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Biopolytics and Bioeconomics in health: the paradigm of risk in informed consent and defensive medicine

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Abstract
At the beginning, it was the French philosopher Michel Foucault who explicitly defined medicine as a matter of biopolitics, making evident the role that, in his opinion, medical knowledge assumed in certain strategies of power. Starting from this assumption, the bioeconomic paradigm has been embodied in a form of governmentality of human behaviors, where the individuals are first and foremost considered biological living units. The biopolitical and bio-economic paradigm must not be considered as a space of absence of power, but a place where power leads to obedience by activating alternative devices, acting on population wishes and needs. These dynamics have slowly modified and even subverted the relationship between doctor and patient, determining the default of the paternalistic relationship and the strengthening of defensive medicine.

Keywords: biopolytics, bioeconomics, health, defensive medicine

Biopolitics and bioeconomy

The French philosopher Michel Foucault, in the second half of the last century, proposed a fructuous reflection focused on the concepts of biopower and biopolitics, whose interpretation, however, is not univocal; it is useful, therefore, to consider, in the first instance, some meanings that the terms "biopower" and "biopolitics" assume in the huge production of the author.
In 1974, Foucault spoke for the first time about the concept of biopolitics during the conference held in Rio de Janeiro about " The birth of social medicine". On this occasion two fundamental data emerge: the first, concerning the connection between biopolitics and capitalism, able to determine the possibility of implementing a control on individuals, not only by consciousness and ideology, but also through the body.
The second, because of the first, is the importance that the body assumes as a biopolitical reality and medicine as a biopolitical strategy (Foucault, 1997, 222).
The real focus of Foucaultian researches, however, is not the living body, but rather its constitution as a scientific object, as the specific knowledge indispensable for the exercise of a certain power. For this reason, Foucault's attention is often turned to all the published and inedited scientific speeches on the body.
The initial reference of biopolitics to the body and medicine changes and expands a couple of years later, when he explains how the life power has developed in two directions, one focused on the body-machine, the other on the body-species. In the first case, it is an anatomical-political of the human body. It is materialized through processes of discipline and supported by mechanisms of power, both focused on the body to strengthen it, but also to make it "docile" and to incorporate it into effective and economical control systems.
In the second case, Foucault speaks specifically of biopolitics of the population, as the set of interventions and regulatory controls that, since the mid XVIII century, have addressed the set of living bodies constituting the population. Also, in this perspective, the binomial constituted

by knowledge and power assumes a fundamental role. The affirmation of specific fields of knowledge, which not only include medical knowledge, but also demography, statistics and political economy, determines the possibility of managing the dynamics concerning health, hygiene, food, sexuality and all the biological processes shared by living beings, as birth, proliferation, mortality, etc.

Foucault precise that until the XVIII century, such management of the bodies were performed according to the directions mentioned above in a distinct way. Together they inaugurated bio-power era, which the author considers as an essential element for the development of capitalism, because of the controlled introduction of the bodies in the production chain and the adaptation of population phenomena to economic processes (Foucault, 1978, 123-124). The State has therefore adopted an economic rationality, determining the state transposition of "oikonomia" (the administration of the house), making it as a specific mode of intervention in the public sphere (Esposito, 2015, 19-20).

Biopower, moreover, has shifted attention to the concept of norm, which has also begun to make its way in the legal context. Although it does not replace the law (i.e. the legal norm connected to power in the classical sense), it has undoubtedly led the law to function as a norm. It can be deduced from the fact that the juridical institution has increasingly integrated itself with other apparatuses, having medical and administrative regulatory functions. Unlike the law, which differentiates individuals based on what they do, playing on the contraposition between lawful and unlawful and, consequently, prohibiting or condemning, the norm usually identifies and differentiates both individuals and populations based on what they are, focusing on the normal-pathological duality.

What is outlined is, finally, a new technology of power, which Foucault sees fully realized in the framework of the so-called liberal "governmentality". Because of the mentioned concepts, it appears not attributable to the simple juridical analysis of sovereignty. Moreover, biopower requires the contribution of the economic dimension. The object of this governmentality is the sum of singular and collective living beings, anatomical bodies and biological bodies. The political rationality is in some measure forced to treat "omnes et singulatim", producing at the same time individualizing and totalizing effects (Foucault, 2001, 145-146).

Normalization and medicalization

In the medical field, the governmental process called "medicalization of society", characterized by "a generalized medical conscience", was implemented by the task of controlling either individual life, through the identification and treatment of diseases, or collective life, in order to define and implement specific health parameters. (Sorrentino, 2008, 108). In this context also hygiene represents, besides medicine, a specific field of knowledge within a structured regime of health of the populations. It was based on the analysis of the habitats (cities, districts and houses) and on the rates of morbidity and mortality of the inhabitants, justifying authoritarian medical interventions in all those places at risk for possible diseases and epidemics (Foucault, 1997, 195-196).

The importance of medicine, not only methodologically but also ontologically, in the constitution of human sciences has thus emerged. It was the possibility for the individual to be, at the same time, subject and object of his own knowledge (Foucault, 2005, XVII).

Until the middle of the twentieth century, however, the role of medicine connected to the problem of health, undoubtedly fundamental, was seen from an essentially nationalist perspective. It was particularly aimed at ensuring health, to preserve the national physical force, the workforce, production capacity and military strength.

For this reason, Foucault considered 1942 a date with a strong symbolic value. In that year the Beveridge plan was drawn up, showing, unlike what had happened in the past, that the phenomenon of the consolidation of medicine was connected for the first time to a right to health. In addition, even though it was made explicit in a world context in which paradoxically millions of human lives were suppressed, the Beveridge plan appeared essential for the organization of health after the end of World War II. It consolidated not only the right to life, but

a different right, more important and complex, represented by the right to health.

With the Beveridge Plan, the State takes on the social task of taking charge of the health of the members of society, with a profoundly different meaning from what had happened up to then. This is a reversal point of view, because the health concern does not longer apply to the State itself and its priorities, but rather individuals. No longer the healthy individual at the service of the State, but the State at the service of the healthy individual. Foucault specifies how a kind of body morality has been defined, which, in the 19th century, had focused on cleaning and hygiene practices as a guarantee of good health. On the contrary, starting from the 20th century, it even goes so far as to support the right to suspend work because of illness. Health and illness thus became a budget item of the State, falling within the government macroeconomic sphere. The Beveridge plan ultimately outlines the idea that the risks, connected with health and the possible interruption of work, no longer concern individuals but the State, which must therefore bear them (148-149). It is precisely on the basis of this approach that the aim of politics takes the name of welfare, because the state of well-being is guaranteed to citizens, who commit themselves to the contractual conditions of a pact, where the sacrifice of work is exchanged for insurance guarantees on health and old age. In this perspective, the management of the economic crisis by the capitalist economy assumes the connotations of a policy of salvation and of almost religious matrix. It is also highlighted by the etymology of the terms "healthy" and "safe", which, within the social reforms of the second post-war period, highlight the overlap between the religious value of salvation and the biological value of health (Esposito, 2015, 67).

Crisis of modern medicine: a game of relational asymmetries

For Foucault, from the time of Constantine, many governments, including European ones up to the 18th century, have distinguished themselves for their theocratic role, characterized by pursuing the salvation of souls as their main objective; this role, however, has finally given way to a somatocracy, in which the main objective of State intervention is the care of the body, physical health, the relationship between health and disease (Foucault, 1997, 205).

What Foucault reflects further on, however, is the crisis that is evident in current medicine, attributable to the distance that would exist between scientific and effectiveness of medicine. In short, the possible negative effects of medicine, including the risk of death, have been represented as a partial consequence of the ignorance of the doctor or of medicine itself, so, the harmfulness was proportional to its non-scientific nature. At the beginning of the 20th century, however, the harmfulness of medicine was linked to its knowledge, to its being a science (206).

The crisis of medicine has been even more marked by the changes in the relationship between doctor and patient, a relationship from the remote past, starting from to the Hippocratic Oath, despite the Hippocratic principles are very current. Beyond the specific principles and contents, however, the Hippocratic Oath highlights the strong relational character, aimed at guaranteeing unconditional respect for the person at the weakest end of the care relationship. Moreover, the Hippocratic care relationship is strongly characterized by an asymmetrical distribution of resources between the person receiving the care and the person providing it, with the former totally subject to the latter. This asymmetry, inherent in the technical contents of the treatment, producing a radical distance between those who administer the treatment and those who receive it, is not, however, an asymmetry that hinders relationality. In fact, it does not lead to prevaricating outcomes, while it should lead to concrete positive solutions, as the result of a real cooperative spirit. (Ruggeri, 2010, 17).

The relational asymmetry that emerges from the doctor-patient relationship is a constant element of any power relationship, as highlighted also in the foucaultian genealogical reconstruction. If this asymmetry, in the context of sovereignty, was clearly structured between the sovereign and his subjects, nevertheless it remains in the biopolitical perspective. Life, even though it is no longer subject to that power of life and death that acts by taking it, is managed because of relationships within a fundamental

asymmetry between those who hold the truth and knowledge, and those who are subject to it.
Obviously, even the doctor-patient relationship is not exempt from this mechanism. The medicalization of society itself has been possible by subjects possessing medical knowledge and considered authoritative. They were able to induce certain behaviors and manage certain dynamics into the society. However, the doctor-patient relationship, sometimes defined as paternalistic, provided that the doctor had the power to treat but, at the same time, to choose the therapy considered most suitable for the case in question. The only limit to this power was the fact that the choice had to be made in science and conscience, with the patient's will practically nil (Grassini and Pacifico 2012, 14).
It was only later that the so-called informed consent had on a crucial role. It finds its beginning during medical experimentations, conducted at the beginning of the 20th century. It acquired its greatest fame in the Nuremberg process, from which arose in 1946 the Nuremberg Code, which states the principle that "the voluntary consent of the human being is essential".
It is however important to underline that this Code was developed as a response to the abuses carried out in the extermination camps during the Second World War, highlighting how experimentation was not a strictly therapeutic activity, but that it had the potential to cause physical and psychophysical injuries to individuals.
A different case was in the traditional medical practice, which was not prosecuted in Nuremberg, where the activity of the doctor, aimed at identifying and treating a certain disease following a more or less safe therapy, was justified on the basis of a state of need, real or supposed (13). It is only in the last decades that the principle of informed consent has firmly established in the relationship between doctor and patient, ratifying the end of the paternalistic relationship and the advent of the autonomy of the patient. It was also expressed by the National Committee for Bioethics in its 1992 Opinion "Information and consent to the medical act", which also revealed the close link between the consent that the patient must give and the information that is provided to him.
The philosopher and sociologist Jürgen Habermas, referring to the Freudian analysis of the therapeutic dialogue between doctor and patient, has taken up the peculiarity of the asymmetrical relationship in the distribution of roles, linking it to the potential of communicative action. In this perspective, he defines "therapeutic criticism" a form of argument that can solve cases of self-deception, to which the patient is often victim (Habermas 1997, 78). This is evident in the relationship between the psychotherapist and the patient, where the latter is induced to reflect on himself and on his own situation. Thus, the behavior of a subject appears rational when he can rid himself of his own illusions, that are not the result of an error, but rather of a form of self-deception. For this purpose, it is essential that the patient first acquires an opening towards those who can shed light on what, at least initially, appears to be a form of irrationality. A rational attitude presupposes a willingness to understand and, if there are communication disorders, also a reflection on linguistic rules.
This reflection can be extended to any professional doctor-patient relationship and to all those situations in which the difference between the patient's self-deception and the physician's knowledge is most evident. The concept of communicative action becomes crucial. It is realized every time that an interpersonal relationship is established between at least two subjects capable of action and language (with verbal or extra-verbal forms). The main aim is to reach an understanding that leads to a common agreement on the action plans to pursue. Language, in this process, is fundamental because the level of interpretation of specific situations susceptible to consensus depends on it (157).
The communication process has clearly become indispensable in order to proceed to any medical act, as also underlined by the Code of Medical Deontology in art. 33, which highlights the duty of the doctor to provide the patient with detailed information on the diagnosis and prospects of intervention and treatment.

From informed consent to defensive medicine

The singular and in some ways surprising fact, therefore, emerges from the history of the doctor-patient relationship, especially with reference to the historical period that began in the twentieth century. In such period, medicine acquired a great therapeutic security, attributing to doctors, for the first time in history, the power to effectively treat common diseases. Paradoxically, at this very juncture, the doctor-patient relationship cracked, risking compromising the prestige that doctors had enjoyed until then. Prestige and medical authority, moreover, played a fundamental symbolical role as indicators of the ability and power of a doctor to transmit confidence during his work and in the possibility of recovery to the patient.
Foucault, reflecting on the possibilities that science and medicine offered to populations, especially since the second half of the last century, highlighted how the current medical tools have different effects on population. Although they are not generally considered harmful, tools can nevertheless be incontrollable, forcing the human species to enter a dangerous history, into a field of probability and risks the extent of which cannot be precisely measured. The philosopher from Poitiers emphasized that, although the medical risk, that is the difficult connection to break between positive and negative effects of medicine, is not a novelty, today this risk has entered a new dimension. It is no longer imputable only to the treated subject or to its descendants, but to the entire human species. The possibility of medical and genetic interventions on DNA has placed life in its entirety (no longer the life of an individual or a specific population) in the field of medical impacts, marking the entrance into what Foucault defines as bio-history. In this dimension, human history can modify life and can exert fundamental effects on its process. This can determine one of the main risks of current medicine, the problems of communication from doctors to patients (and “vice-versa”), in addition to the technical anxiety that doctors and biologists feel about their practice and their knowledge.
Apart from the crisis resulting from these dynamics, Foucault believed that there is also the phenomenon of indefinite medicalization, which has led medicine to act outside its traditional field, going beyond the encounter with the patient and the disease. Medicine is increasingly proposed as an act of authority, regardless of the patient's demand (for example, screening policies or the role that doctors and psychiatrists play both in the workplace and in the judiciary). Finally, the subject of medical intervention is no longer exclusively illness, but health in the broadest sense. Thus, all medical interventions, that in general are aimed to improve the health conditions of individuals, respect the principle that the preponderance given to the disease has become a form of general regulation of society.
Lastly, Foucault considered among the characteristics of modern medicine what he defines as the "political economy of medicine". It would not be a novelty, meaning that from the beginning it was precisely the economic problems that determined the medical organization. However, while in the past medicine was assumed as an instrument of conservation and renewal of the workforce for the functioning of modern society, today it directly produces welfare to the extent that health represents a desire for one and a luxury for the others. Health has effectively become an object of consumption and has become a market product. As a result, the body has also entered the market twice, once by wages, when it has sold its workforce, and once by health, where the body comes to be an object of sensations and desires. Incitement to prevention, empowerment and optimization (different screenings, healthy eating regimens, not smoking, improving own individual performance, etc.) cannot, however, be addressed to everyone. This inevitably is the price to be paid, taking the form of exclusive and exclusionary medicalization (Bazzicalupo 2006, 111-113).
In addition, rapid technological and scientific progress has also led to the reduced perception of death as a possible outcome of the disease, but rather as an avoidable complication. This led to paradoxically believe that, in the event of an unfortunate outcome, it is the doctor who handled the clinical case who has committed a mistake and must pay.
Inevitably, there has been a fracture of the doctor-patient relationship, to which many factors

have contributed, including the progressive bureaucratization of medical services, the process of technocratic and political transformation of the health organization, the increasing costs of care. These factors determine the consequent recourse to the assessment of health costs and benefits for patients, and finally the progressive abandonment of the physical approach to the patient, replaced by clinical investigation and by the growing use of technological tools.

Moreover, the increasingly predominant role of the economy and the costs in the current health has become more evident, transforming hospitals into "Health Authorities", in which the health of citizens is a product or rather a commodity, correlated with the payment and/or the refund by the state for hospital services. Consequently, even ethical values are continuously questioned and often subordinated to economic interests.

These changes have led, especially in recent times, to a growing level of complaints related to so-called "malpractice" cases. Claims arising either from patients' greater awareness of health care, or from a considerable increase of economic compensations established in courtrooms, led to a greater readiness by the public to appeal to jurisprudence for medical ligations.

The increase in awareness of the right to health when receiving treatment and in expectations of public health facilities has perhaps reached excessive and often unjustified levels. So that medical treatment, which does not produce the desired clinical outcome, is often interpreted by the patient as a mistake, whereas it can simply be scientifically impossible.

Currently, an increasing number of patients use internet to search for diagnoses and treatments (the "e-doctor" phenomenon) going after that to the family doctor or a specialist to confirm their results. By these dangerous behaviors, many potential patients consider internet as a substitute for the family doctor.

The most obvious consequence of this situation is that doctors are increasingly relying on defensive medicine, allowing their diagnostic and therapeutic strategies to be conditioned by "judicial caution" rather than by their scientific beliefs. This has a serious economic impact, resulting from the excessive provision of care and unnecessary recourse to tests and clinical examinations.

In addition to the doctor's fear to be dragged in a court by patients, another reason for defensive medicine increasing phenomenon is the poor organization of complex health structures, in which the reference protocols do not adequately specify roles and responsibilities.

The burden of each judicial case therefore falls on the individual doctor, who is the last link in the chain of organization of the health system. Consequently, doctors daily face with bigger problems than themselves and resort to defensive medicine, which is just an attempt to share the burden of responsibility with others.

Another consequence of the increase in claims on malpractice is the growing cost of insurance premiums, so much so that recent political proposals on medical claims go in the direction of translating in the civil right rather than criminal process. This would lead to an increase in insurance premiums, the cost of which would not be charged to the individual doctors but to the health facility in which they operate. These insurance policies would encourage risk management, adequately supported by the health service, in order to reduce unfair practices and thus keep insurance premiums to a minimum.

Risk management considers all the huge medical complex activities, undertaken to improve the quality of health care and ensure patient safety. Only a proper risk management can lead to substantial changes in clinical practice, making it more suitable to the needs of both patients and healthcare professionals (Toraldo, Vergari and Toraldo 2015).

Already in December 2001, the National Bioethics Committee (NBC), in an opinion on "Purposes, Limits and Risks of Medicine", demonstrated that medical failures are often the most visible aspects of medical practice in the wider sectors of the population. They generate collective reactions expressed and amplified by the media, with legal consequences and demands for individual damages.

The solution to these problems lies first in educating the public of potential patients. The involvement of society requires ethical communication addressed to all citizens, designed to inform them about the nature, possibilities, limits and risks of modern medicine, both in scientific than in practical terms. Adequate communications mean to provide transparent information and news, even when they are unpleasant or

disappointing. Only in a context of effective transparency is possible, according to NBC, to find solutions to legal and bioethical issues, concerning medical responsibility and of strong social relevance.
It would be essential for all the media to consider their aim to correctly inform citizens, also highlighting the differences that, in health terms, inevitably arise in the various geographical, technological and logistical contexts.

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