnesses are also variable. New illnesses may occur in some periods. And certain diseases may disappear in some particular periods.

Thirdly, within the different epochs of the history of medicine, the individual who is at the target of the medical practice, and his/her body are comprehended and described according to the different knowledges. For instance, in the fifteenth century, the body was considered under the determinative effects of spiritual forces. On the other hand, in the seventeenth century, classical mechanical approach was adopted, and so the body was freed from its spiritual references. Thus, in the seventeenth century the body was surrounded with the mechanical images of clock, hydraulics, elevator, piston, and so forth (Corbin et. al., 2008, p. 8). If we look today, it is obvious that the metaphors and views of fifteenth or seventeenth centuries are invalid and perhaps even ridiculous. As Rose underlines, we capture the body totally different from the ones of fifteenth or seventeenth centuries. According to him, today, the body is imagined "at the molar level, at the scale of limbs, organs, tissues, flows of blood, hormones, and so forth" and he adds that "it is this molar body that we act upon and seek to perfect through diet, exercise, tattooing, and cosmetic surgery" (Rose, 2007, p. 11).

The rise of novel biological knowledges[6] has an important role in these changes. The long established answers of the question "*what can be count as biological concerning body?"* have been changed with the rise of novel biological technologies, and with the advances in the life sciences such as human genetics, molecular biology, genetic medicine and biotechnology. For instance, The American Human Genome Initiative, which was formally founded in 1990, can be exemplified as the milestone of this change (Rabinow, 1996, p. 92). Hereafter, not only what is considered as biological and assumed to belong to the field of nature has questioned, but also the modernist distinction between nature and culture has dissolved in the context of social sciences, as Gibbon and Novas present,

> … in this sense nature could no longer be considered as an entity or object which obeys its own laws and rhythms, but instead became a site that can be thoroughly assisted by human intervention, a place where reproduction could be technologically assisted and new forms of life could be created through the practice of science (2008, p. 3).

Thus, the biological body, which has been the indispensable object of medicine down the ages, is not the given space of natural constraints, or the divine fate of the individual today. Rather, the biological body is the very space of predictions, new life forms, genetic intervention and most importantly a lot of kinds of potentialities for the current medicine. All of these make the vital biological processes of the body open to the medical regulations. Moreover, these also make the future of the body predictable in the short run. As a result, different historical perspectives towards the body, and the new knowledges that are introduced by the life sciences, unavoidably effect the construction of the notions of health, disease and the practices of one's caring his/her own self.

[6] Craig Venter and Daniel Cohen, two of the world's leading genetic scientists, state that "if the 20th century was the century of physics, the 21st century will be the century of biology" (2004, p. 73). The main cause of this statement for them is the new biological knowledges derive from genome researches. These researches lead to the expectations of providing "the complete genetic blueprint of a species, including the human species" and having "a complete description of life at the most fundamental level of the genetic code" (p. 73).

Fourthly, the individual's conducting her/himself in relation with the particular medical discourse is also volatile. For instance, the Ancient Greek people's reactions towards their illnesses and the meanings that they attached to their health and bodies were different from today. In the same manner, in Medieval Ages, the role and value of health in the lives of the people were different from today. The solutions they employed in order to cope with the feeling of unwell were also different. The remedies, which they applied to deal with diseases were different than the ones people experiencing today. Because there are many different types of experiencing and knowing the world. Moreover, there are various ways for appointing one's own place in the world.

As Rose clearly puts, "our relation to ourselves is historical and not ontological"; and as he emphasizes that there is not "essential and transhistorical subjectivity lies hidden and disguised beneath the surface of our contemporary experience" (1998, p. 3). In his study on the history of self, Roy F. Baumeister explains that the issues of selfhood have different characteristics, in the specific historical stages which they belong to (1987). He makes a periodization in order to present the birth of our modern selves. He begins with the late medieval period. In this period, the unity of single human life developed in a gradual manner. For him, during the period between the late medieval ages and twentieth century, the belief in personal uniqueness was developed. (1987, p. 163). The critical point in his discussion is that "the concern with problems of selfhood is essentially a modern phenomenon. The medieval lords and serfs did not struggle with self-definition the way modern persons do" (p. 163). Thus, our modern selves which are surrounded with the medicalized concerns of self-esteem, self-awareness, self-handicapping, self-verification, self-presentation, and so on are time dependent.

2.1.2 “Changeable Social” versus “Fixed Biology”

These four grounds, I developed and discussed above, reveal the interrupted course of medicine. They reveal that the history of medicine full of ruptures and discontinuities. On the other hand, concentrating on these ruptures and discontinuities, indicates that the social context plays an important role in the development of medical knowledge. Therefore, if we focus on the role of ‘changeable social’, rather than the idea of ‘fixed biology’, we can read the history of medicine in a different perspective. This perspective stays out of biological determinism. However, prioritizing the effects of the social in the field of medicine could also lead to the emergence of some questions. For instance, “are the meanings and experiences of health, illness and body purely socially constructed?” “Are the pain, death and disease merely context-bounded and socially constructed illusions?” If so, “how do we explain the pain, hurt, nausea, dizziness, and many other bodily conditions?”

Stating the socially constructed character of medical issues does not necessitate ignoring the realities of the biological body. With greater reason, focusing on health, illness and the body, from the perspective of social constructivism, enables considering medicine as a relational category. As Conrad and Baker notes social constructionism presents a conceptual framework that emphasizes “how meanings of phenomena do not necessarily inhere in the phenomena themselves, but develop through interaction in a social context” (2010, p. 67). From this angle, it is possible to say that, what is described as an “illness” or who is considered as “healthy” or what is qualified as “biological”, are always open to the social negotiations. Therefore, the judgments about health and illness, the conceptualizations of the diseases, the normalizing tendencies concerning the body, the well accepted imaginations of the body, and one’s relations with her/his own body are all embedded into the existing medical knowledge. These are also in

relation with the socially constructed experiences of the health and illness. Moreover, the cultural meanings attributed to health, illness and the body, social interactions, shared cultural traditions and shifting relations of the power play important roles in the existence of certain kind of medical configurations.

In order to comprehend the relational character of the medicine, by moving away from the traps of deterministic approaches towards medicine, it is necessary to ask some questions about the relation between the social and medicine. The arising questions are as follows: "How and through which mechanisms the social is constructed in the field of medicine?" "How does the constructed pervade?" "How does the constructed knowledge gain acceptance?" "How the changing power knowledge relations get settled?" "How they are resettled?" "Which concepts, tastes, choices, sensitivities function, and in which ways do they function in the field of medicine?" "How do these get outmoded?" Moreover, from a historical perspective, "how should we read the relations between the old and the new?" "Are they only the matters of simple transitions or developments?" "Does the new naturally construct upon the heritage of the old?" "Does the new rise upon the exact rejection of the accumulated knowledge of medicine?" "What is the role of past in the present?" Inquiring the answers of these questions, carry us to a methodological concern.

In order to comprehend the relations between the old and the new, it is necessary to focus on the present. There are both the old and the new in the present. Thus, for answering these questions, it is necessary to capture the details of the existing present. "Present" is a historical process. The mechanisms that construct, deconstruct and reconstruct the medical knowledge and medical practice are embedded in the existing present. Hence, the question of "constructed but how?" necessitates paying attention to the present. Below, I discuss the question of "how we stand and snoop around in the slippery present and catch the ruptures and the

shifts of the history of medicine?" by contemplating on the method or a certain kind of historical reading way of genealogy. Genealogy stands here as the historicization logic of this study. It is the methodological (or anti-methodological) way of this thesis.

2.2 Methodological Concerns: "How Should the History of Contemporary Medical Subject Be Made?"

Medicine is something which has certain relations between the cultures in which we live. It is in relation with our ways of knowing, our world of knowledge, our attitudes towards vitality and body. It plays crucial roles in the construction of already existing identities and selves. Professional dynamics specific to current medical practices and our daily medical sensitivities are important determinants in the fabrication of contemporary lifestyles. Moreover, medicine is also a field that has reciprocal relations with rationalities, truth regimes, forms of medical subjectivity, and relations of power peculiar to today. All the aforementioned domains which medicine is in relation with are the certain parts and parcels of each other. In other words, as a relational configuration, current field of medicine is the result of the determinative relations between these domains.

In order to comprehend such a medicine, and reveal its relational configuration, it is necessary to consider the divergences from the past. The unique implementations of current medicine are in relation with the existing "meticulous rituals of power" (Dreyfus and Rabinow, 1982, p. 188) which were established in the domain of medicine. Current medicine operates through its historically specific knowledge. And current medicine has a historically specific understanding of the body. What will give the opportunity of reading the uniqueness of current medical configuration is to focus on the ways of making

"the history of the present" (Foucault, 1995, p. 31) or "cartography of the present" (Rose, 2007, p. 4).

2.2.1 "The History of the Present" and the "Cartography of the Present": Genealogy as a Methodology

For making the "the history of the present" or "cartography of the present", both Foucault and Rose indicate the way or method of genealogy. Making "the history of present" is a Foucauldian way for reading history. Here, it enables seeing the power-related aspects of medicine, without bounding a history that merely considers the medical developments, and a philosophy that thinks upon the foundation of medicine. Furthermore, considering current regime of medical practices through genealogy gives the opportunity "of making visible not its arbitrariness, but its complex interconnection with a multiplicity of historical processes" (Foucault, 1991a, p. 75). Besides Foucault, Rose's theory expands horizon of genealogy. Because Rose takes into consideration the rise of molecular biopolitics, the construction of molecular body and the existence of new pastors of contemporary lives (2007a). While reading the present of medicine, Rose's genealogical approach lights the intersection points of the biological and the social which the current medical configuration rises upon. The novel conceptualizations, which Rose comments on, help to comprehend current tendencies of medicine such as investigating biological opportunities of the body and biological manipulation of the human life.

It is obvious that genealogy includes historical sensitivities. However, a genealogist does not look back or the history for the sake of the past. On the contrary, by considering the past, a genealogist tries to diagnose the present. In line with these, genealogy deals with the questions of "what is happening at the

present, and what are we who are perhaps nothing other than that which is currently happening?" (Foucault as cited in Nilson, 1998, p. 69.). Furthermore, genealogy addresses the questions of "how are we constituted as subjects of our own knowledge? How we are constituted as subjects who exercise or submit to power relations? How are we constituted as moral subjects of our own actions?" (Foucault, 1991b, p. 49).

As Foucault describes, genealogy is "the union of erudite knowledge and local memories which allows us to establish a historical knowledge of struggles and to make use of this knowledge tactically today" (1980a, p. 83). The Foucauldian way of genealogy, is a way through which one can make and read history in a specific manner. It enables seeing how specific discourses are historically constructed, and afterwards, how these discourses are changed and reconstructed via qualitatively different practices (Meadmore, 2000, p. 464). For Foucault, the present is the outcome of numberless and very concrete human practices which can be altered by other practices. Thus, the present is not "simply the result of compulsory historical necessity", rather it has "the very potential of changeability" (Nilson, 1998, p. 71).

Different from *traditional historical approach*[7], genealogy keeps away from the origins, and continuities. It does not seek a certain subject or a specific event as the creator of history. On the contrary, genealogy focuses on the historical descents, sudden ruptures and discontinuities, and considers these historical events in a close relation with the displacement of one constellation of power

[7] I am using the notion "traditional historical approach" by following Larry Shiner's discussion. He puts that the matrix of traditional historical approach is formed by the notions of "origin-continuity-subject-event" (1982, p. 387). Thus, this approach assumes that historian can trace ideas or institutions by searching a sort of founding era or moment when the essential meaning was first revealed. Then, in the context of continuous development -either it is progress or fall- historian sees the individual as the creator or bearer of the history. As a last point, traditional history operates by comprising events (p. 387).

knowledge relation by another. According to Foucault, genealogy is "a form of history which can account for the constitution of knowledges, discourses, domains of objects, etc., without having to make reference to a subject which is either transcendental in relation to the field of events or runs in its empty sameness throughout the course of events" (1980b, p. 117).

On the other hand, Rose, a theoretician standing in the post-Foucauldian line, also underlines the importance of genealogical approach in reading contemporary vital politics. However, he departs from Foucault in destabilizing present for the sake of present. Different from Foucault, Rose offers reading present not for seeking to "destabilize the present by pointing to its contingency", but for seeking "to destabilize the future by recognizing its openness" (2007a, p. 5). Thus, different from Foucault, Rose makes a stronger emphasis on future. In this manner, Rose's emphasis on the future is significant, because we are living in an "amnesic age". In this kind of age, present is already something unanchored and precarious. Thus, the relationship between past, present and future is being changed, in our age. That is to say, we are apt to forget the past quickly, we are living for the sake of the possibilities of the future. And present, in such a table, is something which is slippery and volatile.

This kind of present suffers from *mnemonic convulsions.* It is chaotic, fragmentary and free floating. In this context, "temporal anchoring becomes even more important as the territorial and spatial coordinates of our late twentieth-century lives are blurred or even dissolved by increased mobility around the globe" (Huyssen, 1995, p. 7). For the very reason, Rose puts that

> "today, to destabilize our present does not seem such a radical move. Popular science, media representations, pundits, and futurologists all portray our own moment in history as one of maximal turbulence, on the cusp of an epochal change, on a verge between the security of a past now fading and the insecurity of a future we can only dimly discern. In the face of this view of our present as a moment when all is in flux, it seems to me that we need to

> emphasize continuities as much as change, and to attempt a more modest cartography of our present (2007a, p. 5).

Rose's emphasis on the future is an important point for reading current medicine; because current medicine looks for the clues of future in the existing circumstances of the patient. Even, it attempts to predict future diseases of the individuals who are not already ill. The medicine attempts to control future by moving from today. Besides treating existing diseases, today's medicine works for preventing disease that may arise in the future. Therefore, it is interested in the future, in a way not seen in the previous medical practices. Thus, Rose's differentiating point of view concerning future, is an important source in making the genealogy of current medicine.

Although the way of reading the present is somewhat different in Foucault's and Rose's views, both of them offer focusing on the same axes for making genealogy. These axes are power, knowledge, and body. Both of their analyses indicate that genealogy is a trivet that concentrates upon power, knowledge, and body. As Dreyfus and Rabinow succinctly depict the genealogist is a diagnostician who focuses on the internal relations between knowledge, power, and body in modern society (1982, p.105). In other words, genealogy reveals the present that exists at the intersection points of a scalene triangle which is composed of knowledge, power, and body.

2.2.2 Power: A Genealogical Axis

I would like to start to discuss power by highlighting two concepts. The first one is Foucault's biopolitics, and the second one is the Rose's molecular biopolitics. These two concepts refer to two different historical stages. As it is known, Foucault discusses the emergence of bio-power and modernity as simultaneous

events. In other words, in Foucault's theory, bio-power and modernity are discussed as events that are rooted inside each other. On the other hand, Rose, as a theoretician standing in a line following the Foucauldian theory, discusses how the dynamics of bio-power undergo a change with the development of postmodernity. In his theory, Rose presents that, in the postmodern times molecular biopolitics takes the place of modern biopolitics. Thus, while Foucault speaks about the modern version of power, Rose speaks about the postmodern (molecular) version of power.

Foucault summarizes the main aim of his works as "to create a history of the different modes by which, in our culture [in the western culture], human beings are made subjects" (1982, p. 208). And he underlines that, in his works, he does not attempt to analyze the matter of power all by itself or to evaluate the foundations of the analysis of the power (p. 208). However, it seems that the matter of power puts down roots in the main axis of his works instinctively. While Foucault tracing the formation of certain subjects in his works, he sees that the practices which transform and/or (re)construct the subjects are in a close relation with the implementations and functioning logic of the power which is peculiar to modern times. This power, which is considered by Foucault as peculiar to modernity, is conceptualized in his theory of biopolitics.

In his path-breaking theory of biopolitics, Foucault develops an approach which interprets modern power not as a constraint, negativity and coercion. Foucault puts that modern power emerged almost in the seventeenth century. Different from the previous power mechanisms which was constructed upon the sovereign's capacity of deciding one's death, modern power rules through mastering the bodies of the individuals adroitly, and regulating lives of the individuals carefully (1990). Thus, we cannot see such a functioning power, as a process which is working from top to bottom or oscillating between prohibition and permitting. Rather, modern power is immanent to economic processes, knowledge

relationships, sexual relations and many other kind of mobile and unequal relationships. In a complex network, modern power intersects numerous times with these relationships, and produces them again and again (Foucault, 1990, p. 94). It directly produces these relations and molds these relations (p. 94). Thus, for Foucault, modern power is not something repressive. On the contrary it is productive.

Modern power circulates in the capillary of daily life. It exists throughout society. It appears in innumerable micro-situations attending to an array of issues which are constructed under the effect of the micro-situations of a given regime of power (Bevir, 1999, 349). It does not function in the form of a chain; rather it circulates within a net-like organization. It has not a constant station. "It is never localized here or there, never in anybody's hands, never appropriated as a commodity or a piece of wealth" (Foucault, 1980a, p. 98). In this case power is something that is productive.

In this context, according to Foucault, bio-power operates through dispositifs. Foucault describes dispositif as "a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions" (1980c, p. 185). In his works Foucault focuses on "the system of relations that can be established between these elements" (p. 185). Dispositifs can be considered as apparatuses, devices, machineries or contraptions of power. They produce and organize the knowledge of individuals. For Foucault, "the apparatus [dispositif] is … always inscribed in a play of power, but it is also always linked to certain coordinates of knowledge which issue from it, to an equal degree, condition it" (p. 196).

It is seen from Foucault's oeuvre that Foucault studies on dispositifs by concentrating on specific times, sets of knowledges, certain places and certain

subjectivities. For instance, roughly saying, modern psychiatric knowledge operates in the closed space of asylum and produces the coordinates of madman. In the modern times, modern disciplinary knowledge operates in the prison and produces the definition and content of criminal or modern medical knowledge operates in the clinic and produces the modern patients. Thus, bio-power does not see individuals as something to be suppressed. Rather, it sees them as something whose knowledge can be produced and through this knowledge who can be governed.

Via dispositifs, the modern productive power produces the knowledge of individual and it builds certain kinds of subjectivities. In other words, certain bodies, certain gestures, certain discourses, certain desires come to be identified and constituted as individuals through the effects of power (Foucault, 1980a, p. 98). With Foucault's own words,

> This form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him that he must recognize and others have to recognize in him. It is a form of power that makes individuals subjects. There are two meanings of the word "subject": subject to someone else by control and dependence, and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power that subjugates and makes subject to (Foucault, 1982, p. 212).

What is important here is that the subject is not only produced by the external constraints of power-knowledge relations, but also she/he produces these relations by her/his own internalizations. In other words the subject constructs her/himself in accord with the existing configuration of power-knowledge relations. Individual seeks to stylize her/his attributes in order to make her/himself a coherent subject of her/his own conduct through choosing certain practices, ideals, norms and techniques (Osborne, 1994, p. 517). Thus, individuals do not passively endorse the implementations of power by adopting a position right across to the

power. The relationship between the modern power and individuals is a matter of mutual influences.

On the other hand, in a similar vein with Foucault, Rose puts that in the case of the productive power "ruling becomes a 'reflexive' activity" (Rose, 2004, p. 7). Political power primarily takes into consideration the conducts of its subjects. It focuses on the particular moral engagements of the conducts of subjects. At this point, governing traverse multiple areas, in which the conduct of subject can be governed. The practice of governing pervades into many areas, from offices to airport, from schoolrooms to bedrooms, from clinics to prisons, from shopping malls to sexual relations and much more areas. Concordantly, power relations function at the molecular level. As Rose puts,

> … they [power relations] flow through a multitude of human technologies, in all the practices, arenas and spaces where programs for admiration of others intersect with techniques for the administration of ourselves. They focus upon the various incarnations of what one might term 'the will to govern', as it is enacted in a multitude of programs, strategies, tactics, devices, calculations, negotiations, intrigues, persuasions and seductions aimed at the conduct of the conduct of individuals, groups, populations – and indeed oneself (p. 5).

It is seen in the works of Rose, while he is making a power analysis of recent times, he emphasizes the constitutive role of medicine. He puts that we are at the age of molecular biopolitics. For him, molecular biopolitics is a domain which is dominated by medicine and 'psy' disciplines. Thus, Rose sees the medicine and 'psy' disciplines such as psychology and psychiatry are the most important dispositifs of current power (Rose, 1999; 2007a; Rabinow and Rose, 2003; 2006).

Molecular biopolitics is exceedingly soma-centric[8]. Medicine is the dominant ruler of this soma-centric politics. Thus, in the postmodern age, biopolitics gains a

[8] The concept of "soma-centric" indicates that the body is standing at the heart of social organisation.

rationality which functions through medicine. Medicine has become a principal dispositif. Whereas, what we learned from Foucault's oeuvre was that, medicine, sexuality, punishment and confession were separate dispositifs on their own account. However, Rose's molecular biopolitics departs from the Foucauldian one at this point. It is reflected from Rose's understanding that, in the postmodern age, medicine imposes itself to other dispositifs. Then, many areas of life from death to sexuality, from aging to birth, from happiness to health and so on are medicalized. This is something that was never seen before and that is particular for today.

Medical vocabulary and medical criteria disperse in almost every space of our daily lives. For instance, health as a medical criterion has become an indispensable condition in a large area extending from objects to biological processes, from daily routines to working processes. "Healthy eating", "healthy sexuality", "healthy sleep", "healthy shoes", "healthy offices", "healthy houses", "healthy relations", "healthy clothes" and many other things are all referred to medicine today. On the other side, disease prevention efforts infiltrate every aspect of life. The possibility of being sick in the future puts in pledge individual's future and also today. It is possible to hear the words on the causes of diseases anytime, anywhere such as, genes that cause illness, genetically modified products, stressful environmental conditions, harmful agricultural production, mobile phone technology which leads to cancer and so on. Thus, power's ways of understanding its subjects is medicalized to a great extent. Moreover, there is a close relationship between the contemporary government strategies of power and medical developments. On the other hand, the measurements that subjects employ for reasoning their conducts are also medicalized to a great extent.

Rose interprets such a developments as the displacement of *zoé* and *bios* (2007a, p. 83). *Zoé* and *bios* are two terms coming from Ancient Greeks. Both of them express what we mean by the word of life. *Zoé* refers to the common properties of all living beings such as human and animal. It is the simple or bare life. On the

other hand, *bios* refers to the individual's or group's lifestyle. It is qualified life. It refers to a particular way of life (Agamben, 1998, p. 1). On the transposition of *zoé* and *bios*, Rose says that "the question of good life -*bios*- has become intrinsically a matter of the vital processes of our animal life -*zoé*". (2007a, p. 83). Thus, under the reign of medicine, vital processes of biological life, namely *zoé*, becomes the precondition of good life. Hereinafter, the answers to the question "what is a good life", is sought in the biological conditions of individual. Individual has the chance of good life, if she/he is healthy, if she/he is doing what needed for being healthy, if she/he can predict she/her future diseases, if she/he endeavours to avoid them. Today, there is almost no possibility for seeing an unhealthy life style as a good life. Shortly, medicine has become a very important criterion in understanding and managing the life.

Both in Foucault's and Rose's works, medicine as a dispositif produces the knowledge of vitality; it constructs regimes of authority; it presents practices of interventions. Medicine brings contestation strategies about human vitality. However, unlike Foucault's times, today, the knowledge of the object of power has changed. Namely, the knowledge of body and its vital processes have changed. Thus, for Rose, medicine and its roles as a dispositif has changed. For Rose the changes in the grasping of human biology have transformed the role of medicine since 1960's (2007a, p. 13). Since 1960's biology has produced molecular knowledge of vitality. Molecular biology has opened the way of considering vital processes as contingent and open to the interventions. Moreover, biology's capacity of directing human's future has developed. Therefore, different from Foucault, the emphasis in Rose's works shifts from population to individual, especially to the biological existence of individual (Rabinow and Rose, 2006). In this view, medicalization as a pattern of molecular biopolitics creates medically governable individuals. What is different in the age of contemporary biopolitics is that the biovalue of the body has undergone a considerable change. Today,

molecular bio-power identifies individuals by concentrating on biological terms. Molecular bio-power thinks and acts upon the bodies at the molecular level. Not only new knowledge but also new forms of knowledge associated with new genetics have begun to accumulate (Novas, 2006, p. 290). These new forms of knowledges effect the strategies of bio-power.

Besides medicine, the 'psy' disciplines play an important role in the construction of governable subjects. The 'psy' disciplines offer certain inscriptions governing the energies and capacities of human soul. By developing measuring instruments, they have transformed human soul into something which can be calculated. Doing so, the 'psy' disciplines have played a role within the systems of power, in which subjects have become caught up (Rose, 1999, p. 7). Then human subjectivity and inter subjectivity has fallen under the calculations of power. In this way,

> Subjective features of human life can become elements within understandings of the economy, the organization, the prison, the school, the factory and the labour market. On the other, the human psyche itself has become a possible domain for systematic government in the pursuit of sociopolitical ends. Educate, cure, reform, punish – these are old imperatives no doubt. But the new vocabularies provided by the sciences of the psyche enable aspirations of government to be articulated in terms of knowledgeable management of the depths of the human soul (p. 7).

Here, Rose takes molecular biopolitics as something inherent to daily life, body and soul of the subject. This is a similar point with Foucauldian analysis of power. Both for Foucault and Rose, power affects the conduct of the subject. It governs both the body and the soul. Such an understanding of power enable reading the subject's experiences, which were previously seen as if they were merely subjective acts or choices that strike out in an empty space, as issues about internal controls associated with the positive aspect of power. In this context, certain kinds of conducts and attitudes of subjects' can be considered as values and truths that are built within the specific type of power-knowledge relations. For instance, subject's calculations of the risks concerning their own health, their

desire to take the responsibility of their lifestyles, their cares towards their health as if it is a duty, their concerns about what they eat and drink, their interests in new generation drugs, their constant monitoring, their medical testing become issues in relation with type of power-knowledge relations.

Therefore, by doing the complex analysis of power, genealogy opens a niche through which one can see how power constructs and reconstructs the daily practices of the individual. On the other hand, it reveals how individual produces and reproduces specific power relations via her/his individualistic acts and manners such as choices, daily routines, conversations, attitudes, beliefs, judgments, feelings, bodily conditions, health and illness. All these acts and manners which are seen as if they are individualistic are indeed social and power-related at the same time. They are also certain parts and also products of power relations. Hence, genealogy digs a surface; a surface which is constructed by individualistic manners and acts, scientific activity, social activity, beliefs, emotions, daily practices of individuals and practices of power. On the other hand, as Foucault underlines, genealogy is interested in the question of "how both scientific objectivity and subjective intentions emerge together in a space set up not by individuals but by social practice" (1982, p. 108). Thus, genealogy avoids the search for mysterious depths, meta-narratives, fixed essences and specific individuals as the makers of history. It provides seeing the surfaces of events, surface practices of individuals, small details, minor shifts, subtle counters, strategies, daily flux of events and attitudes.

2.2.3 Knowledge: A Genealogical Axis

Medical knowledge is not something self-evident. Producing medical knowledge through scientific activity does not mean that there is an incontrovertible medical

knowledge. What makes a drug developed in the laboratory as a result of scientific endeavor, superior than a folk remedy? Or, what makes a modality of treatment which is employed in a hospital, superior than a folk method of therapy? What makes a certain kind of medical information more valuable than others is the power of domination that belongs to the mechanism which produces knowledge. Here, I am referring to the word of mechanism in it is relation with the historical alliance of various elements. For instance, for considering a medical knowledge valid today, an alliance between the following elements is needed: pharmaceutical industry, hospital bureaucracy, medical school curriculum, patient experiences, governing agendas concerning the body of the population and individual, and social and cultural acceptances. Therefore, medical knowledge is not just a scientific production. As a matter of fact, scientific knowledge is not independent of value and is not context-free.

As a result, the knowledge of the body, health and illness which are obtained by individuals are not objective and given. These knowledges, which are employed by individuals for stylizing their conducts concerning their health, are socially constructed. The descriptions of health and illness and the experiences of individual are embedded within the power-knowledge relations. Medical knowledges, similar to other kinds of knowledges, are responsive to specific truth regimes which function within the specific type of power-knowledge relations. As Dreyfus and Rabinow explain

> … Foucault owes us a radically new interpretation of both power and knowledge: one that does not see power as a possession that one group holds and other lacks; one that does not see knowledge as objective or subjective, but as central component in the historical transformation of various regimes of power and truth. This of course is exactly what genealogy attempts to provide (1982, p. 117).

Foucault presents that every historical epoch and every society have certain kinds of political economies of truth. Every specific power-knowledge mechanism

produces its own truths. These truths are in relation with economic production, political power and scientific discourses. Thus, the truths peculiar to health, illness and the body that we access, believe and take as a departure point are something intermeshed with power-knowledge relations. They are perspectival and built into the knowledges of life sciences and within individual's performances.

Medical truths are essential flagstones in "embody[ing] a particular way in which human beings have tried to understand themselves –to make themselves the subjects, objects, targets of a truthful knowledge" (Rose, 1999, p. vii). Thus, in our daily livings the truths of medicine play crucial roles in our judgments concerning our lives and our bodies. Medical truths affect, govern, control and shape our opinions and our acts upon our bodies and selves. They are also certain reference points for the mechanisms that organize, administer, govern, improve and control us. They pervade into many areas of our daily livings from pedagogy to beauty, from eroticism to consumption, from habits to punishments and so many other areas. The images, values, presuppositions, beliefs, norms, metaphors and judgments, which we employ while we are evaluating our and other's health, illness and other kind of bodily conditions, feed from the existing medical truths.

It is obvious that medicine is a kind of repository of the truths today. Medicine, of course, has always been a prestigious area. However, medicine's dominant role, as an important determinant in all decisions about life, is something new. The crucial point here is the changing position of medicine among the other incontestable repositories, namely religion and law. This point is strongly stressed in the theory of Bryan Turner especially under the title of "from sin to sickness" (1987, p. 18).[9] According to him, there have been three crucial institutional arrangements, which have managed the unusual features of the body. These are

[9] In the next chapter, I am going to return and enlarge Bryan Turner's discussion of "from sin to sickness" in the contexts of secularization, modernity and medicine.

religion, law and medicine. Concentrating on Foucault's works, Turner describes the role of these three institutions as below:

> Religion, through a variety of ritual practices, regulated and constrained the human body with the aim of developing our spiritual existence. The law has been concerned especially through criminal law with the management of crime and in particular with the urban surveillance of populations. Finally, medicine can be seen as a powerful form of regulation, restraint and representation of the body as flesh. In the terminology of Foucault, we can suggest that law, religion and medicine were three discursive formations for the rational and disciplined management of the body and populations (1987, p. 19).

In our contemporary world it is important that the medicine, as a kind of repository of truths, takes the places of religion and law. Thus, the hierarchy between the three has changed. Today, we make judgments "not in the name of virtue or legitimacy, but in the name of health" (Zola, 1972, p. 487).

As I mentioned above, the changes in the history of medicine cannot be captured only by reference to the scientific and technological developments. Instead those changes are closely related with the processes of knowledge production. The variations of the medical discourses and medical practices are not simply the results of progressions in the field of medicine. Rather than following a linear progression, entire history of medicine is full of ruptures. Here rupture indicates "a change of problematic defined in terms of an orientation towards a given set of theories and questions within an established science" (Bevir, 1999, p. 346). Reading the changes as ruptures rather than as scientific progressions invites us looking somewhere beyond the strict borders, of the field of medicine, as if there are. In order to read medicine out of the linear development logic it is necessary to consider the socially constructed meanings of the medical implementations and experiences. The idea of rupture here provides the base for questioning the claims of existence of essential and unchangeable medical truths and for focusing on the socially constructed nature of medical truths. Through the idea of rupture medical

knowledge can be considered "not as an incremental progression towards a more or refined and better knowledge, but as a series of relative constructions which are dependent upon the socio-historical settings in which they occur and are constantly renegotiated" (Lupton, 1994, p. 11).

In this vein, we should understand the differentiating medical practices and experiences as certain parts of certain regimes of truth. As Foucault puts,

> "Each society has its regime of truth, "its general politics" of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true" (1991c, p. 73).

Every specific medical discourse has strong ties with its own context's formulations of life and death, social and cultural explanations of health and illness, attitude towards the body and power-knowledge regime. Therefore, in order to understand current medicine it is essential to develop an understanding which focuses on the context in which today's medical practices, scientific or daily believes, implementations, experiences and understandings embedded.

The rules governing current medical discourse are different from the ones that governed the older models. More importantly, the rules that govern current medical discourse and the current medical discourse itself operate within the power-knowledge network, peculiar to the specific moment of history. Current medical configuration, or in other words "games of truth" peculiar to current medical understandings, does not arise in some abstract space of thought. As it is valid for all "games of truth", current medical configuration is always in relation to specific practices. It is in relation with "the places and spaces, the apparatuses, relations and routines that bind human beings into complex assemblies of vision, action and judgment" (Rabinow and Rose, 2003, p.14).

2.2.4 Body: A Genealogical Axis

The body, is a crucial entity through which one can trace the crystallized forms of the specific practices of games of truths. As Lash underlines, "genealogy patently, all are agreed, concerns knowledge; it concerns power; it concerns probably above all the body" (1991, p. 256). In our ambivalent and health-conscious age, the body and its social, biological and cultural aspects, human embodiment, contingencies of the flesh and the potentials of the body are also titles of the core problematics of medical sociology (Williams, et. al., 2002, pp. 8-9). In fact, it is difficult to speak about the body because it is something elusive. At the same time, it is everywhere and nowhere. It is a resource and a constraint. It is the innocent shelter of health and illness. It is both given and socially constructed. It speaks about who we are, since "our identities are interbound with the dynamic processes of embodiment, including incidents of pain, illness and medical care" (Lupton, 2000, p. 50). It is an indicator in everyday life. It is both the cause and solution apparatus of diseases. Thus, on the one hand, body is exceedingly tangible. On the other hand, it is unattainable and intangible.

Reflecting on this complicated character of body, Chris Shilling's argument can be enlightening. Shilling underlines that the body is a project which is, both sociologically and biologically unfinished (2012, p. 138). The perspective that sees the body as a phantasm, which is biologically and socially unfinished, that contains in itself the tacit knowledges of limitlessness and the potentiality. Although the body is something that has a certain end, its potentials and capacity continue their existence until we die. For the very reason, the body is something that is always open to the new individualistic performances, social constructions and medical interventions. The time between birth and death remains open to all kinds of medical creativity. Even birth and death are also open to a number of

interventions and conversions. Current medical practice creates projected births and delayed deaths. Thus, one of the most important tasks of contemporary medicine is to contemplate on the unrealized potentials of the body. Current medicine explores the mysteries of the body, which are not denounced at the birth, life and death. The ground, through which the slippery medical knowledge of the body is produced, is this limitlessness and the potential capacities of the body. In other words, the body at the target of medical knowledge is this unfinished body.

It can be said that, the full biological and also theoretical potentials of the body have not come into light yet. This is valid not only for the field of medicine, but also for the field of sociology. While the body has been handled by medicine in a subtle way, the history of comprehensive sociological analysis of the body is not very old, because, the body has been considered as a marginal academic interest for a long time in sociology. The heritage of modernity's way of thinking has a strong impact in the negligence of body in the literature of sociology. Modern way of thinking often applied to clear distinctions which were primarily based on binary oppositions. In accordance with such a way of schematic thinking, the body and mind were seen as two poles which are sharply separated from each other.

However, this kind of attitude towards the body has changed during the 1980's, with the rise of postmodernism and poststructuralism. The intellectual gaze has started to be oriented towards "feeling bodies rather than embodied minds" (Shilling, 2005, p. 1). In this way, many sociological studies which explicitly focus on and theorize the body have been published.[10] Genealogy keeps an

[10] Chris Shilling sums up the sociological interest in the subject of the body in five subject headings, which have been raised since the early 1980's. Firstly, with the changes in the structure of advanced capitalism, the sociologists, such as Mike Featherstone, has started to focus on the relations between consumer culture and the *commercialized body*. Secondly, second and third wave feminist schools have opened new debates on the bodily issues such as nature-culture, sexuality, queer, embodiment, gender, and oppression and subordination. Thirdly, the studies of

important ground within these flowering theories of 1980's on the body. Because genealogy provides a useful point of view for seeing "the body as the place where the most minute and local practices are linked up with large scale organization of power" (Dreyfus and Rabinow, 1982, p. 111). Thus, here, genealogy presents a specific corporal light in the mapping of the formation of current medical configuration.

Today, the body is an indispensable part of sociology. And it is one of the main sources of current medical discourses. Current medical discourses always remind us that we have a body. Medicine talks about sexualized bodies, pregnant bodies, aging bodies, disabled bodies, fat bodies, slim bodies, healthy bodies, fit bodies, masculine bodies, feminine bodies, child bodies and so on. The language of current medical discourse on the body is surrounded by medical terms. Thus, today it is impossible to think, feel or mention about our bodies and their functions without applying medical terms (Faure, 2011, p. 15). It can be said that our time suffers from body fetishism. Especially healthy, young, fit and slim body rises as the exaggerated object of desire.

In this age of body fetishism, there is a flux of information about the body, and there is a verbiage concerning the body. In this context, it is difficult to find a flourishing theoretical way for evaluating the issue of the body. At this point, by focusing on the body, genealogy opens a niche. Genealogy enables to comprehend that beyond its biological character, the body is also a product "of strategic, shifting, historically contingent configurations of power-knowledge" (Williams,

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Michel Foucault broadened the horizon of the investigations of body, especially focusing on the modes of transformation of human beings into the subjects of the western world. Fourthly, the *reality* of the body and its given *borders* have been challenged by the scholars who consider the technological advancements, such as Donna Haraway. And fifthly, with the increased popularity of the issue, the body became to be added as a supplementary issue to various sociological studies by some mainstream sociologists, such as those who escape from Talcott Parsons' ideas (2005, pp. 2-6).

2006, p. 7). Genealogy digs up "how the body has become a crucial entity for the operation, spread and localization of power relations in the modern society?"

In this context, Foucault's genealogical works are brilliant examples which presents the relations between the body and power. His genealogical searches manifests that the organization, control and regulation of the bodies are the constitutive functions of the bio-power. As Foucault puts, with the rise of bio-power, "the body is directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs" (Foucault, 1995, p. 25). What is crucial for Foucault is that the political technologies of the body do not function via a particular type of institution or merely via state apparatus (p. 26). Moreover, Foucault does not see the relationship between bio-power and the body as a pressure comes from top to down, or a directly domination relationship. Foucault does not speak on pure violence or direct control. The relationship that Foucault shows us is much more subtle. He examines the relationship between the bio-power and the body, in a more finely woven web of relationships.

Foucault discusses in his studies, prison, medicine, and sexuality are the institutions alongside the state, through which bio-power functions and subjugates the body of human in modern times. Furthermore, "the control of society over individuals is not conducted only through consciousness or ideology, but also with the body. For capitalist society biopolitics is what is most important, the biological, the somatic, the corporeal" (Foucault, as cited in Hardt and Negri, 2001, p. 27). Thus, our ways of relating with the existing type of bio-power are not stuck in the dilemma of obedience to the rules of power, or disobedience. Or individuals' relations with the existing bio-power do not travel back and forth between formal political participation and rejection. Rather our lives, vitality,

death, birth, production, consumption, property, social and biological reproduction are located in the space in which bio-power functions (p. 26).

Foucault's insights provide exceedingly stimulating perceptions about the body, and his works present a valuable conceptual toolbox. Foucault's works examine the positioning of the body within a particular time frame. The specific historical context, in which Foucault reflects on the body, is modernity. He concentrates on what happened to the body in modernity. Scott Lash overviews Foucault's works and summarizes the modern medicine's axis which Foucault underlines as follows: Modernity witnessed the birth of clinic. With the development of medical imaging technologies doctors came to know the body and its organs in-themselves. Physiology provided corporal penetration, so experimentation is replaced with deduction. And then, bodies' interior movements became calculable (1991, p. 258). However, it is difficult today, to read the body in medical discourses by merely adhering to the oeuvre of Foucault, because in the last decades we observed many changes in the field of medicine as well as in many other fields. Innovations of modern medicine have already become worn out. In addition to that, while reading post-Foucauldian theoreticians' epistemological breaks from Foucault it is important to consider the events which are dated after Foucault's death. As Rabinow and Rose underline, "Foucault wrote before the collapse of Soviet empire, before the 'New World Order', before the internet, before the genome project, before the global warming, before genetically modified organisms, before pre-implantation diagnosis of embryos, before 'pharmacogenomics'" (2003, p. 7).

In this context, it can be said that, postmodern medicine is arising by adopting a perspective which is different from the modern one. The modern medical tendencies of discovering, measuring and calculating are leaving their places to the postmodern medical tendencies of forecasting, preventing and realizing the

potentials. Postmodern medicine is rising upon the principle of probabilistic uncertainty analysis. Postmodern medicine is considering the biology of human as something changeable and it is attempting to enhance this changeable biology. It is recirculating the boundaries of the modern body. This novel understanding of medicine is redefining the inside and outside of the body. It suggests new alliances for the body. In the postmodern context, even they are intermixing, machinery and human are getting closer. Metal and plastic are seeping into the flesh. The parts of the bodies are replacing each other.

In the postmodern context of medicine, the knowledge of the body and the answer of the question of "what the embodied subject exactly is" have been changing. These changes happen through the advances in transplant surgery, in-vitro fertilization techniques, genetic engineering, neuroscience, gene therapy, cloning, organ transplantation therapy and so on. This novel construction of medicine has a notable endeavour, not only in curing disease and protecting health but also in enhancing the biological capacity of human being. For instance, the body parts can be moved from individual to individual and bionic organs can also be produced in the laboratories. These are not merely technological triumphs of medicine. Rather, new arts of governments and new technologies of self, which equipped with the understanding of molecular body, emerge.

Since the current medical configuration imagines the body as a collection of replaceable parts, the biological, natural and cultural borders of human body are needed to be reconsidered. For this consideration Rose offers novel conceptual categories which are different from the ones we see in the theory of Foucault. As I mentioned above, for investigating the collapse of monoblock body, Rose offers the concept of molecular biopolitics. He underlines that since 1960's biotechnologies have developed and the molecular knowledge of life has accumulated (2007a, p. 13). Thus, for Rose, a new kind of vitality is rising. Rose

puts that the object of this novel vitality understanding of postmodern medicine is the molecular body. Molecular body is an entity whose components are storable, freezable, movable, replaceable and demountable. Rose's thought on the changing body and on the results of this change are as follows:

> (…) these are giving rise to a new molecular ontology of life, a 'flattened' biomedical epistemology, and circuits of vitality, in which the elements of life are accorded a new mobility. Vitality can now be decomposed, stabilized, frozen, banked, stored, commoditized, accumulated, exchanged, traded across time, across space, across organs and species, across diverse contexts and enterprises in the service of both health and wealth. I suggest that we have seen the birth of a new 'somatic' sense of ourselves, which extends to self and identity itself – hence we are becoming 'neurochemical selves'. Our corporeal existence has gained unrival salience in our conduct of our lives -our 'Lebensführung' is now shaped by what I term a somatic ethic (2007b, p. 3).

In his theory, Rose, snaps the attention to the minor shifts in the field of biology. He elaborates how the minor shifts in the field biology affect the field of medicine. He examines the field of medicine by concentrating on the advanced medical and health technologies based on elaborated biological knowledge. In his works, Rose underlines that "today, to deem something biological is not to assert destiny or fatalism, but opportunity" (2012, p. 3). From now on, genetic conditions are not considered as a biological destiny or an implacable fate. In this context, the promissory discourse of current medicine brings a new "political economy of hope" (Novas, 2007, p. 11). This kind of "political economy of hope" consistently fosters the hope that new cures or treatments for many diseases will be found in the near future. I want to add here some novel conceptualization for the political economies of the body. The emphasis on the possibilities on the body not only evokes hope, but also it brings about uncertainty, wonder, fear and risk. Thus Novas' conceptualization of "new economies of hope"[11] can be diversified

[11] Carlos Novas discusses this concept in his article "Genetic advocacy groups, science and biovalue: creating political economies hope" in 2007.

as “new economies of wonder”, “new economies of uncertainty”, “new economies of fear” and “new economies of risk”.

The changes in the field of biology and the changes in our understandings of our bodies and selves have got a strong impact on the stylisation of contemporary biopolitics, namely molecular biopolitics. In the case of molecular biopolitics, the body of the individual enters into the field of political calculation at the molecular level. Not only the body enters into this field, but also the future possibilities of the body which embedded in its present are also enter into the field of politics. Thus, hopes, wonders, uncertainties, risks, fears concerning the future of the body are transformed into political apparatuses which govern the present of the body. As a result, the functioning logic of molecular biopolitics is similar with the Foucauldian one. However, the object of molecular biopolitics, namely the body of human, is comprehended different from the modern one. While the body that Foucault speaks about was the monoblock one, the one which Rose speaks about is the molecular body. In other words, Rose both adheres to Foucault and also takes a step further from Foucauldian theory, by concentrating on the new ontology of life that is taking shape at the molecular level (Rose, 2007b, p. 6). On the other hand, Rose’s consideration that identifies biology with opportunity sorts together with Shilling’s conceptualization of “unfinished body”. With the rise of the conceptualization of biology as an opportunity, countless medical operations are developed which can be applied to the body, to the organs, to the cells and even to the genes.

As a result, today the developments in the field of biology and their reflections to the expert and lay discourses and practices conduce to the understanding of the body as the space of enormous biological potentialities. The body as the space of enormous biological potentialities is a novel spatialization which does not exist in Foucault’s works. However, it is possible to read this new spatialization by

following Foucauldian line. This new spatialization is congruent with Foucault's thought, because the spatialization of body as the home of biological potentialities does not make it free from controls, regulations and interventions. This kind of body is again the space in which the trivet of genealogy, namely power, knowledge and the body, functions.

However, as a last point about the discussion on the body, it should be noted that, there is still an important "problem" about the body. And this "problem" is the death. The presence of death is just sitting there by emphasizing the finiteness of the body. Despite all the endeavours of rationality project of modernity, the *problem* of death continue its existence. Moreover, the postmodern medicine is not also able to overcome the "problem" of death. Despite its all potentials, body is a project who has an absolute end, in modern times as well as in postmodern times.

In the next chapter, I am going to discuss postmodern medicine thoroughly. I am going to explore contemporary medicine, by comparing it with the medical practices which are specific to modern times. Following chapter begins with the discussion of modern medicine, and it continues with the discussion of postmodern medicine.

CHAPTER III

FROM MODERN MEDICINE TO POSTMODERN MEDICINE

Today's medicine has got distinctive features which interplay with the historical, social and economic conditions of postmodern times. It is proper to refer contemporary medicine as postmodern medicine because it holds its specific subject, body, death and life comprehensions peculiar to postmodern times. To reach the content of postmodern medical configuration, it is necessary to perambulate modern medicine from its start to finish. In other words, for grasping the historical context in which contemporary medical practice can be embedded, it is necessary to go back only a few centuries ago. It can be said that, modernity was an epoch that included the prodromes of the current medical understandings and the nucleus of postmodern medical subject. Therefore, the early forms of the measurements, values, implementations, practices, advices which are peculiar to current medicine bushed out in the modernity. Moreover, the development of early forms of current medical knowledge and practice is coextensive with the birth of modern modes of thought and practices.

However, despite there are continuities between modern and postmodern medicine, there are also certain ruptures between them. These certain ruptures

give the postmodern medicine its own unique character. Thus, focusing on ruptures and differentiations is more important than focusing on continuities and affinities, in order to catch the unique character of postmodern medicine. Such a point of view also indicates a methodological choice. In order to read 'today' with historical concerns, especially by focusing on certain differences and discontinuities between modern and postmodern medicine, genealogy provides an illuminating path.

In this chapter, focusing on genealogical axes of power, knowledge and the body, I am going to discuss the modern and postmodern medical subjects and also modern and postmodern medical configurations. On the one hand, I try to place the concepts of modernity and postmodernity into a historical framework. On the other hand, I try to explain the transformation of medicine in this historical framework. Below, I do not try to reach the present by following the developments of medical concepts or tools. I do not concentrate on the question of "how is medicine today", by following the history of medicine. Rather, I try to reach today's medicine by using sociological concepts and sociological periodizations. As it was previously pointed in chapter two, the medical knowledge is not something given and unchangeable. The production of medical knowledge is open to the developments in the fields of economy, biology, sociology, history, philosophy, psychology, psychiatry and politics. And of course, the transformations in the field of medicine affect these other areas. Therefore, it is possible to contemplate on medical knowledge in an intersecting network of relationships.

Below, firstly, I am going to discuss modernity and medicine in modern context. I am going to indicate modernity as a certain rupture point from the previous medical understandings. By starting from modern medicine, I attempt to capture the history of today's medicine. I am going to elaborate modernity as the home of

the early and nucleus form of today's medical subject. Secondly, I am going to concentrate on postmodern times. I am going to discuss the ruptures that postmodernity brings in the field of medicine. The aim of such a discussion is to read postmodern medicine within the current configuration of the relations between power, knowledge and body.

3.1 Modernity and Its Imagination of Medical Subject

Giddens clearly puts that, modernity "refers to modes of social life or organization which emerged in Europe from about the seventeenth century onwards and which subsequently became more or less worldwide in their influence" (1996, p. 1). Modernity commemorated with a number of developments which are as follows: the scientific investigation of nature, the human desire of control over nature, the pervasion of industrialization, the rise of urbanization, democratization and secularization movements, the increase in value of scientific knowledge based upon empirical-analytical approaches, the belief in universal reason and progress, the increasing rationalization, the revere to the individual freedom, the rise of nation states, the establishment of bureaucratic administrative systems, the differentiation and separation of public and private spheres.

Hereby it should be stated that none of these changes happened in isolation. They affected each other. Through their transformative impacts in the social, economic, political and cultural spheres, they gave rise to the novel forms of social, cultural, ideological and scientific discourses. In this modern context, the role of health and medicine was far from peripheral. The changes in the consideration of the body, health and illness and the transformation of medicine and medical practice reflected and contributed to the fashioning of modern culture and society (Lawrence in Bury, 2005, p. 5).

It is generally stated that, in the process of modernization, the previous beliefs, practices, meanings, implementations concerning health, illness and the body which were commonly approved by the members of society, by the healers, by the doctors, by the sick people and so on were substantially abandoned. In the process of modernization, the medical practice institutionalized via the establishment of clinics and hospitals. Medical expertise became to be subjected to a series of rules and institutional training. Medical knowledge which was previously spread to the society, beginning to gather in one hand. This (one) hand was the medical science. Thus, scientific medical knowledge declared its sovereignty. Modern medicine, not yet with the promise of creating human out of nothing, but with its novel promise of keeping human alive aspired the throne of god and fate.

Although it is difficult to support this transformation with empirical data, the well-known picture can be roughly sketched out as such: Health and illness were removed from the domain of good and evil forces. The relation between illness and the punishment of the god was cut out. The relation between health and the blessing of the god was broke out. The opinion of the indication of the sins as the cause of illnesses lost its validity. The interpretation of the pains as the displeasure of the god ended. The 'bed' of patient was not considered anymore as the field of ordeal and penance. Making diagnoses through applying the intuitions was abandoned. Using amulets, repent, and sorcery for therapeutic purposes became invalid. The close and old tie between the death and the fate drifted away. Superstitious beliefs lost their roles in explaining and curing the diseases. The prayers accompanies to the healings were cut down.

This was more than a simple linear progress. With the rise of modernity, while the whole world was changing, medicine was changing too. The change of medicine was a part of this multi-dimensional change. Mary Lindemann, in her work *Medicine and Society in Early Modern Europe (2013),* discusses that the

transition from the medicine of Middle Ages to modern medicine was not a process in which people found the wrongs of medieval medicine and then corrected them (p. 113). Moreover, according to her, this transition did not indicate a remove from the ages of ignorance, misery and superstitious beliefs. It was not a simple transition to the modern world which is considered an age that bears the stamps of knowledge, science and wealth either (p.15). Also as Wagner warns us "it has been immensely difficult to both exactly define the characteristics of modern societies and to show when they actually broke with traditional social formations" (1994, p. 3). In this case, we cannot say that medieval medicine' practices were suddenly abandoned. Or we cannot say that old medical knowledges lost their validity completely at that times. As we learn from genealogy, the shift from medieval medicine to modern medicine brought changes in the constitution of knowledge, discourses and domain of objects.

For instance, it is known that in the seventeenth century, the changes in the medical practice and philosophy paved the way of formation of scientific medicine. In this context, the trained physicians gained importance. However, at those times, trained physicians served for only the rich people. And so impoverished peasants and workers lived and died without the assistance of physicians or surgeons. It was impossible for the common people to afford the physician fees and the elaborated remedies that physicians prescribed. As a result, under these conditions, the trained physicians and the great army of 'irregular practitioners' such as barber-surgeons, apothecaries, midwives, empirics and peripatetic quacks practiced medicine at the same time (Magner, 2005, p.355). As Lindemann puts forward, the modern medicine was not something constituted in a non-contradictory manner and it did not functioned whiter than white. Rather, in the age of modern medicine religious treatments, traditional remedies, superstitious beliefs were not totally alternatives of 'scientific' medicine, rather

they functioned at the same time with the evidence-based scientific medicine (2013, p.14).

However, besides the beliefs and habits which were abandoned in the modern times, a literature which was skeptical of ancient medical dogmas flourished. Thus, it can be asserted that behind the scenes of everyday life, there was a change in the medical knowledge production. These changes in the knowledge production can be shown as the constituent of modern medicine. For instance, in those times, chemical remedies, which were challenging traditional Galenicals[12], were composed. For investigating the natural world the novel instruments like the telescope, barometer, pulse clock, and thermometer provided new perspectives (Magner, 2005, p.355). In parallel with the logic of investigating nature, the corporality of human was also submitted to the 'rational' investigations and implementations. Medicine as a 'positive science' undertook the mission of investigating the body and of curing its maladies.

In this way, especially in the sixteenth, seventeenth and eighteenth centuries, new medical devices were invented. And through these devices the modern medicine sailed the inner places of the body. For instance, the development of surgical forceps enabled the removal of urinary stones. The invention of stethoscope enabled to hear inner voices of the body and diagnose certain diseases even if there were no visible surface symptoms. The syringe based hydraulic press, then the hallow needle syringe, then the hypodermic syringe were developed. The development process of syringe points to the refinement. As it was developed, the injections pervaded into the all secluded parts of the body. Ligation was achieved through detailed equipment such as thin needles and hemostats. Then, amputation

[12] The word of Galenic indicates something which is related to Galen or his medical principles or method. Galenical is a kind of medicine (remedy) prepared by extracting one or more active constituents of a plant. Retrieved May, 29, 2014 http://www.merriam-webster.com/dictionary/galenical

was achieved through sharp scalpels. These incidents gave birth to the early idea of movable prostheses. Weighing chair was discovered. This was the early form of medical weighing instrument which calculated the change of the body weight during the meal. It was the attempt of understanding body as a quantifiable entity and it was the precursor of rationalization of diet. Scale was put on the clinical thermometer and human body temperature was measured "exactly". This was also something about the attempt of reaching the calculable indicators of the body. Puppet machines showing the moment of giving birth were made in order to educate midwives and the knowledge of giving birth was removed from the knowledge of uneducated traditional midwives (Porter and Vigarello, 2008, pp. 273-300).

One can find many examples in the modern history of medicine similar to these. What is critical here is that, all of these did not occur suddenly and in a sharp manner. All goings-on were neither a miracle nor the peak point where human reason reached at that times; rather they were contextual and related with wider scale events. Although these events and tools indicate a certain tendency, this tendency is not something that takes place in the linear progressive way of history of medicine. Rather, it indicates that with the modernity novel knowledges and regimes of truth occurred and a certain rupture was experienced. In the historical context of modernity, novel epistemologies peculiar to this context occurred. This was the reconstruction of the "epistemological field that allows for the production of what counts for knowledge at any given moment, and which accords salience to particular categories, divisions, classifications, relations and identities" (Poovey as quoted in Rose, 2004, p. 29).

What is also critical here is that, as Deleuze and Guattari put "technology makes the mistake of considering tools in isolation: tools exist only in relation to the interminglings they make possible or that make them possible … a society is

defined by its amalgamations, not by its tools" (1987, p. 90). When we consider these medical tools under the light of Deleuze's and Guattari's comments, it can be said that these medical tools were not only certain parts of history of technology and history of medicine. They hold certain places in the changing codes of power over the body and a series of events concerning the body and they did not change the trajectory of medicine by an exterior imposition.

The consideration of the rise of modern medicine as a move towards a "better" medicine and curing practice is itself necessitates an unsuspecting submission to the principle of modernity, especially to its principles of progress and rationality. Rather than adopting this kind of position, it is more stimulating to see that the rise of modern medicine indicates a paradigm shift. This shift was closely related with the changes that modern way of thought brought and spread out many areas of the life. It was not an absolute upturn. Rather, the ideology and knowledge behind the eye, looking towards the illnesses and the body, were changed. The modern principles of objectification, rationalization and secularization began to rearrange the field of medicine and medical practices. The modern discourses' rejection of "the *imposition* of a substantive notion of good and right as ordained by a God … [and their] *recognition* of worldly values and rules, existing before and beyond individual, to be discovered, known and followed by human beings" (Wagner, 1994, p. 8), repositioned the field of medicine and altered the character of medical practice.

In this kind of modernist agenda, the medicine was transformed into a modern science, which assumed to have the potential and the duty of discovering the scientific rules of the body. Henceforward, medicine began to adopt a position that depends upon scientific evidence, as a result, empirical evidence became one of the key words of modern medicine. Medical interventions devoted to be rational and measurable. Scientific and rational narratives of the illnesses and

diseases proliferated. The clinical decision making processes, started to be constructed on the truths and knowledge which were derived by the sciences which were based on the principle of rationality. What lies at the core of clinical decisions, was the "modernist belief that treatment decisions can be based on an objective understanding of universal reality" (Foulkner and Thomas, 2002, p. 1). The establishment of the hegemony of evidence-based medicine was occurring in this field.

As Turner indicates, the embracement of the secular paradigms in the field of medicine was the important part of this modernization process (2000a, p. 10). According to him, with the rise of modernization, health and illness became the matter of more secular paradigms which were encircled by various scientific discourses. In this context, the disease entities have been differentiated and disease states were specified. At the same time, the incipient arguments of microbiology strengthened the secular approaches in the medicine by offering the account of minute viruses that invade the body. The account of minute viruses brought this-worldly explanations of the diseases and broke down the old connection between the disease and the moral or religious status of the individual. Then, the scientific explanations for disease began to displace the traditional notions of the quasireligious state of diseases and also colonized the indigenous belief systems. With the valorization of the status of medical professionals, who practice scientific medicine, the status and role of traditional healers such as medicine men, wise women and midwives decreased.

In parallel with the formation of modern medicine, medicine's imagination of the subject and its conception of the human body were changed. Indeed, the birth of modern medical subject was the presence of much wider and more general modernization processes. Hall puts that modern age gave birth to a new form of individualism. At the center of this individualism, the human stood as a central

discursive figure. This discursive figure assumed to have a unified form and rational identity (1996, p. 602). The process of this birth was multidimensional. The movements of the Reformation and Protestantism made individual consciousness free from the direct effect of the religious institutions. Renaissance humanism situated human at the center of the universe. Enlightenment thought presented the image of human who is rational, scientific and freed from dogma. The scientific revolutions endowed human with the capacity of unrevealing the mysteries and the rules of nature through glorifying the notions of inquire and investigation (p. 603).

What is more close to our discussion is that, as Foucault discusses in his work *The Birth of the Clinic: An Archaeology of Medical Perception [1963] (2003),* with the rise of modernity there constituted "a scientifically structured discourse about an individual" (p. xv). As he puts, the bed of the sick person was transformed into the field of scientific investigation step by step (p. xvii). Foucault underlines that the modern medicine gave birth itself in the eighteenth century. In this century, in the context of medicine the practices of saying and seeing changed. The transformations of saying and seeing were discussed by Foucault through the concepts of language and gaze. As Rose points, Foucault's analysis on "different discourses and technologies of medicine were inseparable from distinctive ways of constituting the human body, both in the eyes of the medical gaze and through the cognition of the individual subject" (1998b, p. 48).

With the rise of novel language and gaze, the ideas on body, health, illness, normal and pathological were reconstructed. In its modern context, the medicine was transformed into a clinical science. The medicine as a clinical science developed a language of "positive science". Two principles lie at the heart of this clinical science: experiment and rationality. In this context, medicine became the motivating force of the rising tendency of profanation in the fields of body and

vitality. The theories of scientific healthiness and sickness were developed. With the birth of clinic, the hospitals ceased to be the gathering places of the poor people and the outcasts; and they became instructional institutions. Health and illness were separated from the individual's experience and started to be incorporated in an objective system of medicine. Standards were started to be developed about the diseases. The categories of disease and healthiness were became to be multiplied in the micro level. In parallel with that, medical specialization was developed. Henceforward, the disease rather than the patient began to be cured. The diseases were classified, and the knowledge about them were started to be derived. The course of the illness was started to be recorded.

According to Foucault, the birth and the development of the modern medicine brought new displacements and placements alongside (2003). The patient was taken away from the home, namely from its natural care ground, and was moved to the clinic. Hence, the patient was removed from the immemorially-accumulated knowledge, compassion, traditional care, and the crowd of the family. The patient left in the clinic alone with her/his disease. And she/he became the object of the language and gaze that dominates the clinic. The disease of the human became the object of clinical experiment, the gaze of the physician, and the scientific records and explanations.

In this context, the second spatialization which Foucault underlines is about the body (2003). As Foucault puts, with the development of modern medicine, the disease was removed from body, which was thought to be its natural home. And then, disease gained a self-operating existence. The body of the disease and the body of the patient were separated from each other. The body was reconstructed under the domination of the new medical gaze and it was turned into an object. With the birth of clinic, and with the new medical paradigm it brought, the body of human was transformed into an object which stands where the doctor looks. It

was transformed into the object, in which the disease nests, and through which the doctor pursues the course of the disease. Moreover, the body became the ground of medical examination and experiment; it was converted into the object through which modern medicine produces the scientific knowledge of health, illness, disease, normal and abnormal.

In the modern context, the transformation of the dead body, namely the corpse, into an examination object is also important. In the concluding remarks of *The Birth of the Clinic: An Archaeology of Medical Perception [1963] (2003)*, Foucault emphasizes that with the opening up the corpses for the medical investigation, the dead body was introduced into the mundane world of medicine in a manner which did not leave no room for any religious and moral contest (2003, pp. 241-246). The attempt of knowing the dead body was a certain part of comprehending the living body. In this way, the death was surrounded with the rational discourse of medicine.

The attitude that modern medicine assumed toward death and dead body is the crystallized form of the underlying logic of modern medical implements. Although the death could not be conquered by the modern medicine, it was reduced to an explainable situation. In other words, it was evicted from the life and prisoned into a certain moment. However, as Bauman argues,

> Its [death's] persistence is a scandal. Of all adversities of earthly existence, death soon emerged as the most persistent and indifferent to human effort. It was, indeed, the *major* scandal. The hard, irreducible core of human impotence in a world increasingly subject to human will and acumen. The last, yet seemingly irremovable, relic of fate in a world increasingly designed and controlled by reason. Death was an emphatic denial of everything that the brave new world of modernity stood for, and above all of its arrogant promise of the indivisible sovereignty of reason (1992, p. 134).

As Bauman underlines, modern medicine could not erase the existence of the death, but it could cope with it. Through repulsing the idea of death to the end of

life, modern medicine isolated the idea of death. In this way, death was transformed into a momentary event and a medically explainable situation. To escape from death, modern medicine took shelter in health. Since then, the health and its defense have become a lifelong endeavor.

For Armstrong, the surrounding of the death, with the reason and explanations of modern medicine, indicates the collapse of natural death and gives rise to the pathological death (2002, p. 18). Until the eighteenth century, death was considered as something which comes from the outside of the body; and it was considered as a domestic experience, which the dying human experienced this with her/his family, relatives and neighbors. After the establishment of clinic medicine, the clinicians, pathologists, coroners, clerks and registrars involved in the death of the patient. The pathologist dissected the dead body; the clinician completed the death certificate; the registrar collected the reports. In this way, a profane uproar around the dead body began. The natural death was gone away. Hence, each death gained a specific medical explanation. These explanations are constructed with reference to the new establishing medical idea, which argues that the cause of death was the effect of the pathological lesion inside the body. This shift was also in relation with the secular character of modern medicine. Moreover, the shift from chthonian death to profane death, opened the way of the individualization of death, through ascribing each death a specific pathological cause (Armstrong, 2002, pp. 17-19). Thus, the individualization tendency of modern medicine enlarged its impact area, even including the death of human. As Bauman puts, modern medicine says that "each death is different; each death is individual; each death is a private experience; each death is lonely. And so is life, once colonized by this kind of death: individual, self-enclosed, separated, unshared, lonely" (1992, p. 142).

It is generally discussed that especially after the eighteenth century the medicine has become the main guide in reading and explaining not only death but also the body, health, illness, and disease. The cause of this is not the preferment of the medicine in a supreme scientific cosmos. Rather, medicine has become one of the main sources in producing certain kind of bodies, diseases, deaths, daily lives and social relations. Modern medicine was not coercive in violent or authoritarian sense, but it presented a certain kind of vocabulary for reading the body, life and death of human. Moreover, it exercised certain forms of surveillance over everyday life. The implementations of modern medicine gained a permanent statement in the society and accepted by people as legitimate and normative at the everyday level. On the other hand, aforementioned, Turner puts that similar to the religion, medicine exercises a hegemonic authority, but its coercive character is often disguised and masked by its normative involvement in the troubles and problems of individuals. Thus, for Turner, medicine is coercive, normative and also voluntary (2000b, p. xiv).

As an institution of normative coercion, modern medicine not only steered for solving the problems of individuals, but also operated in the social level. Thus, the history of the modern medicine is also the history of the control of the diseases which wander amongst social relations and dispersed spaces. Since it sets patterns on the contagion of the disease and the provision of the hygiene, this sort of control seems to have generalizing impacts in the first glance. However, it has got a significant role in the construction of the medical subject of the modern medicine. For instance, while considering the birth of the modern subject, Armstrong brings forward the quarantine in the eighteenth century and the sanitary science peculiar to the nineteenth century (2002).

On the one hand, this kind of organization of public health, outlined above, drew the disease out of the inhospitable world of earth, sky and weather. On the other

hand, it developed the rules of conduct against the diseases, which roamed loosely around spaces, such as houses, streets, towns, cities, regions, countries. A cordon sanitaire was pulled around the space of the quarantined disease. Hence, by imprisoning the sick person in the space of her/his disease, the spread of the disease was assumed to be prevented. Despite quarantine was a geographical control system, and despite it was based on the idea that the disease was spread by the spaces rather than the humans, it became a solution parallel to the individualizing tendencies of modern medicine. Because the basic elements of quarantine such as landscape, movement, lines of exclusion and separation provided the formative conditions and embryonic space in which the body of human could materialize (Armstrong, 2002, pp. 5-7).

On the other hand, sanitary science, which was developed in the nineteenth century, presented a clearer tendency of individualization. Whilst quarantine set a cordon between the potential spaces of diseases, the sanitary science set this barrier around the body itself. The main issue of the sanitary science was *dirt*, as a new danger towards health. Sanitary science was concerned about control of the materials which were expelled from corporal space (such as faeces, phlegm, sweat, sperm, and urine) and the materials which entered to this space such as air, water, fluids, and food. In this way, the inside and outside of the body were redetermined and novel monitoring understandings concerning what was entering the body and what was going out from the body were established with reference to novel hygiene rules.

The hygiene politics of modern sanitary science made the body and its changing boundaries the target of everyday practices (Armstrong, 2002, pp. 7-16). Cleansing, monitoring the inputs and outputs, sanitizing, regulating the bodily wastes and controlling the skin and the holes of the body became widespread

daily concerns of human and administrators. Thus, through these new sensibilities, the internal and external maps of the body were revisited.

In a nutshell, the transformations in the field of medicine in the modern times present that, the patient as an independent actor and as a self-practitioner was sighted on the horizon of medicine. The early form of contemporary medical subject was formed in the modern times. Following Foucault's thought, Rose explains that, some of the early forms of central coordinates, which defines our contemporary experience concerning ourselves and bodies and the present, which we inhabit, were established through the rupture that occurred in the field of medicine in the modern times (1998b, p. 49). Keeping up with Foucault, Rose discusses the modern coordinates of medicine as such:

> Medicine was bound up with the delineation of the unique human being, the human person in his or her very individuality and vitality, as a possible object for *positive knowledge*; that is to say, as a territory which could be mastered by a form of truth regulated by rationalities proper to the codes of scientific reason. Medicine was perhaps the first positive knowledges to take the form of *expertise,* in which the human being was not only to be known but to be the subject of calculated regimes of reform and transformation, legitimated by codes of reason and in relation to secular objectives. Medical sites and personnel were bound up with the mutation of political thought into its modern *governmental* form, in which political authorities in alliance with experts seek to administer a diversity of problematic sectors, locales and activities in the population in the attempt to promote a well-being that has become inescapably 'social'. Medicine was linked to the secularization of the *ethical regimes* through which individuals come to describe themselves in the languages of health and illness, to question themselves in terms of norms of normality and pathology, to take themselves and their mortal existence as circumscribing their values. The history of medicine, that is to say, is bound up with the historicity of all the different ways in which we have come to understand what is involved in making us better than we are (1998b, p. 49).

According to Rose's and Foucault's views, the modern context of medicine brought certain ruptures from the past and presented novel engagements. Thus, with its specific context, modern medicine provided a sphere to the individuals in which they would perform their subjectivities.

The embryonic subject of modern medicine is transformed into a more completed and reflexive one. Today, individuals are establishing their own hygienic regimes. They are calculating repeatedly their own health risks. They are monitoring their own bodies in a competitive manner. They are following closely the new health technologies. They are deducing happiness, obsessions, sadness or prestige from their health statuses. They are organizing their daily lives by reference to health rules. They are obsessively controlling their practices of nutrition and exercise in the name of their health. These current habits and so many similar acts, manners and perceptions play crucial roles in the formation of current subjectivities. In addition to these, current medicine attaches specific passions, characters, motivations, wills, interests, desires and sensibilities to the specific individuals. All of these manners and feelings are open to govern. These characteristics are certain parts of subjectivity establishing practices and they bound individuals to an external regulatory system of medicine.

Below, I am going to discuss the transformations in the field of medicine in the postmodern times. I am going to concentrate on the question "what kind of subjectivity that postmodern medicine is giving rise?" Moreover, I am going to describe current medicine as postmodern medicine.

3.2 Postmodern Turn and Its Reflections on Medicine

Almost in the last quarter of twentieth century, "a shift or break from modernity involving the emergence of a new social totality with its own distinct organizing principles" occurred (Featherstone, 2007, p.3). This "break" or "rupture" with the modernity is conceptualized as postmodernity. The prefix of 'post', in the concept of postmodernity, indicates a specific time which means 'comes after'. It

announces the times, which comes after modernity. It signifies a distinction, a break or a rupture with modern.

Although there are different[13] remarks in the literature of sociology, "the term 'postmodernism' is more strongly based on a negation of the modern, a perceived abandonment, break with or shift away from the definitive features of the modern, with the emphasis firmly on the sense of the relational move away" (p. 3). In this context, the break from modernity includes macro-level changes and micro-level changes, both theoretically and practically. On the one hand, in general, the theoretical discussions indicate that,

> postmodernity is a style of thought which is suspicious of classical notions of truth, reason, identity, and objectivity, of the idea of universal progress or emancipation, of single frameworks, grand narratives or ultimate grounds of explanation. Against these Enlightenment norms, it sees the world as contingent, ungrounded, diverse, unstable, indeterminate, a set of disunified cultures or interpretations which breed a degree of scepticism about the objectivity of truth, history and norms, the givenness of natures and the coherence of identities (Eagleton, 1996, p. vii).

On the other hand, the discussions on practical changes range widely from collapse of Soviet power block at the end of 1980's to pervasion of consumerism, from cultural fragmentation to globalized markets, from domination of Western styles of identity and self to social disintegration and so on. Scambler and Higgs summarize the arguments on the postmodernity as a social formation as below:

[13] One of the pivotal focuses of the discussions on postmodernism is about its relation with modernism. Although there is no explicit cutting edge position, the discussion mainly follows two trendlines. One of them is based on the opinion which says there is a serious continuity between modernism and postmodernism. For instance, Lyotard asks the question of "What then is the postmodern?" and he answers: "It is undoubtedly part of the modern. (…) A work can become modern only if it is first postmodern. Thus understood, postmodernism is not modernism at its end, but in a nascent state, and this state is recurrent". Another similar standpoint is stressed by Giddens as such: "Rather than entering a period of post-modernity, we are moving into one in which the consequences of modernity are becoming more radicalised and universalised than before" (1996, p. 3). The other trendline follows the idea based upon that postmodernism is a rupture with modernism rather than continuity. In this thesis, I am also following and developing this second line of thought.

> …the declining importance of the nation state and nationalism in the face of, on the one hand, a growth in supra-national bodies and a globalization of markets and communication systems, and, on the other hand, a concurrent process of 'retribalization' or displacement of national by local political and cultural loyalties; a shift from mass to segmented production, primarily oriented to consumerism; new and predominantly post-industrial or post-Fordist 'flexible' patterns of work; the increasing role of mass media and information technologies; shifts in the social production and circulation of knowledge; the superseding of 'old' class-based politics by the activities of 'new' social movements around the politics of lifestyle and identity; and a fragmentation, diversification and relativization of culture commonly regarded as liberating (2005, pp. x-xi).

Just like the other disciplines such as economics, psychology, architecture and others, the historical shift from modernism to postmodernism affected the discussions within the field of sociology of medicine. Thus, the sociologists inquiring medical field, appealed to postmodernism as a frame of reference. As Scambler and Higgs puts, "medical sociology has been significantly and increasingly affected both by social change, in its multifarious macro- and micro-forms, and by the mainstream debates this has generated" (2005, p. ix). Various scholars have addressed to the distinctive characteristics of the medicine and its context in postmodern times, and medical tendencies peculiar to postmodern times are conceptualized differently from different sociological perspectives.

It is not an easy task to write about the impacts of postmodernity on the medicine and the sociology of medicine. As Burry points "the move from modernity to postmodernity cannot easily be seen in terms which suggest progress, improvement or greater authenticity" (2005, p. 17). The issue is more complex. Each effort of understanding would come up against with the danger of transforming into an illusion in this scene, because postmodern times is the scene of never ending relay between knowledge and power. Thus, it is impossible to see a theory or a sociological explanation as something like the mirror of fundamental reality. On the contrary, each text, each explanation or each assumption constructs

its own reality. Although there is no undivided postmodern theory, or even a coherent set of standings in this theory, it can be said that the main promises of postmodernism lie in its emphasis on fragmentation, difference, possibility, openness, diversity and freedom. Moreover, postmodernism affirms multivocality, radical doubt over metanarratives, epistemological relativism and anti-essentialism (Fox, 2005, p. 32). It carries all the certainties to a slippery slope by rejecting modernity's "universalizing and totalizing claims", "hubris to supply apodictic truth" and "fallacious rationalism" (Best and Kellner, 1991, p. 4).

In order to diagnose the current conditions of medicine in this slippery slope of postmodernism, Rose offers two main methodological beginning points. In the first place, for him, "any investigation that would seek to diagnose our present 'medical complex' in terms of its historical constitution would need to begin with an act of decomposition" (1998b, p. 50). By emphasizing the act of decomposition, Rose implies that we should avoid anchoring to the great certainties. In order to capture the changeable journey of medicine, it is necessary to look at the current *dividing principles* which distinguish health from illness, sin from sickness, disease from fate and so on. It is necessary to look at the *assemblages* of spaces, persons, and techniques which form current medicine. It is necessary to consider the diverse forms of *expertise* and different kind of *technologies of health*. As a last point, it is necessary to focus on the *strategic* dimensions of medicine which are crystallized in public health campaigns, medical institutions and so on (pp. 50-52). These five points are the indicators which show the changing maps of current medicine. Through following them, one can see the macro transformations and also the minor shifts within the field of medicine.

For the second methodological point, Rose emphasizes that "the territory of medicine is formed through the complex interconnections between events and processes with diverse temporalities. To that extent, to study the history of

medicine from the point of view of the present is necessarily to be perspectival" (p. 53). As a consequence, a person who employs the way of genealogy will just reach "a perspectival genealogy of problem spaces, rationalities and technologies", rather than take hold the "general history of medicine" (p. 53).

If we take decomposing great certainties as the starting point, we come across with the necessity of going beyond the routine modern acceptances. First of all, it can be asserted that, what is common in the medical discourse of our "contemporary bio-centric world" (Cooter, 2007, p. 441) or our "bio-tech century" (Rose, 2007, p. 1) is that the borders and descriptions of vitality and body are blurred. That is to say, technology and biology, healing and reality shows, health care and consumption, disease and responsibility, possibility and risk, nature and artifact, implant and tissue, reality and fiction, disease and its narration, and body and its presentation are closely intertwined today. Today, the body, biology, death and vitality of individual are transformed into a soft plastic. This soft plastic is a material which medicine playing with.

As Rose puts we are experiencing a stepchange which depends on the idea that there is "a qualitative increase in our capacities to engineer our vitality, our development, our metabolism, our organs, and our brains" (2007a, p. 4). Medical attitudes towards human vitality are changed. And also, our conception of our vitality is changed. In other words, as Fox depicts "postmodernism challenges the facticity of the human body as constituted in biology or in modern social theory" (2005, p. 34). Today, we are experiencing a certain bio-political shift which gives rise principal novelties in the field of medicine. In conjunction with these, the "anything goes nature of postmodernism" overlaps with the "anything is possible nature of technology" (Hodgkin, 1996, p. 1569). Within the relation of technology and medicine the biological life facts melt away. For instance, it is possible today to change the genetic make-up of an unborn child or to change one's whole face via plastic surgery. It is possible today to remove out a cancerous tissue from the

body or to insert a new kidney instead of the deteriorating one. These examples present that today the medicine acts within the plastic and changeable borders of the flesh. Thus, it can be asserted that the very materiality of the body is conceived today, different from previous times. This is a consideration unique to postmodern times.

In this postmodern context of medicine, utterly unquestioned biological givens are collapsed. The postmodern medical emphasis concentrates on the healthy life. Enhancing the native human capacity becomes the principle aim of medicine. By adopting the principle of enhancing, postmodern medicine concentrates on yet-unrealized potentials of human physical ability, cognition, mood and life span (Bostrom and Savulescu, 2010, p. 2). Enhancement discourse is superseding the modern medical discourse, which was constructed upon the achievements in the cure of diseases. Although new treatments of the illnesses still linger strongly within today's medical discourses, the preventive implementations, and revealing of the potentials embedded in the human body, lie at the heart of current medical discourses. Today's medicine primarily seeks to prevent the occurrence of disease, especially by talking away on healthy life recommendations. If the disease occurs, in order to treat it, postmodern medicine disdains the apparent contours of the body. And it modifies the suffering body by inserting something new, or removing old things. Under these conditions, postmodern medicine moves a position as if it was the master sculpt of the plastic body.

As I mentioned above, with the rise of modern medicine, medicine became a main guide in reading the body and illness. With the rise of postmodern medicine, besides the body and illnesses, medicine becomes a critical source in considering the health of the individual. Now, not only the *pathological* but also *normal* become the issue of medicine. Therefore, it can be asserted that, if modern medicine is something about the illness, the postmodern medicine produces a healthism around the anxiety of being healthy. The changing balance of health

and illness brings along the transformation of the social meanings that attached to health and illness. The sanitization of suffering and compassion towards disease change place with the reactions of accusation and warning of 'take the responsibility of your health'. The assignments of the individual are also changed. With the neo-liberal highlights, the role of individual responsibility, in the case of maintaining one's own health comes into prominence. This also paves the way of individualization of health.

In connection with these, on the one hand, the truth pool of medicine rapidly growing due to the individualization tendency of health discourses. For instance, the truths about the body are proliferating through the indication of the body as the stage of potentialities and the emphasis on the uniqueness of the each body. While the individuals search for the truths which are specific and proper for their own bodies, the powers ascribed to medical personal wear down and the principle of 'one's being her/his own doctor' gains increasing popularity. On the other hand, "health becomes deconstructed into a series of possibilities" (Fox, as cited by Burry, 2005, p. 16). That is to say, health becomes a possible condition which depends on the performances of individual. The conditions of 'the absence of illness' and 'total physical and mental well-being' fall into disuse as the conditions which carry the modern implications of certainty, objectivity and rationality (p. 16).

However, this kind of individualization is not defined with reference to the body's spatial boundaries. That is to say, in the postmodern medical context, the external borders of the body are fragile, impermanent and permeable. Postmodern medicine does not eschew to splinter the boundaries of the body. Postmodern medicine amalgamates the human body with other human's bodies or with machines, while preventing diseases or curing them. Therefore, if there is an individuality which is in relation with the body of human, this individuality is not constructed upon the imagination of introvert body. The individuality, which

postmodern medicine creates, is hidden in the tissue, in the blood types, or in Deoxyribonucleic acid (DNA). That is to say it is hidden in the micro-bodily parts. This is the micro-scale individuality of molecular body. Moreover, all of these micro-scale uniquenesses are open to the reformulations of medicine. Thus they are not unchangeable.

In this vein, the effects of postmodernism make medicine to function in the context of plurality of possibilities and lack of certainties. In the postmodern age, it is difficult to 'reveal' medical truths which stand 'out there' and which wait for discovery. Rather than this, medical truths are provisional and contingent. Moreover, they are constructed by the people with reference to their unique, micro-scale, and molecular bodily conditions. In such conditions personalized medical truths occur. The medical truths of postmodern world which are plural, fragmented, contingent and changeable convulse the hegemony of evidence based medicine with the questions of "whose evidence is this anyway and whose interests does it promote?" (Hodgkin, 1996, p. 1568).

Multiple impacts of medical truths also change according to both the doctors' and patients' positions and wills. That is to say, doctors strive with competing ways of seeing the same clinical situations and competing types of cure. In line with this, doctors' comfortable position, which is grounded on strong edged certainty of modern medicine and their aura endowed with themes which are not religious but whose function similar to religious ones, are collapsed.[14] Thus, while doctors

[14] It is known that medicine had certain religious emphasis before modernity. For instance, in Turkish the term of "hekim", which is originally Arabic, was frequently used instead of doctor. Etymologically this word comes from the word of "hikmet" which means "the aim of the god that cannot be understood by the mortal people". It can be found similar examples in the other languages and religions which indicate that the pre-modern medicine has a certain relationship with religion. What is critical here is that the religious emphasis of the medicine is disenchanted with the rise of modern sciences. Then, with the principles of modern sciences such as objectivity, rationality and so on there was occurred a re-enchantment in the area of medicine. With the rise postmodernity, the principles of modern sciences again melt in the fluidity of knowledge relations. Thus, a disenchantment, which is in this time different from the one that was seen in modernity but

making a decision they are obliged to calculate patients' beliefs and complacence and ethical dilemmas which spring from hydra-headed advances of medicine.

On the other hand, patients are obliged to be careful in calculating their own personal risks and lifestyles while they are choosing a doctor and while they are deciding to exercise a certain kind of cure. The personal responsibility of the patient gains crucial importance in the current medical practices. Michael Fitzpatrick points that in today's world the *tyranny of health* rules and "the fears provoked and sustained by apparently endless series of health scares, backed up by government and public health campaigns, tend to encourage a sense of individual responsibility for disease" (2001, p. 1). Therefore, the discourse of healthy life is inflating by indicating innumerable daily life condition as if they are certain illness, and this inflation makes the condition of being healthy almost impossible. As Bruckner points "this is manifested in the annexation to the therapeutic domain of everything that previously belonged to the order of *savoir-vivre*" (2010, p. 52).

The enormous inflation of the description of ordinary life problems as certain illnesses has almost begun during the 1980's (Conrad, 2007, p. 3). The increasingly growth of therapeutic domain is conceptualized as *medicalization*. As Conrad starkly points out "medicalization describes a process by which nonmedical problems become defined as medical problems, usually in terms of illness and disorders" (2007, p. 4). We can witness the process of medicalization clearly via the novel disease categories which enter in our daily languages. In any moment of our daily lives we are hearing about new generation epidemics, such as "bovine spongiform encephalopathy", "severe acute respiratory syndrome"

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functions in a similar way, occurs again in the area. (The lexical meaning of "hikmet" is retrieved May, 27, 2014 http://www.tdk.gov.tr/index.php?option=com_gts&arama=gts&guid=TDK.GTS.54cca3d52f87f2.50369553).

(SARS), “h5n1 bird flu”, “acute immune deficiency syndrome” (AIDS), “hepatitis B virus” (HBV), “crimien-congo haemorrhagic fever”, “type 2 diabetes”, “obesity”, and so on.

We are meeting with the transformation of certain emotions or feelings into psychosomatic illnesses. For instance, “sick building syndrome”, “multiple chemical sensitivity”, “total allergy syndrome”, “neurasthenia”, “hyperactivity”, “bipolar disorder”, “depression”, and “attention deficit” are some of the popular psychosomatic illnesses. In the process of medicalization the behaviours which are defined before sinful or immoral are also transform into certain disease categories especially under the title of addictive disorders, such as “alcoholism”, “gambling addiction”, “anorexia nervosa”, “bulimia nervosa”, and so on. Moreover, natural parts and some conditions of lifespan such as death, childbirth, menopause, menstruation, aging and so on are also medicalized. The over-medicalization of our everyday lives shows that, in the age of postmodern medicine the borders of *normal* and *pathological* is resetting (Canguilhem, 1991). Moreover, it demonstrates the conditions of acceptable behaviours, bodies, states of being are also revisited by new medical ideologies, medical interventions, and new types of therapies.

Moreover, the transformations in the field of medicine, which have occurred in the last three decades via medicalization, paved the way of pharmaceutical influx. This influx is conceptualized as *pharmaceuticalisation*. Pharmaceuticalisation is the term that indicates the expansion of drug treatment, and so drug consumption, in order to meet health needs. The pervasion of consumerism ideology, drug innovations, medicalization, and state policies supporting drug industry are some of the drivers of increasing pharmaceuticalisation (Abraham, 2010, p. 603). With rise of pharmaceuticalisation of society, different modes of daily life have become mental disorders, trivial complaints are transformed into frightening conditions and more and more ordinary and healthy people are turned into patients

(Moynihan and Cassels, 2005 p. ix.). Pharmaceuticalisation of society has certain relations with the process of widespread medicalization of the certain periods or states of individuals' life. Although pharmaceuticalisation is not the direct or natural result of medicalization or vice versa, there is a relation between these two processes. That is to say, the development of each process extends the other's boundaries and sphere of influence.

In addition to these, current medical patterns such as rising health consumerism, promotions and marketing strategies of pharmaceutical industry, new health policies of the states, the well accepted popular imperatives such as the necessity of one's being own doctor, popular sources such as media that produces lay knowledge and language of health, are some of the causes and also the results of pharmaceuticalisation. On the other hand, the major changes that have occurred within the institution of medicine, for instance, the expansion of medical boundaries from traditional medicine to biomedicine or changing character of medical power dynamics have also certain impacts on the process of pharmaceuticalisation of society.

The issues increasing medicalization of daily lives of people and the spread of the pharmaceuticalisation of society are operating via the risk discourses peculiar to postmodernity. And interchangeably risk discourses on health and illness also rise through these issues. In his insightful work on our contemporary risk context, *Risk Society: towards a New Modernity (1992)*, Ulrich Beck discusses that,

> the risk society is characterized essentially by a *lack:* the impossibility of an *external* attribution of hazards. In other words, risks depend on *decisions;* they are industrially produced and in this sense *politically reflexive.* While all earlier cultures and phases of social development confronted threats in various ways, society today is *confronted by itself* through its dealing with risks. Risks are the reflection of human actions and omissions, the expression of highly developed productive forces. That means that the sources of danger are no longer ignorance but *knowledge;* not a deficient but a perfected mastery over nature; not that which eludes the human grasp but

> the system of norms and objective constraints established with the industrial epoch (p.183).

The risk discourses and possible risk conditions that are constructed upon the knowledge are one of the building stones of today's medical configuration. Today, we are continually facing with the alarm of the risk situations which are derived from our personal choices, private spheres, individual biographies and subjective experiences. Most of these are about our health conditions. For Beck, the medicine, in its most advanced stage is not able to cure many pathological conditions. Moreover, he asserts that medicine, through its *success* depending on its high technology in diagnosis, find new illnesses ever than more (p. 204-205). In this context, medicine creates and manages its own risk situations and risk culture. In addition to that by creating the image of 'active patient', medicine transforms the patient into 'auxiliary doctor'. Through the images of 'auxiliary doctor' and 'active patient' medicine insert the individual in the processes of risk management and risk follow-up (p. 205). Beck describes the individual who lives in this kind of risk culture, as the person who must learn "to conceive of himself or herself as the center of action, as the planning office with respect to his/her own biography, abilities, orientations, relationships and son on" (p. 135).

In parallel with Beck, Mitchell Dean states that "risk is a polyvalent and polysemous vocabulary and set of practices and it would be premature to reduce the different risk rationalities and technologies to one another" (1997, p. 217). Thus, the notion of risk peculiar to today's medicine, which plays a crucial role in giving shape to medical practices and individuals' attitudes towards their own health matters, has its unique rationality, calculation logic and technology. Charles Rosenberg describes the contemporary period in which we live, as the "world of ambient risk" (2009, p. 802) and he describes this world as follows:

> We live in a world of ambient risk. Most of us in the developed world are part of ageing populations, characterised by chronic diseases, managed but not banished. When we imagine our futures we are necessarily forced to

> think about disease: how we will live with it and how we will play the roles dictated by its various narratives. It is hard not to contemplate future illness, especially when we are assailed on television and in newspapers and magazines with warnings about weakened bones, compromised arteries, impaired sexual function, and the ominous presence of "precancerous" lesions. Innovation in screening and diagnosis propel many of us into a world of anxious patienthood, while promising, paradoxically, to allay our consequent fears of the immanent cancer, cardiovascular disease, or diabetes gestating silently in our bodies (2009, p. 802).

The suggestions which say individuals to adopt risk avoiding behaviours, and blame individuals for their lifestyle choices, which take no notice of risks, are some of the main arguments which current healthy life discourses apply frequently. Being 'at risk' and the probability of being 'at risk' are key situations which regulate current medical discourses. The risk notion of today's medicine is not constructed upon concrete situations of danger. Rather, it rules through creating abstract concerns much of which indicates future possibilities. For instance, we always hear or read the popular phrases which say 'the *risk* of cancer is increasing via quick-frozen food', 'do you know what the *risks* you are facing with while using mobile phones?', 'if there is someone in your family who suffer from osteolysis, you should immediately check your bone density measurement because you might also be at *risk*!', and so on.

The shift from dangerousness to risk, which has occurred along the last century, has removed the body of patient being something dangerous itself, and transformed it into something that carries possible risks in it.[15] Such a risk understanding brings interesting medical implementations in some cases. For

[15] As Dean puts "dangerousness is a qualitative judgment based on observable symptoms or empirical occurrences. Risk is both qualitative and quantitative; it is indicated by observable symptoms or by an invisible abstract correlation of factors" (1997, p. 219). Thus, danger is a situation which is embedded in the subject. For instance in the 19th century, although tuberculosis was considered a romantic disease, a person who became tuberculosis was considered as a dangerous person. It is because it was known that the tuberculosis was passing human to human through cough, sneeze and body fluids. However, today, a person who becomes tuberculosis is considered as a factor that increases the risk of being tuberculosis of the other people who are around her/him or considered as the abstract risk carrier.

instance, a certain part of body which is assumed to cause a disease in the future, may be taken out from the body.[16] With its overemphasis on the notion of possibility and its success in creating abstract alarm positions, recent times' risk discourse, "dissolve the notion of a *subject*, or concrete individual, and put in its place a combinatory of *factors*, the factors of risk" (Castel, 1991, p. 281). The decomposition of the subject through the risk discourses, especially the ones about health concerns, overlaps with the postmodern arguments on the subject. Postmodern arguments about the subject assume that, the unified, rational subject understanding of modernity is replaced with the socially and linguistically constructed, fragmented subject, in the postmodern times.

The shift from dangerousness to risk also transforms the mode of surveillance. Lupton conceptualizes this novel mode as 'government at a distance' which indicates the individuals' voluntarily participation of technologies of surveillance through their senses of self- responsibility rather than direct intervention (1999, p. 99). In this way, the individual who makes provisions against the risk all the time, does not came across directly with the situation that cause the risk. However, she/he always lives in the world of ambient risk twitchily.

In this world, a new kind of prudentialism rises. In the age "new prudentialism", individual is transformed into an entrepreneur who have multiple responsibilities in order to minimize her/his potential risks (Rose, 1996b). Moreover, through this new prudentialism a particular type of subjectivity occurs, in which the subject as an autonomous, self-regulating and moral agent, voluntarily takes up governmental imperatives for her/his health (Lupton, 1999, p.106).

[16] For instance, the famous actress Angelina Jolie, removed her two breasts although she did not catch disease, in 2014. Behind her double mastectomy operations lies her idea that she was at breast cancer risk because of her genetic predisposition. Her choice created an "Angelina Jolie effect" and many people get genetic tests done in order to see their risks. Retrieved, January, 3, 2015 from http://www.independent.co.uk/life-style/health-and-families/health-news/the-angelina-jolie-effect-her-mastectomy-revelation-doubled-nhs-breast-cancer-testing-referrals-9742074.html

The transformation of the individual into an entrepreneur through the notion of responsibility, which is feed from the risk discourses, intersects with the issue of health consumerism. On the one hand, consumption culture plays an important role in giving the character to the individuals concerns towards their health issues. The principle of consumer choice, acts an important role in the health issues and reinforces the subjectivity of health. As Burrows and Nettleton points, "today, lay people are obliged to have views a whole range of products and lifestyles including those pertaining to health. These views are then expected to be translated into 'informed choices' concerning (health producing) lifestyles, for example with respect to the consumption of tobacco and alcohol" (Burrows and Nettleton as cited in Burry, 1998, p. 4). People spend money for beauty, holiday, education, clean air and also for their health in order to survive and also to stylize their own lives.

It is known that the modernist extension of human rights incorporates 'the right to health,' complementarily to the rights of liberty and property. While in this modernist extension 'the right of health' was considered almost totally a biological imperative linked to the survival, the issue is more complex today (Baudrillard, 1998, p. 139). As Baudrillard puts today the 'right of health' is also a social imperative which linked to the status (p. 139). The presentation of the body as a prestige object, gives rise to the narcissistic investments for the body and make people to demand more and more medical, surgical and pharmaceutical services. This process pushes individual's body and health into a competitive consumption logic (p. 138-139).

On the other hand, in the novel form of narcissism, which bushes out within the consumer culture, the health consumerism plays a crucial role. As Featherstone puts that, in this novel form of narcissism, people attempt to experience new sensations; they make searches in order to express their selves perfectly; they fascinate themselves with their identities, presentations and appearances. All of

these make people natural consumers (2007, p. 88-89). The imperative of being healthy, which is promoted by the current ideology of "healthism", make people to consume, for the sake of their health. For instance, while in the 1960's there were a few items in the list of 'health-related commodities' such as aspirins, plasters, liquid antiseptic (Dettol) and so on, today the list is seemingly endless which contains food and drink, vitamin complexes, health insurance, exercise machines, membership of sport and health clubs, detox masks, plates videos, anti-aging books, walking boots, running shoes, cosmetic surgery, shampoo, sun oils, psychological therapies and so on (Burrows et. al, 1995, pp. 1-2). In this context, the commodities about health enter into a transvalue process in two directions:

> First, some have been subject to a process whereby their original use value has been transformed into one increasingly articulated in terms of 'health' (for example, the 'greening' of household cleaning products, the shift from decorative to health-enhancing cosmetics and various forms of leisure). Second, and perhaps more significantly, some have been 'transvalued' in the opposite direction, in that their original health use value has been transformed to take on a much wider social and cultural meaning (for example, running shoes, shell suits and body building) (1995, p. 2).

Commodification of health products and construction of certain identities through health consumption indicate that the current ideology of healthism not only transforms the biological body and life of individual, but also re-organizes the world and meaning systems around the individuals and also the meanings and values of the commodities. In other words, the logic and practices of the current medicine pave the way of sociocultural shifts, construct new types of patients, and also novel forms of sensations concerning health. With the intertwinement of *consumer culture* and the hegemonic duty of being healthy, marketization of certain ways of living and the dispersion of health and illness throughout various social and commercial arenas, come into the picture (Nettleton and Bunton, 1995, p. 47).

The other essential aspect of the medicine in postmodern times is about its relation with the notion of happiness. Today, being healthy has become the precondition of being happy. It is because, in a wider context, the project of health maintenance walks arm in arm with another project of *perpetual euphoria*, which dominates the everyday experiences of the people and primarily sacralizes the assignment of being happy (Bruckner, 2010). The predominant principle of today's lives is to reach pleasure and enjoy regardless of how. In the current lives of people which are devoted to hedonism, the situations which do not provide happiness, pleasure and enjoy are the sources of shame, anger and fear.

If there are two legs on which the *perpetual euphoria* stands, one of them is the imperative of being healthy and the other leg is about sexuality. The project of *perpetual euphoria* is driven by norms, such as, 'take care yourself', prohibitions such as, 'stay away from the sun's rays' and jurisdictions such as, 'when you are stressed you do not feel your best'. It creates its own system of values. Bruckner puts that the project of *perpetual euphoria* functions as a new kind of religion, whose roots are not in the next world, but in this world's daily life. Then, he conceptualized this kind of religion as the *religion of felicity* (2010, p. 41). The idea of mastery lies at the heart of the *religion of felicity*. One's being the master of her/his own fate, one's ability to build her/his own life and one's performances devoted to her/his own health become the criteria of happiness. Thus, "happiness has been entered alongside technology and science in the list of Promethean exploits: we should produce it in the two fold sense of the term, create it and display it" (p. 41). In order to display and create happiness one should be, feel and look as if she/he is always -and forever- healthy. In the age of project of *perpetual euphoria*, health as a prerequisite of happiness, falls under both individual's and society's calculations, presentations and continuous scrutiny.

In this context, health is transformed into a social imperative linked to status and self-control, rather than being a biological imperative linked to survival. Thereby,

beyond the illness and disease which are naturally visible and somatic, in the age of *somatic society* and *tyranny of health,* "any loss of prestige, any social or psychological reversal is immediately somatized (Baudrillard, 1998, p. 139). As a result, "medicality is assuming its full scope" through transforming the body into the scene of "narcissistic investment and prestige display" (p. 139). For this reason, individuals undertake never-ending implementations on their bodies and souls and they endeavor in order to be more fit, more bronze, more slim, more healthy, more young. In line with these, the body of the individual is turned into the space of a new kind of ascetism. The new ascetic body is the space through which individuals control, regulate, monitor, and keep eye on their selves.

This new ascetic rules by involving whole life of the individual. It puts a certain emphasis on the lifestyle of the individual. Through opening up each moment of life to the medical gaze, from sexuality to addiction, from nutrition to consumption, from contraception to childrearing, from day-to-day routines to extraordinary events, lifestyle becomes "a medical explanatory framework" (Hansen and Easthope, 2007, p. xiii). When the notion of lifestyle, which is a heavily laden cultural baggage, enters into the medical discourses in a widespread manner, medicine strengths its potential of "transforming complex socially and culturally embedded behaviours and practices into quantified risk factors for disease" (p.61). Speaking about lifestyle over and over again reinforces and reproduces contemporary concerns with management and containment of risks which are associated with commodifying and commercializing the body and health (p. xiii).

The emphasis on the lifestyle functions as an empty indicator which creates an abstract vacuum where each behaviour, attitude, choice, addict and move of the individual, carry the potential of being the cause of her/his own illness or success of her/his own health. The emphasis on the lifestyle strengthens the performativeness emphasis of current medicine. Moreover, as a medical

explanatory framework, it enlarges the movement area of medicine. In the increase of medicalization, pharmaceuticalisation, medical surveillance and medical control, it plays crucial role by incorporating every moment of the life into the terrain of medicine.

Today, in order to be healthy, it is necessary to develop momentary scrutiny to the risks of the body and the world beyond the body. Moreover, it is necessary to consume in order to pursue a healthy way of life or to maintain and present a healthy body. While individuals perform in order to catch the chance of being healthy, they follow closely the recommendations on the healthy life which spread like wildfire and produce the truths and practical knowledges of the body, health and illness.

On the one side of the coin, some aspects of the medicine -as a science- still bears the stamp of strongly modernist practices and modes of thought. In order to strengthen the persuasiveness of the medical recommendations, the language of medical professionals and the language of the popular medical discourses frequently apply the phrases which include modernist highlights. For instance, we frequently hear about the phrases of "it is proved by the scientists", "it is tested in the conditions of the laboratory", "it is tested on the mice", "the breakthrough in the cancer treatment", "cutting edge technology in the surgical operations", "the gene that cause obesity is discovered", "the newest antibiotic with minimal side effect is developed" and so on. These leitmotif phrases reflect that, applying to the modern principles of the rationality verifiability, objectivity of science, experimental medicine, and linear progress still work in the field of medicine. Thus it can be asserted that,

> the anomalous position of medicine in contemporary culture -an island of rationalistic modernity floating in a shifting sea of subjective postmodernity- a castle of objectivity besieged by the forces of relativistic cynicism… (Charlton, 1993, p. 497).

However, on the other side of coin, there is the flux and plurality of rapidly changing medical truths. Medical knowledge does not progress incrementally towards a more refined and better knowledge. Rather, the existing medical implementations and remedies on the healthy life become relative constructions which are constantly renegotiated by individuals. In the experiences and conversations of lay people concerning their health, the preferences and the self-interests cooperate with objectivity. Fashion and popularity of medical implementations take the place of progressivity. Certainty of medical truths melts in the discourses of risk and consumption. The hegemonic principles of healthy life, longevity, beauty, feel-good dominate the direction of medicine, as well as the diseases and their causes and treatments.

Rather than seeking the timeless and objective medical truths, individuals seek for the proper medical truths which are tailor-made for their own lifestyles and bodies. Rather than applying the medical truths out there without a question, individuals search for the medical implementations or remedies which are adoptable to their way of life. What is unambiguously common for the individuals whose experiences and approaches toward health and illness are fragmented and provisional, is the internalization of the popular and hegemonic duty of adopting a healthy life style.

In this context, from the perspective of the subjects of the current medicine, it can be said that, in the age of postmodern medicine, health is transformed into a possibility which is imprisoned in the acts, manners and souls of individual. Correspondingly, health, illness, the duty of well-being, and health caring activities serve as apparatuses for self-production; then, certain kind of subjectivities endowed with the capacities of responsibility, choice, and will occur. In addition to that, in the postmodern culture, which is “depthless, decentered, undergrounded, self-reflexive, playful, derivative, eclectic, [and] pluralistic”, the boundaries between art and everyday experience blur (Eagleton,

1996, p. vii). Thus, the daily practices of the subject which are exercised in the name of health can be read as the artistic arrangement of the life. In other words, an artistic way of governing the subject's her/his own life, body and soul, which bears the stamp of the health concerns and health sensations, may come into the picture.

It can be asserted that, the subjects of postmodern medicine carry a clock inside their selves. The ticktacks of the clock whisper to their ears the conditions and possibility of self-governed health. What is essential here is that, the subjects of postmodern medicine do not discover a clock embedded in their souls or bodies instinctively or suddenly. On the contrary, the ticktacks of the clock are relational with the spirit of outer world of us. The clock which is ticking inside us is something which has certain relations with the transformation of the tactics of the power. In Foucauldian terms, the shift from sovereign power to disciplinary and then pastoral forms bring deinstitutionalization and the internalization of the control by the individuals. The ruling type of pastoral power adheres strictly with the inside of the subject. Foucault explains this as below:

> …this form of power [pastoral power] cannot be exercised without knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies knowledge of the conscience and an ability to direct it.
>
> This form of power is salvation oriented (as opposed to political power). It is oblative (as opposed to the principle of sovereignty); it is individualizing (as opposed to legal power); it is coextensive and continuous with life; it is linked with a production of truth-the truth of the individual himself (1982, p.215).

Today, the implementations of medicine provide a fruitful ground for the operation of the contemporary version of pastoral power. For Foucault, the pastoral power which is peculiar to today is different from its early forms which had predominantly has religious attachments. Current version of pastoral power

does not aim an after-death salvation. Rather, it ensures the salvation in this world via "health, well-being (that is sufficient wealth, standard of living), security, protection against accidents" (1982, p. 215). In this context, the healthy life discourse presents a base for self-construction by offering languages, criteria and techniques through which individuals act upon their bodies, souls, thoughts and conduct in order to achieve happiness, wisdom, health and fulfillment (Rose, 1999, p. 11). The duty of well-being is endowed with the technical terms of medical language not only in the expert languages, but also in the lay language. Genetic modifications and manipulations, healthy foods, obesity, bulimia, organ transplantations, expanding life span, duty of wellbeing, stigmatization, genetic screening, plastic surgery, bodily rates as cholesterol or blood pressure, cancer narratives, in-vitro fertilization, health consumerism, new generation of psychiatric illnesses and drugs, fabrication and regeneration of organs are only a small part of the issues which expressed in the lay and expert conversations on health, illness, disease and medicine. In the current era of individualism, self-construction is an infinite task and the healthy life practices constitute a substantial stage for this infinite task.

3.3 Constituent Tendencies of Medicine in Postmodern Times: First Steps towards a Sociological Analysis of Organ Transplants as a Postmodern Medical Case

Up to here in this chapter, I attempt to evaluate the postmodern turn and its reflections on medicine. I aim to discuss pivotal tendencies of the current medicine and their effects on the body and life of individual. I present a general picture concerning medicine and its reflections on the daily lives of people. The main tendencies of postmodern medicine, which I can catch, may be summarized as such: In the postmodern medical context, the relation between biology and

technology has developed in an unprecedented manner. Thus, we are experiencing the technologization of vitality. The materiality of the body has also transformed. We are at the age of plastic and borderless bodies. The knowledge of this body is plural and fluid today. This kind of knowledge eliminates essentialist arguments of biology, and opens more rooms for the arguments of role of changeable social in the medical field. Moreover, postmodern medicine has become the home of medicalization of daily life and pharmaceutical influx. Recent risk discourses have undertaken an increasing role in the health and disease issues. In line with this, lifestyle has transformed into a medical category. Health consumerism has inflated. *Perpetual euphoria,* as a specific kind of ideology of happiness, has constructed strong ties between the conditions of 'being happy' and 'being healthy'.

In the next chapters of this thesis, I am going to continue to try to read/understand postmodern medicine. The medical picture I tried to discuss up here, presents that postmodern medicine operates in a different world from the one in which modern medicine operated. When we look at the overall medical picture peculiar to postmodernity, the specifications of this picture are more or less as follows: postmodern medicine is a medicine which is equipped with high technology, so it is technology based. Postmodern medicine functions on a body which it conceives as if it was a soft plastic. It is not only a hospital and illness based medicine, but also a preventive one. It concentrates not only on the treatment of diseases, but also the care of health. It is risk oriented. It is consumption oriented. It is multisectoral and multidisciplinary. It is constructed upon the active participation or self-regulation of the individual.

Hereafter, I examine postmodern medicine from a closer inspection. To do this, I concentrate on a specific postmodern medical case. In other words, to see more specifically postmodern medicine, and to discuss the ruptures it has created, I concentrate on a unique therapy of medicine. This therapy is the organ

transplantation which has been effectively using in the medicine, for almost the last fifty years. Here, I propose that the organ transplant therapy of medicine carries the potential of demonstrating the ruptures between modern and postmodern understandings of life, death and the body. Moreover, I offer that organ transplant therapy of medicine is a suitable case through which one may pursue the shifts from modernity to postmodernity, from bio-power to molecular bio-power.

In simple terms, organ transplantation is based upon the medical act of removing a body part from one body to another body. In other words, basically, organ transplantation is the transmission of the organs from the people who are about to die or just now died, to the patients who need a new organ to live. In this context, almost every organ, except the brain, can be moved from one body to another body. For example, kidney, liver, heart, face, skin, pancreas, intestine and uterus can be moved from one body to another body. Tissues such as cornea, bone, skin, heart valves, tendons, cartilage also can be moved from one body to another body via transplant operations.

Medical dictionaries and prestigious universal health organizations explain organ transplantation almost with the same sentences. Some examples from the definitions are as such:

> You may need an organ transplant if one of your organs has failed. This can happen because of illness or injury. When you have an organ transplant, doctors remove an organ from another person and place it in your body. The organ may come from a living donor or a donor who has died.[17]
>
> Organ transplantation is often the only treatment for end state organ failure, such as liver and heart failure. Although end stage renal disease patients can be treated through other renal replacement therapies, kidney transplantation is generally accepted as the best treatment both for quality of life and cost effectiveness. Kidney transplantation is by far the most frequently carried

[17] Retrieved Jan, 5, 2015 from http://www.nlm.nih.gov/medlineplus/organtransplantation.html

> out transplantation globally. The procurement of organs for transplantation involves the removal of organs from the bodies of deceased persons. This removal must follow legal requirements, including the definition of death and consent.[18]
>
> *Organ transplantation* is the process of surgically transferring a donated organ into a patient with end-stage organ failure.[19]
>
> An organ transplant replaces a failing organ with a healthy organ from another person. Organs most often transplanted are: kidney, liver, heart, pancreas, lung, small intestine. More than one organ can be transplanted at one time. For example, a heart and lung transplant is possible.[20]

The medical descriptions of organ transplantation basically focuses on the medical *travel of a piece of flesh* from one body to another one. When we consider the organ transplants from a sociological perspective, we may see more complex issue than the *travel of a piece of flesh* (Hamdy, 2012; Lock, 2002; Rose, 2007a; Scheper-Hughes, 2005, 2002; Sharp, 2006, 2000).

Focusing on the organ transplantation case provide a basis in order to understand and interpret under which constitutive patterns, conditions and processes do the postmodern medicine operate. In order to understand and discuss the ruptures of postmodern medicine, I choose this specific therapy among many other novel therapies. In other words, I see the organ transplantation therapy as a capable and flourishing medical case in order to discuss the paradigm shift which leads to transition from modern medicine to postmodern medicine. There are several reasons for this choice.

[18] Retrieved Jan, 5, 2015 from http://www.who.int/transplantation/organ/en/

[19] Retrieved Jan, 5, 2015 from http://www.organdonor.gov/about/transplantationprocess.html

[20] Retrieved Jan, 5, 2015 from http://www.webmd.com/a-to-z-guides/organ-transplant-overview

First of all, organ transplantation is a novel medical therapy. It can be said that the organ transplants has a very short history. It has been developed in the 21st century. It has become increasingly widespread since 1950s, especially after the first successful kidney graft. Some landmarks of this treatment may be put briefly as such: The first kidney transplant was made in 1954. The first heart transplant was made in 1967. The first single lung transplant was made in 1983. The first full face transplant was made in 2010. It is obvious that this treatment can be applied since the second half of the twenty-first century. The novelty of this therapy is important for seeing the ruptures of postmodern medicine. To put up a new thing instead of a failing body part is a pre-existing idea, in the history of medicine. Throughout the history of medicine, to this doctors violated the Hippocratic dictum of "above all, do not harm" and made experiments by stealing body parts, by using animals, by butchering cadavers (Richardson, 2006, p. 159). Although there were efforts which of earlier dates resembles to this therapy, none of these efforts ended up successfully. The idea of transplant remained as a myth. Thus, the idea of exchanging vitality between humans may be old, but the realization of this idea became possible under the postmodern conditions of medicine. The realization of organ transplants under the conditions of postmodern medicine, transforms it a valuable source in reading the specificities of its historical context. This short history of organ transplantation has had enough to tears down a lot of borders which have been stationary for long years. The borders between nature and artifact, biology and sociology, life and death, one's body and another's body are replacing through this novel medical therapy.

Secondly, organ transplantation therapy is improving along with the technological innovations in the medical field. In the realization of organ transplant operations, technology is not a supplementary or secondary factor. Rather, it plays a *vital* role in the transplant operations. For instance, it maintains the heartbeat of the patient whose brain death occurred through the intensive care

technologies; and converts this patient into a potential organ donor. That is to say, the body, that is kept alive by means of technology, becomes the source of life for other bodies that are on the verge of death. On the other hand, the patient who is waiting for kidney transplant can cope with this waiting period without surrendering to death through the dialysis technologies. Therefore, the working of technological machines instead of failure human organs, is something new, and indicates a rupture from the supplementary role of technology in the medical treatments. In this case, technology is ceased to be the assistant of medicine and it becomes the active element of the processes of giving a life and claiming a life. However, it is not impossible to say that the organ transplants are successfully realized thanks to the growing medical technology. This issue is not only related with the development of technology. Rather, the use of developing technology in such a manner is the crucial point. The use of technology in such a manner is the concrete example of the abstraction of technologization of vitality and death. From this perspective, the case of organ transplantation carries an enormous potential to show the relationship between technology and medicine.

Thirdly, in organ transplantation therapy, the employment of a piece of human vitality as a treatment material, creates a unique difference. To put it differently, the treatment material which is employed in the organ transplantations, is very different from the ones that are using in the other methods of treatment. What creates here a rupture is the using manner of human vitality. When we look at the many other new developments in the field of medicine, the developments usually include the discovery of new drugs, the flowering of new treatment technologies, and the formation of new treatment style and the improvement of surgical techniques. On the one hand, organ transplantation comprises these novelties. On the other hand, organ transplants have a different feature from all of these developments. This difference is about the material of treatment. For treating a human, using a part of vitality of another human is a very unique difference, in

terms of the history of medicine. In addition to that, it is also an important rupture in terms of the imagination of human biology. It indicates a biological novelty. Therapeutic exchange of vitality between the bodies, is a certain challenge toward the essentialist biological arguments defending the idea which emphasizes that the introvert body is naturally given.

Fourthly, the organ transplantation therapy is based upon a unique body understanding which is never seen before. The organ transplants bring novel experiences and discussions about the questions of where the body starts and where it ends. They alter the definitions of the body parts. Organ transplants bring new set of social relations by opening the bodies into a new kind of dialogue. They bring donors and recipients together and mix their bodies regardless of their religious, national, class, sexual, ethnic, age related belongings. They challenge the borders between humans which are constructed with reference to their biology. The bodily borders between the categories of *me* and *other* blur. The organ transplants are the results of the plasticization of the biology; as well as they are plasticizing the biology itself. They produce new procedures and comprehensions about the outer and inner borders of the body. They resolve the introvert, molar and well defined body of modern medicine and functions through a postmodern body understanding whose parts mobile and meaningful in themselves.

As a last point, organ transplantation therapy brings a novel perspective towards life and death of human. Organ transplantation therapy offers to multiply lives by removing the organs between the bodies. Thus, through this novel medical therapy, there develop a new kind of exchange between life and death. While it is multiplying lives and presenting potentials for enhancing the bodies, it transforms dying patterns which are peculiar to the modern medicine. On the one hand, medicine makes new negotiations with death by giving a new life to the organs of deceased or to the organs of the person who is almost dying, by transporting them

into a new body. In this way, medicine disintegrates death and reorganizes it in the multiple bodies, through organ transplant operations. Organ transplants bring novel ideas and implementations about the end of the life. Moreover, they construct novel spaces between the life and death, such as brain death which neither exactly means life nor death. On the other hand, medicine makes new negotiations with life, by carrying a piece of vitality between the bodies, and by transplanting a piece of new vitality, which comes from outside of the patient's body, to the patient's body. In this way, medicine scatters life and restarts it in the new bodies, through organ transplant operations.

In the following chapters, I am discussing organ transplant therapy as a medical implementation which is functioning under the effects of postmodern comprehensions of the body, the death and the life. Thus, organ transplant therapy, whose history has begun in 1960s, is a medical implementation specific to postmodern times. Although there are metaphors or fictions about the hybridization of human body throughout the history, organ transplants create hybrid bodies in the true sense of the word. This practice of medicine invites us to reevaluate the embodied human subject who is also considered as the main actor in the social field since modernity.

CHAPTER IV

POSTMODERN MEDICINE, ORGAN TRANSPLANTS, AND THE BODY

There is always a relationship between the body and medicine which cannot be cut away. Medicine is a field, directly related with the human body. However, there is no stable, unchangeable and given relationship between the medicine and the body. Moreover, the body is not something unchangeable and given at the level of medical imagination. There have been different medical gazes oriented towards the body, throughout the history of medicine. And also, different medical knowledges concerning body have been produced. As we know from the theory of biopolitics, the notions of medical gaze and medical knowledge do not flourish independently from sociological, economic, political, historical courses of events. Thus, the historical conditions in which medical gaze and knowledge formed, have got a certain impact on the relation between medicine and body. That is to say, historically specific modes of production, or hygiene sensibilities, or procedures of public life have significant roles in the formation of medical imaginations. These kinds of historical circumstances have got also direct impacts on the medicine's imagination of the body. Thus, medicine evaluates the body from an angle which is filtered from the historical context. In other words, the

historical context, in which medicine exists, frames the medical gaze towards the body.

On the other hand, historically specific and context dependent medical imaginations of the body, have got an important role in the regulation of life. Moreover, historically changing comprehensions of the body would cause the application of different tactics in the government of subjects. The knowledge about the body that is produced by medicine plays an important role in the regulation of many aspects of life. Some examples on this issue of regulation may be outlined as such: the medical knowledge, which is produced about the fertility of woman body, is significant in the regulation of population politics. Or, medical knowledge, which is produced on the death of the body is also significant in the regulation of population politics. Medical knowledge, which is produced about child body plays a crucial role in the process of nation-building when it is employed in education, in sports or in raising of awareness of mothers. Medical knowledge, which is produced about the physical capacity of the body is an important source in the determination of the working hours of workers. There is a close relation between planning sewerage system of a city and bodily hygiene understanding of medicine. In a nutshell, medical imagination of the body circulates in almost all spheres of life. It operates in economics, politics, urban planning, and demography and so on. In addition to these, medical knowledge of the body which changes with respect to historical conditions, causes different implementations in different historical epochs.

By following this kind of walking line, in this chapter, I concentrate on the postmodern medicine's body imagination through the case of organ transplants. I argue that the postmodern medicine has its unique body understanding. The body understanding of postmodern medicine is grounded on and works in the postmodern conditions of world. In the fragmented, constant state of flux,

decentralized, and hybrid world of postmodernity, has a medicine which pursues its characteristics.

In this context, I argue that the case of organ transplants which are peculiar to postmodern medicine have the potential of demonstrating the postmodern medicine's imagination of the body. Examining organ transplants is a proper ground to discuss the genealogical ruptures of postmodern medicine from modern medicine. Organ transplanting is a kind of medical therapy basically constructing upon the translocation of human organs. A certain kind of body imagination, which is peculiar to postmodern medicine, lurks behind the translocation of organs. Through its specific body imagination, postmodern medicine treats the body different from modern medicine. Postmodern medicine's unique body understanding and its unique diagnosing, handling, monitoring and treating manners and techniques make the translocation of organs possible. Thus, organ transplanting as an advanced practice of treatment, which is recently specific, enables to comprehend how postmodern medicine sees the body. Below, I discuss the postmodern medicine's ruptures from modern one, by concentrating on the body, in the organ transplant operations. In other words, under this title, I try to present the characteristics of the molecular body which is peculiar to postmodern medicine, by comparing it with the molar body of modern medicine, by concentrating on organ transplants.

4.1. Molecular Body as a Network: New Spatialization

"Fresh challenge away from the usual shoot'em ups, ORGANise is about saving the lives. Try it. Being a hospital hero becomes addictive! You don't have to be surgeon to save lives." [21]

These interesting sentences are the slogan of a computer game called "ORGANise*".* The name of the game connotes both to form a whole by regulating interdependent parts and to arrange the organ parts for the performance of the functions which are necessary to live. The game promises to its ordinary players being a hero in the cyber world by transplanting organs. In this game, the player transplants organs and then scores points. The player sees the patients and the pieces of the organs, such as heart, kidney or lung which the patients need, and the donors with the organ pieces which they want to donate, in the computer screen. Then, the player tries to match the proper donor and patient by considering the organ pieces. There is also a clock in the screen which indicates how many minutes that the player has in order to save the patient, so the player races against time. If the player matches wrong organs, there emerges a skull on the patient, which means the patient has died, and the player loses points.[22]

[21] The game is retrieved May, 27, 2014, from http://www.mydoctorgames.com/organ-donor/game/. In the Internet there are so many games on organ transplants whose content and logic are almost the same. Here, I am focusing upon one of the most popular organ transplant game. In the Internet there are many games on organ transplantation whose contents diverse from alien surgery to scoliosis surgery, from filling the body with correct organs to exchanging organs. Organ transplanting is one of the popular subjects of internet games in the recent times. These games include promises such as spending funny time, learning the working of the human body, being a hero, saving a life and the like. Some examples from these games can be reached from at the addresses counted below: retrieved May, 27, 2014, from http://www.oyungemisi.com/organ-nakli-oyun-oyna/, retrieved May, 27, 2014, from http://www.mydoctorgames.com/organ-transplant-2/game/, retrieved May, 27, 2014, from http://www.fupa.com/games/1/organ-transplant.html, retrieved May, 27 from, 2014, http://www.surgerygameonline.com/organ-transplant-4-game.html, retrieved May, 27, from 2014, http://www.surgerygameonline.com/organ-transplant-2-game.html, retrieved May, 27, from 2014, http://www.hospitalgames.co.uk/surgery-games/transplant-surgery, and so on.

[22] See Appendix A, figure 1

The pieces of heart or kidney, which are jumping around in the computer game, whisper us something about our current body imaginations. The game indicates a body whose borders are open to new entrances and exists. It constructs upon the possibility of organ interchanging. It implies that the organs, which stand apart from the body, include vitality in their own accounts. The fictional world of the game feeds from the real world of current medicine. The game constructs upon the molecular body understanding of postmodern medicine. By comparing this game with a modern fiction, we may catch some clues about the differences between modern and postmodern medicines' insights on the body.

From almost two hundred years ago, Marry Shelley wrote on the similar theme in her famous gothic novel named *Frankenstein, or the Modern Prometheus* ([1818], 2008). When we look at the words which come from two centuries ago, we see a huge gap between the feelings and considerations which the game slogan, mentioned above, inspires:

> I had worked hard for nearly two years, for the sole purpose of infusing life into an inanimate body. For this I had deprived myself of rest and health. I had desired it with an ardour that far exceeded moderation; but now that I had finished, the beauty of the dream vanished, and breathless horror and disgust filled my heart. Unable to endure the aspect of the being I had created, I rushed out of the room and continued a long time traversing my bed-chamber, unable to compose my mind to sleep (Shelley, [1818], 2008, p. 57).

In Shelley's novel, Dr. Frankenstein, who is an educated gentleman scientist, picks up some pieces from dead bodies and gathers them, so he creates a life out of the fragments of death. He creates a monster by suturing the fragments of dead bodies with twine, and then, he animates the body he created with the help of the powers of science and electricity (Helman, 1992, pp. 21-22). For many years, the creature of Dr. Frankenstein, the nameless monster, has been the source of inspiration for horror stories, films and plays. This novel is one of the early examples of science fiction and it includes moral dilemmas for science. The

dilemmas which it gives birth are about the notions of the creator, creation and control.[23]

As Petersen puts, fictional imaginaries and narratives often foreshadow actual developments and facts (2007, p.17). Therefore, the two examples which I introduced above, give important clues about the body understandings of their times. Unlike the Marry Shelly's time, now, the removable body parts should be the subject of a computer game which is played by people in order to enjoy or spend time. In Shelly's novel there is a horror causing from removing the parts of the body. There is discomfortable feelings causing from uncontrolled vitality. The ability of creation attributed to a scientific action is presented as a moral scientific dilemma, in the novel. However, the feeling and discussions which the novel gives birth are passé issues today. Today's medicine sets aside all these modern dilemmas. The fictitious body parts can jump around in the banal and ordinary computer game. Because within the period of two hundred years, from *Dr. Frankenstein's Monster* to *ORGANise*, we have experienced a serial of transformations about our conceptions of the body, especially in the area of medicine.

While *Dr. Frankenstein's Monster* represents the world in which modern medicine flourished, *ORGANise* mirrors the spirit of postmodernity metaphorically. Although both two fictions on the body are constructed upon the idea of hybridization, the climate of their historical epochs are totally different. In the case of *Dr. Frankenstein*, a scientist holds the power of defining the boundaries of the body, doubtfully. Contrarily to the doubtfulness of modern hero, in the case of *ORGANise*, the player creates new bodies confidently. Furthermore, while *Dr. Frankenstein's Monster* is the product of the logic of juxtaposition,

[23] See Appendix A, figure 2.

integration, centralization and homogenization; *ORGANise* is the product of synchronization, fragmentation, decentralization and differentiation.

Today the imagination of molar body has been overcome by postmodern medicine. Now, this issue is the dispersed pieces which constitute the body. Postmodern medicine undermines the taken-for-grantedness of the body. The control over the borders of the body and its fate has changed hands. For instance, medieval medicine used to devote a big place to the will of the god, in the conclusions of medical practices. Modern medicine excluded religious attributions and put emphasis on being scientific in its medical practices. However, modern medicine had not been courageous enough to square the circle of recreation. Postmodern medicine, by equipping itself with advanced technologies, tries to do works like recreation. Although postmodern medicine could not create a *de novo* body, it plastificates the given body.

In this context, today, the body should be simply the sphere of assemblage of parts through transplant hair, intraocular lenses, denture prosthesis, nail extensions, hearing aids, and transferred tissues and organs of other people. The existence of synthetic and organic in the body together or transferring body parts from individual to individual are not extraordinary but feasible ideas and practices today. Moreover, emerging biotechnologies bring novelties such as embryo selection, pre-implantation diagnostics, cloning techniques for reproduction and therapeutic purposes, neural implants, mood-altering and memory-enhancing psychopharmaceuticals and so on. Current biotechnologies intervene the life processes. They construct novel relations between humans and machines, between born and made, between treatment and enhancement. These novel relations give birth to new categories such as technologically enhanced humans, non-organic life, intelligent machines, bio-engineered nature and so on (Sharon, 2014, p. 1). In this way, medicine takes the acts of handling, perceiving, diagnosing and treating

a step further. At this forward step, medicine seeks for changing all kind of givens.

Postmodern medicine's challenge to the given body, evoke and also overlap with the inferences of contemporary theorists of science such as Hans-Jörg Rheinberger and Donna Haraway. For instance, Rheinberger underlines that the current biotechnologies creates a scientific conquest which alters our natural essences, if there are, and at the same time, remove the modern distinctions of natural and social. For him, the present biomedicine has the capacity of "rewriting" life, thanks to the advent of recombinant Deoxyribonucleic acid (DNA) technologies. Thus, the existing biotechnologies do not only repair or modify the existing vitality of human, but also reprogram and alter it (Rheinberger, 2000, pp. 19-29).

What the biotechnologies are making today is totally different from Enlightenment's and modernity's wish of controlling external nature. Rather, they are controlling and altering the inner nature of the human. On the one hand, they produces engineered vitalities at the molecular level, on the other hand they produce hybrid vitalities similar to Donna Haraway's ironic dream of *cyborg*. As Haraway describes, "a cyborg is a cybernetic organism, a hybrid of machine and organism, a creature of social reality as well as a creature of fiction" (1991, p. 149). Haraway interprets the scientific understandings or scientific results, here the *cyborg*, as something that is not the pure result of objective scientific activity. Rather, for her, besides the scientific activity, *cyborg* is the result of "interpretative devices, taxonomic conventions or situated and historically specific understandings of how we know anything at all" (Haraway in Franklin, 2006, p. 178).

Haraway's cyborg is not an ironic dream today, rather it is a *straight actuality* which revisits the lines of science, technology, nature, vitality, body, fiction and

artificial. If so, the genealogical question, which should be asked, in order to understand current medicine, is as such: how do we reach to the *straight actuality* of the particular vitality or movable parts of the body? This actuality is in close relation with the historical journey of medicine and the changing imaginations of the body, especially in the last fifty years.

Beginning in the 1930's, and more noticeably in the late 1950's molecular biology, which visualizes life at the molecular level by concentrating on submicroscopic developments, emerged as a dominant disciplinary field (Kay, 1993, p. 3). Rose puts that since 1960's the laboratory has become a kind of factory for the creation of new forms of molecular life by dint of all sorts of highly sophisticated techniques of experimentation that have intervened upon life at molecular level (2007a, p. 13). In parallel with these cumulative modifications and so not surprisingly, the first successful kidney transplant from a living donor was achieved in 1954. Consequently, the years of 1950's and 1960's represents a certain rupture from molar body and rise of molecular knowledge and understanding of the body in the field of medicine.

In the history of the modelling of the body, we are at the stage in which the individual is reduced to his/her abstract and genetic formula now (Baudrillard, 1993, p. 113). At this stage, the body of human is exposed to serial propagations. The body is not just a given biological identity for current medical imagination. Rather, the body is something open to the reconstructions and redesigns, for the existing medical gaze.

The medical insight of devisable body is operable today through the advanced biotechnologies. All these technologies and their product of devisable body operate through a certain kind of medical gaze. This novel medical gaze is postmodern molecular gaze and it indicates a rupture from the modern clinical medical gaze. In this context, it can be argued that, while modern medicine

understood the body as a systemic whole, the postmodern medicine understands it as a piecemeal unfinished entity. Thus, one of the major shifts from modern medicine to postmodern medicine is the birth of molecular formulation of the body which has taken the place of the molar formulation of the body.

4.2 A Comparison between Molar Body and Molecular Body

As Foucault discusses in *The Birth of the Clinic: An Archaeology of Medical Perception [1963](2003)* the modern medicine, which had flourished especially at the end of eighteenth century and at the beginning of nineteenth century, considered the human body as the origin from where the diseases distribute (p. 1). The modern anatomic atlas, which imprisoned the body of illness into the body of patient, thought the human body as a molar entity. The body in modern medicine was something whose exterior wall was its skin. In other words, the molar body was something which was skin-encapsulating.

This skin-encapsulating molar body was modelled as a self-confined and unified organic whole. It was thought as something which was distinct from its environment (Sharon, 2014, p. 113). It was assumed to be a systemic whole, which functions properly due to the function of its constituent sub-systems such as circulatory system, urinary system, immune system, digestive system, nervous system, respiratory system, endocrine system, lymphatic system, cardiovascular system and so on. It was considered that, all of these systems were bounded each other and they had certain relations with each other. According to modern medical imagination, with their bounds and relations, the subsystems constituted the introvert molar body. In line with these, Foucault writes, "their [subsystems'] link and status do not refer an essence, but indicate a natural totality that has only its principles of composition and its more or less regular forms of duration" (2003, p.

111). In addition to these, the disease, in this kind of systemic whole, was also considered as something a whole: "A disease is a whole, because one can assign it its elements; it has an aim, because one can calculate its results; it is therefore a whole placed between the limits of invasion and termination" (Audibert-Caille as cited in Foucault, pp.111-112).

In the opening sentences of *The Birth of the Clinic: An Archaeology of Medical Perception [1963](2003),* Foucault underlines that the modern medicine's conception of the body and the disease are not essential. Contrarily, they are paradigmatic comprehensions:

> For us, the human body defines, by natural right, the space of origin and of distribution of disease: a space whose lines, volumes, surfaces, and routes are laid down, in accordance with a now familiar geometry, by the anatomical atlas. But this order of the solid, visible body is only one way -in all likelihood neither the first, nor the most fundamental- in which one spatializes disease. There have been, and will be, other distributions of illness (2003, p. 1).

By corroborating Foucault's this genealogical statement, Rose announced the "death of the clinic" in the opening sentences of his work *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-First Century (2007)* as below:

> Foucault's book, first published in 1963, was written at the end of the "golden age" of clinical medicine. While the 1960's did not mark the "death of clinic", the medical assemblage that took shape in the last quarter of the twentieth century was already very different from the clinical medicine born in the early nineteenth century. The dynamics of these medical changes involved cumulative modifications along multiple dimensions over at least half a century (p. 10).

What Rose announces is a paradigm shift. Similar to the *birth of clinic, the death of clinic* is the result of transformations in the comprehension of the body in the

field of medicine.[24] In an open manner, while the modern medicine conceived the body as something molar, postmodern medicine conceives it as something molecular. As I pointed out above, this is one of the crucial ruptures of postmodern medicine. Since late 1950's the molecular knowledge of the body and also life have proliferated in relation to the exploding technology. The biotechnologies which are applied in various areas such as cloning breakthroughs, embryonic stem cell researches, genetic manipulations, organ and tissue transplants, blood transfusions and so on open the era of reengineering, repairing, reshaping the body of human. The exercises of these technologies are intrinsically link to the molecular body imagination of postmodern medicine.

Postmodern medicine's molecular body is the scene of open-ended networks. It is made up from flexible and mobile elements that can be transferred between bodies. It is the assemblage of molecular entities such as fluctuant organs, tissues, enzymes and so on. Its non-rigidified borders are constantly fluctuating. The subsystems of the molar body which I mentioned above gain the characteristic of being self-contained systems. Thus, a system's malfunction or failure does not affect the operation of the other systems of the molecular body.[25] The molecular body is the space of densities, masses, flows and beats, all of whose information can be represented through the genetic formula of the body.

[24] The imagination of molecular body is something different from the one that clinic medicine acted upon and Foucault wrote on. Foucault's oeuvre adheres to the notion of an integral body, or to the notion of monoblock body. Thus, his analyses on disciplinary technologies, whose focus is the formation of the body, are based on the idea of a closed and delimited body. However, as Lemke underlines, today biotechnologies and biomedicine allow for the body's dismantling and recombination to an extent that Foucault did not anticipate (2011, p.94). And all of these announce the death of clinic.

[25] I will discuss this kind of operation of the molecular body's systems more detail through the case of immune suppressant drugs which stop immune system in order to prevent foreign organ rejection, in the next title of this thesis.

Every day it is announced in the media that the scientists discovered a new gene or a new hormone in the human body associated with its maladies. In news and other media these discoveries are presented via metaphors which declare the scientists as the finders of the 'the secrets of life', 'code-breakers' and 'detectives' (Petersen, 2005, p. 205). Scientists, as the seekers of the truths of the body, concentrate upon contemporary maladies such as cancer, diabetes, hypertension, and obesity which are seen as embedded in the depths of the body's parts or processes. In addition to that, the maladies of the molecular body are searched and seen with the sophisticated imaging systems such as ultrasound, computer tomography, magnetic resonance imaging which penetrate into the deeper levels of the body and present more and more detailed information concerning the disease. What important here is that,

> the techniques that make possible the molecularization of life do not only assume that molecular entities and mechanisms can be identified and isolated in greater and greater detail -they also assume that they can be manipulated, mobilized and recombined. It is this aspect of the molecular model that indicates a real shift from the molar (Sharon, 2014, p.117).

It is obvious here that the localization of the disease in the molecular body is different from the molar one. Contrary to the clinic assumption, which completely combined the body of disease and the body of the patient, in the postmodern case the body of the disease is partially matched up with certain parts or processes of the patient's body. Moreover, in the postmodern case, medicine attempts to isolate the disease where it is seen in the body. Then it attempts to modify and/or decode only the disease or its causes, not all the body.

Postmodern medicine deals with body fragments. It does not concentrate upon the whole body. This attitude of postmodern medicine is in relation with the spirit of its age in which it has flourished. The world of postmodernity embraces disunification, fragmentation and, decentralisation. All of these are serious challenges towards a consistent and well-defined totality. In line with this, the

body, which was considered as a totality in the modern medicine, is disintegrated under the postmodern medical gaze. As Baudrillard summarizes,

> this is how the totality is eliminated. If all information is contained in each of its parts, the whole loses its significance. This means the end of the body also, the end of that unique object which we call the body, whose secret is precisely that it cannot be broken down into an accumulation of cells because it is an indivisible configuration (1993, p. 116).

What Baudrillard announces is the end of the body as we know it. His perspective on the end of the body confronts to his theory of "the end of the social". While he is discussing the end of the social he puts that "all the great schemas of reason have suffered the same fate" (1983, p. 8). Moreover, he depicts that "the social is not clear and unequivocal process… Everything depends on one's understanding on the term and none of these is fixed; all are reversible" (p. 65). With these words Baudrillard, implies that modernity attributed content to the social and appointed a certain direction for its development, and for him, we are at the end of all of these modern attributions today. The fate of social is also true for the fate of body.

It can be asserted that the molar body of the modern medicine is a great scheme which is constructed in detail through modern reason. Each step in the development of modern medicine was a contribution to the imagination of molar body. For instance, the establishment of the modern distinction between normal and abnormal, the modern classification of diseases, the clinical experiments, the examination of the corpses, the modern implementations of the public medicine are medical works of modernity which were built on the assumption of integral body. On the other hand, all of these modern medical works constructed the molar body through which modern medicine acted and spoke. But what we are seeing now, similar to the other great schemas of modernity, the molar body also comings to an end. Today, postmodern medicine is building its own subject, namely molecular body.

Indeed, both in the modern times and in the postmodern times, the medicine rediscovers and redefines the body. Both modern and postmodern medicines construct certain kinds of gazes toward body. The notion of gaze indicates an ethos, an approach, a language, a perception and a perspective which includes diverse techniques and practices that pave the way of production of certain kind of knowledge in a certain field (Foucault, 2003; Rose, 2007a). In this context, both the modern and postmodern medicines produce certain kinds of styles of perception and they offer certain kinds of languages concerning the body via their specific gazes.

While modern medicine sees the body from a clinical gaze, postmodern medicine sees it from a molecular gaze. One of the main differences between clinical gaze and molecular gaze is about the part/whole relation. On the one hand, clinical gaze explores the body for *discovering* certain parts of the whole. On the other hand, molecular gaze explores the body for enlarging the boundaries of whole. In the postmodern case, the whole, namely the body, becomes transparent and its parts are scattered around. Furthermore, clinical gaze of modern medicine assumed that it enlightens the body with its discoveries. Conversely, the molecular gaze of postmodern medicine assumes that it produces the codes and maps of complex parts of the body via its discoveries. Moreover, molecular gaze goes one step further and it attempts to recode and rewrite the body, its parts and so its fate.

Although their "material" is same, namely the human body, the discoveries of modern and postmodern medicine produce different imaginations of the body. For instance, it is known that Leonardo da Vinci's *Vitruvian Man*[26], which was drawn around 1490, is an iconic step in the early history of modern anatomy. Because with his painting, Leonardo da Vinci, went beyond the medieval belief of sanctity of human body and oriented a scientific and also artistic gaze towards the body.

[26] See Appendix A, figure 3.

And with his iconic painting he revealed the naked, profane body of man and its muscles, proportion, tendons and the mechanical activity. This was an important step in the modern scientific comprehension of the boundaries of the body. Then, in the line of modern medicine, the gaze of the scientists turned toward the inner map of the body. For instance, in the 16th century, Bartolomeo Eustachio, who is one of the founders of modern anatomy, *discovered* the Eustachian tubes, the suprarenals, the thoracic duct and the abducen nerve (Kelly, 2010a, p. 22).

Each of these discoveries was interpreted as the crucial steps in the way of understanding how the body works. Each of these discoveries was the foundation of the parts of inner map of the body whose borders were well-defined. They were the lost parts of the puzzle. Therefore, modern *discoveries* shed light on the boundaries and the parts of the body which make possible the molar body's function. The aim of these modern medical works was discovering the body. They did not aim to change the body. They considered the body as something given. However, what was critical for modern medical works is to rescue the body from the shadow of religion. Modern medicine tried to move the body from an area ruling by religion to an area ruling by science.

Whereas, the stories of postmodern discoveries are different from the modern ones. For instance, in 1953 Watson and Crick identified the structure of Deoxyribonucleic acid (DNA). This was an important step in reducing the characteristics of the whole into its smallest parts. Another example occurred in 1954, Joseph Murray developed a novel approach on tissue typing. Afterwards, he overcame the problem of body's rejection of foreign organ by revealing the tissue compatibility of identical twins.[27] This was a step in opening the body to the

[27] Retrieved May, 29, 2014 from http://news.harvard.edu/gazette/story/2011/09/a-transplant-makes-history/.

various possible relations with other human bodies. Moreover, this was a serious challenge to the unique, introvert, molar body. Another example can be given from the works on heart transplant. It is known that in 1957 first artificial heart tested in a dog, then in 1967 first heart transplant was made, and then in 1969 first artificial heart implanted in a human (Kelly 2010b, p. 152). These works opened the body into complex relations. That is to say, postmodern medicine invites new relations with the heart and kidney transplant efforts. Thus, molecular imagination was extended by including the possible relations between human bodies, between human and animal, between human and artificial objects, especially machines.

At this juncture, my aim is not presenting pioneering figures or specific events in the history of modern or postmodern medicine through these examples. Rather, as I discussed in the second chapter of this study, from a genealogical perspective I am focusing on the sudden ruptures and discontinuities. The cases of heart transplant works and kidney transplant developments demonstrate us that today we are speaking on a body which is different from the molar body of modern medicine. The examples are the results of a certain discontinuity. That is to say, they are the results of the shift from clinical gaze to molecular gaze. The cases of heart transplant works and kidney transplant developments present that postmodern medicine comprehends the body within a network.

Molecular body is a body which is into the flux of organs and tissues that can be interchanged with the bodies of other humans, with the artificial organs, with the bodies of animals. Molecular body is the space of open-ended networks and interchanges. Contrary to the molar body of modern medicine, which exists with reference to itself and whose dark spots enlighten as they are discovered, molecular body is something relational. Each possible relationship of the molecular body, which is discovered within a network, give rise to the birth of more novel possibilities. As the molecular body is being discovered it moves, changes its place within a network. Each discovery is a displacement rather than

stabilization. As I mentioned above, firstly the artificial heart was made, then it was experienced on a dog and then it was implanted in a human. These steps do not aim to complete a circle which will complete itself step by step or they are not the steps on a linear line on which medicine reaches more advanced points. Rather, these are experiences and steps which occur in an open-ended network. And the fluxes of the body within this open-ended network demonstrate that the molecular body is the space of countless shuffles, displacements and transpositions.

4.3 Plasticity and Softness of the Body

It can be said that the molecular formulation of the body frequently emerges in the case of organ transplantation in its crystalized form. In other words, the current comprehension of the body as a composite object is apparently seen in the case of organ transplantation. Organ transplantations are the result of the adoption of a treatment approach that focuses on the parts of the body. Postmodern medicine does not allow the disease to destroy the entire body. On the contrary, postmodern medicine tends to localize and cure the disease in the location where it occurs. In some cases this is result in the removal of the body part, where the disease occurs, from the body. Some types of cancer are the most known examples of such a treatment method. For instance, in general the breast cancer is cured through the operation of mastectomy. In the case of organ transplants, similar to the cure of cancer, the failing organ is removed from the body. Then, the empty space left behind is being refilled with a new organ. In the organ transplant therapy, both the subtraction and then refilling the gaps are being experienced.

However, the important point here is that, in the process of re-establishment of the body parts different from the usual line-up, medical science stands as a guarantor.

Organ transplant is done, of course, for the sake of the health and survival. Thus, in the result of organ transplants, *freaks*[28], which are placed outside of the anatomic representations, do not arise. Moreover, Homunculus[29], or Frankenstein, or Chimera[30], all of which are old monsters that imagined to be formed as a result of the transformation of usual anatomic atlas, does not occur in the result of the organ transplantation therapy. On the contrary, via organ transplants, the anatomic representation itself is changing. In other words, a kind of body which cannot be classified under the anatomic representation does exist at all. On the contrary, certain kinds of bodies, which transform the anatomic classifications, are constructed in the result of organ transplantations.

Removing an organ from a body, and then introducing it into another body, embraces many possibilities about the conditions of two bodies, namely the bodies of the donor and recipient. For instance, the heart of beating-heart, brain-dead donor, may be transferred to someone who needs a new heart to live. This traveler heart may be the home of the feelings of two lives, if there are still a metaphorical relationships between the heart and feelings remaining. Or a face of brain-dead donor may be transferred to someone whose face is damaged as the result of a serious accident. The traveler face may experience two different lives. A stranger's or her own mother's uterus may be transferred to a woman who

[28] The freaks who stand outside of the anatomic representations are defined their threshold positionality: "They occupy the impossible middle ground between the oppositions dividing the human from the animal (Jo-Jo, the dog-faced boy; Percilla, the monkey girl; Emmitt, the alligator-skinned boy; the "wild man" or "geek"), one being from another (cojoined twins, "double-bodied wonders", two-headed or multiple-limbed beings), nature from culture (feral children, "the wild man of Borneo"), one sex from the other (the bearded lady, hermaphrodites, Joseph-Josephines, of Victor-Victorias), adults and children (dwarfs and midgets), human and gods (giants) and the living and the dead (human skeletons)" (Grosz, 1996, p. 57).

[29] Homunculus is mythological figure which refers to a human created by alchemists.

[30] Chimera is a mythological figure. It is "in Greek mythology, a fire-breathing monster with a lion's head, a goat's body and serpent's tail" (Blackburn, 1996, p. 62).

could not be a mother with her innate uterus. The recipient woman may be mother with her new uterus. In this way, single uterus may give birth to two generations.

These intertwinements, encounters, exchanges do not merely indicates the triumph of surgical techniques. Moreover, they do not mean the medical conquest of the body. Contrarily, they are the results of a paradigm shift in the field of medicine. This is the paradigm of plasticity peculiar to postmodernism (Bordo, 1998, p. 46). The plasticity paradigm of postmodern medicine resembles to early modern imagination of body as a machine. In the early modern ages, especially in the seventeenth century, medicine conceived the body by taking the machine imagery as a model.[31] This early medical imagination employed the metaphors of clocks, watches, collection of springs in order to find out the functioning logic of the body. The imagination of body as a machine served for constructing the idea of predictable body. Considering body as a machine was a fruitful ground in order to discover the laws of regulation and order of the body (p.46).

However, this early imagination operated through the idea of molar body. Although the idea of body as a machine implicitly includes the collection of different parts, early modern medical imagination did not focus on those parts. Modern medicine got rid of the idea of God as a watchmaker; on the other hand it did not see itself as a watchmaker either. At the most, modern medicine saw itself as watch repairer. In addition to that, modern medicine noticed the parts of the body, but it did not venture to change the places of these parts. It is because, not only the technologies of modernity, but also the ideology lies behind the modern medicine did not allow for the realization of this kind of attempts.

[31] Julien Offray de La Mettrie's book which was written in 1748 and was titled "Man a Machine", is one of the leading examples of this way of thinking.

Postmodern medicine also has got a body comprehension which resembles to the machine-body analogy of early modern medicine. However, there are certain differences between the early modern and postmodern analogies. If postmodern medicine sees the body as a machine, this machine is a "soft machine"[32]. It is soft, because it is easy to go beyond its envelope through current medicine. Postmodern medicine is able to cut this machine into pieces. It is able to change the locations' of the pieces. It is able to replace old or failing parts with new ones. Therefore, postmodern medicine does not admire the integrity and harmony of this soft machine. Moreover, this postmodern machine does not operate like a clockwork without having subjective properties. Thus, there are contradictory coexistences in this soft machine. On the one hand, it is an object whose parts can be installed and taken down. On the other hand, it has got unique emotions of genetic code which make it subjective. Under any circumstances, contemporary medical attention is on the parts of this soft machine. In the organ transplantation case, healing the parts or healing through the parts changes the meanings of the parts of this soft machine.

[32] "The Soft Machine" is also the name of the famous novel which is written by William S. Burroughs, in 1961. This is about the control mechanisms that invade the body.

4.4 Organs Jettisoned Out of the Body: From "Abject" Elements to Biovaluable Things

"We are very sad.
He is no longer living, but his organs will live"
(The mother of a deceased organ donor, Turkey)

From now on, it will be unsufficient to think an organ in relation to single human body. Rather, single organs can establish relationships with multiple bodies. Moreover, an organ can be the leading actor of some processes without any "body" accompanying it. Organ transplant therapy includes the processes of decontextualization and deterritorialization of the organs. Then, by introducing these displaced organs to their novel places, namely the body of recipient, organ transplant therapy includes the processes of recontextualization and reterritorialization.

I want to discuss the processes of decontextualization, recontextualization, deterritorialization, and reterritorialization, by referencing an example from Turkey. In 2012, a medical accident, which was greeted with astonishment and a great response by the people happened. In that year, Turkey's first face and arm transplants were done successfully, in Antalya. Following these successful operations, a competition began to be experienced between the hospitals, throughout the country. Hacettepe University, Faculty of Medicine participated this race by establishing a transplant team. The team went into an overdrive for a new face transplant. However, the suitable donor was found in İzmir and the

hospital in which the transplant would be made and the patient who was waiting a face was in Ankara. Therefore, the organs had to be moved between the two cities. And then, the team set about to carry the organs from İzmir to Ankara. The *bizarre* and *puzzling* event appeared during this transport.

The organs, which would be transplanted, were bagged into the big blue garbage bags and the garbage bags were settled into the big cardboard boxes. The cardboard boxes full of organs reached to Ankara. The ambulance carrying the organs arrived in front of the hospital. Then, the team began to carry the organs to the operating room. The team was scampering around with the cardboard boxes. They were carrying the cardboard boxes into the hospital, by taking them from the ambulance in front of the hospital. The hospital was very crowded. Patients, journalists, doctors, nurses… In brief, everybody was waiting and wondering the organs. The cardboard boxes were very heavy, and so two people could carry only one box. In the middle of this mess, one of the boxes was torn and the big blue garbage bag fell to the ground. The man who was trying to carry bag alone panicked and attempted to put the bag into the cardboard box, but he could not achieve because the box was torn. The voices began to rise around at that time. Then, another man came and he also tried to put the bag into the box. He also could not achieve and then he hugged the bag and started running towards the elevator.[33]

The scenes of the incident were much talked about; they drew media attention; they were written in the newspapers; they were interpreted and criticized again and again. The comments were accompanied to the news as below:

"I wish it was used more special tools rather than cardboard boxes in the transport of such *vital organs.*"[34]

[33] Retrieved September, 19, 2014, http://www.medyafaresi.com/video/133458.

[34] Retrieved September, 19, 2014, from http://www.hurriyet.com.tr/saglik/19992184.asp.

"The team's way of the transport was *outdated*, although they made an effort for delivering the organs to Hacettepe in good faith and with great excitement."[35]

"I found the style of transport *bizarre*, which caused the organs to fall to the ground. Perforation of the box shows that this is not a correct method."[36]

"Transplant is successful, transport is impuissant." [37]

"We made transplant operation western-mindedly; we transport the organs in cardboard boxes eastern-mindedly."[38]

"If we could know to box it and keep it boxed until delivery, too!"[39]

What the people, who watched these scenes, find *bizarre*, and what they get *sad* for, and what make them *surprised* were not only an ordinary transport accident. The attributions about the subject of the transport were determining the people's reactions. It is because people undoubtedly considered the organs which fell to the ground as they were life itself. Here the questions, which are about our discussion, are about the organ's whatness, howness and relatedness: what are the meanings of these organs falling to the ground? What are they? Why are they different from the organs of dead body? What is their relation with the body they are extracted from? What sort of entities are they? Are they entities on their own account?

If the donor had not been donated his organs, the organs felled to the ground would be buried within the body to the accompaniment of religious funeral and they would be left to rot. If the organs were buried with the body, there would not

[35] Retrieved September, 19, 2014, http://webtv.hurriyet.com.tr/2/28758/0/nakil-yapilacak-organlar-tasinirken-yere-dusuruldu.

[36]Retrieved September, 19, 2014, http://www.radikal.com.tr/turkiye/ikinci_yuz_nakli_hacettepeden-1079849.

[37]Retrieved September, 19, 2014, http://www.radikal.com.tr/turkiye/ikinci_yuz_nakli_hacettepeden-1079849.

[38] Retrieved September, 19, 2014, http://www.haber61.net/kutudaki-organlar-yere-dustu-106602h.htm.

[39] Retrieved September, 19, 2014, http://www.gazetevatan.com/turkiye-nin-ikinci-yuz-nakli-hacettepe-den--432952-gundem/.

be anything to worry or to surprise for the people. If it were the case, people would be upset for the absence of the deceased, not for the organs which were buried. However, the organs falling to the ground was different. They were objects whose ties broke down with the deceased's body. The donor's mother said for his son and for the mission of his son's organs these sentences: "better be life to another body on the ground than fade away buried underground"; and she added "we are very sad. He is no longer living, but his organs will live".[40]

Here, I offer thinking a different scenario from an ordinary funeral. If we encounter suddenly and inappropriately some organs which are dissected from a body aimlessly, they utterly would be *abject*. As Julia Kristeva describes, "it is … not lack of cleanliness or health that causes abjection but what disturbs identity, system, order" (1982, p. 4). If this was the case, the inaccurately scattered organs would be something which reminds to the subject her/his own death incongruously.[41] Thus, suddenly encountered organs would be something, which

[40] Retrieved September, 19, 2014, http://www.ahaport.com/koliyle-organ-tasidilar-yerlere-dusurduler-362922h.htm.

[41] Julia Kristeva writes on encountering a corpse as such: "The corpse (or cadaver: *cadere,* to fall), that which has irremediably come a cropper, is cesspool, and death; it upsets even more violently the one who confronts it as fragile and fallacious chance. A wound with blood and pus, or the sickly, acrid smell of sweat, of decay, does not *signify* death. In the presence of signified death—a flat encephalograph, for instance—I would understand, react, or accept. No, as in true theater, without makeup or masks, refuse and corpses *show me* what I permanently thrust aside in order to live. These body fluids, this defilement, this shit are what life withstands, hardly and with difficulty, on the part of death. There, I am at the border of my condition as a living being. My body extricates itself, as being alive, from that border. Such wastes drop so that I might live, until, from loss to loss, nothing remains in me and my entire body falls beyond the limit—*cadere*, cadaver. If dung signifies the other side of the border, the place where I am not and which permits me to be, the corpse, the most sickening of wastes, is a border that has encroached upon everything. It is no longer I who expel, "I" is expelled. The border has become an object. How can I be without border? That elsewhere that I imagine beyond the present, or that I hallucinate so that I might, in a present time, speak to you, conceive of you—it is now here, jetted, abjected, into "my" world. Deprived of world, therefore, *I fall in a faint.* In that compelling, raw, insolent thing in the morgue's full sunlight, in that thing that no longer matches and therefore no longer signifies anything, I behold the breaking down of a world that has erased its borders: fainting away. The corpse, seen without God and outside of science, is the utmost of abjection. It is death infecting

should be veiled, buried or the place they touched need to be cleaned immediately. They would be something out of the symbolic cultural order and something bring dirtiness to mind. As Mary Douglas points that dirt is not a quality in itself; rather it is in relation with frontier infringements:

> … all margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. Any structure of ideas is vulnerable at its margins. We should expect the orifices of the body to symbolise its specially vulnerable points. Matter issuing from them is marginal stuff of the most obvious kind. Spittle, blood, milk, urine, faeces or tears by simply issuing forth have traversed the boundary of the body. So also have bodily parings, skin, nail, hair clippings and sweat. The mistake is to treat bodily margins in isolation from all other margins (2001, p. 121).

Her examples of spittle, milk, urine, tears or nail clippings are something what we are accustomed to see in our daily lives. Ever at that, seeing them in a wrong place disturbs us. It is undeniable that seeing an organ outside of the place where it is belongs to, namely body, will evoke stronger feelings than Douglas's examples, such as filthiness or horridness.

However, the organs in the blue garbage bags were different; they did not evoke the feelings of filthiness or horridness. It is because, they were as valuable as not to be excluded from the life by indicating as an abject or dirt. Moreover, they were far from the palliative symbolic system of a religious funeral. In other words, they were neither a dead which will be buried nor abject nor dirt elements which will be raced away. In the case experienced in Turkey, which I narrated above, the organs in the blue garbage bags were certain parts of vitality. They were the life itself. They were not placed in the blue garbage bags because they were dirty; rather, this was just an ironic transport scandal.

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life. Abject. It is something rejected from which one does not part, from which one does not protect oneself as from an object. Imaginary uncanniness and real threat, it beckons to us and ends up engulfing us" (1982, pp. 3-4).

It is obvious that, the man who donated them died; but the organs in the blue garbage bags were still living. This was the clear example of fluid and molecular body, partial death and molecular body which are the characteristics peculiar to postmodern medicine. The organs were promising life by themselves. They were decontextualized and until they would be recontextualized they gain the ability of representing life itself. They left their places in the body. Their feeding vessels were cut. They were no longer under the skin. They were no longer in the tegmens which prevent mixing of things in the body. They were removed from the body in which they had been dwelling for many years; and they became the subject of a journey on their own. They did not die with the body. Thus, they were still including biovalue. Pure and simple, they were decontextualized and they were waiting for their recontextualization. In this vein, the thing that makes these organs valuable and clean, was their winning of a mission in the sense of medicine's definitions. Henceforward, they were in the "high security", "sterile" field of medicine, as if they were certain kinds of medical objects.

This case presents us that the organs extracted from body firstly are something deterritorialized. Because this deterritorialization includes a certain medical aim, so the previous cultural metaphors surrounding "ambulatory organs"[42] or "organs without bodies" are changing. They are transformed into objects which are open to interchange, ownership, damage and destroy. It can be asserted that, objectification of an organ, is one of the prior conditions of its commodification.[43] For instance, a face, a finger or a kidney dissected from the body of the organ-giver, transforms into a separate entity; or a piece of lung that transplant surgeon holding in her/his hands is something displaced. This displaced *thing* turns over a

[42] See Appendix A, figure 4.

[43] I am going to discuss the commodification of organs, in the sixth chapter in detail.

new leaf. It has a metamorphosis. It turns into an entity in itself, which has a meaning, a life, and a function depended from the body it is dissected from.

4.5 Concluding Remarks: The Piecemeal Body

To conclude the discussion I made under the title of molecular body, it can be said that the modern medicine and postmodern medicine have different body imaginations. While the modern medicine constructed the molar body understanding and then acted upon it, postmodern medicine sees the body as an open network. Such a network is not purely biological or purely artificial. Rather the body of postmodern medicine is open to new encounters.

Different from modern medicine's body, the body in the current medical configuration is not a static entity which gives its secrets and formulas through the medical examinations. Rather, today, each novel medical intervention or invention opens the body to the possibilities of new hybridizations. It can be said that, two different dispositions may be found interwoven in the body imagination of postmodern medicine. First of all, the organization of the body has been changing. Fragmentation is the basic tenet of this change. On the other hand, this over-changing and over-fragmenting body stands in the middle of a medical network which is more organized and more complex than before. Moreover, molecular body is itself a network in which "independent" body parts or bodily systems, technological vitalities, the parts of other bodies and artificial organs construct certain relations. Then, the body loses its previous borders and presents increasingly disheveled character in the eyes of medicine.

The dominance of technology in the field of medicine, the hybridization of the body, medicine's adoption of the target of enhancement of the given human body, the rule of molecular gaze in the medical field can be indicated as the some of

these underlying patterns. In this context, organ transplants present the crystallized form of body understanding of postmodern medicine; they are also results of this kind of understanding. The molecular body is the scene of organ transplants. Through the therapy of organ transplantation there are ongoing medical bargains between the given, the failed and the newcomer.

For instance, the man who speaks in the public service announcement on organ donation in Turkey says,

> I will not need these eyes in some day. My heart, my lung, my kidneys… I will not need any of them. I am donating my eyes for the ones who are happy with seeing that the world is full of beauty. I am donating my heart for the loving hearts not to stand alone. My lung, my kidneys, my liver… I am donating all of my organs to saving the lives of others. My organs are my greatest legacy.[44]

The man speaks in the world where organs multiply and reshuffle. He presents his body as a collection of body parts and as the storage of preservation and presentation of organs. He mentions his lung or his kidneys as if they are materially distinct from him as a commodity such a car or a house. Therefore, he objectifies his organs. On the other hand, by keeping away from the definitions such as a heart is a pump and by preferring to construct relations between his heart and emotions such as loneliness he subjectifies his body parts. Hence subjectification and objectification of vitality go hand in hand in the messages of the announcement. In the announcement, the organs are presented as novel kind properties which are called by the man as his *greatest legacy*. This sort of legacy challenges the traditional family trees and proposes novel kinds of kinships which are open-ended networks. Moreover, he puts that he gifts his life, namely his organs, to the others who need a life. Thus, the others fate amalgamate with his fate. Here the fate does not belong to God or mysterious powers; rather, with the

[44] Retrieved June, 4, 2014, from http://www.youtube.com/watch?v=KLoDlY6SjCw.

emphasis on the ownership of the organs and the role of them in saving the life of the other, it is presented that a mortal also should save or give a life.

What is important here is that, all of these inferences on objectification, subjectification, materiality, gift exchange, fate and mortality which I derived from the announcement, are the results of the shifts from molar body to molecular body, from clinical gaze to molecular gaze, from entire death to partial death, from modernity to postmodernity in the area of medicine. In consequence, molecularization is a process which includes "reorganization of the gaze of the life sciences, their institutions, procedures, instruments, spaces of operation and forms of capitalization" (Rose, 2001, p.13)

CHAPTER V

POSTMODERN MEDICINE, ORGAN TRANSPLANTS, AND THE DEATH

The past century was filled with contradictions, in terms of the relationship of human with death. Humanity experienced mass deaths caused by wars in an unprecedented way, as well as the medical developments to prevent particular deaths. This era has experienced massacres and hopes together. On the one hand, in the global wars centered in Europe, that is to say First World War (1914) and Second World War (1939), millions of people died in the last century. Beginning from 1918 in Russia, and from 1933 in Germany, concentration camps were established. These camps were the dishonor examples of human history in which people were animalized, reified, leaved to starvation, tortured and killed in mass, in order to erase their identities. They were unique cases of an inhuman and also human-established relationship between the body and death (Becker, 2013, pp. 267-272). Sadly, the examples of wars and civil wars may be multiplied, because battles also took place in the second half of the twentieth century.[45] It is clear that,

[45] There were wars in Algeria between the years 1954 to 1962, in Vietnam between the years 1965 to 1972, in the former Yugoslavia in the 1990s (Audoin-Rouzeau, 2013 pp. 235-237). There were wars between Iran and Iraq between the years 1980 to1988. There were wars in Iraq that begun 1990-1991 and re-evoked in the 2003-2012 period. There were bloody conflicts in Libya, Iraq and

as a result of the wars, a lot of people died in the last century. From this point of view, world is a place in which dying by means of war becomes ordinary.

On the other hand, contrary to the scenes of war, medicine made great efforts to prevent deaths since the last century. In the fields of biology, chemistry, physiology, pharmacology and technology, many novelties are developed. These developments brought ruptures in the field of medicine. In the last century, the development of germ theory and science of blood, and the discoveries of penicillin and x-rays revolutionized the medicine. Infectious diseases were controlled through the fight against microorganisms that cause many serious diseases. Tetanus, diphtheria, pertussis, tuberculosis, smallpox, yellow fewer, typhus, influenza, measles, mumps, meningitis vaccines were developed. Insulin was started to be used in the treatment of diabetes. (Kelly 2010b). The developments in the medical chemistry, such as the extension of vaccination and discovery of antibiotics led to prevention of serious epidemics. Through the medical developments, child and infant mortality declined and life expectancy has increased since the last century.

In the second half of the century, first kidney transplant, first artificial heart, and first heart transplant were made. First test-tube baby was born. First mammal, a sheep, was cloned from an adult cell. First draft and then advanced version of human genome is introduced. However, in the recent years, medicine re-entered into a death turbulence. Some diseases, which were not seen before, have appeared such as AIDS, Legionnaires' disease, Lyme disease, mad cow disease, Ebola fever, Rift Valley fever, SARS, avian influenza, monkey pox, Nipah virus,

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Syria since 2010, and there are ongoing civil wars and conflicts such as those in Colombia since 1964, in Philippines since 1969, in Afghanistan since 1978, in Uganda since 1987, in Somali since 1991, in Nigeria since 1999, in Iraq since US invasion in 2003, in Yemen since 2004, in Burma since 2010, in Syria since 2011, in Libya since 2011, in Central African Republic since 2012, in Northern Mali since 2013, and in Sudan since 2013. The list of wars is retrieved January, 2, 2015, from http://en.wikipedia.org/wiki/List_of_wars_2003%E2%80%9310.

Lyssavirus, Chandipura virus, and so forth. Since some pathogens have become antibiotic-resistant, some old diseases have risen again (Magner, 2005, p. 537). In addition to these, infectious diseases began to spread again for some reasons such as worsening environmental condition, population growth, increasing migrations, international travels and commerce, uncontrolled industrial wastes, climate change causing from global warming, poverty and lack of basic sanitary facilities which seen in undeveloped regions of the world and so on (p. 538).

When we look such a general picture of death it is difficult to say 'everything is getting worse' or 'everything is getting better'. There are wars, genocides, civil wars and (old and new) diseases causing deaths on the one side, and medical preventions and innovations that fight against death on the other side. There is no indication which neither says death will be delated completely nor it will exist forever. This general picture concerning death, which is full of massacres and hopes, shows something: since the last century, the humanity has established a contradictory and inconsistent relationship with death.

In this chapter, I am going to focus on death in a specific context of postmodern medicine. Within this contradictory picture of death that I tried to summarize above, postmodern medicine produces its own unique attitude towards death. In the postmodern medical context, "death ceased to be a one-off act, a single, unique event with irreparable consequences" (Bauman, 1992, p.173). To do this, postmodern medicine plays with the long-established perceptions of death, which sees it as natural, biological, inevitable and individualistic. It can be asserted that, in the postmodern medical context, not only the body, but also its birth and deaths are conceived as something which are plastic, programmable and partial.

In order to capture the novel patterns of death, I am going to focus on the medical issue of organ transplantation, as a case from where one can derive the discontinuities of postmodern medicine. Below, I concentrate on the construction

of the notion of brain death as a postmodern novelty, in the field of medicine. I suppose that the notion of brain death, which is a crucial concept in the short history of organ transplants, is a genealogical rupture. The concept of brain death leads to a tremendous change in the moment of death. It radically alters the meaning and use of the dead body. Through conceptualizing the brain dearth, postmodern medicine rearranges the knowledge of death. Thus, the notion of brain death presents that if the death has got a nature, postmodern medicine understands this nature as something plastic and therefore changeable.

5.1 Reconfiguration of the Death: Delayed and Partial Deaths

"We live in an age of the Cadaver, the Comatose and the Chimera.
Liminal spaces proliferate."
(Stelarc)

Death is an inevitable consequence which is known by the people since the beginning of their lives. However, we, the people who are still living, may know the death only through the medium of the other's death. Indeed, it is possible to experience death individually. Anyhow, it is impossible for the owner of this experience to tell her/his experience. The words and feelings to tell "what is actually death?" pass away with the deceased individual. It is possible to experience the death, but it is impossible to narrate it then. On the other hand, we may witness the death. For instance, we may watch one's dying because of a shooting from the television screen, or we can see someone who died in a traffic

accident. From the screens of devices of a hospital's intensive care unit, we may digitally watch a relative's death or the death of a person who was never met before. We may get impressions on death from some rituals, such as, mourning practices, obituary notices or from symbolizations such as, martyrdom. Therefore, it is obvious that we may reach the experience, interpretation and knowledge of death through indirect ways.

Medicine is one of the most important areas that produces this indirect knowledge of death. It is a very powerful tool in directing our convictions about death. As I stressed earlier, this knowledge of death, generated by the medicine, is contextual. The medieval medical configuration, the modern one or the postmodern one, produces their own specific death conceptualizations. In his valuable work on the sociology of death, *Constructing Death: The Sociology of Dying and Bereavement (1998)*, Clive Seale discusses that medicine contains fundamental classificatory ideas. For instance, through constructing classifications, medicine separates nature from culture, healthy from diseased, normal from pathological, hygienic from the polluting, the living from the dead and the sacred from the profane (p. 75). Then, employing these separations, medicine serves an important guideline for reading the death. Here, the important point is that the divisions of medicine vary from one socio-historical context to another. The current medical configuration also has got its unique separations that serve ground for its considerations about death.

In this vein, it can be said that one of the most important rupture, which postmodern medicine has created, is associated with death. It can be asserted that the postmodern medicine not only comprehends the vitality of the body in a molecular manner, but also it grips the body's death piece by piece. Postmodern practice of medicine could not overcome the death yet. However, it stops the death to be a horrific and abrupt end. Current medicine disintegrates the death. It spreads death over time, through novel technologies such as respiratory equipment, intensive care units, dialysis machine and the like. These technologies

amalgamate the human's breath and the machine's energy. Moreover, in the postmodern age, death-like situations occur within the body. The death-like situations, neither mean a death nor a life, in the strict sense.

On the other hand, postmodern medicine has built a chaotic medical bureaucracy against the simplicity of death. Since current medicine cannot tolerate a causeless death, medicine records all pieces and causes of deaths in a very detailed manner. For instance, the hospitals prepare documents which indicate the cause of the death. The processes of staying at the morgue, finding and buying cemetery plot and transporting the funeral are some affairs each of which requires a separate procedure. Municipalities prepare permission documents to bury the dead bodies. If the death is the result of an accident, or suicide, or homicide, the legal issues such as autopsy or witness acknowledgements are involved in. As a result, chaotic medical bureaucracy about death occurs. By bureaucratizing death as such, postmodern medicine produces its own rationality about death.

In addition to these, contemporary medicine explains death with a detailed cause-effect relationship. By indicating a certain disease as the cause of death, medicine makes the death explainable. In other words, medicine cannot explain the death in the strict sense, but it describes the disease that caused the death. Thereby, by providing another explanation instead of death, it escapes from explaining the death. In addition to these, the starting moment of death is indicated as simultaneous with the starting moment of the disease that leading to death. Thus, death loses its status as an inevitable end, and turns out to be an inevitable consequence of a disease process. In the contemporary medicine, death is considered as if it was a disease whose treatment is failed. Thus, for the current medicine, death is no longer a simple termination of life, but it is also an incurable disease.

In this context, almost all deaths are associated with a cause which is defined clearly in the medical literature; so it is almost impossible to come across a natural death today. No matter how old the person who died, the old age itself is not seen as a sufficient and scientific cause for dying.[46] The old age can be the subject of death, if it is accompanied by medical explanations such as senile cardiac insufficiency or age-related renal failure. Thus, it can be said that, a new medical terminology related with death rules. The rituals, conceptions, procedures, status and moment of the death have been transformed by the reconstruction of the knowledge and experiences of death. Moreover, the corpus left behind after the death is also reorganized for instance as a teaching aid, as a research model or as a valuable source of cadaveric transplant. Cadaveric transplants, which were not seen in the modern medicine, are something new and peculiar to postmodern medical age (Crowley-Matoka and Lock, 2006).

However, it is known that the relation between death and the medicine is not restated for the first time with postmodern medicine. Modern configuration of the medicine also made new regulations concerning death in its own context and presented dying patterns which were different from the ones of its predecessors. By tracing the imaginaries of death of modern and postmodern medicine, I intend to discuss the postmodern rupture here. In order to do that, I am now going to concentrate on the question "through which medical apparatuses the venue of the decay, namely dead body, firstly had become the subject of scientific interest, in modernity?" And then, "how it has become the source of organs which multiplies the lives, in postmodernity?"

It is possible to claim that the medicine's visits to dead body and/or the body about to die create two crucial ruptures within the history of medicine. The first

[46] Indeed, the knowledge of old age is being rearranged by current medicine. Recently, the aged body is medicalized and the old age itself is transformed into a curable disease (Katz, 1996).

one is the modern rupture, occurred in the 18th century through the development of clinical medicine, which constructed the modern imagination of understanding the living body via the dead one. The second one is the postmodern rupture, which has developed since 1960's with the conceptualization of brain death, which sees the dead body as the source of organs that can be transferred to the other living bodies. These ruptures paved the way of construction of new medical measures, practices and imaginations via death, in their own contexts.

5.2 Death in the Modern Context of Medicine

Foucault discusses in his work *The Birth of the Clinic: An Archaeology of Medical Perception [1963] (2003)* that, modern medicine's early *attacks* or *visits* towards the dead bodies intended to discoveries. By means of its relationship with dead body, namely transforming of the dead body into a scientific investigation object, modern medicine created a skip which differs it from previous periods. Seeing the dead body as the primary resource in understanding the vitality was the success and courage of modern medicine. What made possible to rediscover the given body, different from the body imaginations existing before, was the cadaver's getting on the stage of the medicine. The cadaver was the key object in ensuring the knowledge of vitality from the knowledge of death. The cadaver as a source of knowledge represented the rationalization of death, for modern medicine. The investigation of the cadaver depended on the idea of 'what happens under the skin have the potential of demonstrating how the living body functions'.

The exact time of the establishment of the connection between the openings of cadavers and the development of modern medicine is a controversial subject.[47]

[47] It is possible to present examples on opening of the cadavers from different dates. For example, Andreas Vesalius's works which challenged the medieval medicine can be interpreted as the closest examples to the perspective of modern medicine. Vesalius' text and illustrations on human

However, the birth of the clinical medicine, at the end of the 18th century, can be regarded as a starting point. The reason of taking the clinical medicine as a starting point, in the case of changing relation between modern medicine and deaths is the novel death imaginary flourished with the clinic medicine.

Clinical gaze constructed a certain kind of attitudes towards death and organized the physician's approach which was investigating the cadaver. In *The Birth of the Clinic: An Archaeology of Medical Perception [1963](2003),* Foucault discusses this issue under the title of "*open up a few corpses*" (p. 152). Foucault sees that, modern medicine created a certain rupture from the previous ways of healing by rationalizing the death. Clinic medicine produced the scientific knowledge of the death by inserting the death and the dead body into scientific experiment. In this way, the death was torn away from the idea of unknown and uncontrollable nature and from the metaphysical explanations, to which the death had been thought in relation with, for centuries (p. 243).

In the modern context, the discourse about the death changed. The modern medicine's discourse explained the death *scientifically* and *enlightened* it by this-worldly concept. Although death has always been an integral part of human life,

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anatomy opened the way of major transformations in the field of medicine (Kelly, 2010a, pp. 23-27). The cover page of his epochal work of *De Humani Corporis Fabrica (1543)* is about cadaver opening. We see from the image situated at the cover that more than seventy people and some animals met for following the autopsy. In the middle of the scene there is a woman's body whose abdomen is open and organs are seen (see Appendix A, figure 5). The way of examination of the cadaver and the atmosphere of the autopsy are quite different from the present. On the one hand this atmosphere resembles a carnival; on the other hand it represents the scientific power of man over the nature and the woman body. As the time progresses we see that the examples of autopsies comes closer to modern medicine. For instance, *The Anatomy Lesson of Dr. Nicoales Tulp* was painted by Rembrandt in 1632 presents a closer autopsy atmosphere. The picture shows the autopsy that Dr. Tulp performs. There are seven surgeons around Dr. Tulp who are carefully looking to the lifeless body and Dr. Tulp examines and demonstrates the dead man's arm muscles (see Appendix A, figure 6). In this case the dead body and the surgeons are not anonymous. This is a public anatomy lesson and the man who is examined is an executed criminal. In this case, we see a theatre rather than a carnival.

clinic medicine attempted to explain it as an isolated technical event, and achieved this aim by exploring the dead body, namely the cadaver.

Cadaver, for the clinic medicine, was a research object independent from both life and as well as death. The medical knowledge, which was derived from the cadaver, shed light on the diseases of living body. However, the death ceased to be the last phase of a disease. It was turned into a medical condition in itself. In this fashion, life, disease and death were separated as different medical and technical issues. Different medical identifications and control mechanisms were developed for each of them. Bauman puts that modernity,

> …reinterpreted the chimera of final victory over death as the long chain of temporary triumphs over its currently most publicized causes. It replaced the big worry about survival with many small -manageable- worries about the assorted causes of dying. All in all, it 'de-metaphysicized' mortality. Death under modern conditions was no more 'tamed'; but it has been *rationalized* instead. It has been given its own location in social space, a segregated location; it has been put in custody of selected specialists boasting scientific credentials; it has been mapped into a mental space populated with named and knowable objects and events; it has been linked to a network of techniques and practices of measurable efficiency and effectiveness (1992, pp. 152-153).

In a nutshell, the history of modern medicine involves a series of displacements concerning death. In the modern times, death moved from unpredictable world of nature to the predictable and controllable world of medicine. It moved from the circle of unquestionable will of God to the circle of questionable medical practices. It moved from a subjective field to the objectivity field of medicine. It moved from the sight distance of deceased's relatives to the sight distance of hospital staff. In the age of modern medicine, death was medicalized, routinized, objectified and hospitalized.

In addition to these, death was disconnected from its traditional space, from the patient's home, and moved to the hospital. Doctors and nurses replaced the patient's relatives who were accompanying the death for centuries. On the one

hand, hospital procedures and records which simulated and bureaucratized all deaths took the place of each death's singularity caused by the individual's own life experiences. Thus, despite their heterogeneous characters, deaths were governed within the bureaucratic, administrative structure of the hospitals through medical implementations. On the other hand, by assigning each death a medical explanation modern medicine individualized each death. As a result, modern medicine surrounded death from all sides.

5.3 Partial Deaths in the Postmodern Context of Medicine: The Notion of Brain Death

Postmodern medicine combines this besieged death of modernity with machines in the intensive care units. It divides the dead body into parts and opens the parts of dead body to reuse. The postmodern medicine's rupture from modern medicine depends upon the revaluation of the body at the death's door and the body who just died. Postmodern medicine creates a new value from these two bodily conditions, which are intertwined with death, through transferring the organs of these bodies to other bodies.

It is known that, the organs which are used in the transplants can be derived from two sources; these sources are the living donor and the cadaveric donor (Sharp, 2006, p. 11). Firstly, a *living/fresh* organ can be taken from a living donor. What this means is that organs of the living body can be transferred to another living body. For instance, kidney transplants can be made while both the donor and the recipient are still living. Secondly, a *living/fresh* organ can be taken from a *dead* body. What this means is that organs of the dead/dying/about to die body, also can be transferred to a living body. This second one is called as "cadaveric organ transplant".

The cadaveric organ transplant can be made from the donor whose brain death is occurred. The concept of brain death is important in terms of reinterpretation of death. It is also important in terms of the recycling of the dead/dying body. It indicates a sharp transformation about the knowledge of body, especially about the knowledge of dead body. It brings radical innovations to the medicine's attitude towards death. Thus, brain death is a genealogical rupture for postmodern medicine.

Brain death is a critical conceptualization in the long medical history of death and also in the short medical history of organ transplantation, because it has transformed the conditions of dying and reorganized the space of dead body since its acceptance in 1960's. "Since early in its clinical history, organ transplantation has been associated with the concept of 'brain death' – the determination and declaration of an individual's death on the basis of medical tests that show irreversible cessation of all functions of the entire brain, including the brain stem" (Fox, 2005, p. 240). The foundation and acceptance of brain death is peculiar to postmodern medicine. It is an important rupture which postmodern medicine creates.

In the beginning of 1959, three scientists from France, Wertheimer, Jouvet and Descotes described the term of *"the death of the nervous system"* by focusing on the absence of electro-encephalographic (EEG) responses of the brain. Moreover, they suggested stopping the ventilator, if the condition of *"the death of the nervous system"* is clinically diagnosed (Machado, Korein, Ferrer, et.al., 2007, p.198). This was a crucial description which announces that some systems of the body may function while some systems of the body may be dying. This was the first step in the way of seeing death and life in the same body simultaneously. Also, this is the first step of seeing the body that has a dead brain and a beating heart as died body.

Months later, the entrance of concept of *"the death of the nervous system"* into the medical literature, that took place around the end of 1959, two French neurologists Mollaret and Goulon introduced the term of *"coma dépassé"*(irretrievable coma). They were the first ones who defined the death on the basis of neurological criteria and who discussed the clinical, electrophysiological and ethical issues of what we know today as brain death (Laureys, 2005, p. 898). They described the conditions of *"coma dépassé"* as such: no spontaneous respiration, no reflexes, polyuria and low blood pressure if norepinephrine was not given continuously and the absence of all EEG activity. However, they offered to see the patient in the situation of *"coma dépassé"* as not dead (Machado, Korein, Ferrer, et.al., 2007, p.198). Mollaret and Goulon's works and arguments show that, although the situation of coma is irreversible, the process of death cannot be considered as completed. Thus, it is obvious that, when the death is examined with reference to the function of brain some uncertainties arise and it become difficult to answer the question "when does the materiel end of the body occur?"

In 1968, Harvard Medical School convened an ad hoc committee to examine the definition of brain death. The committee put an end to these debates, by decelerating the criteria of brain death. This committee presented a report entitled "A Definition of Irreversible Coma" in *The Journal of the American Medical Association* and defined *"coma dépassé"* as the criterion of brain death. In the beginning sentences of that report, the committee defines their aim as follow:

> Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is need for a definition: (1) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes these efforts have only partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by

> these comatose patients. (2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation (1968, p. 337).

The report established four basic principles in the diagnosis of brain death: 1. unreceptivity and unresponsitivity, 2. no movements or breathing, 3. no reflexes, 4. flat electroencephalogram (pp. 337-338). This report explicitly identified brain death with death per se.

After the publication of this report, neurological examination technologies became more and more sophisticated. For instance, brain death confirmation tests have developed including electro-encephalographic, cerebral angiography, transcranial Doppler ultrasonography, somatosensory evoked potentials, scintigraphy and the like (Sundin-Huard and Fahy in Kellehear, 2008, p. 1535). Thus, many minor details were added to the diagnosis criteria of brain death but the basic principles, which the Harvard report revealed, remained valid. Moreover, in the following process, the brain death also divided into pieces such as brain stem death. The physiological statuses of the constitutive parts of the brain, such as cerebral hemispheres, brain stem, cerebellum and spinal cord were also included the diagnosis of brain death. That is to say, the conceptualization of brain death is divided into pieces in itself since then.

The discussions that I present about the conceptualization of brain death demonstrate that medicine produces the knowledge of death. Medicine is able to change the patterns of dying. It is able to replace the settled conceptualizations. However, as I discuss in the previous chapters, the medicine's knowledge production process is something that has close relations with the social contexts. In this context, it is important to note that the notion of "brain death" was not accepted immediately and in a smooth way by all societies. In this regard, two examples become prominent: Denmark and especially Japan are extremely vocal in their rejection of the concept. On the one hand, in 1987, Danish parliament rejected the brain death legislation. In the Denmark case, the issue was about

public discussions. In Denmark, the Danish Government set up the Danish Council of Ethics in order to discuss the issue of brain death. The council declared that the ordinary people's notions of death did not correspond with the criteria of brain death. Thus, the cause of 1987 rejection was the attempt of preserving a death description which overlaps with the ordinary people's opinions. Then, after long public discussions, in 1990, a law accepting brain death passed in Denmark (Gill, 2000, p. 218).

On the other hand, Japanese case is the best known example of the contesting against seeing the brain death equate with death. Thus, in Japan brain death become recognized as the end of life very recently. In 1997, Japan adopts brain death legislation and permits cadaveric organ retrieval. Japanese debate clearly presents that the brain death and organ transplantation are not only biological issues. Rather, they are in relation with cultural settings. Japanese rejection of brain death criteria and organ transplantation is about the gift exchange relations. As Lock puts, in Japan "gift-giving is deeply embedded in an economy of reciprocal exchange; thus the idea of giving objects of value to complete strangers one has had no personal contact appears strange to many" (2002, p. 10). Moreover, here the gift is an organ, so what given as a gift is a life. This is very precious gift. It is because the person giving this gift is dead; the person who receives the gift will not return favor. In this instance, many Japanese find it to engage this kind of gratuitous relation culturally improper. The examples of Denmark and Japan indicates that "the biological reduction of dying to collection of bodily symptoms is itself a cultural construction" (Seale, 1998, p.2).

The historical developments that I try to summarize here regarding brain death, demonstrate that postmodern medicine's rationalities concerning the death are different from the envisions of modern medicine. No doubt, as Rose underlines, in the face of medical developments "we are not neither at the beginning nor at the end, but in the middle" (2007a, p.252). Thus, the future of the concept of brain

death is open to discussions and novelties. However, the already existing notion of brain death has a lot to say on the current conception of death in postmodern medicine. The acceptance of brain death which is equated to death, disintegrates the death itself. Brain death is a representative concept which reflects the relation between postmodern medicine and death. In this context, death is divided into pieces at the level of the medical technology and practice, as well as at the level of experience and at the level of discourse.

As I stressed above, the postmodern medical imagination not only comprehends the living body as molecular, but also understands its death piece by piece. Delayed and fragmented death is peculiar to today. However, contemporary medicine's intervention to the vital processes of the body is not limited with death. Similar to the blurring of the certainty of the death, the certainty of the exact time of birth is also a questionable issues today. That is to say, the logic of brain death resembles to the frozen embryos. While the establishment of the notion of brain death is transforming the conditions of death, the notion of frozen embryos transforms the conditions of the birth. Thus, we are living in a medical age, in which the delayed and partial deaths and as well as projected births rule.

The establishment of brain death criteria and the acceptance of brain death are path-breaking events, and they bring novelties to the field of medicine. First of all, with the acceptance of the brain death as equal to death, the long established *sine qua non* criteria of death which depends on the cessation of heart's beating and breathing fall into disuse.[48] Until 1960's, the observation of cardiopulmonary activities was the main method in diagnosing death (Waisel and Truog, 1997, p.

[48] In this text, I am discussing the brain death by focusing on its relation with organ transplantation. Thus, the abandonment of the criteria of heart beating is only valid for organ transplantation cases. As Fox puts, although 'brain death' has come to be viewed as the 'new definition of death', it has not superseded the 'older' cardiopulmonary method for pronouncing death on the basis of the irreversible cessation of circulatory and respiratory functions, which continues to co-exist alongside it (2005, p.240).

684). Since then, the organ in the body which announces the death is the brain, rather than the heart. Correspondingly, the acceptance of brain death equal to the death, the organ supply for the organ transplantations has increased.

In 1967, before the Harvard declaration of brain death criteria and after the description of *coma dépassé,* the first successful heart transplant was made, with the heart coming from a donor whose brain was dead and whose heart was still beating (Levin, Farrell, Staworn, et. al., 1993, p.337).[49] This transplantation was a turning point in the history of death and in the history of organ transplantation.

This first heart transplant was the first concrete and also metaphoric example of the de-centralization of the body. A surgeon cut out the donor's heart; handled it; then placed it into the body of recipient. With this case, a human's body's anatomic and also metaphoric center was transferred to another body. As Helman writes, the surgeon who made this transplant "strayed into a mythic landscape, a land of signs and metaphors, where 'Heart' still stood as a universal symbol of emotion, courage, intimacy, and will" (1992, p. 2). With this transplant, the heart, the center of the body, and also a center in many other senses, was removed from one body to another body. Through the heart transplant, many important metaphors, which had been attached to the personhood for centuries through this organ, were dislocated. This was the first example of the medicalization of an organ which was surrounded with emotional metaphors.

Another result of the acceptance of partial death is the transformation of the characteristics of the dead body. In other words, through the shift from heart to brain in the diagnosis of death, postmodern medicine reaches a new kind of

[49] First heart transplant was accomplished by South African surgeon, Dr. Christian Bernard, in Cape Town, in 1967. Dr. Bernard transferred the heart of twenty five years old woman, who was fatally injured in a traffic accident, to fifty five years old man suffers from heart disease. The patient was survived only eighteen days. Despite this short period of time, the surgery takes its place in the literature of medicine as the first successful heart transplant. Retrieved June, 12, 2014 from http://hearttransplant.com/history.html.

cadaver which was different from the completely died, cold cadavers of modern medicine. The novel cadaver is the beating-heart cadaver. It is a body whose skin is still warm, whose pulse can be felt, and who is still evacuating and excreting; but also who is not alive (Waisel and Truog, 1997, p. 684). It is a body which is medically dead, but still has got some living organs. These living organs of the beating-heart cadaver can be transferred to the other bodies.

Beating-heart cadaver is the result of intensive care technologies. It is possible to see hospital scenes in which the machines are breathing instead of breathless human and the machines are beating instead of a failed heart, through intensive care technologies. These kinds of deaths are completely novel; and it can be asserted that they are technologically created (Lock, 2002, p. 4). Moreover, these technologically supported deaths are not sudden events. Rather, technologically created deaths come to an end within a process. This dying process creates liminal aspects, phases, stages or dimensions of embodiment which resemble to sleeping (Williams, 2005, p. 178). The body in the process of technologically supported death cannot be turned to life, but at the same time it cannot dismissed from life. It is sociologically dead, but biologically in a situation alive-like or dead-like. These are the result of purgatory stages between life and death such as coma or vegetative stages, which mean neither life nor death and so all of which are betwixt and between.

These liminal phases annihilate the modern dichotomy of life versus death. The borders between life and death got blurred through these intermediate phases. The moment in which the death comes and the life ends lost its certainty.

> Death has been dissected, cut to bits by a little series of steps, which finally makes it impossible to know which step was the real death, the one in which consciousness was lost, the one in which breathing stopped. All these silent deaths have replaced and erased the great dramatic act of death, an no one any longer has the strength or patience to wait over a period of weeks for a moment which has lost a part of its meaning (Aries, 1976, pp. 88-89).

Thus, the machines and equipment such as mechanical ventilators, feeding tubes, catheters, dialysis, external pacemakers and the like, produce bodies in which life and death walk arm in arm. In some conditions they produce bodies which use the organs of other bodies. In some conditions, they produce bodies whose some systems functions naturally, some systems function by the help of machines, and some systems failed. For instance, in the intensive care units doctors deal with the "situations where the patient is alive but in a coma, without functioning heart, lungs, kidneys, or gastrointestinal tract, with a transplanted liver, a reversed coagulation system, a blocked immune system, and a paralyzed musculoskeletal system" (Levin, Farrell, Staworn, et. al., 1993, p. 338).

In this context, the establishment of brain death does not only change the criteria of death and create partial deaths, but also through the intensive care units, which make the brain death possible, it brings new impulses to the healthcare industry. In this way, it produces deaths whose cares are grueling and expensive. Thus, while the intensive care technologies are producing vitality statuses that were never seen before, they constitute bridges between the clinics, hospitals and the health market. They have produced a new kind of patient model who is hospital-dependent and who cannot be left to die, but also who cannot be taken back to the home.

As Ivan Illich demonstrates, health industry plays a critical role in the establishment of the intensive care units (2006, p. 104). Recently, health industry has turned towards the rising demand of the defense against death. The health industry has produced and sold expensive pharmaceuticals, tests, machines and technologies which promise life extension for terminal patients. Moreover, an intensive care unit required more staff and equipment than the normal patient care. With Illich's own words "intensive care is but the culmination of a public worship organized around a medical priesthood struggling against death" (p. 105). Today, people save money or pay for health insurances during their lifetimes, in order to

purchase life care services at the last period of their lives. Then they go to the hospitals for dying. Especially intensive care units are the last stops of the death tourism and market. People in the intensive care units leave the judgment of their deaths to the hand of health professionals, hospital bureaucracies and care technologies. As Illıch puts "death without medical presence becomes synonymous with romantic pigheadedness, privilege, or disaster" (p. 100). Thus, current deaths are captured by medicine and by its technologies. Death processes are ending under the shadow of health industry. Today, it is almost impossible to find a death which is not surrounded by pharmaceuticals, which is not delayed for a while by the machines, which is not measured by the hospitals, and which is occurred far from the eyes of doctors.

5.4 Creating Partial Deaths in the Living Body: Immunosuppressants

The discussion which I presented above by focusing on brain death and organ transplantation, are about the people who are close to death and whose organs will be replaced with other bodies. Hereafter, I am going to discuss the issue of partial deaths concentrating on the recipients' bodies. As I mentioned before, death in the postmodern medical context is a partial affair. The partial deaths of postmodern medicine are not limited to brain death. Brain death transforms the corpse into the storage of organs which are open to re-use. However, the partial death not only visits the body of brain death donor, but also it stands out in the body to which the organ is transplanted.

Until late 1980's, most of the organ transplant operations resulted with the death of the recipients shortly after the transplantation. The main reason of this problem was the foreign organ rejection. Foreign organ rejection is the result of the attack of immune system to the newcomer organ. The foreign organ rejection resembles

an organic warfare between the "self" and "non self" (Joralemon, 1995, p. 337). The immune system of the recipient's body attacks and destroys the newcomer organ, because it cannot identify the foreign substance and treats this foreign substance in the same manner as the viruses. Thus, foreign organ rejection is an immune system response which blocks the accommodation of foreign substance in the body. The problem of foreign organ rejection was solved by the development of the immunosuppressant drug "cyclosporine".[50]

Cyclosporine was discovered in the 1970's in the laboratories of Sandoz and its clinical use became widespread in the 1980's (Heusler and Pletscher, 2001, p. 299). On the one hand, while the problem of finding proper organs for transplanting was overcame by the conceptualization of brain death, to a certain extent, the problem of foreign organ rejection was solved by the presence of cyclosporine. On the other hand, similar to the metaphoric meanings of heart transplant case, which I discussed above, the suppression of the immune system brings metaphoric comments into mind.

As Haraway discusses, immune system is an issue in which myths, laboratory and clinic are intimately interwoven, because it is both an iconic mythic object in high-technology culture and it is an important subject of research and clinical practice (1991, p. 205). She describes the immune system as "a plan for meaningful action to construct and maintain the boundaries for what may count as self and other in crucial realms of the normal and pathological (p. 204). Moreover, immune system is known, by the scientists and non-scientists, as the message carrier among the parts of the body so it is known as a system which organizes the communication within the body (Martin, 2000, p. 132). It is the memory of the

[50] There is a consensus in the medical literature about the positive impacts of the cyclosporine in the prevention of foreign organ rejection. Humar, Matas and Payne points that "the major breakthrough for the field came in the early 1980s, with the introduction and clinical use of the immunosuppressive agent cyclosporine" (2006, p. 198).

body. It recognizes, identifies or ignores things which are a threat to the body's health. It knows what to do in order to response the threats. It is an educated system. For example, vaccinations play important role in the education of immune system. Thus, in some cases, for instance for the familiar flu viruses, it remember the threat from seeing it previously (p. 132). In some cases, for instance, for the implant of foreign organs, it does not recognize or misrecognizes the situation because of the novelty of the situation.

In this context, the development of cyclosporine allows artificial interventions to the immune system. Cyclosporine is a kind of drug which disables immune system for a while. By this way, the foreign organ settles in the body. The functioning logic of the cyclosporine overlaps with the molecular body understanding and the partial deaths. It is because the body is not considered as the sum of interdependent systems, each of which function for the whole, it is expected that inactivating one system will not create a problem for the whole. This expectation affirmed itself and cyclosporine worked in the recipient's body.

A death-like situation occurs in the body through the use of cyclosporine. Certainly, the case of cyclosporine may not be read in a similar way to the brain death case, whose connection with death is more open and direct. However, the case of cyclosporine presents that, in the contemporary medicine the function of a system in the body can be stopped or suppressed. To stop the operation of a system is similar to placing a small, local and artificial death into the body. In this context, cyclosporine kills the memory of the body. It is erasing the memory of the body by stopping the immune system for a while. In order to establish the newcomer organ, cyclosporine clears away the existing education of the immune system. It changes the body's categories of familiar and foreign, by postponing the body's natural defense mechanisms. Thus, through cyclosporine, medicine transforms the body into a soft plastic, and then remolds it.

In addition to these, the medical language of the immunology, has a distinctive vocabulary which reflects the medicine's approach towards transplantation. Renée Fox (2005) presents this terminology as below:

> To a striking degree, the language of immunology is pervaded by vivid, teleological concepts, terms, and images. Incorporated and assimilated into its scientific lexicon are notions of the 'tolerance', 'acceptance', and 'rejection' of transplanted tissues and organs; the capacity of the body of a recipient to 'recognize' tissues and organs that are 'foreign' to it, and to distinguish 'self' from 'nonself', and 'tolerating self' from 'attacking nonself'; 'natural killer', 'target', and 'helper' cells, portrayed as protagonists in the warlike conflict between two immune systems that 'acceptance/rejection' involves; the 'migration' and 'colonization' of cells between transplanted organs and their recipients; and the 'chimeras' of genetically different groups of donor and recipient cells that are formed – a term derived from the name given in Greek mythology to a fire-breathing monster with a lion's head, goat's body and serpent's tail (p.236).

This 'biological' and 'medical' terminology on immune system reflects how the body seems to be from the medical lenses, in the case of organ transplant cases. The body is not a place in which spontaneous processes are left to their natural flow. Here, the body resembles a battleground. In this battleground, where attacks, migrations, deaths and colonization rule, foreigners and habitants make war. There are parts of enemies and friends in this war. If the immune system is activated, the strangers cannot settle in the body and the body dies. If the immune system can be disabled, the foreigners settle in the body and life goes on. Body is seen the ground of fights by this medical terminology. Medical practices support one side of this fight and intervene in the fight by collaborating supported side. The cyclosporine case refers this intervention. Medicine becomes the side of the war between life and death, which rules in the body through drugs such as cyclosporine. After transforming the body into a soft plastic and after remolding the plastic, medicine goes to wars in this soft plastic for rescuing its life.

5.5 Concluding Remarks: Blurred Deaths

To conclude the discussion I made under the title of death, it can be asserted that the postmodern medicine operates through a certain kind of death understanding which makes vitality exchange possible. When the cases of brain death, intensive care units and cyclosporine are considered together, it is seen that postmodern medicine produces its own specific knowledge, rationality and patterns concerning death. The transformation in the medical decision of the death, more openly, the shift from the death based upon the absence of heartbeat to the brain death, is one of the crucial shifts from modern medicine to postmodern medicine. It is obvious that, through the establishment and acceptance of brain death criteria, the knowledge of death is reconstructed in the medical field. The conceptualization of brain death creates the conditions of finding suitable donors and so finding the suitable organs, through which vitality exchange is achieved. However, the question of when the materiel end of the body occurs is a controversial issue for the postmodern medicine.

Contemporary medicine touches the borders between nature and culture, me and other, living and dying, through the notion of brain death, usage of cyclosporine and development of intensive care units. Death is not conceived as the material limit of the body by postmodern medicine. Rather, as the organ transplantation case demonstrates, the dead body can be the source of life for other bodies. Organ transplantation creates a novel kind of transitivity between the death and the life, which was not seen in the modern medicine. In the postmodern context, the death of a body may mean the life for another body. Vitality may be exchanged between different bodies. The death of a body may be distributed to the other bodies as a life. In such a case, it is difficult to decide where and when one death ends and the other life restarts. Moreover, in the postmodern context, death become dependent on other variables in a way that never seen before. Technology, life insurances,

intensive care units, health industry and health market have been involved into the death process as variables affecting the death. It can be said that, today the reproductive trafficking of the organs is organized in a network in which the knowledge of death is reconstructed

CHAPTER VI

POSTMODERN MEDICINE, ORGAN TRANSPLANTS, AND COMMODIFICATION

Medicine is a practice which always has got close relations with the mode of production, specific to the age in which it operates. Accordingly, current medicine operates in the conditions of current global capitalism. Competitiveness, profit-orientedness, globalized-market-drivenness, multinational flows of commodities and capitals may be put as some features of global capitalism. However, all of these may be also put as some features of contemporary medicine. Thus, it can be argued that the conditions of global capitalism flow into the soul of medicine.

Today it is well-known that market conditions has a strong impact on the determination of priorities and services of healthcare systems. Pharmaceutical industries' profit and loss statements effect the treatment methods of existing diseases and the descriptions of newcomer diseases. Global insurance companies, global companies that sell medical technologies, care services, intensive care equipment or antidepressants have an important voice in the trajectories of medicine. Today, in the field of medicine almost everything has monetary equivalent. Not only the treatment of a disease, but also health is a state one can

reach by purchasing medical products and services. Almost all kinds of health-related products and services are in a trading relationship. For instance, health insurance, tube baby therapy, cancer medications, check-ups, flu vaccine, cholesterol testing, care services, prosthetic limbs and many other things are bought and sold. In this way, our health and disease lurch between the pendulum of buying and selling.

In the recent times a new commodity is added to the long chain of medical products and services. This newcomer commodity is "fresh organ". All kinds of "fresh organs" without bounding a body circulate in the market. They can be bought and sold, like a medical equipment or service. Thus, commodification of the organs, in the recent decades, presents that the impacts of capitalism penetrate into the body of human, not only metaphorically but also in real terms. On the other hand, the relation between the medical developments concerning organ transplants and commodification of the organs has radically transformed and expanded the answers of the question "what purposes does an organ serve?"

In this chapter, I am going to discuss the travels of the organs that cut the painter with the body. In chapter, I am going to examine the parts of the body, such as tissues, kidney, a portion of liver, a lung, an eye, blood, Deoxyribonucleic acid (DNA) information, ova and sperms, are turned into commodities, how vitality is bought and sold under market conditions. And I am going to discuss the answer of the question "what is the role of the postmodern practices of medicine in this transformation?" Below, I argue that the achievements of postmodern medicine in the organ transplantation are historically specific acts which transform previously non-commoditized organs into certain commodities. And so, it paves the way of new and subtle forms of exploitation of the human body. Even, this exploitation is realized under the auspices of medical "improvement". Thus, commodification of the organs can be considered as one of the results of the newly established alliances between capitalist market and medicine.

On the other hand, I am going to discuss the "gift exchange" discourse which is commonly employed when the organ transplantation is considered from a sociological and anthropological perspectives (Fox and Swazey, 1974). The gift exchange discourse is not the opposite pole of commodification discourse about the organs. The simultaneous existence of these two discourses show the character of medicine in the postmodern which is ridden with contradictions.

6.1 Exchanging Organs: Organs as Commodities without Bodies

"It is plain that commodities cannot go to market
and make exchanges of their own account."
(Karl Marx, Capital I)

As it was discussed in the previous chapter, since the 1990's, the organ transplants became increasingly prevalent. One of the most prominent reasons for this proliferation was the notion of brain death, which started to have agreed-on definitions from the late 1960's. Since the establishment of these criteria, procurement of organs from individuals, whose brain deaths were diagnosed, started to become possible. Another reason for this was the invention of cyclosporine in the 1970's, and its increasing prevalence in the 1980's. With the invention of cyclosporine, the problem of foreign organ rejection was overcome. Besides other medical and technological developments, these two inventions had transformed the ways of death defined by modern medicine as I discussed in the previous subtitle. In this way, the vitality exchange between humans has started to be actualized in a way never seen before.

However, there is an incipient obstacle, which prevents the unrestrained transplantation of organs to every patient who is waiting for transplantation. This

incipient obstacle is the rising transplant rhetoric of the vast worldwide shortage of organs, proper for transplantation. Despite the conceptualization of brain death transformed certain bodies, whose brain deaths were occurred, into mines (or fields) of organs, and increased the organ *supply*, the *supply and demand equilibrium* for the organs never to be totally established. Today, one of the most vital issues for the patients, who are waiting for organ transplantation, is to find a suitable organ. It can be asserted that, the rising transplant rhetoric of "organ scarcity" (Scheper-Hughes, 2005, p. 145), and the assessment of vitality exchange in the context of *supply-demand relationship* are the results of the commodification of vitality. That is to say, with the commodification of vitality, vitality itself (for instance one's kidney as a *fresh* organ) gains economic value as something which can be bought and sold in the (black and grey) market, generally by bypassing the laws and longstanding codes of medical ethics.

Today, the processes for finding suitable organs demonstrate a considerable variety, but this variety follows certain patterns and function through certain networks. Investigation of these processes have got the potential of presenting how the vitality peculiar to humans is commoditized in parallel to the development/functioning of late capitalism. It can be stated that, in general, there are two ways of organ *supply*, one of which is legitimate and socially accepted and the other one is illegitimate and unfair. The first one is the procurement of the organs in accordance with the existing laws of the local countries, international laws, human rights and medical ethics. For instance, the organ taken from a donor within the bounds of laws, the organ taken from the brain death donor or the organ exchange between family members based on tissue compatibility and volunteering are some of the examples of the first way. Furthermore, by extending the definition of the organ we may include the blood donation, sperm and egg donation into the first category. This first category is driven by the mantras of "saving a life" and "gifting one a life" by donating an organ.

The second way of organ supply is about the black and grey markets of organs which function globally. These markets function through the acts of organ trafficking, transplant commercialism and travel for transplant tourism.[51] In these markets the mottos of saving and gifting a life do not function. In these global black markets people sell parts of their bodies, or the body parts, which are stolen from people, are sold. And the global black market has an important place in the organ *supply*. Therefore, here we have two conflicting debates on *supply*: the first one is about altruism and gift exchange and the second one is about commodification of organs.

Despite it is possible to exclude unequal capitalist relations seen in the case organ exchange realized under the shadow of capitalist market economy, and then considering organ exchange as a type of gift exchange relationship, the notion of gift exchange is insufficient for presenting the quality of every organ exchange relationship. In other words, the notion of gift exchange is too naïve for

[51] These notions are described in the *Declaration of Istanbul on Organ Trafficking and Transplant Tourism* (2008*)* as below:

"*Organ trafficking* is the recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation.

Transplant commercialism is a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain.

Travel for transplantation is the movement of organs, donors, recipients, or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes **transplant tourism** if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals, and transplant centers) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population" (International Summit on Transplant Tourism and Organ Trafficking, 2008, p. 1228).

explaining all kinds of organ exchange. Because buying and selling organs is something much more than a gift relationship. When we look at the details and social role of the notion of gift exchange, we may understand the differences between the gift exchange and organ exchange. Arjun Appadurai describes the characteristics of gift exchange as below:

> Gifts, and the spirit of reciprocity, sociability and spontaneity in which they are typically exchanged, usually are starkly opposed to the profit-oriented, self-centered and calculated spirit that fires the circulation of commodities. Further, where gifts link to things to persons and embed the flow of things in the flow of social relations, commodities are held to present and drive - largely free of moral and cultural constraints- of goods for some another, a drive mediated by money and not by sociality (2005, p. 36).

Thus, it will not be correct to assert that organ transplants are all about gift exchanges in the era of capitalist relations, where there are many people whose organs are stolen, many others who are thrown into selling their organs, where the organ black markets beset. Moreover, using the concept "gift exchange" conceals many unequal exchange relations, and social reactions. It is to say that, like cyclosporine deactivates the immune system, there are arguments which emphasize that the notion of gift exchange suppresses the mechanisms of social reaction and resistance (Joralemon, 1995, p. 343-344).

For the sake of the argument, we may consider organ exchanges as a specific kind of gift exchange which depends upon historically particular conditions. Supposing like that, we see, on the one side of this gift exchange relationship, there are patients who wait for an organ in order to survive or live in a more healthier condition or live longer; and on the other side, there are patient's relatives who want to *save the life* of their nearest and dearest or there are people as poor as forced to sell their healthy organs in the black or grey markets.

The ethnographic research conducted by social anthropologist Nancy Scheper-Hughes clearly shows that there is a close relationship between poverty and

becoming the victim of organ trafficking. She conducted extensive field researches in dangerous locations. She made interviews with brokers in the organ black market, poorer individuals who sell their organs, owners of illegal clinics, surgeons who made illegal organs transplants and the organ transplant mafia (2002). Then, she puts that the kidney sellers answer the question "why did you sell your kidney?" by saying "in order to feed my family". Scheper-Hughes says that this is a common response worldwide (2002, p. 1).

As a result, under these conditions, it is difficult to see the properties of gift exchange relationship such as symbolically charged gift and reciprocity. Rather, as Lesley Sharp underlines, in these cases which are in no way connected to gift, employing "the language of gift exchange may obscure capitalist forms of commodification" (2000, p. 292). Thus, in order to understand the quality of this vitality exchange, the processes of the commodification of the organs, which is peculiar to postmodern medicine, must be investigated.

6.2 What Kind of Commodity is an Organ?

In the previous two subsections, I tried to catch the breakpoints from modernity, while discussing the fragmented body understanding of postmodern medicine, and the transformation of the notion of death in the context of postmodern medicine. However, since the organs themselves gained the quality of commodity quite recently, I don't make a comparison between modern medicine and postmodern medicine in this subsection. In other words, the commodification of the human organs, and the trade of the organs in the market are entirely peculiar to the postmodern medicine. This is an outcome of the development of the technologies of medicine, and the field of biomedicine. The developments in the bio-science and in the transplant surgery have opened the way of commodification of body

parts. It is possible today to fragment and isolate the body parts through the development of novel medical technologies. The bodily components have entered into the commercial transactions with their fragmentation and isolation. (Seale, Caver and Dixon-Woods, 2006, p. 25). Thus, it can be asserted that, there is not any similar period in the history of modern medicine and also throughout the history of medicine which one can compare this kind of commodification. Because, in this novel case, not the whole body but the organs, body fragments or the information peculiar to body such as Deoxyribonucleic acid (DNA) consequences become commodities themselves and they circulate in the free, black or grey markets.

On the other hand, when we browse through the history of exploitative commercialization of the body, we may find some situations or cases which resemble with the commodification of the body parts, such as the circulation of the cadavers in Renaissance anatomy theaters, the slave trades occurred during the long history of European colonial expansion, the exploitation of the women's body by abusing their sexuality, reproductive potential and fertility, surrogacy, militarily use of soldier's bodies, the exploitation of male virility, endocannibalism, transnational trade of adoptable children and so on (Sharp, 2000; Thacker, 2005). The common quality of these examples, which belong to modern and pre-modern ages, is that they are all related to the whole body.

There are similarities and differences between the new situation of commodification of the organs and the previous examples that I count here. First of all, neither the body nor its parts are certain kind of things which had initially been commodities in the pre-modern, modern times and postmodern times. It is obvious that both the whole body and bodily fragments are transformed into commodities while they are being bought and sold under the market conditions. Thus, the first resemblance between the commodification of body and

commodification of bodily parts is about their acquired characteristic of *exchangeability.*

At this point, Marx's discussions on commodity bring light for understanding the basic dynamics of the commodification of the body and its parts. As Marx underlines in the first volume of *Capital: A Critique of Political Economy*, "objects that in themselves are not commodities, such as conscience, honor, &c., are capable of being offered for sale by their holders, and of thus acquiring, through their price, the form of commodities" ([1887], 2010, p. 69). Thus, similar to Marx's examples of honor and consciousness, the body and its parts gain the character of commodity thorough moving the situation of exchangeability in the market. And those exchanges take place for a certain sum of money which is determined under the market conditions.

The second resemblance between the commodification and exploitation of the body at the level of macro anatomical-system and at the micro level of molecular fragment is about their *conditions of production*. Their *production* processes are different from industrial products. In the current stage of capitalism, we are witnessing the proliferation of commodities; and moreover, we even know from our daily lives that,

> commodities are not only made in the production process -such as in the factories- they are also created when things that are already exist are transformed into goods and services that are sold in the markets for a price. Water, for example exists naturally in the environment, but when it is bottled and sold in the market, it becomes a commodity (Spies-Butcher, Paton and Cahill, 2012, p. 34).

At this point, Marx's discussion on land as a commodity provides theoretical insights for understanding what sort of commodities are the body and body parts. In the third volume of *Capital: The Process of Capitalist Production as a Whole,* Marx writes on land and some other things which are not the results of product of labour as below:

> … the price of things which have in themselves no value, i.e., are not product of labour, such as land, or which at least cannot be reproduced by labour, such as antiques and works of art by certain masters etc., may be determined by many fortuitous combinations. *In order to sell a thing, nothing more is required than its capacity to be monopolized and alienated* ([1894], 2010, p. 453, emphasis added)

The organ and the body can be added to Marx's examples here, as commodities which can be bought and sold, and fetch price without being a product of labour. Different from the industrial products, the body and its fragments are non-produced things. Both the whole body and its parts, which are commercialized, are commodities which are not the products of labour. They are not the products of labour; they are not produced in the conditions of capitalist production; rather they are products which are extracted from the body. For instance, different from a car, the male virility or a piece of organ is not a commodity which is produced in the third-world sweatshops. However, similar to an industrial product, a kidney or a cornea or the fertility of a woman possess use and exchange values in the market; but rather than an industrial product their characteristics as commodities resemble to mines, lands, bottled water, antiques or works of art.

On the other hand, there are differences between the commodification of the whole body and body parts. The new situation of commodification of body parts occurs within "a new political economy of life" (Rose, 2007a, p. 34). The transformation of body parts into commodities is an historical act. It is something time and context dependent. This historical act has an unbreakable relation with the existing medical implementations which bring body parts the capacity of exchangeability. That is to say, through the developments in the field of medicine, the body parts gain new kinds of uses never seen before.

In the opening sentences of the first volume of *Capital: A Critique of Political Economy*, Marx underlines that something which was not previously considered as a commodity previously, can be turned into commodity in time.

> A commodity is, in the first place an object outside us, a thing that by its properties satisfies human wants of some sort or another … Every useful thing … is an assemblage of many properties, and may therefore be use in various ways. *To discover the various uses of things is the work of history*" ([1887], 2010, p. 26, emphasis added).

By keeping the words of Marx in mind, it can be said that, through the recent developments in the field of medicine and biotechnology, novel conditions of vitality occur. These recent developments embrace various novelties from medical techniques of transfusion, insemination and transplantation to stem cell technologies, from experimental genetic medicine to the development of new generation antirejection drugs, and so on. As a result, we are at the age in which circulation of biological materials is possible. Therefore, considering Marx's emphasis on the historicity of *discovering various uses of things*, we have to state that current implementations of medicine provide bases for novel usages of organs. Today vitality fragments are transformed into commodities which are ownable, tradeable and commodifiable; which are open to the acts of exchange, distribution and consumption; and which bear the features of fluidity, mutability and mobility.

A broadly changing political economy of life context lies at the background of these newly acquired properties of organs. That is to say, there is a new political economy of life, in which the body stands in the exchange networks at the level of cellular or molecular fragment. The reasons that led to this are the changes in the medical field. More specifically, biotechnological reformulation of vitality results with the birth of novel biological commodities, which can be bought and sold, so which have exchange value. For instance, it is impossible to imagine selling or buying a kidney without reference to the developments in the area of medicine. Thus, the births of these novel commodities are bound up with new forms of medical imaginations and interventions. As Rose persistently underlines, through the exercises of medicine, a kind of dis-embedding, concerning human vitality,

has occurred these days: “vitality has been decomposed into series of distinct and discrete objects, that can be stabilized, frozen, banked, stored, accumulated, exchanged, traded across time, across space, across organs and species, across diverse contexts and enterprises, in the service of bioeconomic objectives” (2007a, p. 38).

In this context, different from the commercialization of the whole body, in the case of commercialization of the body parts, the ties between corporality and personhood are looser. For instance, while it is more possible to discuss the exploitation of women’s bodies in relation to the cultural meanings, personal associations and social attachments, it is difficult to discuss the commercialization of a dead woman’s cornea through conventional categories on the linkages between personhood and corporality. The break of the bond between personhood and corporality is also in relation with the dehumanization tendency of medicine.

Dehumanization results from the structural and organizational features of postmodern medicine. While solving medical problems, postmodern medicine decomposes individual and her/his symptoms into physiological systems and subsystems. While making diagnosis and curing the disease medical professionals treat the patient as a mechanical system made up of interacting parts (Haque and Waytz, 2012, p. 178). They concentrate on organ systems, organs, tissues, cells, molecules. In general, they do not consider the patient as a fully social entity. Rather they comprehend the patient as a mechanical system (p. 179). Thus, commercialization of body parts conforms to the dehumanization tendency of current medicine. In addition to this, Andrews and Nelkin, probably the first theoreticians exploring the characteristics of vitality in the market, depict that the body parts circulating in the market are treated as if they are “*extracted* like a mineral, *harvested* like a crop or *mined* like a resource” (1998, p. 54, emphasis added). The metaphors of Andrews and Nelkin may go to extremes, but still there have a grain of truth in what they say. As it might be clearly seen, something

never seen before happens to the human organs. The organs cut the painter with the body. They transform into "ambulatory organs" (Scheper-Hughes, 2005, p. 148); there "organs without bodies"[52] emerge. The "ambulatory organs" or "organs without bodies" become the actors of some processes on their own accounts.

6.3 "Complex Connectivities"[53] of the Dirty Organ Market

Frederic Jameson puts that one of the most important features of the capitalism of our time is a "prodigious expansion of capital into hitherto uncommodified areas" (1997, p. 36). Health market also pursues this expansionist pattern of capitalism. On the one hand, wide variety of products and services are sold in the health market. For instance, beauty industry, cosmetic surgery industry, pharmaceutical companies, medical research companies, life insurance enterprises, anti-aging industry, antidepressant industry are some actors of this market. Thus, the health market plays a constitutive role in reshaping the body, enhancing the health of the

[52]This definition belongs to Stelarc, who is a famous performance artist who uses his body in his art and attempts to transform his body into cyborg. In his artworks, he attempts to open his body to unlimited interactions. In order to combine his body with technology, he makes wounds or he bores holes in his body and then he places prosthesis and implants into these holes and wounds. His works of "the ear on arm" and "third hand" are the examples of these attempts. (see Appendix A, figure 7 and figure 8). As a result, in order to challenge the anatomic, sociologic and anthropologic fate of his body, he combines his body with technology. For this cause he has a series of medical operations. While he is explaining his artworks he puts that "… instead of a "body without organs", now we will have "organs without body". Organs awaiting bodies." Retrieved September, 11, 2014, from http://stelarc.org/documents/StelarcLecture2009.pdf.

[53] "Complex connectivity" is a definition offered by John Tomlinson in order to describe the character of globalizing world. For him, we are living in a global world in which food, movies, tastes, desires, cultures, politics, commerce, lifestyles and many other things go beyond their national borders and circulate around the world. The things that are circulating in this flux establish many connections. And then there occur a complex worldwide network in which numberless people, things, objects, ideas and so on connect to each other (1999).

individuals and curing the diseases. On the other hand, abstract feeling situations such as hope, risk, expectation, desire, ideals of beauty, wellbeing, danger, fear, perfection, happiness, and insecurity are also transformed into purchasable commodities in the health market. Moreover, in this market there are various medical products, for the individuals who are supported to realize the popular mottos of "take care yourself", "be happy", "be fit and energetic", "carpe diem", and "feel young" and so on. In this way, health market turns the ways of one's governing his/her soul into marketable entities (Rose, 1999, p. vii) by commercializing the knowledges and practical techniques and feelings through which the subject construct and act upon his/her self. In addition to these, medical knowledge, expertise, care services, medical technologies are saleable things in the health market, all of which play crucial roles in the "truth games" (Foucault, 1988, p. 18) of individuals, via modifying their skills and attitudes concerning their lives.

In such a market, in which so diverse *products* are bought and sold, buying and selling human organs started to become something "a bit ordinary". The recent history's biotechnological *breakthrough* of organ and tissue transplant gave rise to the birth of new hopes concerning repairing the body and enhancing the health of the human. As Petersen puts, in this situation, the body and its parts have become one of the major items for exchange value and exploitation within late capitalist consumer-oriented societies (2007, 133). Moreover, with the rise of commercial language of *supply* and *demand* in the vitality market, the body is reduced to something which is similar to a utilitarian object, whose parts can be bought and sold.

It is commonly discussed in the literature of sociology of markets that the markets are social arenas and certain kinds of social structures, which are characterized by extensive social relationships (Fligstein and Dauter, 2007, p. 105). Accordingly, markets are economic and social networks. In these networks humans, objects,

artifacts, techniques, ideas and agents construct many interrelations. Black organ market also has similar characteristics.

When we focus on the social and economic structuring and ongoing dynamics of black organ market, we can find a number of notable patterns: Firstly, the existence of black organ market challenges the *gift exchange* discourse which is commonly applied in order to overcome the transplantable organ shortage. Secondly, the organ market is a market in which *fresh* organs move from poor bodies to rich bodies. Thirdly, in this market, the *fresh* organs not only cross the boundaries of the body, but also cross the boundaries of the countries and the direction of the flux of organs between countries is also from poor to rich. Fourthly, this is a market which is organized in a *transnational* scope. Fifthly, this market does not only rule through organ sellers and organ buyers; rather, it functions through a *network* in which a lot of actors play a lot of roles. Sixthly, medical expertise functions in this market by crossing the national borders. Below I am discussing these points in detail.

It can be asserted that selling an organ is almost equal to selling a piece of vitality. Selling or buying pure vitality challenges the lifesaving discourse which remains in the forefront of organ transplants. In fact, the capitalist patterns rule behind the organ transplant discourse's "noble lies", such as gifting, scarcities and human needs (Scheper-Hughes, 2005, p. 147). By going beyond these "noble lies", some people's very biological lives have entered directly into the capitalist relations of black and grey organ markets.

When we focus on the question of "who are these some people?" or more explicitly, "who are these people who are forced to sell their organs?", we can see the exploitation of the poor people's bodies for the benefit and life of the rich. By concentrating on the circulation of kidneys in the black market, Scheper-Hughes describes the routes of commoditized vitality parts in the market as below:

> …these new transplant transactions are a blend of altruism and commerce; consent and coercion; gifts and theft; science and sorcery; care and human sacrifice. On the one hand, the spread of transplant technologies, even in the murky context of illicit surgeries, has given the possibility of new, extended, or greatly improved life to a select population of mobile kidney patients from the deserts of Oman to the rain forests of Central Brazil. On the other hand, the spread of ‘‘transplant tourism’’ has exacerbated older divisions between North and South, core and periphery haves and have-nots, spawning a new form of commodity fetishism in demands by medical consumers for a quality product – ‘‘fresh’’ and ‘‘healthy’’ kidneys purchased from living bodies. *In general, the circulation of kidneys follows the established routes of capital from South to North, from poorer to more affluent bodies, from black and brown bodies to white ones, and from females to males, or from poor males to more affluent males. Women are rarely the recipients of purchased or purloined organs anywhere in the world. We can even speak of organ donor versus organ recipient nations* (2005, p. 150, emphasis added).

In the current *transnational* period of capitalism, we witness a number of fluxes: money, capital, services, knowledge, technology, human capital and human labour, crimes, beliefs, and even body parts. Crossing beyond the borders, they continuously move from one place to another, and they communicate with each other. This flux is also valid for *fresh* organs. What is critical here is that, the flux of organs in the black organ market pursues a certain direction.

The direction of commercial transplant is from poor to rich, from disadvantaged people to advantaged people, from vulnerable people to powerful people. The *fresh* organs move from poor bodies to rich bodies. It is stated in *Declaration of Istanbul on Organ Trafficking and Transplant Tourism* (2008)[54] that illiterates, impoverished persons, undocumented immigrants, prisoners, political or economic refugees are at the victims of organ trafficking (p.1228). And the *Declaration* puts that “because transplant commercialism targets impoverished

[54] This declaration was made in Istanbul, Turkey, 2008, by the participants of the *International Summit on Transplant Tourism and Organ Trafficking* convened by *The Transplantation Society* and *International Society of Nephrology.* More than one hundred and fifty representatives of scientific and medical bodies from around the world, government officials, social scientists, and ethicists attended the *Istanbul Summit*. The main aim of the *Istanbul Summit* is “to address the urgent and growing problems of organ sales, transplant tourism and trafficking in organ donors in the context of the global shortage of organs” (2008, p. 1227).

and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited" (p. 1228). Moreover, the *fresh* organs move from poor countries to rich countries, from underdeveloped countries to developed countries. As *World Health Organization* (WHO) reports that, India is a most known organ-exporting country. China exports organs which are procured from executed prisoners. Egypt, Philippines, Pakistan, Bolivia, Colombia, Brazil, Iraq, Israel, Moldova, Peru and Turkey are reported as the countries which provide *fresh* organs for the market. On the other hand, Australia, Canada, Oman, Saudi Arabia and USA are reported as major importing countries.[55] Thus, organs are commodities which are bought and sold transnationally[56]. In a similar way, in 2012, *European Committee on Crime Problems* (CDPC) reported that illicit trade of in human organs is a well-established fact which is seen both at national and international levels. According to CDPC report, trafficking in human organs involves different actors and different criminal acts.[57]

[55] Retrieved October, 20, 2014, from http://www.who.int/bulletin/volumes/85/12/06-039370/en/

[56] Iranian model is an exception in this transnational organ transplantation cases. In Iran, organ transplantation is managed by a state controlled institution. The name of the institution is "Dialysis and Transplant Patients Association". In Iran, both of the individuals who want to be recipient and who want to be givers apply this association. There is no role for a broker in this model because the giver and recipient directly apply to this association. Then this association matches suitable recipients and givers. The condition of being a relative of recipient is not required for the giver. After the transplant achieved the giver receives an award and health insurance from the government. And the giver also receives an award from the recipient. If the recipient is poor, a charitable organization gives the award instead of the poor recipient. The point here is this: this system is totally national. For preventing transplant tourism, foreigner recipients are not allowed to undergo transplantation from Iranian donors. Also, foreigner givers they are not permitted to volunteer as organ donors to Iranian patients. In this case, a receiver or giver from outside the country cannot enter the system. Through this introverted system, the renal transplant waiting list is almost completely eliminated in Iran (Ghods and Savaj, 2006).

[57] Retrieved October, 21, 2014, from http://www.coe.int/t/dghl/standardsetting/cdpc/CDPC%20documents/CDPC%20(2013)%205%20-%20e%20-%20Draft%20Explanatory%20Report%20to%20the%20draft%20Convention%20against%20Trafficking%20in%20Human%20Organs_Rev_2.pdf

As a result, the commercial travel of *fresh* human organs realized between people, between countries, between nations. This commerce takes places in the global level by exceeding scopes of countries. Moreover, it takes place beyond the scopes of categories of age, class, economic status, social status, ethnic belongings, religious belongings and gender. Ironically, *fresh* organs are bought and sold by tearing down all kinds of economic, social, cultural and religious boundaries. And again, ironically, in a dirty ground, *fresh* organ commercialization interpenetrates the bodies of the citizens of the world.

6.4 Human Stories Embedded into the Organ Market

Besides the reports of recognized organizations, as I mentioned shortly above, it is possible to get information about this black market by doing a cursory research on *Google*. In other words, although it is a black, illegal and secretive issue, the existence of the market, in which organs are merchandised is a well-known fact for almost everyone today. In addition to that, the commercial exploitation of the body parts in this black market, and the tragic human stories which are embedded in this commerce, frequently appear in media. The appearing news reflects the characteristics and patterns of this market and presents how the body parts shuffle across within this market as commodities.

In this subtitle, I argue that the organs are transformed into certain commodities. And I argue that traded organs, just like other commodities traded in the market, are subject to the conditions and trends of capitalist market economy. Although the organs are transformed into commodities in their own right, while they are circulating in the market, they lead to intertwining of multiple people's stories. There are a lot of actors in the black organ market such as givers/sellers,

buyers/recipients, organs itself, brokers, medical professionals, clinic owners and so on.

In this crowded and dirty trade network, contradictory situations exist together. For instance, the endeavor to save lives and fraud can be seen in the same case at the same time. Or, exploitation of a body and recovering of another body from an apparent death can be seen in the same case, at the same time. Moreover, the organ transplant operations, as a medical practice requiring advanced expertise, leave deficient bodies on the one side; and on the other side, they create bodies endowed with a new life. This is the clear example of a medical practice working in alliance with market conditions that sees some lives more valuable than others. Below I concentrate on some human stories from black organ market which have the capacity of presenting the patterns of *fresh* organ trade and its relation with medical practice.

The transplant story of a man from *Canada* is as such[58]: The man had been waiting for a kidney in order to live. And it is told to him in *Canada*, in his home country, that he should wait for a kidney twelve years because the official organ transplant waiting list of the country is very crowded. Then, through brokers, he went to *Kosovo* and he agreed with a *Turkish* surgeon for the transplant operation. The kidney that he was waiting for came from *Russia*, from a woman who was volunteering for selling her kidney, and then his operation was done. The story of man indicates that the organ trafficking and medical operations which are inseparable part of this traffic occur in the context of global capitalism. The global circuit of organs and medical practices resembles to the circuit of other

[58] Retrieved October, 22, 2014, from http://health.usnews.com/health-news/health-wellness/articles/2013/11/11/exploring-the-gray-area-in-organ-trafficking

commodities and services. Similar to the reports, the story reflecting from media presents that black market for organs is a global market.

This global market works thanks to the various communication networks and it functions in a very different spheres. In some cases, different communication spheres such as social media can be transformed into a part of black organ market. Thus, the organ commerce may be realized in different spheres, rather than in a particular market place whose address and relations are apparent. For example, it is possible to reach people who want to sell their organs via social networks such as Facebook.[59] For instance, the story of a well-off man from *Japan* is as such[60]: when the *Japanese* man's kidney had failure, he had to make a decision. There were two options for him. He would remain in Japan and wait for a suitable kidney or he would try to reach a suitable donor outside from Japan. He chose the second option because the number of the people who donate their organs in Japan is scarcely any and he had to hurry in order to live. Then, he checked out online for the donors who were selling their kidneys. He met with a *Japanese* broker in the social media. And then the broker found him a suitable and "cheap" kidney, meanwhile "cheap" is the word of recipient. After his operation successfully ended, the man learned that his e-donor was a young executed prisoner from *China*.

In this global market, arising on different communication networks, different disadvantaged groups whose poverty stem from various reasons sell their organs. For instance, Scheper-Hughes counts the groups who are selling their kidneys and who are buying kidneys as below:

[59] Retrieved October, 18, 2014, from http://www.sundaypost.com/news-views/uk/poverty-is-driving-people-to-sell-their-internal-organs-on-the-black-market-1.260168

[60] Retrieved October, 22, 2014, from http://www.independent.co.uk/news/world/asia/japans-rich-buy-organs-from-executed-chinese-prisoners-470719.html#.

> The spread of transplant technologies initially created a global scarcity of transplantable organs at the same time that economic globalization released an exodus of displaced and "surplus" persons to do the shadow work of production and, alter, to provide bodies for sexual and medical consumption. The "open" global market economy provided the ideal conditions for an unprecedented movement of people, including mortally sick bodies traveling in one direction and "healthy" organs (encased in their human packages) in another direction, creating a bizarre "kula ring" of international body trade. Like any other business, the organs trade is driven by a simple market calculus of supply and demand. Its brokers organize and bring together affluent kidney buyers from Japan, Italy, Israel, and Saudi Arabia with the stranded Moldovan and Romanian peasants, Turkish junk dealers, Palestinian refugees, AWOL soldiers from Iraq and Afghanistan, and the unemployed stevedores of Manila's slums from whom they will buy a lifesaving commodity (2005, p.149) .

Sometimes, the suppliers from disadvantaged groups change places in the market. In some cases, a particular supplier group of black organ market leaves its place to another group of people who are needier, and so who sell their organs cheaper.

The story of a 19-years-old Syrian refugee, who escaped from the Syrian civil war, is an example of this mobility in the market[61]: a young Syrian man escaped from the war with his family and refuged Lebanon. After escaping, the money they took with them run out of quickly. While the young man was trying to find money to live on, he heard from a relative that he could earn money by selling his organs. Then, via his relatives, the young man met with a member of a gang. The gang was buying organs, especially kidneys, in Lebanon's poor areas and was selling them to the rich Arabs from Persian Gulf and to the rich customers from U.S. and Europe. The gang member doctors make the transplant operations in shady underground clinics. The young man decided to sell one of his kidneys via this gang. The gang member doctors told to him that his kidney would grow back again and there would not be any after-effects of the operation. While a gang

[61] Retrieved October, 28, 2014, from http://www.spiegel.de/international/world/organ-trade-thrives-among-desperate-syrian-refugees-in-lebanon-a-933228-druck.html

member doctor removing the young man's kidney in an illicit clinic, the man's father went to the shopping with another gang member. His father bought mattresses, winter clothing, a fridge and an oven in exchange for the man's kidney. It was obvious that the young man's kidney was sold at a very cheap price because there was a competition in the Lebanon black organ market between destitute Palestinians and desperate Syrian refugees. The Syrians fleeing from the civil war, by entering the Lebanon black organ market took the place of the Palestinians in the market. The entrance of a lot Syrians, who sell their organs cheaper than Palestinians, to the market, has lowered the organ prices in the market and also has caused to the displacement of these two supplier disadvantaged groups in the market.

Another story of poverty and desperation that resulted one's selling his organs is as such[62]: a poor and uneducated man was living in a tiny district of Kavre which is known as the ground zero for the black organ market in Nepal. This man's all assets were two cows, a dilapidated country house and a tiny plot land. His income was not enough to support his family. Because of this, he went to Kathmandu to find a job in construction. One day, while he was working in a construction area, the foreman came and said to him that he could make good money if he let doctors cut a "hunk of meat" from his body. And the foreman added that the cut piece would grow again. Then, he decided to sell a "hunk of meat". In response to his decision he was given food and clothes, and he was taken to see a movie. And then, his transplant travel began. He was taken to hospital in Chennai state of India by the members of organ trafficking gang. The gang members organized fake documents for him, in which he was shown as the brother of the recipient. Before the operation, while the gang members and doctors were talking, he heard the word of "kidney" in their conversation, but

[62] Retrieved December, 18, 2014, from http://edition.cnn.com/2014/06/26/world/asia/freedom-project-nepals-organ-trail/

because he only knows the local language of his home country, he did not understand what the word "kidney" means. After his operation ended, he was paid much less money than the gang promised before, and he was sent back to his home country. However, his health deteriorated. He went to the doctor to understand what happened to him and he learned that one of his kidneys was missing. Then he understood that a "hunk of meat" that he sold was one of his kidneys. Now, he has not got any money for his treatment and he is worrying about his and his family's future.

The stories of the young poor Syrian refugee and the poor Indian peasant, reflecting from newspapers, show that the medical achievement of organ transplantations not only encloses "new economies of hope", but also includes a dirty hope trade, especially in the cases of organ trafficking. In this dirty hope trade, on the one hand, the organ givers hope to escape poverty by selling their organs. On the other hand, the recipients hope to save their lives by purchasing an organ, regardless of the ways in which the organs are obtained. As Scheper-Hughes puts the commodified organ becomes an object of desire for one population and a commodity of last resort for 'the other' disadvantaged population" (2002, p. 2). Thus, the organ selling cases of desperate and poor people, demonstrate that it is wrong to consider medical progress as a success just aims to favor. On the contrary, medical developments work in the contradictory conditions of the economical context in which they occur. In addition to that, in the cases that I express here, the character of medical practice includes two conflicting conditions at the same time.

The character of the medical practice in these cases resembles to the Ancient Greek's equivocal concept of *pharmakon*, which is the only word for drug in Ancient Greek, meanings both the power to cure and the power to kill (Illich, 2006, p. 44). It emphasizes both the remedy and the poison, as the two sides of the same coin (Derrida, 1981). Similar to the ambivalent meanings of *pharmakon*, the

cases of organ trafficking is double- sided. That is to say a single medical action results with one's getting closer to death and one's getting closer to living. Moreover, besides the "noble lies", such as gifting, scarcities and human needs (Scheper-Hughes, 2005, p. 147) which are associated with organ transplants, "ignoble" lies are involved into the organ transplant operations.

6.5 Concluding Remarks: Vital and/or Fatal Contradictions of Postmodern Medical "Progress"

The commodification of the organs is a clear manifestation of recently-specific capitalist medical tendency in which vitality rapidly became marketable by overthrowing previously established bodily borders, moral borders and human desires. As a result of their commodification, human organs circulate in the market networks of global capitalism. Thus, the human organs not only cross the borders of the body, but also they cross the borders of countries through their commerce. This kind of commercial and also medical circulation of organs are in relation with the medical gaze of postmodern medicine which sees the body as something molecular and as something in flux. Moreover, the alliance between global capitalism and postmodern medicine transforms the modern and pre-modern answers of the question of "is an organ a commodity?".

Substantially, an organ is not *produced* as commodity as of its nature. In any case, an organ is not something which is *produced*. As I discuss in this chapter, in the light of Marx's theory of commodity, an organ gains the character of commodity through moving the situation of *exchangeability* in the market. Without being a *product of labour*, an organ is a *product* extracted from the body of human. Thus, it resembles to the mines and lands, whose production processes different from industrial products. What makes all of these commodity is their conversion into

something which may be bought and sold in the market. Moreover, As Marx clearly puts “the discovery of these different respects and hence of the manifold modes of utility of things is an historical act” ([1887], 2010, p. 26). The trading process of organs, requires a *medical work* on organs, besides market relations. Here, the phrase of medical work correspond to Marx’s historical act and Foucault’s genealogical rupture.

Clearly saying, with the medical work I indicate here the postmodern medical implementations including the medical technologies and practices enables to displace an organ from a body and enables to replace it another body without losing its vitality. Thus, this medical works are historical acts laying behind the isolation, objectification and then commodification of organs. And they are genealogical ruptures which differentiate the pre-established, especially modern borders of the body and which produce novel knowledge of vitality. Through these medical works a vitality fragment, for instance a kidney, transforms into the source of value, by cutting its painter with the body.

The organ which cuts its painter with the body transforms into a valuable object for the two sides of the transplant operation, namely for recipient and for the donor who sells his/her organ. However, this kind of objectification turn against the donor when it is realized under the effect of grey and black organ market. On the one hand, the *fresh* organ is a life-saving and so priceless object for the recipient. On the other hand, the *fresh* organ has a vital price for the donor who sells it. The seller donor uses this money which she/he gets from her/his organ to sustain her/his life. Not in the all transplantation operations, but especially in the ones which the *fresh* organs are procured through the dirty relations of black organ market, the focus of brokers and doctors is on the organ itself. The person who provides the fresh organ is ignored. Thus, this kind of objectification of an organ in a dirty commerce endangers the life of the seller. And this demonstrates that, when we dig the surface of organ transplants, which are assumed to be

medical practices that grants new lives, the “other” lives abandoned to death shows up.

Along these lines, it can be assumed that, at the first glance these medical works which enable to organ transplants, may be seen as if they are absolute life-saving developments and achievements. However, when we consider these in relation with global market economy, we see that while they save some lives, they are leave some lives for dead. For instance, the human stories reflecting from black and grey organ market demonstrates that while medicine is very compassionate towards “some lives”, on the other side it is very cruel towards “other lives”. As the reports put and human stories tell, transplant commercialism results with a dirty organ trade. In this dirty trade, *fresh* organs move from poor bodies to rich bodies, from disadvantaged people to advantaged people, from vulnerable people to powerful people, from poor countries to rich countries, from undeveloped countries to developed countries. The lifesaving rhetoric and gift exchange issues which are always thought with organ transplants melt away such an unequal and dirty picture of black and grey organ markets.

In this context, it may be asserted that, behind the unfortunate personal stories of organ givers of black market, lurk the contradictory story of postmodern medicine. The personal stories that I express in this chapter demonstrate that postmodern medicine exists with its obvious contradictions. It is difficult for postmodern medicine to find a shelter for escaping its contradictions. For instance, pre-modern medicine could get rid of its faults through divine attributions. In this way, a wrong therapy could be linked to the will of god or inescapable fate of individual. And also, for modern medicine, there was the shelter of scientific progress. So, for modern medicine, thanks to the scientific advances which would occur in the future, the existing needs and shortages would be satisfied. In other words, there were a modern belief which says medicine would always evolved for better through scientific developments and medicine’s

tomorrow would be more successful than its present. Different from modern medicine, postmodern medicine does not function by putting an emphasis on the notion of progress. Rather it functions through its promise of enhancing the capacities of the human body. The promise of postmodern medicine is to discover and enhance new potentials of human body day by day. However, this emphasis on the future, do not cover up the existing contradictions. The human stories reflecting from grey and black organ markets reveal two points: firstly, current medical practice is powerful enough to replace the broken parts of the human body and it is powerful enough to save the lives of "some" people. Secondly, it is as weak as to do this by subtracting some "other" bodies. The alliance that medicine forms with global capitalism has a big share in its weakness.

CHAPTER VII

CONCLUSION: LIFE AND DEATH IN THE GRIPPER OF MEDICINE

We are currently experiencing path breaking changes in the patterns of vitality, body and death. These novelties are what we now envision in the context of postmodern medicine. In the last half of twentieth century, a shift or a break from the medicine of modern times, involving the emergence of new medical imaginaries and birth of novel vitality patterns, emerged. Such a similar rupture was also experienced in the birth of modern medicine. Even so, the modern and the postmodern medicines operate through different medical imaginaries and they fabricate different embodied subjects. Current developments are creating new forms of subjectivities, social relations, as well as medical practices that were never seen before. The changes, that postmodern medicine constitute, transform our understanding of body, health and illness, as well as the medical gaze towards itself (the medicine) and the patients, the healthy ones and the humanity. Since the modernity, medicine had been the ultimate acknowledged and respected knowledge-producer on crucial issues concerning life, death, birth, body, health, illness, and vitality. The content of medical knowledge and the scale of medical implementations started to change with the 1960's onwards. The molecular

knowledge of life began to accumulate and the introverted body of modernity started to dissolve.

This thesis investigates the shift from modernity to postmodernity and from bio-power to molecular bio-power, focusing on the novelties in the field of medicine. In order to investigate novel medical knowledges and implementations, here I concentrate on the organ transplantation therapy as a postmodern medical case. This study is based on the argument that the embodied subject of modernity is broken to pieces in the postmodern times and medicine has got an important role in this disintegration. The disintegration of the modern subject is a leading discussion topic in the sociology of postmodernism. From Deleuze and Guattari to Derrida, from Baudrillard to Laclau and Mouffe, from Bauman to Cixous, from Irigaray to Kristeva, from Haraway to Lyotard, many theoreticians who contemplate on postmodernity, focus on different aspect of this fragmentation. "Cultural fragmentation", "situated knowledges", "micro-desire politics", "fluidity", "deconstruction", "nomadic subjects", "simulacrum", "hyperreality", "cyborg" are some of the conceptual tools through which the theoreticians of postmodernity criticize the modern postulate of rational and unified subject who is considered as the main social actor.

In this study, I am following a specific line of thought that is included in this rich sociological debates about postmodernity. This path of thought is based on Foucault's theoretical discussion on the modern technologies that construct the modern subject; and Rose's discussions on the postmodern technologies that deconstruct the modern subject. Correspondingly, this path of thought presents the ways of reconstruction of the current subject, in a different manner from the modern one. On the one hand, in his oeuvre, Foucault makes a comprehensive criticism of modernity, and concentrates on the modern mechanisms that transform human being into a meaningful and docile subject. He displays that, in

the modern times, the vital processes of human fall into the calculations of power. He conceptualizes this power as bio-power. On the other hand, Rose discusses recent developments which lead to molecular scale vital politics. He puts that different from the modern mechanisms that regulate subject, postmodern governmentality practices rule in micro scale. Thus, for him, in the contemporary world the life itself has become open to politics at the molecular level. Rose conceptualizes this novel form of power as molecular bio-power. What is important for the discussions of this study is that these two theoreticians pay attention to the transformations that occur in the patterns of vitality. They see that changing patterns of vitality play an important role in the construction of certain subjects. In this context, both of them discuss medicine as an important dispositif. In their theories, we see a power machine that encircles the vitality, body, life and death of the subject, by means of medicine.

In this vein, the transformations in the patterns of vitality are a particular concern to the field of medicine. The medical knowledge and medical implementations are important sources in the arrangement of vitality patterns and in transforming the definitions of the embodied subject. Thus, medicine is not a field that retire into its shell; rather it deserves critical sociological readings. At this point, it is important to see the medicine is a relational field because medical knowledge and implementations have certain constituent relations with the cultural, economic and social conditions in which they bush out.

Medical decisions are in relation with people's ways of knowing, their existing world of knowledge, their attitudes towards vitality and body, life and death. On the other hand, medicine plays crucial roles in the construction of the existing identities and selves. Professional medical dynamics, medical practices, medical gazes and individual's daily medical sensitivities are important determinants in the fabrication of certain medical subjects and lifestyles. Moreover, medicine is a

field that has reciprocal relations with rationalities, truth regimes, forms of medical subjectivity, and networks of power peculiar to its socio-historical context. Thus, medical knowledge and medical practices interplay with the historical, social and economic conditions of the time in which they operate. As a result, the medical knowledge and implementations that encircling the subject differ from context to context.

The medical knowledge and medical postulates are historically fluid and context bounded. Medical knowledge does not proceed by exploring the "biological facts" or "physical symptoms" just standing there and waiting to come to light. First of all, the idea of existence of unchangeable "biological facts" and "physical symptoms" is misleading since biological or physical indicators and also health, and diseases are always interpreted by medicine, reference to the existing medical criteria. Moreover, considering medical knowledge as something progressing linearly is strongly modernist attitude, and again misleading. The history of medical knowledge full of paradigm shifts. The construction of novel medical gazes and the rise of new medical implementations are related to the fluxional medical truths, as well as changing social conditions.

The religious or scientific beliefs, social acceptances, economical drives and political aims that regulate the field of medicine differ from time to time. Then, medical configurations which are specific to their historical epochs occur. In this study, I discuss two main historical ruptures that prepare grounds for the formation of novel medical configurations. First of all, with the rise of modernism, the medicine was transformed into a modern science that produces respected knowledge of vitality. In this modern context, medicine as a secular and rational science undertook the duty of discovering the scientific rules of the body. It adopted a position that depends on scientific evidence. Empirical scientific evidence became one of the key words of modern medicine. Then, scientific and

rational narratives of the illnesses and diseases, vitality and death proliferated. Following the modern fashion of objective understanding of universal reality, medicine attempted to produce the objective and universal knowledges of health and illness, birth and death, vitality and life.

Modern medicine created its own unique medical subject. This modern medical subject was shaped under the reflections of much wider and more general modernization processes. Indeed, modern epoch gave birth to a new form of subjectivity. At the center of this subject creation process, the superiority of human was standing as a central principle. The human subject was assumed to have a unified form and rational identity. Modern human was projected as a subject who has a consciousness free from the direct effect of the religious institutions. Modern humanism situated the human subject at the center of the universe. This central figure was assumed to be rational and freed from dogma; and modern subject was endowed with the capacity of unrevealing the mysteries and the rules of nature through glorifying the notions of scientific inquire and investigation.

Postmodern epoch witness the deconstruction of this modern, unified, rational, coherent and progressive subject. A novel subject different from modern one is emerging under the postmodern conditions. Some of the major coordinates of this novel subject are produced by contemporary medicine. Medicine itself is also changing. After the modern one, the second paradigm shift occurred in the field of medicine which has reciprocal relations with the flourishing of postmodernism. Contemporary medical configuration is being shaped under the effect of postmodern times. It is not an easy task to describe the postmodernism clearly, because postmodernity carries all the certainties to a slippery slope. In the postmodern times, modernity's universalizing and totalizing claims melt away. The postmodern emphasis on the possibility deposes the modern hubris of

supplying apodictic truth; and modern fallacious rationalism is itself transformed into an irrational fashion. Different from modernism, postmodernism contains multivocality, radical doubt over metanarratives, epistemological relativism and anti-essentialism. Thus, the main promises of postmodernism lie in its emphasis on fragmentation, difference, possibility, openness, diversity and freedom.

In this context, current medicine operates in a postmodern climate which is depthless, decentred, self-reflexive, playful, eclectic, pluralistic, derivative, hybrid, and fragmented. The medical configuration of this epoch pursues the characteristics of postmodernity. Postmodern medicine has got its own unique characteristics which are different from the modern ones. Contemporary medicine reconstructs the knowledges of vitality, body, life and death. It touches the borders between culture and nature, made and born, synthetic, mechanic and organic. Then, it rearranges these borders. Current medicine does not concentrate on the uniformity of the body; rather, it is the specialist of vital replacements. In this age, people can give each other a piece of vitality, such as blood, kidney, a piece of lung and tissues. Through these exchanges, the introvert construction of the molar body collapses. The borders between bodies become permeable. Medicine interknits the bodies, deaths and lives of humans. Contemporary medicine is equipped with high technology; it is a technology based medicine. It is not only a hospital and illness based medicine, but also a preventive one. It spreads over almost all spheres of daily life. It concentrates on not only the treatment of diseases, but also the care of health. It is risk oriented. It is consumption oriented. It is multisectoral and multidisciplinary. It is constructed upon the active participation and self-regulation of the individual.

Postmodern medicine functions on a body which it conceives as if it was a soft plastic. In this medicine the biology of the individual is considered as something remouldable. Thus, from the eyes of contemporary medicine, the biology is not a

fate in which the bodies and lives of the individuals are trapped. Moreover, the vitality is not something enwrapped with the outer borders of the body, namely with the envelope of the skin. Contrarily, vitality parts cross the borders of the body and they are able to live without to the accompaniment of the body. For instance, an embryo, an organ or a piece of tissue is able to live although its connections with the body is torn away.

As a result, in the world of postmodernity, medical knowledges of the body, life and death are being reconstructed. In this way, the human who is at the target of medicine is being changed. As a result of these developments the subject of social is also changing. Such a change was foreseen by Foucault theoretically. Foucault described human as an "effect of the change in fundamental arrangements of knowledge" (1994, p. 386). With his these words, Foucault indicates the human subject as a category which is peculiar to modernity and the change that he underlines is about the rise of modern sciences. Thus, for him, this category of human was constructed through the knowledge that modern sciences produced, such as medicine, biology, economics, psychiatry and penology (1988, p. 18). However, Foucault presages on the future of this category of human as such: "As the archeology of our thought easily shows [hu]man is an invention of recent date. And one perhaps nearing its end" (1994, p. 386). If we continue from where Foucault left, it can be said that we come to the end of human whose knowledge was produced by the modern life sciences.

Rose takes over the discussion from where Foucault left and offers the concept of molecular biopolitics. He underlines that since 1960's biotechnologies have developed and the molecular knowledge of life has accumulated. In this way there is a new kind of vitality rising upon the body whose components are storable, freezable, movable, replaceable and demountable. Rose points that human body is fragmented into transferable components. The body is being regulated today at

the scale of these transferable components such as tissues, cells, organs, Deoxyribonucleic acid (DNA) fragments. Particular vitalities can be isolated, identified, manipulated, mobilized and recombined with any other thing. Recently, human life is envisaged and acted upon in this novel molecular scale (Rose, 2007a; 2007b). Moreover, contemporary technologies of life attempt to optimize the future of the individual. Thus, medicine intervenes the current stage of vitality in order to secure the best future. In the age of molecular biopolitics, individuals are encumbered with new responsibilities which are related to their own health and diseases. Then a novel kind of somatic ethics, at whose heart bodily existence and corporeal concerns lie, is formed. New ways of governing human the conduct, which place the somatic existence of human into its target, are developed. Novel links are formed between the vitality and market which are driven by hope, cure and optimality. As Rose points "biopolitics inextricably intertwined with bioeconomic" (2007a, p.7). As a result, Rose's theoretical discussions proclaim that recently, we are embracing a novel human category both epistemologically, medically and socially.

When the case of organ transplant therapy is read through the conceptual line from Foucault to Rose, it is seen that postmodern medicine has brought significant transformations for the embodied subject of modernity. The consideration of human body as a monoblock entity is collapsed today. The death is not experienced as a single piece event anymore. The vitality is as mobile as which cannot be constrained into a single body.

The organ transplantation therapy, which has been implemented successfully for almost the last fifty years, presents the crystallized form of postmodern medicine's body imagination. Enhancing the given human body by playing its given borders and hybridizing it are the main motives of this therapy. Recently, the human body greets its new guest quite easily with the help of medical

implementations, as well as the novel medical imaginations. The new guest of the body may be a battery-operated heart pump, or a synthetic blood vessel, or, in the case of organ transplant, an organic kidney removed from the body of another individual. All these new guests come to enhance the biological capacity of the human. They are not endowed with the capacity of overcoming the death yet, but they come to the body to postpone the death of individual to a later time. They come to the body to reduce the pain, to expand the lifetime and to clear up the shortcomings of the body.

In this context, the organ transplant therapy is both the cause and the result of the reorganization of medical gaze towards body. This reorganization is one of the sources of the shift from molar body to molecular body. The molar body was a modern imagination which was walking arm in arm with modern principles of juxtaposition, integration, centralization and homogenization. The molecular body, on the other hand, is an imagination which is taken inspiration from postmodern principles of synchronization, fragmentation, decentralization and differentiation. Thus, the organ transplantation therapy creates a "network body" in which independent organic vitality parts, technologic vitalities, organs coming from other bodies and artificial organs circulate and construct relations.

Organ transplantation therapy creates "organs without bodies". In this therapy, organs are decontextualized; and then they recontextualized, while they are shuffling between bodies. In these processes they promise life by themselves, without the help of the bodies. They are becoming a part of a journey on their own account. They do not necessarily die with the dying body. The organ transplant therapy does not create *de novo* body, but it plastificates the given body; and transforms the theoretical abstraction of *cyborg* into an ordinary actuality.

In addition to these the biotechnological reformulation of vitality results with the birth of novel biological commodities, which can be bought and sold, so which

have exchange value. While Rose is discussing the molecular bio-politics and changing patterns of vitality, he stresses that new economic relations and new forms of capitals are formed which depend on the exchange of vitality. The organ transplant case also reflects this newly forming economies of vitality. The break of the bond between the individual and her/his organs causes the dehumanization of organs. Currently, these dehumanized, ambulatory organs circulate in the market without bounding a body. They can be bought and sold, like a medical equipment or service. Thus, commodification of the organs, in the recent decades, presents that the impacts of capitalism penetrate into the body of human, not only metaphorically but also in real terms.

Focusing on the organ transplantation therapy displays that postmodern medicine not only plasticizes the human body, but also it elasticizes the death of human. In the context of postmodern medicine, the long established imaginary of death, which considered the death as natural, inevitable and irrecusable, is dissolved. Postmodern medicine creates programmable, partial, delayed and technologically supported deaths. While the modern medicine closed in the death with medical knowledge and medical surveillance, postmodern medicine combines this besieged death with the machines of intensive care unit.

As we see in the case of organ transplantation, postmodern medicine divides the dead body into pieces. Then, it opens these pieces for being reused. It reevaluates the bodies who are standing at the death's door and who just died. Postmodern medicine creates new values from these two bodily conditions, which are intertwined with death, through transferring their organs to other bodies. The formulation of "brain death" is an important step in these processes. Conceptualizing the "brain death", contemporary medicine produces novel patterns and knowledges of death. Shifting from the heart to the brain in the diagnosis of death, postmodern medicine reaches a new kind of cadaver which

was different from the completely died, cold cadavers of modern medicine. The novel cadaver is the beating-heart cadaver that is a body whose skin is still warm, whose pulse can be felt, and who is still evacuating and excreting; but also who is not alive. It is a body which is medically dead, but still has got some living organs. These living organs of the beating-heart cadaver can be transferred to the other bodies. In this way, organ transplantation therapy creates a new kind of transitivity between the death and the life, which was not seen in the modern medicine.

In the context of organ transplants, it is clear that postmodern medicine reinterprets the death. It divided the death into pieces at the level of the medical technology and practice, as well as at the level of experience and at the level of discourse. Another important point here is that such a novel interpretation of death leads to new envision of life. Until the development of organ transplants, the life was beginning with the action of birth. However, through organ transplants, the life can be restarted when it is about to finish. Thus, in the context of postmodern medicine, birth is not a sole action which gives a new life. Even, some deaths may be transformed into action which gives life to another body via organ transplant operations. For instance, a piece of liver that is procured from a brain-dead organ donor can be transplanted to the patient, who is lying on the deathbed. In this way, a life is born from the death of the donor. On the other hand, the recipient returns from the threshold of death, thanks to a piece of vitality that is left from another individual's death.

Gathering or producing a life, from such a dark conclusion, namely death, coincidences with Foucault's words on the birth of modern medicine. In the conclusion part of *The Birth of the Clinic: An Archaeology of Medical Perception (2003),* Foucault purely writes on the ties between the changing notion of death and the formation of modern medicine. His discussion is approximately as such:

modern medicine as a positivist investigation practice sought for the life at the heart of the death. By breaking off the ties between death and counter-nature, modern medicine set a scientific light to the death. Modern medicine searched the lifeless body down to its last detail, by opening and working on corpses. By reaching and producing the knowledge of the dead body, modern medicine accumulated the knowledge of curing the alive body (Foucault, 2003, pp. 241-246). In this context, the investigation of the case of organ transplants points that while modern medicine searched for the knowledge of life at the heart of death, postmodern medicine searches for just life itself in the heart of dead body.

By going a step further, postmodern medicine searches for the life in the body of dead; not metaphorically but in the real sense of the words. While modern medicine cuts into pieces the dead's body in order to investigate it, postmodern medicine disintegrates the death itself. In this way, postmodern medicine can scoop out a piece of body which is still living in the dead's body. Postmodern medicine cannot return a dead person to life, but it can snatch an alive part of dead body from the jaws of death, by playing the descriptions of death. For instance, as I discussed in the issue of brain death, the beating, and so alive heart is able to be extracted from a body whose brain death just happened. This alive heart is able to be transplanted to another body which is about to die. In this case, the recipient individual escapes from death's grasp and gets a second chance of life. Postmodern medicine creates a new life through the living heart of a lifeless.

As a result, what we are seeing now, similar to the other great schemas of modernity, the embodied subject of modernity also comings to an end. In our contemporary world, the vitality, which was considered as embedded in the body for many years, is circulating without the companion of the body. The death, which was considered as single piece event for many years, is fragmentized today. The "organs without bodies" spill out of the envelope of the skin. Fragments of vitality gain exchange value. When we look such a general picture of postmodern

medicine, it is difficult to say “everything is getting worse” or “everything is getting better”. These transformations, which become in the field of medicine, are open-ended processes; and the future of medicine is full of possibilities. Postmodern medicine tore down the pride of modern humanocentrism at whose center a unique, rational and monolithic individual was standing. Currently, postmodern medicine is building its own unique subject, who rests in a molecular body, who experiences projected births and delayed and partial deaths, and who has got exchangeable biological values. What is changing is today is not only the subject of medicine, but also the embodied social subject of modernity.

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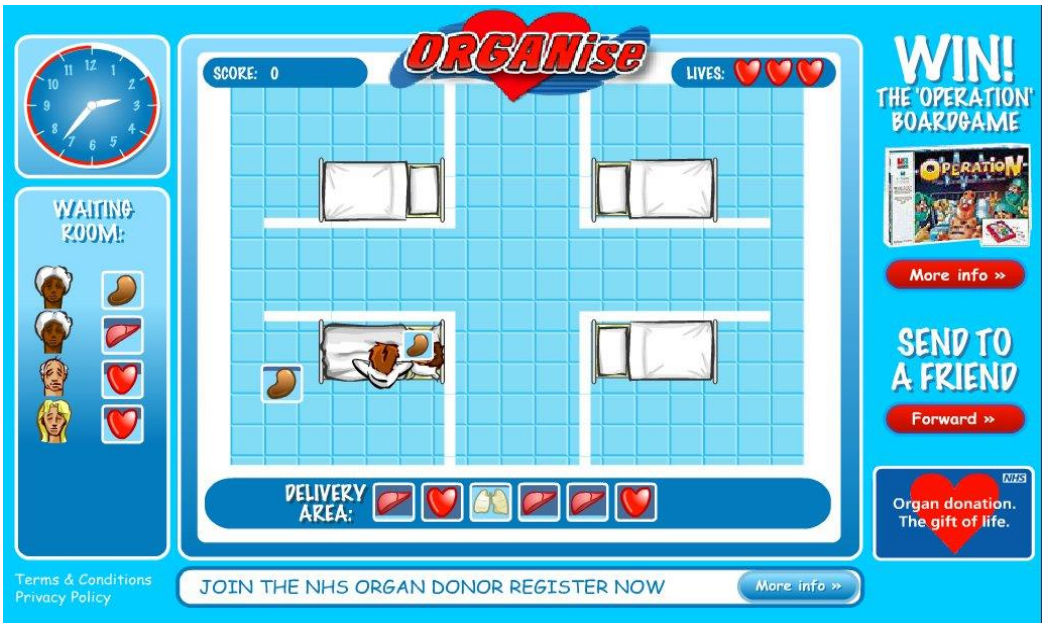
APPENDICES

A FIGURES

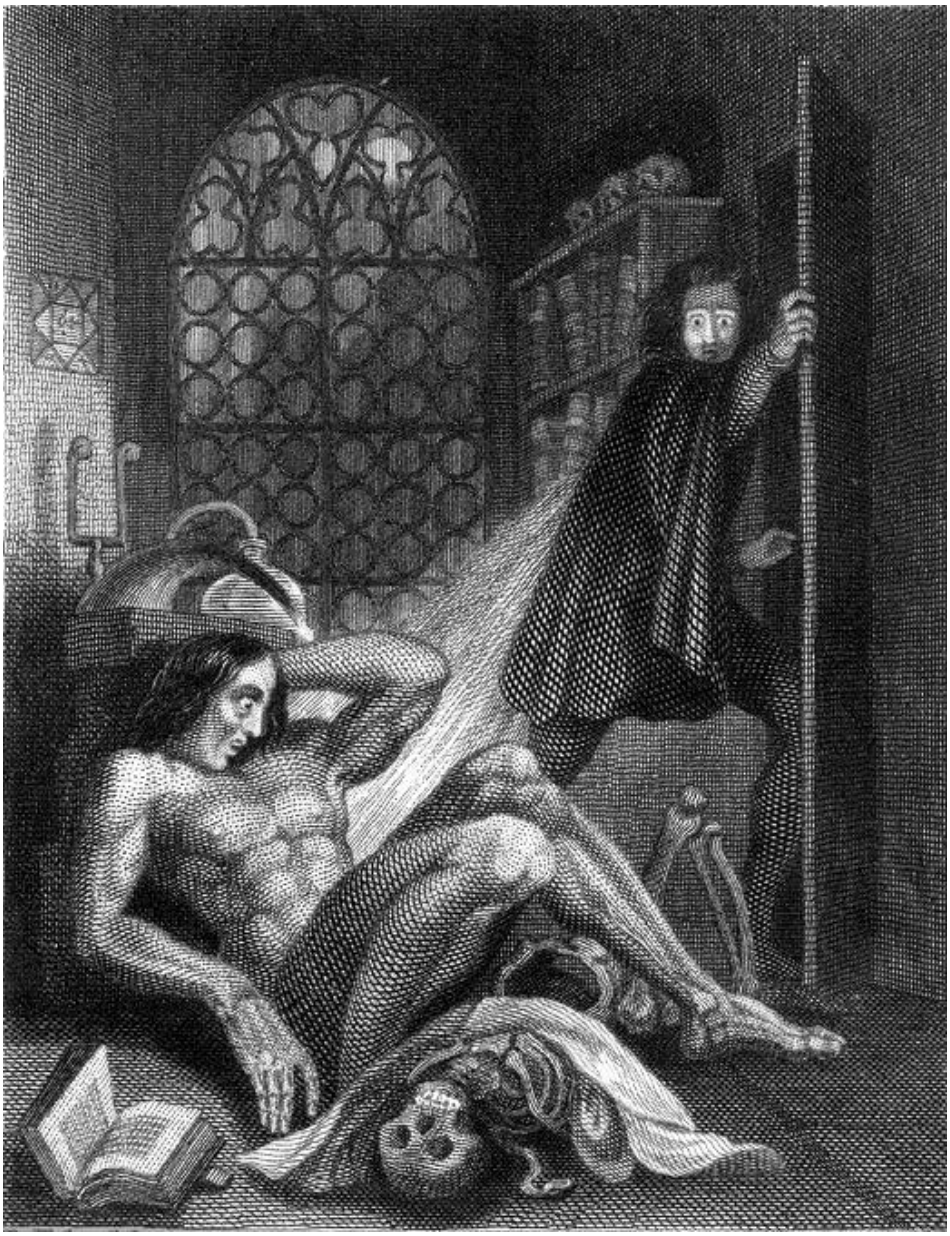
Figure 1



A screenshot from ORGANise online computer game.

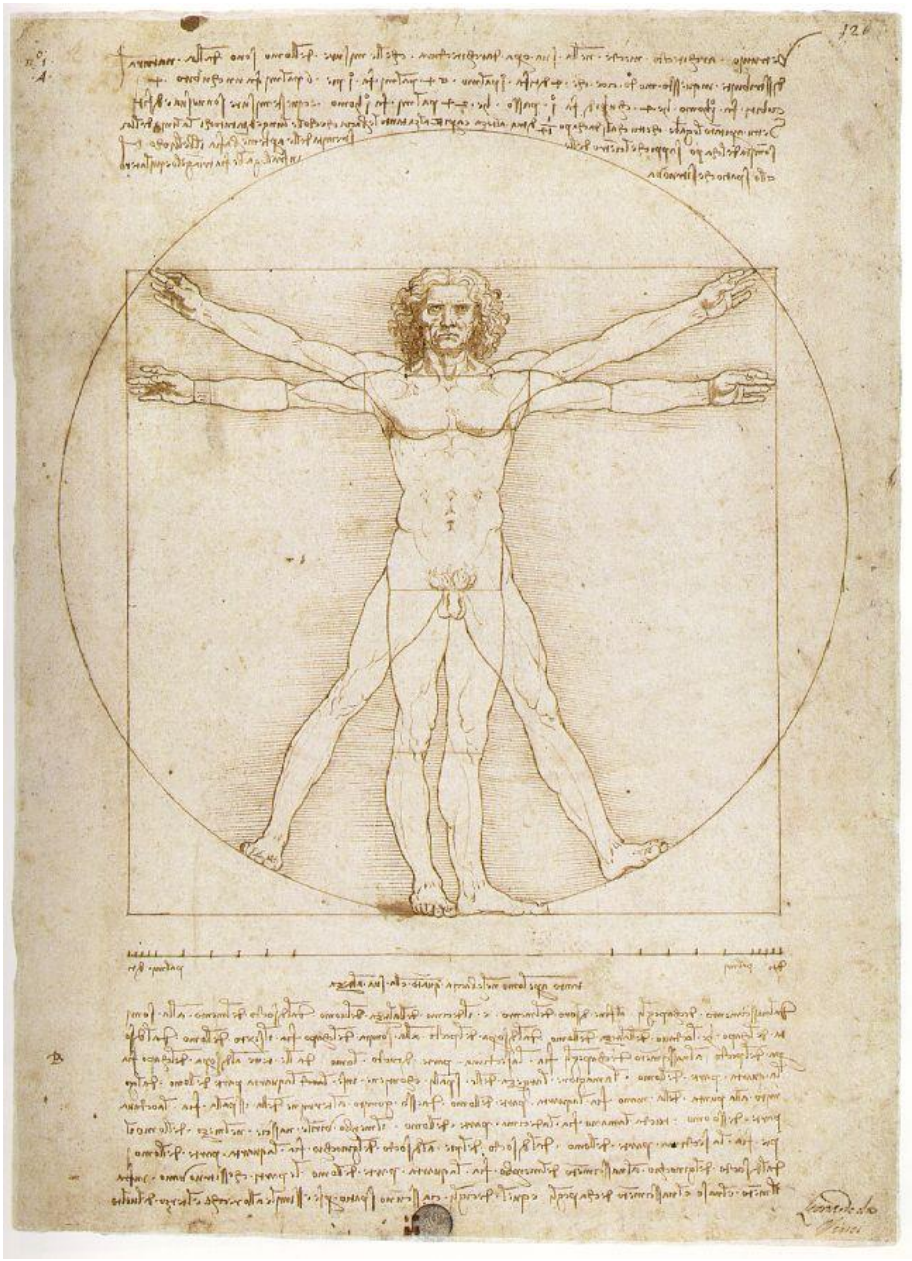
Retrieved May 27, 2014, from http://www.mydoctorgames.com/organ-donor/game.

Figure 2



The frontispiece of 1831, Colburn and Bentley, London edition of Mary Shelley's *Frankenstein, or the Modern Prometheus (1818)* by Theodore Von Holst. Retrieved, June 1, 2014 from http://upload.wikimedia.org/wikipedia/commons/e/e6/Frontispiece_to_Frankenstein_1831.jpg

Figure 3



Vitruvian Man was drawn by Leonardo da Vinci around 1490

Retrieved, 3 July, 2014 from http://www.artchive.com/artchive/L/leonardo/proports.jpg.htm

Figure 4

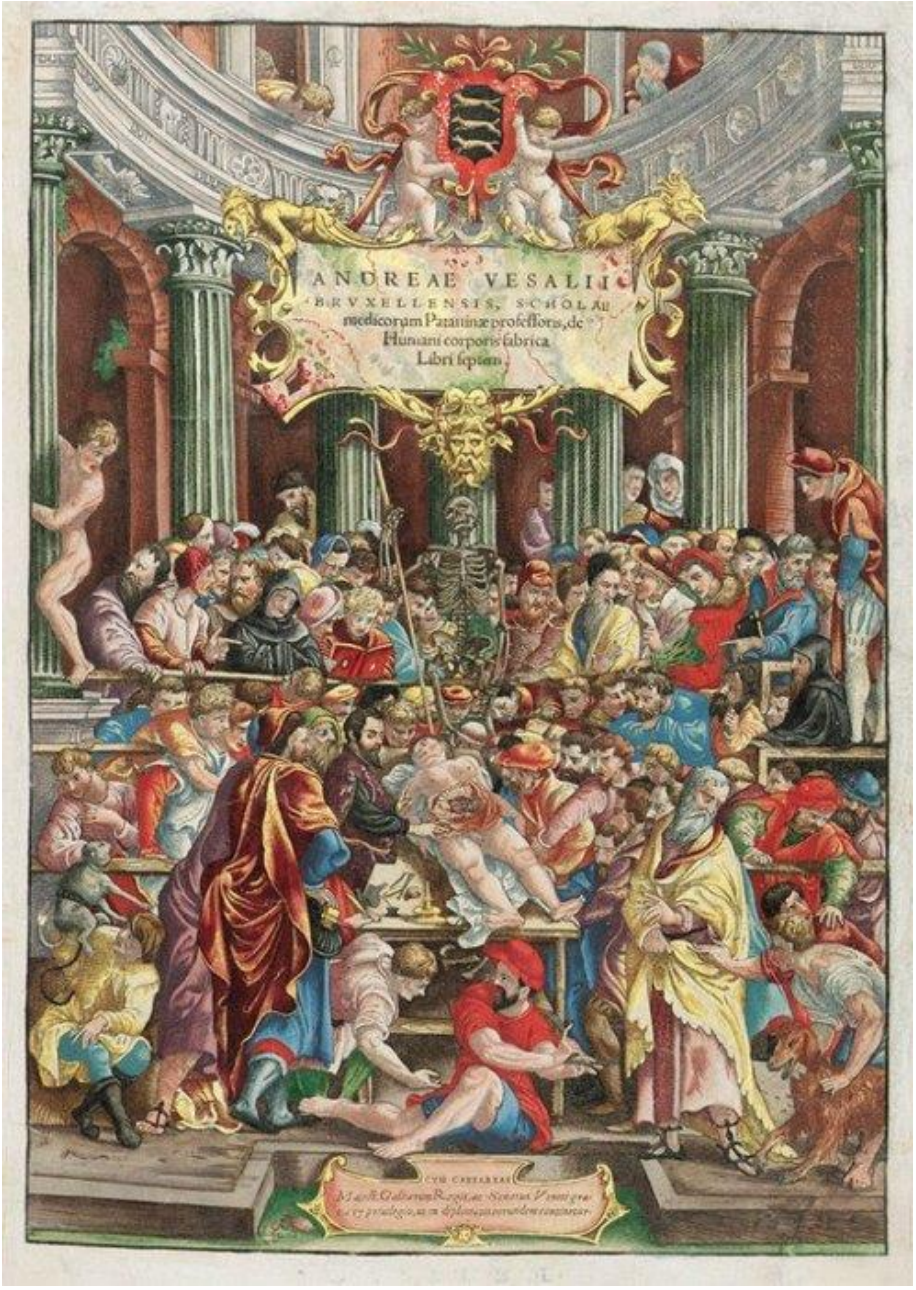
Back Ache, Helen Pynor's installation- photograph, 2007

Retrieved September 12, 2014, from http://www.medinart.eu/fields/anatomy-medicine/.

Head Cold, Helen Pynor's installation- photograph, 2007

Retrieved September 12, 2014, from http://www.medinart.eu/fields/anatomy-medicine/.

Figure 5



De Humani Corporis Fabrica, hand colored under the direction of Vesalius in 1543.

Retrieved, 3 July, 2014 from http://www.codex99.com/anatomy/45.html

Figure 6

The Anatomy Lesson of Dr. Nicoales Tulp was painted by Rembrandt Harmen-szoon van Rijn in 1632

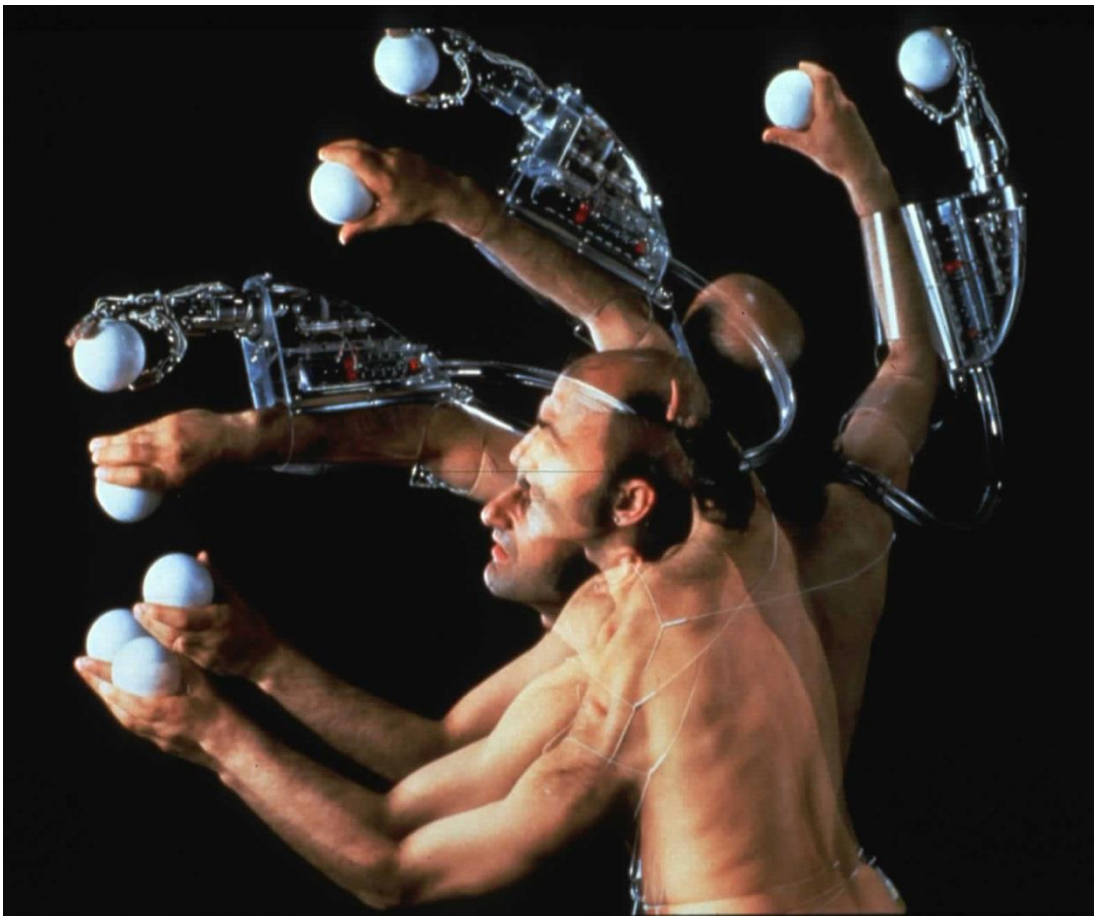
Retrieved, 2 June, 2014 from http://www.rembrandthuis.nl/en/rembrandt/belangrijkste-werken/de-anatomische-les-van-dr-nicolaes-tulp

Figure 7

Two photographs from Stelarc's performance of *Ear on Arm*, 2008.

Retrieved September 13, 2014, from http://stelarc.org/?catID=20290

Figure 8



A photograph from Stelarc's performance of *Third Hand*. The hand was completed in 1980 in Yokohama. It has been used in performances by the artist between 1980- 1998.

Retrieved September 13, 2014, from http://stelarc.org/?catID=20290

B CURRICULUM VITAE

PERSONAL INFORMATION

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EDUCATION

2008-2015 PhD, Sociology Department, METU. Thesis title: *From Modern Medicine to Postmodern Medicine: The Case of Organ Transplants*.

Summer School, 27th June 2011 – 8th July 2011 "The Politics of Ethnicity, Nationality and Citizenship", Summer University, Central European University, Budapest, Hungary.

2005-2008 MSc, Political Science and Public Administration Department, METU. Thesis title: *A Critical Examination of Anti-Aging Discourse: The Relevance of The Works of Michel Foucault and Susan Sontag*.

2000-2004 BA, Public Administration Department, Uludağ University.

ACADEMIC INTERESTS

Sociology of Body, Sociology of Literature, Gender Studies, Sociology of Ageing.

SCHOLARSHIP

2011 Education Award, CEU Summer University, Central European University, Budapest, Hungary.

2011 Travel Award, CEU Summer University Open Society Institution, İstanbul, Turkey. (http://www.aciktoplumvakfi.org.tr/ebulten_2011-1.php)

AWARD

(28 December 2013) With the article of "Hikâyeler Anlatırken Öznel(l)ikler Kurmak: Anne, Yurt, Jilet", Dicle Koğacıoğlu Article Award. Sabancı University Gender and Women's Studies Forum.

WORK EXPERIENCE

2010 – 2013 Research Assistant, Sociology Department, Artvin Çoruh University, Artvin, Turkey.

PUBLICATIONS

Books

(2011) *Ben Değerliyim: Nar Taneleri Güçlü Genç Kadınlar Mutlu Yarınlar Projesi Güçlenme Hikayeleri Biriktiriyor – Sosyolojik Değerlendirme Raporu.* İstanbul: Boyner Yayınları.

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Articles

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(2011) "Modernitenin Beden Projesinin Günümüze Yansıması: "Yaşlanmayan Beden" Fikrine Eleştirel Bir Bakış" *6. Ulusal Sosyoloji Kongresi Bildiriler Kitabı.* pp. 1190-1204. Ankara: Sosyoloji Derneği Yayınları.

Other Publications

(2013) "Apartman Boşluğunda Güvercin Uçurmak" *Amargi, 30*, pp. 139-142.

(2013) "Ayna Tam Anlamıyla Bir Şeytan Kıçıdır." *Amargi, 29*, pp. 51-54.

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PRESENTATIONS

International

(31 August 2013) “Considering Transbiology Narratives in Turkey via Nikolas Rose’s Molecular Biopolitics”. 11th European Sociological Association Conference: Crises, Critique and Change. Turin, Italy.

(29 August 2013) with Meral Akbaş. “Challenging Hydro Electric Power Stations Through the Memorial Knowledge of Elderly Women: The case of Turkey” 11th European Sociological Association Conference: Crises, Critique and Change. Turin, Italy.

(1 August 2012) with Mehmet Bozok. “Pharmaceuticalization of Society through the Popular Healthy Life Discourse: The Case of Turkey”. The Second ISA Forum of Sociology: Social Justice and Democratization. Buenos Aires, Argentina.

(19 May 2012) with Mehmet Bozok. “Endless Bargains on Belonging ‘This Side’ or ‘Other Side’: The Case of Georgian - Turkish Border in Hopa”. Crossing Borders: History, Dialogue of Languages and Culture 5th International Scientific Conference on the Border of the EU In Narva, Tartu University, Estonia.

National

(2 October 2013) “Biyografilerin ve Yapısal Süreçlerin İç İçeliğinde Biçimlenen Stratejiler: Genç Kadınların Yetiştirme Yurdu Yaşantıları” 7. Ulusal Sosyoloji Kongresi: Yeni Toplumsal Yapılanmalar: Geçişler, Kesişmeler, Sapmalar, Muğla Sıtkı Koçman Üniversitesi, Muğla.

(18 October 2012) with Meral Akbaş. “Aylak Adam ve Tuhaf Bir Kadın Caddelerde Gezinirken: Aynı Caddeler, Ayrı Deneyimler” Modern Türkçe Edebiyatı Sempozyumları II: Yusuf Atılgan. Kadir Has Üniversitesi Amerikan Kültürü ve Edebiyatı Bölümü, İstanbul.

(24 May 2012) with Meral Akbaş. “Ankara’da Bir Ev, Evde Bir Kadın, Kadının Aklında Geçmiş…” II. Kadın Yazarlar Sempozyumu: Erendiz Atasü Edebiyatı. Yeni Yüzyıl Üniversitesi, İstanbul.

(1 March 2012) “Türkiye’de Modernleşme ve Endüstrileşmeyi Bütünleşik Süreçler Olarak Şeker Fabrikaları Üzerinden Okumak: Ankara Şeker Fabrikası Örneği” 3. İzmir Ulusal Ekonomi Kongresi, Dokuz Eylül Üniversitesi, İzmir.

(14 December 2011) “Tersyüz Eden, Bozan, Eğip Büken Tutunma Stratejileri: Genç Kadınların Yetiştirme Yurdu Deneyimleri” 12. Ulusal Sosyal Bilimler Kongresi, Orta Doğu Teknik Üniversitesi, Ankara.

(21 October 2011) with Meral Akbaş. “Çocukluğun Gecelerini Soğutan Bugün…” Modern Türk Edebiyatı Konferansları I: Tezer Özlü. Kadir Has Üniversitesi Amerikan Kültürü ve Edebiyatı Bölümü, İstanbul.

(21 May 2011) with Meral Akbaş.. “Cadı Ağacı'nın Sesiyle: “Ne Ölü Değil(d)im, Ne de Hiç Yaşama(dı)m!”” I. Kadın Yazarlar Sempozyumu: Ayla Kutlu Edebiyatı. Yeni Yüzyıl Üniversitesi ve Adalar Belediyesi, İstanbul.

(27-28 March 2010) “Dezavantajlı Grup Nedir?” Sosyal Hizmetler ve Çocuk Esirgeme Kurumu Eğitici Eğitimi, *Nar Taneleri Projesi. UNFPA, Boyner Holding ve PERYÖN,* İstanbul.

(1-3 October 2009) “Modernitenin Beden Projesinin Günümüze Yansıması: “Yaşlanmayan Beden” Fikrine Eleştirel Bir Bakış.” 6. Ulusal Sosyoloji Kongresi, Adnan Menderes Üniversitesi, Didim, Aydın.

C TÜRKÇE ÖZET

MODERN TIPTAN POSTMODERN TIBBA: ORGAN NAKİLLERİ ÖRNEĞİ

I. Başlangıç

Tıbbın hâlihazırdaki tarihi bir başlangıç ya da bir sona işaret etmez. Bir şeyin tarihi her zaman ortalarda bir yerdedir. Bugüne özgü tıbbi uygulamalar, tıbbi teknolojiler ya da tıbbi imgelem, yine bugüne özgü tarihsel, sosyal toplumsal koşullarla birlikte düşünüldüğünde bir anlam kazanırlar. Aksi takdirde, koşulsuz bir bilimsel ilerleme söylemi içinde ve hastalığa sağlığa ilişkin gündelik laf kalabalıkları arasında eriyip giderler.

Bugüne özgü tıp alanına baktığımız zaman iki ana eğilimden söz etmek mümkün görünüyor. Birincisi postmoderniteye özgü olduğunu düşünebileceğimiz bir dağınıklık tıp alanında hüküm sürmektedir. Bu ilk eğilimi düşünürken, tıbbın bir nar gibi çatlayıp hayatın her alanına dağıldığını, değdiği yeri kendi rengine boyadığını hayal edebiliriz. İkincisi ise "bilimsel ilerleme" vurgusudur. Bu vurgu modern tıbbın doğuşundan bu yana tıp alanı içinde bir hayalet gibi dolaşır. Tıp biliminin gidişatı çoğunlukla "pozitif" bir ilerleme vurgusuyla anılır. Bu iki imge ya da eğilim bir zıt ikiliğin karşıt unsurları değildirler. Biri diğerini dışlamaz. Her

ikisi de bugünün tıbbının hayatı yaşamı ve ölümü dönüştürmesiyle yakından ilgilidir.

İlk olarak, son zamanlarda tıp alanı neredeyse her şeyi içine alacak kadar genişledi ve bir "sünger referans"[63] halini aldı. Böylesine genişleyen her kategorinin başına geleceği üzere, tıp kategorisi de genelleştikçe özgüllüğünü yitirmeye ve temas halinde olduğu diğer kategoriler tarafından emilmeye başladı. Bugün her şey tıbbi olduğunda, artık hiçbir şey tıbbi olmamaya başlıyor. Böyle olunca, tıp alanında belirleyici ilkeler bulmak gün geçtikçe zorlaşıyor. Her tavsiye kendi üzerine katlanıyor, bir tavsiye diğerini çürütüyor ve sağlığımızla ilgili düşüncelerimiz gitgide bir kaosa teslim oluyor. Sonuç tam bir kafa karışıklığı oluyor. Bu kafa karışıklığı içinde ölüme, hayata, bedene cinselliğe, umuda, akrabalığa, tedaviye, sermayeye ilişkin bilgi ve düşüncelerimiz yeniden şekilleniyor. Bu yeniden şekillenmede tıp önemli bir belirleyen haline geliyor.

Bugünün tıbbına ilişkin ikinci eğilim ise, birinci eğilim olarak andığım aşırı genişlemenin aksine, aşırı uzmanlaşma, ileri düzeyde teknoloji kullanımı ve "bilimsel ilerleme" düşüncesine olan bağlılıktır. Bu ikinci eğilim çerçevesinde, tıp bugün insan bedenini, ölümünü ve yaşamını yeniden biçimlendirme kapasitesi kazanmaktadır. Bu yeniden biçimlendirme soyut düzeyde tartışılabileceği gibi, bir sıvıyı kalıba dökmek ve onu yeni bir şekil vermek olarak düşünülebilecek bir somutluğu da içermektedir. Yine burada sözünü ettiğimiz sıvıyı beden olarak hayal edebiliriz. Bugün tıbbi görüntüleme teknolojileri sayesinde görsel olarak bedenin içleri daha derinden incelenebiliyor. *Homo videns*[64] iktidarını gün geçtikçe arttırıyor. İnsanlar birbirinden kan, böbrek, yumurta, saç ya da doku alabiliyor. Bu alışverişlerle bireylerin bedenleri arasındaki sınırlar

[63] Jean Baudrillard bu kavramı bugün sonuna geldiğimizi düşündüğü "toplumsal" olanı tanımlamak için kullanmaktadır (1983, s. 1).

[64] *Homo videns* gören insandır. Giovanni Sartori, bu kavramı görmenin iktidarının son zamanlarda aldığı biçimi tartışmak için kullanır. Ona göre *homo videns* içinde yaşadığımız dönemi sembolize eden insandır (Sartori, 2006, s. 11).

geçirgenleşiyor. Bedenin içine yerleştirilen yapay uzuvlar alabildiğine çoğalıyor ve mekanikle organik arasındaki sınırlar yıkılıyor. Genetik bireyselliği başka hiçbir bireyde bulunamayacak sayılara tercüme ediyor. Böylece aşırı öznel ama soyut sayılar düzeyinde temsil edilen bireyselliklere sahip oluyoruz. Tıp hayatı yeniden üretebilmek için deneyler ve planlar yapıyor. Koyun Dolly insanın da kopyalanması yakındır sinyallerini veriyor. 3-D yazıcılarda organlar çoğaltılabiliyor. Anne karnındaki bebeğin cinsiyeti üzerinde söz sahibi olunabiliyor. Böylece doğmuş ve yapılmış, doğal ve insan eliyle yapılan arasındaki, büyük ölçüde modern zamanlarda şekillenmiş, sınırlar yerinden oynuyor. Tıp hastalıkların tedavisinde bütün bir bedenin varlığına değil, hastalığın ortaya çıktığı bölgeye odaklanıyor. Canlılık olgusu daha önce görülmemiş biçimlerde biyo-bankalarda depolanabiliyor. Bedeni temsil edebilecek en küçük canlılık parçası aranıyor. Bu şimdilik gen olarak gösteriliyor. Hastalıkların tedavisi bu mikro ölçekli temsil düzeylerinde gerçekleştirilmeye çalışılıyor.

Burada özetlemeye çalıştığım bu iki eğilimi beraber düşündüğümüzde tıbba ilişkinin uygulama ve bilgilerin nerde başlayıp nerede bittiğine karar vermek giderek güçleşiyor. Sadece tıbbın kendisi değil, tıbbın dokunduğu hayatlar, ölümler, bedenler de çözülüyor. Buradaki önemli nokta, bugün kendisine ulaştığımız böyle bir tıbbi manzaranın tesadüfi bir olumsallık olmadığıdır. Hali hazırdaki tıp alanı bir dizi “yer değiştirme” ve “kopuş” sonucu biçimlenmiştir. Moderniteden postmoderniteye ve biyo-iktidardan moleküler biyo-iktidara geçiş, bu kopuş ve yer değiştirmelerin altında yatan zemini göstermektedir.

Bu tez, hâlihazırdaki tıbbi konfigürasyonu tarihsel bir açıdan okumayı amaçlıyor. Bugünün tıbbını tarihsel bir kopuşlar ve geçişler süreci içinde okumayı hedefliyor. Böyle bir tarihsel okuma için jeneolojik yaklaşımı metodolojik bir araç olarak benimsiyor. Bugünün tıbbi konfigürasyonunu okumak için, organ nakli tedavisini postmodern bir tıbbi vaka olarak seçiyor ve inceliyor.

Çalışma yedi bölümden oluşuyor. Başlangıç bölümünün ardından gelen ikinci bölüm, tıp bilgisinin tarihsel olarak değişkenliğine odaklanıyor ve bu değişken tarihselliği okuyabilmek için jeneolojik bir tartışma yürütüyor. Üçüncü bölüm, modern ve postmodern tarihsel dönemler arasındaki kopuşları ortaya koyuyor ve bu iki farklı bağlamın nasıl iki farklı tıp anlayışına sahip olduğunu tartışıyor. Bundan sonraki bölümler ise organ nakli tedavisine odaklanıyor ve organ nakli tedavisi aracılığıyla postmodern döneme özgü tıp pratiğinin beden, ölüm ve canlılık meselelerine ilişkin getirdiği dönüşümleri okuyor. Ardından günümüze özgü kapitalizm ve tıp alanı arasındaki ilişkileri ve ittifakları küresel organ karaborsalarına odaklanarak tartışıyor. Çalışma sonuç bölümüyle birlikte nihayete eriyor.

II. Tıbbın Kaygan Bilgisi

Hasta ya da sağlıklı olmak arasındaki ayrım her ne kadar biyolojik bedensel göstergeler ve durumlara atıfla tanımlanıyor gibi görünse de, hastalık ve sağlık kategorilerinin içeriğini etkileyen toplumsal ve kültürel etkileşimlerin ve düzenlemelerin etkisi de bu ayrımı biçimlendirir. Yalnızca hastalık ve sağlık arasındaki sınır değil, hastalığın ve sağlığın bireysel deneyimlenme biçimleri de toplumsal olanla ilişki içindedir. Sağlığın ve hastalığın toplumsal ve kültürel boyutlarının varlığına işaret etmek, sağlığa ilişkin sosyolojik bir bakış açısı geliştirmenin ve sağlık ve hastalık ile ilgili meseleleri sosyolojinin araştırma, anlama konularından birisi haline getirmenin başlangıç noktalarından biri sayılabilir. Çoklu başlangıç noktalarından bir diğeri ise bedenin, hastalığın ve sağlığın doğal deneyimlenme mekânının, bizzat kendisinin de sadece biyolojik bir organizmadan öte toplumsallıkla ilişkilenen bir şey olmasıdır.[65]

[65] Hâlihazırda beden bir olanaklar mekânı olarak, bir sunuşlar sistemi olarak, deneyimlenen, hissedilen bir şey olarak, iktidarın hedefindeki şey olarak, arzu politikalarının elzem bir unsuru

Diğer önemli nokta, hastalığın ve sağlığın tarihsel koşullardan bağımsız, evrensel, sabit tanımları ve deneyimlenme biçimlerinin olmayışıdır. Buradaki mesele hastalığı ve sağlığı belirleyen sabit bir odaktan veya değişmez bir özden söz etmenin mümkün olmayışıdır. Hangi durumların hastalık olarak tanımlanacağı, hastalığın tedavi yeri, hastalık nedenlerine ilişkin açıklamalar, hastanın karşılaştığı toplumsal dışlamanın boyutları ve içeriği, tedavi edici kişiler ve tedavinin yöntemleri, kültürel, tarihsel, mekânsal, algısal olarak farklılık gösterir. Keza sağlıklı olmanın sınırları ve göstergeleri de sabit değildir. Hangi ruh halinin, bedensel göstergelerin, beden biçiminin, sağlıklı olarak kabul edildiği veya algılandığı meselesi de değişkendir.

Hastalığın ve sağlığın sınırları, bu ikisinin birbirine karşı pozisyon alışları, bu kategorilere ilişkin söylemler tamamıyla düz bir tarih hattında ilerleyen ve birbirini sırasıyla takip ederek olgunlaşan tıbbi ya da teknolojik gelişmelerin sonucunda belirlenmezler. Çünkü yeni ortaya çıkan hastalıklar, sağlığı güçlendiren yeni yöntemler, tıp alanındaki gelişmeler ya da teknolojik ilerlemeler başka türlü ilişkilerden, toplumsal, ekonomik, bireysel alanlarda olup bitenden bağımsız birer veri değildir. Dolayısıyla, sağlığın, hastalığın, bedenin, yaşamın, ölümün ve tüm bunlara ilişkin bilgi kategorilerinin, pratiklerin, deneyimlerin nasıl şekillendiğini ve nelerden etkilenerek dönüştüğünü kavramak için gündelik alanda dolayıma giren kesintili, tutarsız, süreksiz söylemlere de bakmak gerekir. Ve elbette, bir taraftan bu söylemleri şekillendiren, diğer taraftan kendisi de bu söylemlerin işleyişiyle birlikte şekillenen iktidar ağları da dikkate alınmalıdır.

Bu bağlamda, tıbbın ürettiği bilgi değişmez ve zamana meydan okuyan bir bilgi değildir. Bu bilgi sabit ve keşfedilmeyi bekleyen biyolojik gerçekliklere de dayanmaz. Foucault'nun altını çizdiği üzere bilgi bir boşlukta işlemez; belirli

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olarak ve diğer birçok bağlamda tartışılmaktadır. Bu tartışmaların büyük bir kısmı hastalık ve sağlık meseleleriyle de ilişki içindedir.

teknolojiler, uygulamalar, kurumlar ve tarihsel bağlamlar bilginin üretilmesi ve işleme konmasında önemli belirleyicilerdir (Hall, 2001, s. 76). Ayrıca, tıbbın üzerinde işlediği, tahayyül ettiği insan özne de verili ve değişmez bir tanıma sahip değildir. Tıbbın hedefindeki özne, onun bedeni, canlılığı, biyolojisi farklı farklı tarihsel bağlamlarda yine farklı farklı tahayyül edilir. Örneğin on beşinci yüzyılda doğaüstü güçlerin etkisi altında biçimlendiği düşünülen beden, on yedinci yüzyıla gelindiğinde kendine özgü kurgusuyla tıkır tıkır işleyen bir makine olarak düşünülmüştür. Bugün ise beden ucu açık bir potansiyeller, olasılıklar mekânı olarak tahayyül edilmektedir.

Dolayısıyla tıp tarihi, boşluklar, tutarsızlıklar, kesintiler ve değerler dizisi değişimleriyle doludur. Bu durumda geçerli, doğru, değişmez bir tıp bilgisinin peşine düşmek sonuçsuz bir çaba olacaktır. Tıp alanında üretilen bilgi sosyal olarak da kurulmaktadır. Sosyal, tarihsel ve ekonomik koşullar tıbbın bilgi üretme mekanizmalarının bizzat kalbinde yatmaktadır. Tıbbın bilgisine ilişkin bir tarihsel dönemlendirme yapmak ve özellikle bugüne özgü tıp pratiğini ve bilgi üretimini okuyabilmek için bu çalışma jeneolojiyi bir metodolojik araç olarak benimsemektedir.

Jeneoloji, Foucault'nun çalışmalarından süzülen anlamıyla, bugünün (şimdiki zamanın) tarihini yazmak ya da yapmak çabasıdır. Foucault'nun teorik çizgisini takip eden ve Foucault sonrası literatürde önde gelen teorisyenlerden olan Rose da jeneolojiyi bugünün (şimdiki zamanın) haritalandırılması olarak tarifler. Şimdiki zamana özgü tıbbi konfigürasyonu tarihselleştirmek, Foucault'nun tartıştığı üzere, hâlihazırdaki tıbbi manzaranın gelişigüzel rastlantısal bir hal olmadığını, aksine karmaşık iç bağlantıların ve çoğul tarihsel süreçlerin ürünü olduğunu göstermeye yarar (1991a, s. 75). Rose ise jeneolojinin ufkunu genişletir ve bugüne tarihsel olarak bakmanın sadece şimdiyi anlamaya değil, geleceğin nasıl da olasılıklara açık bir yer olduğunu görmeye yarayacağını söyler (2007a, s. 5). Rose'a göre bugünün tarihini yapmak, sadece bugüne özgü olumsallıkların altını çizerek

bugünü tutarsızlaştırmaya değil, aynı zamanda geleceğin ucu açık bir süreç olduğunu kabul ederek geleceği de tutarsızlaştırmaya hizmet etmektedir (2007a).

Jeneoloji, kök-süreklilik-özne-olay döngüsünü takip eden geleneksel tarih okuma yönteminden farklı bir tarihsel yöntemdir (Shiner, 1982, s. 387). Jeneoloji tarihe geçmişi ortaya sermek için bakmaz. "Bugün kendi bilgimizin özneleri olarak nasıl kurulduk?" sorusunun yanıtlarını arar (Foucault, 1991b, s. 49). Jeneoloji bir sacayağı olan bilgi, iktidar ve beden arasındaki kesişimleri ve ilişkileri yüzeye çıkarmayı hedefler.

Bu çalışmada öncelikle Foucault ve Rose'un birbirini takip eden ve geliştiren bir çizgide bu üç ekseni (bilgi, iktidar ve beden) nasıl kavradıklarını tartışıyorum. Daha sonra, bu tartışma ışığında ve bu tartışmanın kavramsal araçlarından faydalanarak bu güne özgü tıp pratiğini okumaya girişiyorum.

Foucault araştırdıklarının ve yazıp çizdiklerinin temel amacını, "batı kültüründe insanı özneye dönüştüren farklı usullerin bir tarihini oluşturmak" olarak özetler. İktidar olgusunu analiz etmek ya da böyle bir analizin temellerini değerlendirmek gibi merkezi bir amacının olmadığının da altını çizer (Foucault, 1982, s. 208). Ne var ki iktidar meselesi, onun tüm çalışmalarının ana eksenine kendiliğinden gelip oturmuş gibidir. Çünkü Foucault insanın bir *özne* oluşunun izini sürerken, onu dönüştüren ve/ya (yeniden) kuran pratiklerin moderniteye özgü bir iktidarın uygulamalarıyla ve işleyiş mantığıyla kesip atılamaz bir bağ içinde olduğunu görür. Foucault'nun moderniteye özgü olduğunu düşündüğü bu iktidar biçimi biyo-iktidardır. Foucault, biyo-iktidarın on yedinci yüzyılda şekillenmeye başladığını ve kendinden önceki iktidar biçiminden farklı olarak öldürebilme gücünde değil de bedenlere incelikle hükmetmede ve yaşamları dikkatlice yönetmede simgeleştiğini söyler (1990, s. 140).

Foucault'ya göre "toplumun bireyler üzerindeki kontrolü yalnızca bilinç ya da ideoloji yoluyla değil, bedenle ve bedende sağlanır. Kapitalist toplum için en

önemli şey, biyolojik, somatik ve bedensel olan şeydir, biyo-politikadır" (Foucault'dan akt. Hard ve Negri, 2001, s. 27). Sözkonusu biyo-iktidarla ilişkilenme biçimimiz ise sadece iktidara itaat ya da itaatsizlik, biçimsel politik katılım ya da ret gibi unsurlarla şekillenmez. Tüm hayatımız, ölümümüz, servetimiz, üretimimiz, tüketimimiz ve toplumsal yeniden üretimimiz biyo-iktidarın işlediği alanda yer alır (s.26). Bu tür bir iktidarın işleyişini, yasaklama ve izin verme arasında salınan, yukarıdan aşağıya doğru işleyen bir süreç olarak düşünemeyiz. Biyo-iktidar ekonomik süreçlere, bilgi ilişkilerine, cinsel ilişkilere ve başka türlü hareketli, eşitsiz ilişkilere içkindir. Biyo-iktidar, karmaşık bir şebeke içinde bu ilişkilerle sayısız defa kesişir ve onları doğrudan üretir, biçimlendirir (Foucault, 1990, s. 94).

Foucault bilgi iktidar ilişkilerinin ürünü olan düzenleyici söylemleri, bedeni ve dolayısıyla öznelliği biçimlendirmede tek yönlü olarak işleyen belirleyenler olarak görmez. Bu bağlamda, biyo-iktidarın tek yönlü, dikey olarak işlemeyen yapısına baktığımızda, öznenin bilgi iktidar ağlarıyla çeşitli ilişkilenmeler aracılığı ile kurulduğunu ve ilişki içinde olduğu bu bilgi iktidar ağlarını bizzat kendi pratikleriyle (yeniden) kurduğunu görürüz. Bir taraftan özne kendi üzerinde eylemesiyle birlikte özneleşir. Diğer taraftan da onun özneleşme pratikleri, kendisi üzerinde(n) işleyen iktidarı var eder, dönüştürür, biçimlendirir. Foucault'ya göre iktidar, bireyi cezalandırılacak, parçalanacak, bastırılacak bir şey olarak görmez. Birey de iktidarın dışında ve karşısında bir konuma yerleşerek iktidarı pasifçe onaylamaz. İktidarla birey arasındaki ilişki bir karşılıklı etki meselesidir. "…bir bedenin, hareketlerin, söylemlerin, arzuların bireyler olarak tanımlanması ve kurulması tam olarak iktidarın birincil etkilerinden biridir" (Foucault, 1980a). Biyo-iktidar bireyleri özne yapan bir iktidar biçimidir. Bireyi kategorize eder, bireyselliğin içeriğini ve sırlarını belirler. Bireyden kendine özgü bir hakikat yaratmasını ve bu hakikati hem kendisi hem de başkaları tarafından tanınır hale getirmesini ister. Bu hakikat yasasını dayatırken de gündelik hayata

doğrudan müdahale eder. Burada kurulan özne hem denetim ve bağımlılık yoluyla başkasına tabidir, hem de vicdanı ve kendine ilişkin olarak ürettiği öz-bilgisiyle kendi kimliğine bağlanmıştır (Foucault,1982, s. 212).

Nihayetinde Foucaultcu teoride özne üretim ve tüketim eylemlerinin, bilim ve tıp pratiklerinin, kültürel ve sosyal etkinliklerin, bedenle kurulan ilişkilerin, gündelik hayatı tüketme kalıplarının bir ürünüdür. Özneyi biçimlendiren bu unsurların merkezi, evrensel, tarih ötesi ve aşkın tanımlarına ulaşmak ise mümkün değildir. Dolayısıyla Foucault, bugünkü haliyle ele aldığımız özneyi tarih ötesi bir kategori olarak değil, "bilginin temel düzenlemelerindeki bir değişikliğin sonucu" ve tarihsel bir "icat" olarak nitelendirmektedir (1994, s. 386).

Foucault'nun tartıştığı yaşam üzerinde işleyen bu biyo-iktidar, bedeni insan yaşamının tümünün kendisine indirgendiği bir biyolojik sınır olarak bilgi ve iktidar hesaplarının merkezine yerleştirir. Böyle bir odağa yerleştirilen beden artık yalnızca kendimizi içinde yaşattığımız bir mekân, doğal olarak birlikte yaşadığımız bir şey ve kim olduğumuzun bir parçası olmaktan çıkar. Sağlığı, hastalığı, doğurganlığı, ömrü, cinselliği ve başka birçok biyolojik özelliği iktidar hesaplarında ve dolayısıyla rıza gösterme biçimlerinde elzem belirleyenler olarak yönetilir. Beden, özne olma pratiklerinin ve yaşam temsillerinin üzerinde ve sayesinde deneyimlendiği bir performans sahnesine dönüşür.

Öte yandan, bedene ilişkin değişmekte olan bir tıbbi imgelem söz konusudur. Biyo-politika şimdilerde başka türlü tahayyül edilen bir beden üzerinde işlemekte ve dönüşmektedir. Bu başka türlü beden moleküler, parçalı, dağınık bir bedendir. Parçalar(ın)a ayrılmış bir beden üzerinden işleyen iktidarın aldığı yeni biçimi, Rose (2007a) "moleküler biyo-politika" olarak kavramsallaştırır. Rose'a göre hayatın moleküler bilgisinin üretilmesi süreci 1960'larda başlamıştır. Foucault biyo-politikadan söz ederken "biyolojik süreçlerin dayanağını oluşturan beden" fikrinden yola çıkar. Onun sözünü ettiği bedenin her bir parçası henüz kendi

başına hayatiyet ve hareket imkânı kazanmamıştır. Oysa Rose'un moleküler biyo-politikada söz ettiği beden, kendisinden ayrıştırılmış her bir öğesinin yeni bir canlıymış gibi muamele gördüğü bir nesnedir. Bu anlayış bugün biyo-politikanın aldığı yeni bir biçimdir ve hayatın moleküler ontolojisini sunar.

Moleküler biyo-politika canlılık olgusunu ayrıştırılabilir, sabitlenebilir, dondurulabilir, biriktirilebilir, depolanabilir, metalaştırılabilir bir şey haline getirmiştir. Bu yeni canlılık olgusu, zamanlar, mekânlar, türler arasında hareket ettirilebilir ve ticarileştirilebilir. Hem sağlık hem de zenginlik adına kendisine yatırım yapılabilir (Rose, 2007b s. 3). Moleküler biyo-politika çağında, panoptik bakışın baktığı yerler de değişmiştir. Ultrason, mamografi, beyin ya da kalp elektrosu, tomografi gibi izleme teknikleriyle organik bedenin içerilerine bakılır. Moleküler biyo-politikanın yükselişiyle birlikte, bedenimizle kurduğumuz ilişki de dönüşüme uğrar. Bunun sonucunda, organları, dokuları başka bedenlerde gezinebilen, hücreleri, DNA parçaları gözlemlenebilen, biyo-bankalarda istif edilebilen, ticarileştirilebilen bir nesneye sahip bireyler haline geliriz (Rose, 2007a, s. 11-15).

III. Modern Tıptan Postmodern Tıbba

Bu bölüm modern dönem tıbbı ve postmodern dönem tıbbı arasındaki farklılıkları ortaya koymayı amaçlamaktadır. Bugünün tıbbını tarihsel bir bağlam içine yerleştirebilmek için modernitenin başlangıcına doğru geri yürümek gerekir. Çünkü modern dönem tıbbı, postmodern dönem tıbbının tohumlarını içinde büyütmüştür. Ancak, modernite ve postmodernite arasında, modern tıp ve postmodern tıp arasında, her ne kadar süreklilikler olsa da, postmodern tıbba kendine özgü karakterini kazandıran şey, bu süreklilikler değil, farklılıklar ve kopuşlardır. Burada, süreklilikleri değil kopuşları ele alarak bugüne özgü tıp

pratiğini çözümleme tercihinin ardında yatan mesele, tezin metodolojik olarak jeneolojik bir tarihsel okuma yöntemine yaslanmış olmasıdır.

Giddens'ın açıklıkla ifade ettiği üzere, modernite on yedinci yüzyılda başlamış, Avrupa'da biçimlenmiş, daha sonra dünyaya doğru yayılmış olan toplumsal yaşam biçimi ve organizasyonudur (1996, s. 51). Modernite bir dizi gelişmeyle birlikte anılır. Bu gelişmeler şöyle sıralanabilir: doğanın bilimsel olarak araştırılması hedefi, insanın doğayı kontrol etme arzusunun ortaya çıkması, endüstrileşmenin yaygınlaşması, kentleşmenin yükselişi, demokratikleşme ve sekülerleşme hareketlerinin yaygınlaşması, deneysel ve analitik bakış açısıyla edinilen bilginin değer kazanması, evrensel akla ve ilerlemeye olan bağlılık, akılcılaştırmanın yükselişi, bireysel özgürlüklerin yükselişi, ulus devletlerin yükselişi, bürokratik yönetim sistemlerinin yükselişi, kamusal ve özel lanların ayrıştırılması. Tüm bu değişimler birbirini etkileyerek var olmuşlardır. Böylesine özetlenebilecek modern bir tarihsel bağlamda tıp da dönüşmüştür. Tıp alanındaki dönüşümler modern kültür ve toplumsallıkların oluşumunda dışsal etkileyenler değildirler (Lawrence içinde Burry, 2005, s. 59). Tıbbın dönüşümü bu modern tablo içerisinde önemli bir yerde durmaktadır.

Modernleşme süreciyle birlikte, daha önceleri toplumun üyeleri, sağaltıcılar, doktorlar, hastalar tarafından kabul gören, bedene, hastalığa, tedaviye dair eski inançlar, yorumlar, anlamlandırmalar ve çözüm yolları terk edildi. Modernleşme süreciyle birlikte tıp büyük ölçüde kurumsallaştı. Bu kurumsallaşmada "kliniğin doğuşu" büyük bir rol oynadı. (Foucault, 2003). Tıbbi uzmanlaşma eğitime ve bir dizi kurala tabi kılındı. Daha önce toplumsal alanda dolaşan tek bir elde toplanmaya başladı. Bu tek el modern tıp bilimi idi. Böylece "bilimsel" tıp bilgisi diğer tıp bilgileri üzerinde egemenliğini ilan etti. Modern tıp bilimi kaderin ve tanrının etkisini tahtından indirdi. Modernitenin tıp alanına getirdiği bu dönüşümler şöyle özetlenebilir: hastalık ve sağlık konusundaki açıklamalar "iyi ya da kötü (şeytani) güçler" gibi atıflardan arındırıldı. Tanrının cezalandırması ve

hasta olmak arasında kurulagelen bağlantı koptu. Sağlık ve tanrının lütufları arasında kurulagelen bağ da koptu. Günahların hastalıklara neden olduğu yönündeki açıklamalar terk edildi (Turner, 1987) bedensel acının tanrının hoşnutsuzluğunun yansımsı olduğu yönündeki inanışlar terk edildi. Böylece hastanın yatağının bir cezalandırma yeri olduğu fikri geçersizleşti. Büyüler, sihirler, muskalar tedavi sürecinin dışına çıkarıldı. Doğanın bilimsel incelenmesi eğilimine paralel olarak, beden de "akılcı" ve "bilimsel" incelemenin alanı haine geldi. Tıp, "pozitif bir bilim" olarak, bedeni incelemeyi ve hastalıkları tedavi etmeyi tek başına üstlendi.

Modern tarihsel bağlamda, bu bağlama özgü yeni bir tıp bilgisi birikmeye başladı. Yeni bilgi birikimi, yeni ayrımlar, sınıflandırmalar, ilişkiler, kimlikler getirdi (Rose, 2004, s. 29). Tıp bir bilim olarak, "bilimsel" anlatılar ve açıklamalar üretmeye başladı. Klinik karar verme süreçleri "akılcılık" ilkesi üzerine inşa edilmeye başlandı. "nesnel" ve "evrensel" geçerlilikte tedaviler uygulama ilkesi tıp alanında yaygınlaştı. (Foulkner ve Thomas, 2002, s. 1). Turner tüm bu süreçleri "günahtan hastalığa" doğru bir geçiş, bir evrilme olarak tartışır ve olan bitenin tıp anında bir sekülerleşme, bilimselleşme ve akılcılaşma olduğunu söyler (1987). Foucault da *Kliniğin Doğuşu: Tıbbi Algının Arkeolojisi* [1963](2003) başlıklı çalışmasında bu süreci birey hakkında bilimsel bir söylemin doğuşunun bir parçası olarak değerlendirir ve bu süreçte hasta yatağının adım adım bilimsel inceleme mekânlarından birine dönüştüğünü söyler (ss. xv-xvii).

Modernitenin tıp alanında yarattığı kopuşların benzerleri, postmodernitenin yükselmesiyle birlikte de deneyimlenmiştir. Sosyoloji literatüründe farklı vurgu ve yorumlar içeren tartışmalar varlığını sürdürmekle birlikte, postmodernizm kavramı, modern olana bir karşı çıkışa, moderniteye belirleyen özelliklerden bir kopuşa, moderniteden bir uzaklaşmaya işaret eder (Featherstone, 2007). Moderniteden kopuş uzaklaşma bir dizi mikro ve makro değişimle birlikte anılır. Bu bağlamda, postmodernizm kavramı modernitenin doğru, akıl nesnellik,

evrensellik, özgürlük, büyük anlatılar, nihai açıklamalarla anılan dünyasının eleştirilmesini içerir. Kuşkuculuk, çeşitlilik, çoğulluk, verili doğa fikrine karşı çıkış, çoğul kimlikler gibi meseleler postmodernizmin farklarıdır (Eagleton, 1996, s. vii). Öte yandan, ulus devlet ve milliyetçilik fikirlerinin aşınması, ulusaşırılaşma, küreselleşme, tüketim, kitle iletişim araçlarının yaygınlaşması, eski sınıf politikalarının dönüşmesi, yeni sosyal hareketlerin doğuşu, hayat tarzı ve kimlik politikalarının yükselişi, görecelilik, parçalanma, çoğullaşma gibi meseleler de postmodernitenin yükselişi ile eş zamanlıdır (Scambler ve Higgs, 2005, ss. x-xi).

Rose böyle bir postmodern bağlam içinde tıbbın dönüşümü üzerine, yazarken insan canlılığına ilişkin tıbbi bakışın ve müdahale biçimlerinin değiştiğini söyler. Teknolojinin de hızla gelişmesi ve bu gelişmenin ardındaki tıbbi bakışın değişmesiyle birlikte, bugün canlılığı inşa etme gücümüz artmıştır (Rose, 2007a, s. 4). Biyolojik olarak verili değişmez kabul edilegelmiş "gerçekler" hızla erimektedir. Bugün henüz doğmamış bir çocuğun cinsiyetini belirlemek ya da plastik cerrahi aracılığı ile yüzümüzü tamamen değiştirmek mümkündür. Kanserli bir dokuyu vücuttan çıkarmak ya da çalışmayan bir böbreği başka bir böbrekle değiştirmek mümkündür. Beden bugünün tıbbı için sınırları eğilip bükülebilen bir coğrafyadır. Dolayısıyla, sorgulanamaz, verili değişmez biyolojik bir varlık olarak beden fikri geçerliliğini yitirmiştir. İçinde yaşadığımız biyo-teknolojik (Rose, 2007, s.1) ve biyo-merkezli (Cooter, 2007, s. 441) çağda, beden ve canlılığa ilişkin tanımlar, sınırlar giderek bulanıklaşmaktadır.

Postmodernite ile ve onunla beraber yeniden şekillenen tıp alanda, teknoloji ve biyoloji, tedavi ve reality şov, olasılık ve risk, doğal ve yapay, nakil ve orada olan, gerçeklik ve kurgu, hastalığın kendisi ve anlatısı, beden ve temsili birbirlerine karışmışlardır. Günümüzde beden biyoloji, ölüm, yaşam ve canlılık yumuşak bir plastiğe dönüşmüştür. Tıbbın oynadığı, eğip büktüğü, tekrar tekrar şekillendirdiği, kestiği, biçtiği, diktiği, açtığı, gördüğü, baktığı şey bu yumuşak plastiktir.

Postmodern tıp olasılıkların çokluğu ve kesinliklerin yokluğu ortamında işler. Bugün orada öylece durup keşfedilmeyi ve tanımlanmayı bekleyen tıbbi gerçeklikler yoktur. Tıbbi gerçeklikler olumsal ve perspektife bağlı olarak üretilir. Modern tıbbın deneye ve kanıta bağlı bilgi üretme mekanizmaları yerlerini çoğul, parçalı, değişken, tutarsız, olumsal bilgi üreten postmodern mekanizmalara bırakmıştır. Günümüzde tıp literatürüne hızla yeni hastalıklar eklenmektedir. Gündelik hayat git gide tıbbileşmektedir (Conrad, 2007). Tüketim toplumunun genel eğilimleriyle paralel olarak ilaçlaştırma, ilaç istilası yaygınlaşmaktadır. Risk toplumunun (Beck, 1992) genel gidişatına paralel olarak da risk söylemi tıp alanında kendine önemli bir yer bulmaktadır.

IV. Postmodern Tıp, Organ Nakilleri ve Beden

Beden ve tıp arasında, kaçınılmaz bir biçimde her zaman ilişki olmuştur. Bu ilişki öyle kolayca görülüp açıklanabilir, kavranabilir bir ilişki değildir. Beden, tıbbi imgelemde, değişmeyen, verili ve sınırları kesin bir şey değildir. Tıp tarihi boyunca bedeni farklı biçimlerde gören tıbbi bakışlardan söz etmek mümkündür. Biyo-politika teorisinden de öğrendiğimiz ürere, "tıbbi bakış" içinde biçimlendiği bağlamın ekonomik, politik ve toplumsal olaylarından ve koşullarından bağımsız değildir.

Tezin bu bölümü postmodern tıp olarak kavramsallaştırılan bugüne özgü tıbbın beden imgelemini, organ nakilleri tedavisine odaklanarak tartışmaktadır. Diğer bir söyleyişle, tezin bu bölümü, parçalı beden (moleküler beden) meselesini organ nakilleri tedavisine odaklanarak tartışmaktadır. Postmodern tıbbın kendisine özgü beden kavrayışını ortaya koyabilmek için, modern tıbbın bedene bakışından hangi noktalarda kopulduğu bu bölümün esas meselelerinden birisidir.

Modern tıp, bedeni yekpare, kapalı, dış sınırları deri olan bir şey olarak görmekteydi. Bu molar bir beden anlayışıydı (Sharon, 2014). Postmodern tıp ise

bedeni açık bir ilişkiler ağı olarak görür. Bu ağ içinde sadece biyolojik ya da sadece yapay unsurların ilişkilerinden örülmez. Postmodern tıp için beden her zaman yeni karşılaşmalara açık bir yerdir. Bu bedene ilişkin yeni bir mekansallaştırmanın varlığına işarettir. Modern tıptan farklı olarak, postmodern tıbbın kavrayışında beden incelendikçe sırlarını açığa verecek, keşfedilecek bir nesne değildir. Bunun aksine, bugünün tıbbında, her yeni tıbbi müdahale bedeni yeni melezlik olasılıklarına açmaktadır.

Postmodern tıbbın bedeni kavrayışına ilişkin iki ana eğilimden söz etmek mümkündür. İlk olarak, son zamanlarda bedenin organizasyonu değişmektedir. Bu değişimi yönlendiren ilke *parçalarına ayırmadır*. Öte yandan, *parçalanan* bu beden her zamankinden daha karmaşık bir ilişkiler ağının ortasında durmaktadır. Dahası, postmodern tıbbın moleküler bedeni kendi içinde de bağımsız parçaların, teknolojik canlılıkların, başka bedenlere ait parçaların, yapay organların ilişkiler kurduğu bir ağdır. Tüm bu ilişkiler ağının içinde ve kendisi de bir ilişkiler ağı olarak, beden, daha önce kendisine atfedilen sınırları aşar. Bu beden tıbbın bakışında giderek daha dağınık bir hal alır.

V. Postmodern Tıp, Organ Nakilleri ve Ölüm

Organ nakillerini sosyolojik bir bakış açısıyla okurken karşımıza çıkan şey sadece bedenin sınırlarının parçalanması değildir. Aynı zamanda bu bedenin sonuna yani ölüme ilişkin bilgi, pratik, deneyim ve bakış da değişmektedir. Postmodern tıp, programlanabilir, parçalı, ertelenmiş ve teknoloji ile desteklenmiş ölümler yaratmaktadır.

Organ nakilleri tedavisine bakmak gösterir ki postmodern tıp ölü bedeni parçalara ayırır. Sonra bu parçaların bazılarını yeniden kullanıma açar. Ölümün kapısında duran ya da henüz sıcak ve yine de ölmüş kabul edilen bedeni yeniden değerlendirir. Bu süreçlerde "beyin ölümü" önemli bir iş görür. Beyin ölümünün

kavramsallaştırılması yoluyla günümüz tıbbı ölüme ilişkin yeni bir deneyimler alanı açmış ve ölümün bilgisini köklü olarak değiştirmiştir. Kalp ölümünden beyin ölümüne geçerek, postmodern tıp yeni bir kadavraya ulaşmıştır. Bu kadavra modern tıbbın tamamıyla ölmüş ve soğuk olan kadavrasından farklıdır. Yeni kadavranın kalbi atmaktadır, hala sıcaktır ama yine de ölmüş abu edilir. Kalbi atan bu kadavradan alınan organlar başka bir bedene nakledilebilir durumdadır. Böylece organ nakli tedavisi hayat ve ölüm arasında yeni bir geçişlilik yaratır.

Bu durumda postmodern tıbbın ölümü yeniden yorumladığını söyleyebiliriz. Ölüm deneyim ve söylem düzeyinde, teşhis ve müdahale düzeyinde parçalara ayrılmıştır. Böyle bir ölüm anlayışı yaşama ilişkin tahayyülleri de dönüştürür. Organ nakli tedavisi uygulanmaya başlanmazdan evvel, yani elli yıl kadar önce, doğum yaşamı başlatan eylemdi. Ancak organ nakilleri tedavisiyle birlikte, yaşam tam da ölmek üzere olan hasta için yeniden başlıyor. Bazı ölümler, başka bedenler için ölümün kapısından dönmeyi, hayata tekrar başlamayı sağlıyor. Örneğin, beyin ölümü gerçekleşmiş bir vericiden alınan bir parça ciğer, ölüm döşeğinde yatan ve ciğer bekleyen bir başka hastaya nakledilyor. Böylece, vericinin ölümünden bir yaşam doğuyor. Alıcı ise ölmek üzereyken yaşama yeniden başlıyor, elbette ölümden geriye kalan bir parça canlılık sayesinde.

Ölüm gibi karanlık bir sondan yeni bir hayat devşirmek meselesi, Foucault'nun *Kliniğin Doğuşu: Tıbbi Algının Arkeolojisi* [1963](2003) başlıklı çalışmasının sonuç bölümünde yürüttüğü tartışmayı anımsatıyor. Foucault modern tıbbın bilimsel araştırmalarını ölüme yoğunlaştırdığını yazar. Modern tıp ölüm fikrini karşı-doğadan koparıp bu dünyaya indirmiştir. Kadavralar açıp onların içine bakarak sadece ölümü değil, ölümün bilgisinden yola çıkarak yaşamı anlamaya çalışmıştır. Foucault modern tıbbın ölümün kalbinde yaşamı aradığını söyler (2003, ss. 241-246). Oysa organ nakli tedavisinin incelenmesi gösteriyor ki postmodern tıp ölümün kalbinde yaşamı aramanın ötesine geçmiştir. Postmodern tıp bizzat ölenin kalbi ile yeni bir yaşam yaratmaktadır. Modern tıp orada ne

olduğunu anlayabilmek için kadavra açar ve ölü bedeni parçalar, postmodern tıp ise ölüm olgusunun bizzat kendisini parçalar ve erteler. Postmodern tıp ölmüş bir insanı hayata döndüremez, ama ölümün dişleri arasından bir parça canlılığı çekip alabilir. Postmodern tıp beyin ölümü kavramsallaştırmasıyla ölümün tanımını değiştirir. Böylece ölü bir bedenden canlı bir kalp çıkarıp onu ölmek üzere olan başka bir bedene nakledebilir. Cansızın kalbiyle ölmek üzere olana yeni bir hayat verir.

VI. Postmodern Tıp, Organ Nakilleri ve Metalaşma

Tıp içinde işlediği çağa özgü biçimiyle ilişkili bir pratiktir. Bu günün tıbbı da küresel kapitalizm koşullarında işlemektedir.

Küresel kapitalizm metaların ulus aşırı akışı, küresel pazarların kurulması ve işlemesi, kar odaklılık, rekabet, tüketim gibi özellikleriyle anılmaktadır. Bu özellikler aynı zamanda bugünün tıbbını da biçimlendirir. Küresel kapitalizm koşulları günümüz tıbbının ruhunda dolaşmaktadır.

Bugün sağlık ve hastalıkla ilgili olarak alınıp satılan çık fazla sayıda ürün ve hizmet vardır. Diyabet testlerinden grip aşılarına, hayat sigortasından check-up'lara, tüp bebek tedavisinden kanser ilaçlarına değin birçok hizmet ve ürün alınıp satılır. Bu uzayıp giden ürün ve hizmet zincirine yakın zamanlarda yeni bir meta eklenmiştir. Bu meta "taze organ"dır. Bugün organlar tıpkı tıbbi cihazlar ya da tıbbi hizmetler gibi alınıp satılabiliyorlar organların metalaşması, kapitalizmin bedenlerimizin içine kadar girdiği yönündeki sözleri metaforik bir anlatım olmaktan çıkarıp bir gerçekliğe çevirmektedir.

Organların metalaşması son döneme özgü kapitalist-tıbbi bir eğilimin açık göstergesidir. Bu eğilim canlılığın alınır satılır bir şeye dönüştürülmesidir. Organlar da metalaşmalarının sonucu olarak, bedenle bağlarını koparırlar ve

küresel kapitalist pazar ağlarında, birer meta olarak, dolaşmaya başlarlar. Bu çeşit bir ticarileşme bir yandan postmodern tıbbın bedeni parça parça görmesiyle, öte yandan da küresel kapitalizm ve postmodern tıp arasında kurulan ittifaklarla ilgilidir.

Organ doğası gereği bir meta olarak "üretilmemiştir". Herhangi bir koşulda organ üretilmiş bir şey değildir. Bu bağlamda organlar madenlere ya da toprağa bezerler. Çünkü bunların da metalaşma süreçleri endüstriyel ürünlerden farklıdır. Bunları metaya dönüştüren şey pazarda alınıp satılabilme kabiliyetini kazanmalarıdır. Marx böyle bir metalaşma sürecini tartışırken, önceden meta olmayan bir şeyin daha sonra metaya dönüşmesi sürecinde "tarihsel bir eylem"in olması gerektiğini söyler (Marx, [1887], 2010, s.26). Organ ticareti de, Pazar ilişkilerinin yanı sıra, bir dizi tıbbi işlem gerektirir. Organların bedenden çıkarılabilmesi, bedensizken canlı tutulması, başka bir bedene nakledilebilmeleri, yeni bedende tutunabilmeleri gibi tıbbi işlemlerin hepsini organ nakli tedavisi başlığı altında tutarak organ nakli tedavisinin "tarihsel bir eylem" ya da Foucaultcu anlamda "jeneolojik bir kopuş" olduğunu söyleyebiliriz.

Bedenle bağlarını koparan, metalaşan, değişim değeri kazanan organlar organ nakli tedavisinin her iki tarafı - alıcı ve verici - için de çok kıymetli nesnelerdir. Ancak böyle bir nesneleşme eğer karaborsa koşulları altında gerçekleşirse vericinin aleyhine işler. Çünkü karaborsa koşullarında gerçekleşen alışverişlerde doktorların ve alıcıların dikkati sadece organın üzerindedir. "Taze organı" sağlayan kişinin sağlığı göz ardı edilir. Dolayısıyla böyle kirli bir ticaret, nesneleştirme ve metalaştırma alıcıya hayat umudu getirirken verici/satıcıya ise ölüm ya da sakatlık ihtimali getirir. Böyle bir ticari bağlamda tıbbi işlem bazı hayatları öteki bazı hayatlardan daha değerli görerek gerçekleşir. Bazı hayatlar kurtulur bazılarıysa ölüme terk edilir. Raporlar, araştırmalar ve insan hikâyeleri gösterir ki karaborsa organ ticareti belirli örüntüleri izler. "Taze organlar" karaborsa ticaretinde yoksul bedenlerden varsıl bedenlere, dezavantajlı

insanlardan avantajlı insanlara, kırılgan gruplardan güçlü gruplara, az gelişmiş ve gelişmemiş ülkelerden gelişmiş ülkelere doğru hareket eder (Scheper-Hughes, 2005).

VII. Sonuç: Tıbbın Kıskacında Hayat ve Ölüm

Son zamanlarda canlılık örüntülerine ilişkin çığır açıcı değişiklikler deneyimliyoruz. Yeni deneyimlerimiz postmodern bir tıbbi bağlam içinde gerçekleşiyor. Yirminci yüzyılın ikinci yarısından itibaren, modern tıptan kopuşa işaret eden, yeni canlılık örüntüleri ve tıbbi tahayyüller ortaya çıkmaya başladı. Modern ve postmodern tıp farklı tıbbi tahayyüllere ve özne üretim mekanizmalarına sahiptir. Burada andığımız son dönem değişiklikler postmodern döneme özgüdür ve yeni özellikleri, toplumsal ilişkileri, tıbbi pratikleri beraberinde getirmektedir. 1960'lardan bu yana hayatın moleküler bilgisi birikmektedir. Bu birikim modern molar bedeni çözmektedir.

Bu tez moderniteden postmoderniteye, biyo-iktidardan moleküler biyo-iktidara geçişi tıp alanı üzerinden incelerken, sosyoloji alanı içerisinde geniş bir tartışma ve teori damarının içinde yer almaktadır. Bu damar modern öznenin parçalanışı meselesine ilişkin tartışma ve teorileri içermektedir. Deleuze'den Guattari'ye, Derrida'dan Baudrillard'a Bauman'dan Cixous'a Irigaray'dan Kristeva'ya, Haraway'den Lyotard'a postmodernite üzerine düşünen bir dizi düşünür postmodernitenin beraberinde getirdiği modern öznenin çözülmesi meselesi üzerine kafa yormuştur. "Kültürel parçalanma", "konumsal bilgiler", "mikro-arzu politikaları" "akışkanlık", "göçebe özneler", "hiper-gerçeklik", "sibernetik organizma" gibi kavramlar modern akılcı, biricik, bütünlüklü öznenin esas sosyal aktör olduğu fikrini eleştirmek için geliştirilmişlerdir.

Bu tez böyle bir düşünsel ve kavramsal çizgide yer almaktadır. Modernitenin parçalanan, yerinden edilen öznesine odaklanarak, bu öznenin bedensel olarak da

dağılıp saçıldığını, tıp alanına bakarak söylemektedir. Özellikle organ nakilleri tedavisini, sosyoloji literatürünün kavramlarıyla okumaya girişen bu çalışma, tıp tarihinin son elli yılında gelişen tıbbi bakışın odağında bedeni, ölümü ve yaşamı parça parça anlaşılan bir insanın var olduğunu söylemektedir.

Organ nakli tedavisi bedenin sınırları değiştirilerek uygulanır. Tedavi sürecinde yapıp edilenler gösterir ki bugün bir "ağ beden"le karşı karşıyayız. Bu ağ beden içinde bedenden bağımsız olarak organlar da kendi başlarına hayatiyet kazanırlar, metalaşırlar, dolaşırlar, alınıp satılırlar, dondurulup saklanırlar. Organ nakilleri "bedensiz organlar" yaratır. Bedenler arasında gidip gelen organlar bağlamından çıkarılırlar ve sonra yeniden başka bir bağlama oturtulurlar. Yüzergezer organlar karaborsada alınıp satılınca ya da değişim değeri kazanınca karşımıza çıkan şey kapitalizmin soyut değil bizzat somut bir biçimde bedenin içine yerleşmesidir.

Organ nakli tedavisine ilişkin okumanın gösterdiği bir diğer şey sadece bedenin değil ölümün de parçalanıp plastikleştiğidir. Bu çalışma "beyin ölümü" ve organ nakli tedavisinde hayati ilaçlar olan "bağışıklık sistemi baskılayıcı"lara odaklanarak ölüme ilişkin bir dönüşümün de izini sürmüştür.

Sonuç olarak, görülen modernitenin diğer büyük anlatıları gibi, bedenlenmiş özne anlatısının da erimekte olduğudur. Bedenin içine gömülü olduğu düşünülen canlılık, artık bir beden kendisine eşlik etmeden de var olabilmektedir. Kesin ve ani bir son olan ölüm parçalara ayrılmakta ve zamana yayılmaktadır. "Bedensiz organlar" bedenin deriden zarfının dışına taşmaktadır. Canlılık parçaları değişim değeri kazanmaktadır. Bu genel postmodern tıp tablosuna baktığımızda "her şey iyiye doğru gidiyor" ya da "her şey kötüye doğru gidiyor" demek zordur. Tıp alanındaki bu dönüşümler ucu açık bir sürecin parçasıdırlar ve gelecek olasılıklarla doludur. Açık olan postmodern tıbbın modern insan-merkezciliğin kibrini alaşağı ettiğidir. Biricik, akılcı, yekpare modern özne ve onun bedeni

parçalanmaktadır. Postmodern tıp yeni bir öznenin bedensel inşasında önemli bir rol oynamaktadır.

Bu yeni özne, parçalı bir bedenin değişken sınırlarında, ertelenmiş ölümleri ve tasarlanmış doğumları deneyimlemektedir. Değiş tokuş edilebilen biyolojik değerlere sahip olmaktadır. Bugün böylesine değişen sadece tıbbın öznesi değildir. Değişen bedenlenmiş modern öznedir de.

D TEZ FOTOKOPİSİ İZİN FORMU

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YAZARIN

Soyadı : Bozok
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Bölümü : Sosyoloji

TEZİN ADI (İngilizce) : From Modern To Postmodern Medicine:The Case Of Organ Transplants

TEZİN TÜRÜ : Yüksek Lisans ☐ Doktora **X**

1. Tezimin tamamı dünya çapında erişime açılsın ve kaynak gösterilmek şartıyla tezimin bir kısmı veya tamamının fotokopisi alınsın. ☐
2. Tezimin tamamı yalnızca Orta Doğu Teknik Üniversitesi kullancılarının erişimine açılsın. (Bu seçenekle tezinizin fotokopisi ya da elektronik kopyası Kütüphane aracılığı ile ODTÜ dışına dağıtılmayacaktır.) ☐
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Yazarın imzası Tarih