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FROM THE ADMINISTERED BODY TO THE SIGNIFYING BODY: BIOETHICS, BIOPOLITICS, AND THE SACRED IN THE MEDICALIZATION OF MATERNITY

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Abstract: The article proposes a reflection on the relations between bioethics, biopolitics, and the medicalization of social life, starting from the thesis that bioethics lacking biopolitical awareness remains naïve, while a biopolitics lacking ethical reflection becomes cynical. On the basis of Foucault's definitions of biopolitics (1976, 1997) and Illich's critique of social and cultural iatrogenesis (1976), the study distinguishes between the anatomo-politics of the body and the biopolitics of the population, and constructs a triple analytical grid — sociological, bioethical, and biopolitical — for contemporary phenomena of medicalization. To this grid is added Aurel Codoban's model of the body as a surface of communication (2011), read here within the horizon of an ontology of the sacred and of the communicational construction of reality: medicalization does not leave the body "neutral", but rather shifts its regime of signification, from the sacred toward the statistical and the communicational. The argument is tested through a case study devoted to the medicalization of maternity and to caesarean birth, in which both the bioethical–biopolitical tension and the ideological capture of the maternal body by pseudo-scientific "great replacement" narratives are analysed — narratives whose quasi-religious structure is critically examined. The conclusion contends that a physician trained solely in bioethics, without an understanding of the power relations traversing the medical act, risks becoming a technical executant, while a physician trained solely in biopolitical terms, without bioethical principles, risks confusing public health with social control.

Key words: biopolitics; bioethics; medicalization of social life; ontology of the sacred; body as surface of communication; relational autonomy; informed consent.

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1. Introduction: Why a Bioethics Without Biopolitics Remains Naïve

The present reflection begins from the observation that bioethics lacking biopolitical awareness remains naïve, since ethical deliberation in medicine cannot be conceived without acknowledging that medicine functions as an instrument of social control (Zola 1972, 487–488). At the same time, a biopolitics lacking bioethical reflection becomes cynical. Not every health policy is, by definition, ethical, and bioethics has the duty to evaluate health policies at least from the perspective of respect for the four principles consecrated by Tom L. Beauchamp and James F. Childress (2019): beneficence, non-maleficence, respect for autonomy, and justice.

Bioethics is, first and foremost, an ethics of the bio-technological civilization. Hippocratic medical ethics, centred on *primum non nocere*, was relatively simple, since it operated in a world in which the physician could do very little either toward curing the patient, and the most important consideration was therefore not to aggravate the patient's condition. The term "bioethics" was introduced by Fritz Jahr (1927, 2–4) and, independently, reintroduced and popularized by Van Rensselaer Potter (1970, 127; 1971); the discipline subsequently constituted itself as a branch situated at the intersection of moral philosophy, clinical medicine, medical sociology, and health law. The moment technology permits intervention upon conception, birth, the end of life, and even upon the genetic code itself, the principle "do no harm" is no longer sufficient. A more complex deliberative framework becomes necessary, one capable of responding to questions such as: what are we permitted to do among the things we are technically able to do?

To this framework — constructed below through the triple sociological–bioethical–biopolitical grid — is added a complementary perspective owed to the philosopher Aurel Codoban of Cluj. In *Imperiul comunicării* (The Empire of Communication, 2011), the author describes a deep cultural mutation — the passage from a "culture of knowledge" to a "culture of communication" — in the wake of which the body becomes an object-medium of communication, a signifying surface through which the subject enunciates his or her status, belonging, and relation to the norm. This shift permits us to understand that a medical act such as caesarean birth is not merely a procedure subjected to a protocol and to ethical deliberation, but also a bodily utterance, which a bioethics attentive to the dignity of the person must hear as such.

Codoban's model, however, opens a further stake, which we assume explicitly. If reality itself is, within the "culture of communication", a communicational construct, then the sacred does not disappear with secularization but rather changes its regime of manifestation: from a substance or a transcendence, it becomes a function of signification that

orders the relation of the subject to the norm, to his or her own body, and to the community. This hypothesis — which we may call a communicational ontology of the sacred — functions, throughout the study, as a fourth filter of reading, alongside the sociological, the bioethical, and the biopolitical, and becomes decisive in the case study devoted to maternity.

2. Biopolitics: Foucault, Agamben, Illich

Biopolitics may be defined, briefly, as power exercised over life, or as the use of medicine — and, in many situations, of threats to life — for the purposes of political control. Michel Foucault (1976) is the one who defines the term and shows that power has always sought to administer life. Whereas in the pre-modern period power controlled the life and death of each of its subjects, with modernity there emerges the idea of an indirect control over life by means of technology. Foucauldian biopower is, before anything else, a power exerted upon bodies — an ontological choice that we will develop further on.

An adequate understanding of Foucauldian biopolitics presupposes a fundamental conceptual distinction set out by the author in the lecture of 17 March 1976 at the Collège de France, published posthumously in *« Il faut défendre la société ». Cours au Collège de France (1975–1976)* (Paris, 1997). Biopower is exercised on two levels. The first is the anatomo-politics of the human body: a disciplinary power over the individual body, developed from the seventeenth century onward in barracks, schools, workshops, and hospitals (Foucault 1975). The second is the biopolitics of the population: a statistical regulation of the population as a living mass, developed from the eighteenth century onward, which targets natality, mortality, hygiene, vaccination, epidemics. The mechanism through which this biopower is exercised has subsequently been named *gouvernementalité* (Foucault 2008). In the medicalization of maternity we encounter both levels — the individual discipline applied to the gestational body (protocols, fetal monitoring) and the statistical regulation of the population through WHO targets and guidelines.

Another aspect of Foucauldian biopolitics is the biopolitics of the population through mass phenomena: the control of natality, the control of mortality, hygiene, vaccination. Here is constituted what Nikolas Rose (2007) calls the *soft* government of populations, and biocitizenship — a citizenship defined through biological parameters, through responsibility for one's own health, through participation in genetic *screenings* and prevention programmes.

Giorgio Agamben (1998) carries the reflection further, through the concept of bare life: biological life stripped of any political-juridical protection. Beginning from the analysis of the concentration camp, the central

paradigm of extreme biopolitics, Agamben draws attention to the latent tendency in contemporary democracies to intensify control over life. The concept has direct relevance for the case study: any protocol of diagnosis, triage, or treatment may slip toward forms of control that reduce the patient to bare life, in place of a citizen protected by rights codified in treaties such as the Oviedo Convention (Council of Europe 1997). The gestational body, subjected to an obstetric discipline devoid of consent, is one of the contemporary figures in which bare life becomes visible.

If Foucault analyses power, Ivan Illich (1976) analyses dependence. In *Medical Nemesis*, Illich describes social and cultural iatrogenesis alongside the clinical one, as the transformation of everyday activities into dependence upon medicine — a dependence that takes the form of a modern servitude. Maternity, old age, anxiety, frustration, the restlessness of childhood are extracted from the economy of the everyday and placed under the tutelage of an expert system that justifies its existence through the permanent extension of its competence. Read together with Foucault, Illich's critique offers the other face of biopolitics: not only the power that administers, but also the subject who loses the very competence to administer his or her own life.

3. The Relation Between Bioethics and Biopolitics

The two discourses — the bioethical and the biopolitical — do not overlap, but they intersect permanently. Bioethics asks normative questions: what is good, what is right, what do we owe the patient, what are we permitted to do among the things we can technically perform? It produces moral justifications and proposes rules of conduct. Biopolitics is concerned with who decides, in whose interest decisions are taken, and how power is exercised through medicine — it describes the relations of force that traverse bioethical questions.

A relevant example is the obligation to vaccinate medical personnel in a pandemic context. The relation between their right to autonomy and the right to public health, respectively the right to safety of citizens, is a biopolitical problem, but it also has an eminently bioethical stake. The problem of compulsory vaccination, alongside the restrictions imposed during the pandemic, is likewise of mixed nature. A control over the population is thereby configured, exercised in the name of public health, and certain conspiracy theories draw attention to the fact that such pretexts may be used to impose an extended control. These theses must not be accepted, but neither should they be rejected *ab initio*; they must be evaluated against the empirical evidence.

From these tensions arises the necessity of a triple perspective on any phenomenon of medicalization: a sociological perspective (who gains and

who loses, how symbolic power is redistributed, how the physician replaces the priest or the judge — in the original formulation, religion and justice — as authority over the body, Zola 1972); a bioethical perspective (how the four principles are articulated, what conflicts emerge between autonomy and beneficence, between autonomy and non-maleficence, between justice and any of the others); and a biopolitical perspective (what forms of power are exercised through the medical act, even when the declared aim is beneficence). To these three filters is added, in the applied portion of the study, the filter of the communicational ontology of the sacred announced in the introduction.

3.1. Two Ontologies of the Human, Two Bioethics, Two Biopolitics

The distinction between biopolitics and bioethics acquires further clarity when we relate it to the two ontologies of the human which, in modern and contemporary philosophy, have been formulated as rivals. On the one hand, an ontology of the primacy of corporeality, according to which *we are a body endowed with consciousness*; on the other, an ontology of the primacy of consciousness, according to which *we are a consciousness endowed with bodily instruments that allow it to exist as will, knowledge, and action*. The two ontologies structure in depth the manner in which a discourse conceives the body, the person, and decisions concerning life.

We treat them here as *ideal-types* in the Weberian sense — extreme theoretical models, analytically useful, which do not exhaust the actual space of positions. A whole phenomenological tradition, opened by Maurice Merleau-Ponty ([1945] 1999), refuses precisely this dichotomy and proposes a third path: the subject is *neither* a body endowed with consciousness, *nor* a consciousness endowed with a body, but rather *lived body* (*Leib*) — an ontological modality anterior to the subject/object opposition. For the purposes of the present argument, the rival ideal-types are sufficient, since it is precisely they that, in the recent history of bioethics, have produced the practical consequences we are about to examine.

Foucauldian biopolitics inscribes itself, through its very object, within the first ontology. The power described by Foucault (1976) operates upon bodies — disciplines over the individual body, regulations over the collective body of the population —, and the subject is a living being *before* being a consciousness. Codoban (2011) prolongs, in another register, the same ontological choice: the body is not the envelope of an interiority, but the surface that signifies. By contrast, contemporary bioethics inherits, through its Kantian and utilitarian lineages, a predominant orientation toward consciousness. Neither Immanuel Kant ([1785] 2007) nor John

Stuart Mill ([1863] 1994) can be reduced to an ontology of consciousness; what we here call "Kantian and utilitarian descent" designates their *canonical reception* in twentieth-century Anglo-Saxon bioethics: the principlism of Beauchamp and Childress (2019), which grounds dignity in rational autonomy, and the preferential utilitarianism of Peter Singer ([1979] 2011), which calculates utility on the basis of the preferences of subjects capable of self-consciousness. In this reception, the person is, first and foremost, a consciousness — and the body its instrument.

This separation has direct — and symmetrical — consequences. A bioethics resting on the primacy of corporeality accepts, in its radical forms, the idea that what counts morally is life itself as biological substrate; from this derives the vulnerability to biologist-nationalist drifts: the racialized pronatalism analysed below, *soft* eugenics (Sparrow 2011, 32–42) and, at the limit, the totalitarian biopolitical thought described by Agamben (1998). Conversely, a bioethics resting on the primacy of consciousness renders acceptable practices that are otherwise troubling: the argument for "after-birth abortion" (Giubilini and Minerva 2013, 261–263), derived from Singer's preferential ethics ([1979] 2011); the redefinition of death as brain death (President's Council on Bioethics 2008), the suspension of the dead-donor rule (Truog and Miller 2008, 674–675), xenotransplantation as the use of the non-human body as a reservoir (Hurst, Padilla, and Paris 2023), and the diminished moral status of patients in persistent vegetative states. In all these cases, the body, in the absence of consciousness, is treated as a substrate devoid of dignity. The paradox is that the shadows of the two ontologies are symmetrical — the primacy of corporeality risks reducing the person to the biological species, the primacy of consciousness risks reducing the body to a reservoir. A responsible bioethics holds them in tension.

4. The Medicalization of Social Life and Its Relation to Biopolitics

Medicalization is defined by Peter Conrad (2007) as the process by which non-medical problems come to be defined and treated as medical problems. This does not mean that the diseases in question do not exist — the present study does not endorse conspiracy theories of the "vaccines cause autism" type. Conrad (2005, 3–14) introduces a counter-intuitive thesis: in contemporary medicalization, physicians themselves have become secondary agents, and the principal engine has shifted to the biotechnology industry, to consumers, and to insurance systems — a sharp rupture from the Parsonian theory of the sick role (Parsons 1951). Contemporary medicalization is decentralized and commercialized: the biotechnology industry creates both treatments and the demand for them (Healy 2012); patient organizations demand the recognition of new

diagnostic categories; insurance systems condition access to services upon the existence of a diagnostic code.

The relation between medicalization and biopolitics is structural. Medicalization furnishes biopolitics with its language and its infrastructure: diagnostic classifications (DSM, ICD), protocols, statistics, registries, *screening* systems, therapeutic guidelines. Biopolitics, in turn, offers medicalization legitimacy, financing, and coercive power. Upon this common skeleton there is exercised, according to Foucault (1976), the government of populations; and upon the same skeleton there is manifested, according to Illich (1976), social and cultural iatrogenesis. Medicalization, read biopolitically, becomes a triple problem: one of redistribution of symbolic power (Zola 1972); one of actual autonomy (Beauchamp and Childress 2019) — is the patient truly free, or is he or she captive within a system of medical norms that define in advance what is normal?; and one of the *soft* governance of populations (Rose 2007), thereby diverting the religious-type governance of social fears toward the management of medicalization within a risk society.

To these is added a fourth dimension: medicalization reconfigures the very status of the body. If in the "culture of knowledge" the body was the passive object of the medical gaze, in the "culture of communication" (Codoban 2011) it becomes a signifying surface, and every medical gesture upon it becomes implicitly also an act of communication. Contemporary sociology of religion has shown that the modern process is not a unidirectional passage from the sacred to the profane, but a dynamic in which the desacralization of certain spheres coexists with the resacralization of others (Aguiluz-Ibargüen and Beriain 2025). Medicalization participates in this dynamic: in emptying the body of its traditional sacred regime, it re-saturates it with another regime of signification, statistical and communicational. Matteo Di Placido and Stefania Palmisano (2025) describe this double mechanism through the formula of the medicalization of the sacred and the sacralization of care. Far from being a "corruptible flesh", the body becomes the sign of a humanity that not merely contains but generates consciousness — that is, an inverse creation from the material toward the spiritual, within a desacralized and human-centric spiritualization. Because the body generates consciousness, the obligation of care becomes, for modern biomedicine, the equivalent of "service" (in the religious sense), and medicine therefore assumes the valences of religion and raises them to the rank of a quasi-religious, non-spiritual register (and not an anti-spiritual one). "We want hospitals, not cathedrals!" — a phrase used by the critics of the construction of the National Cathedral in Bucharest — transmits the message that the hospital becomes a temple of the resacralization of corporeality within the medicalized society. We may glimpse that, simultaneously with the medicalization of social life,

there also emerges an epiphenomenon of medicalization of religiosity, but also of *soteriological ritualization* of the medical act, in which the clinical procedure functions as a rite of *mutual salvation* — for the patient, as access to salvation-as-healing; for the physician, as the exercise of a quasi-priestly vocation.

Moreover, the idea may be inscribed in the wake of what Di Placido and Palmisano (2025) call the "sacralization of care", with a refinement we propose here: the medical act is not merely invested with diffuse sacrality, but is *soteriologically ritualized* — transformed into a rite of mutual salvation, in which the patient seeks salvation-as-healing while the physician exercises a quasi-priestly vocation.

5. Three Frontiers of Contemporary Biopolitics

The logic of medicalization described above is exercised today on a great number of levels: compulsory vaccination, *human enhancement*, assisted reproduction, the medicalization of sexuality and ageing, genetic editing, the medicalization of obesity, the bio-economy of health policies. Some of these have been analysed in the specialized literature (Conrad 2007; Rose 2007; Healy 2012; Greely 2019). The present study does not aim at an inventory but selects three frontiers that serve as steps in the demonstration of the double thesis announced in the introduction — a naïve bioethics generates a cynical biopolitics — which we shall subsequently sustain through the case study devoted to the medicalization of maternity.

5.1. Compulsory Vaccination: The Limit of Autonomy

Compulsory vaccination is the clearest example of the manner in which a public-health stake becomes, simultaneously, a bioethical and a biopolitical one. It is justified through herd immunity, yet generates a discrepancy between the right to autonomy — including the right to refuse vaccination on an informed basis — and the individual's responsibility toward the community, a discrepancy that is sharpened in the case of compulsory vaccination of medical personnel. This first case shows that a bioethics that would treat autonomy as an absolute, without seeing the relation of forces between individual and population, would remain naïve — incapable of thinking the actual situation in which the principles of Beauchamp and Childress (2019) come into conflict with one another.

5.2. Mental Health and the DSM: The Pathologization of the Normal

Mental health offers a canonical illustration of medicalization. The

introduction into the DSM (American Psychiatric Association 2022) of new categories causes aspects formerly treated as the restlessness of a child to be classified today as ADHD. The actual existence of ADHD is not in question; what calls for analysis is the passage toward the pathological of certain borderline conditions — a process that, on the one hand, avoids the "naughty child" type of stigmatization, but on the other may provide a convenient justification for questionable parenting practices. Belonging to the same category are shyness reinterpreted as social anxiety disorder, as well as the anxiety and frustration associated with the pandemic (Sandu 2021). This case displays the reverse side: a biopolitics of mental health that incessantly extends the area of diagnosis, without a bioethical reflection upon the threshold between the normal and the pathological, becomes cynical. It must be mentioned, in this regard, the alternative to medicalization — for instance, a de-medicalization through philosophical practices, or, to quote the philosopher Lou Marinoff, *Plato, Not Prozac!* (1999).

5.3. The Biopolitics of the End of Life: Who Decides Death

The end of life is the ultimate frontier of biopolitics. Here the question is posed under what conditions power may intersect the autonomy of the individual who, freely, desires his or her own end, on the grounds that his or her own biomedical condition is held to be incompatible with a dignified life. Euthanasia is legalized in the Netherlands (2002), Belgium (2002), Luxembourg (2009), Spain (2021), and Canada regulates it through MAID (2016). The Belgian case, in which euthanasia was extended in 2014 to minors, raises profound bioethical problems (Dierickx et al. 2015, 1703–1706; Raus, Vanderhaegen, and Sterckx 2021, 80–107).

In the same register stand palliative care services; the insufficient number of places in Romanian palliative-care centres transforms a problem of principle into a concrete problem of distributive justice. Bioethical deliberation upon autonomy at the end of life is rendered meaningless if it ignores who effectively holds the power to define a "dignified life".

Taken together, these three frontiers show that biopolitics is not a specialized sphere of public policies, but rather the very form in which contemporary medicine exercises its authority, from conception to the end of life — and that neither bioethics nor biopolitics can be conceived in isolation without becoming, respectively, naïve and cynical. Against this background, the case study of the medicalization of maternity acquires a paradigmatic relevance.

6. Case Study: The Medicalization of Maternity and Caesarean Birth

The medicalization of maternity has been chosen as a case study because it constitutes a privileged terrain of analysis: birth is simultaneously a physiological event, a profound personal experience, a cultural ritual, and an object of biopolitical regulation. As a physiological event, it is a spontaneous biological process, yet one accompanied by an associated pathology. At the same time, maternity represents an existential experience, a profound bodily experience, and a sociological and biographical marker of identity — significations which today are undergoing transformation, as women gain access to socio-professional statuses formerly inaccessible to them.

6.1. The Real Benefits and the Symmetrical Dangers of the Medicalization of Maternity

It must be stated from the outset that the medicalization of maternity has, as a positive element, the drastic decrease in mortality at birth. In conditions in which birth is today a hospital-based medical act subjected to protocols, maternal mortality in developed states has been reduced to values on the order of a few dozen deaths per 100,000 births (World Health Organization 2019). Recent global data confirm this progress but also signal its limits: Jane Sandall et al. (2018, 1349–1357) synthesize, in the *Lancet* series, both the benefits of medically indicated caesarean and the short- and long-term risks of its excessive use — uterine rupture in subsequent pregnancies, abnormal placentation, ectopic pregnancy, premature birth.

Reflecting the tension perceived by Illich (1976), Suellen Miller et al. (2016, 2176–2177) propose, in the same *Lancet* series, a remarkable conceptual formulation: contemporary maternal care oscillates between *too little, too late* (insufficient resources, avoidable deaths) and *too much, too soon* (the routine over-medicalization of physiological pregnancy and birth). This is the quantitative translation of Illichian iatrogenesis. To this phenomenon is added the concept of *obstetric violence*, defined by Michelle Sadler et al. (2016, 47–55) as the expression of a structural violence that includes excessive rates of intervention, care lacking consent, and disrespectful treatment of the parturient. In Agamben's (1998) terms, obstetric violence is the moment in which the gestational body, stripped of the protection of consent, slips toward the status of bare life.

We must mention here a tendency toward the desacralization of maternity — and not only its medicalization — not merely through phenomena such as the increase in caesarean births, which may be interpreted as a counterpart to virginal maternity — particularly in the context of certain

assisted reproduction techniques.

Caesarean birth may function as a secularized reply to the model of virginal birth — without pain, without rupture — inverting the sacramental regime which, paradoxically, historically imposed the caesarean (O'Brien 2023), precisely so that no product of conception should die un-baptized or un-christened. In this sense, we return to our reference to Professor Codoban's work concerning corporeality as sign, showing that even the action upon corporeality through surgical techniques and the medicalization of maternity figures as a signifying process for a desacralization that no longer produces a return to a reconstructed sacred, but rather grounds its "transcendence" in the search for the quality of worldly life, and not in an anchoring in the transcendent.

6.2. Caesarean on Request: A Triple Bioethical Problem

On the basis of data from 169 countries, covering 98.4% of global births, Ties Boerma et al. (2018, 1341–1343) estimate that, in 2015, 21.1% of births worldwide took place by caesarean — almost double the proportion of 2000; the figures vary dramatically, however, from 4.1% in West and Central Africa to 44.3% in Latin America and the Caribbean. Ana Pilar Betrán et al. (2021) project that by 2030 the global caesarean rate will reach approximately 28.5%. The WHO recommendation has constantly been 10–15% for medically indicated cases (World Health Organization 2018), a proportion significantly exceeded in developed societies. The caesarean is also performed because birth can be scheduled, with less pain, under reduced stress, and in a hospital setting.

A triple bioethical problem thereby emerges, which Tore Nilstun et al. (2008) analyse explicitly from a principlist perspective. In the register of public health and biopolitics, the medically non-indicated caesarean is a surgical procedure with real risks (Sandall et al. 2018) and major costs for the system; restricting it would respect the principle of distributive justice, and the woman's request cannot be considered purely autonomous, since it is shaped by a medical culture that represents natural birth as risky. In the bioethical register centred on autonomy, the woman's right to decide concerning her own body entails the recognition of caesarean on request as a possible choice, especially in the presence of prior traumas. And in the register of social justice, restrictions deepen inequalities, since access to caesarean on request remains available in the private system (Nilstun et al. 2008).

This tension cannot be correctly conceived through a monadic-Kantian concept of autonomy. Here the concept of relational autonomy intervenes (Mackenzie and Stoljar 2000; Turoldo 2010, 542–549), which Antonio Sandu grounded in his own research on informed consent (Sandu

2022, 715–733). The pregnant woman does not decide as an isolated subject, but within a network of relations — partner, family, physician, community, maternal culture. To invoke the "autonomy of the woman" without recognizing this relational interpenetration is to substitute a liberal myth for a phenomenological reality. The caesarean is, therefore, an exemplary case of bioethical–biopolitical tension: the same procedure may be read as an exercise of relational autonomy, as a biotechnological abuse, as a strategy of the medical industry, as an instrument of risk redistribution, or as an expression of cultural iatrogenesis. None of these readings exhausts the phenomenon.

6.3. The Body as a Surface of Communication Through Aurel Codoban's Lens

The three readings of the body discussed thus far — the biopolitically administered body (Foucault), the body expropriated of its own competence (Illich), and the relationally-autonomous body (Beauchamp and Childress 2019; Mackenzie and Stoljar 2000) — may be supplemented with a fourth, proposed by Aurel Codoban. In *The Empire of Communication* (2011), Codoban describes a deep cultural mutation: the passage from a "culture of knowledge" to a "culture of communication". In the culture of knowledge, the body was an object — of the gaze, of examination, the passive support of an interiority. In the culture of communication, the relation is inverted: the body becomes an object-medium of communication, an organizing centre of meaning in late modernity. The body, in Codoban's reading, "speaks": it communicates status, belonging, biographical control, relation to the norm.

This perspective clarifies an aspect that biopolitics and principlist bioethics, taken on their own, do not capture. Caesarean birth is neither merely a procedure subjected to a protocol, nor merely a decision evaluable through the four principles; it is also an utterance. The choice of mode of birth functions, in the culture of communication, as a signifying act through which the pregnant woman communicates her relation to her own body, to the programmable temporality of modern life, to a certain culture of maternity. The pseudo-scientific narratives analysed in the following section exploit precisely this communicative dimension: they do not attack a clinical fact, but rather attempt to capture the body-as-message.

Unlike Foucault, for whom the body is the object of power, in Codoban the body is the surface of signification — but the ontological stake is the same: the subject is, first and foremost, a body. We therefore retain an important nuance: the medicalization of maternity is not solely a relation of power (Foucault) or of dependence (Illich), but also a reconfiguration of

the body as bearer of meaning. This fourth reading — available in the volume *Body, Image and Relationship* (Codoban 2013) — reminds us that, when a woman decides how to give birth, she does not merely administer a clinical risk; she also enunciates something about herself. A bioethics attentive to the dignity of the person must take this utterance into account, and not only the protocol.

Codoban's model proposes an ontology of the body as *signifying surface* — the body as an object-medium of communication. Pursued consistently, this ontology risks emptying the body of any sacred dimension anterior to communication, since, in the "culture of communication", the meaning of the body no longer precedes the act of signification but is *produced* by it.

6.4. The Body Between the Sacred and the Protocol: A Reading Within the Horizon of an Ontology of the Sacred

If we accept the reconfiguration of the body as signifying surface, as described by the philosopher Aurel Codoban, this raises a question that the study of religions is better positioned to address than principlist bioethics: what regime of meaning does medicalization put in place when it transforms the body into the object of the protocol? The answer cannot be "none". Before becoming the object of the medical gaze, the body — and in particular the maternal body — was, in most religious traditions, the locus of an ultimate meaning: the body as *temple*, as a received gift, as a visible sign of a dignity that precedes any performance on the part of the subject (Frantz, Rego, and Barbas 2025, 791–797). In contemporary theological anthropology, the person does not *have* a body but *is* body — an embodied spirit whose body "speaks" a language of its own (Lee and George 2008). This anthropology refuses the common premise of the two rival ontologies presented above — the mind/body dualism inherited from Cartesian modernity —, affirming the person as an embodied unity. The position converges, under a different vocabulary, with Merleau-Ponty's phenomenology of the *lived body* ([1945] 1999). The formula of a body that speaks is the very one Codoban employs; what differs is the regime of what the body enunciates: in the religious register, the body enunciates a received dignity; in the "culture of communication", it enunciates status, control, and social insertion.

This tension is the bioethical-religious stake of the case study. On the one hand, the biopolitically administered body — subjected to monitoring, to protocol, to the obligatory position at birth — is a desacralized body, reduced to its statistical parameter. The Illichian critique of cultural iatrogenesis and the theological critique of corporeal reductionism converge here: a body treated exclusively as a technical object loses its

signification as the locus of a dignity. On the other hand, desacralization does not leave a void but is accompanied by lateral resacralizations. Di Placido and Palmisano (2025) describe a double process: a medicalization of the sacred and a sacralization of care — the "perfect" birth, the "optimized" body, longevity, receive a quasi-sacral charge. Contemporary maternity stands at the intersection of these processes: emptied of its traditional sacred regime, it is re-saturated either with a communicational regime (Codoban's body-as-message) or with a substitutive and ideologized sacred regime.

A bioethics adapted to the space of religious studies cannot treat the relation between corporeality and religion as a pre-modern residue. In the contemporary world, this relation is active precisely in the form of a dispute over the regime of meaning of the body: who has the right to say what a body "enunciates"? The medical system, through protocol? The subject, through relational autonomy? The religious tradition, through the category of received dignity? Or the ideological apparatuses? A communicational ontology of reality does not resolve the dispute, but renders it visible: the medical "fact" of a birth is never merely a fact, but always also a communicationally constructed meaning — and bioethics has the duty to discern between the regimes of meaning that respect the dignity of the person and those that instrumentalize it.

6.5. A Recent Magisterial Confirmation and an Ontological Tension: The Encyclical *Magnifica Humanitas*

The central thesis — that a bioethics lacking biopolitical awareness remains naïve, while a biopolitics lacking bioethical reflection becomes cynical — receives an unexpected confirmation in a recent magisterial document. In the encyclical *Magnifica Humanitas* (15 May 2026), His Holiness Pope Leo XIV articulates a critique of the "technocratic paradigm" which, although formulated in a theological register, overlaps surprisingly closely with the Foucauldian grid maintained here. His Holiness explicitly denounces the fact that "colonialism no longer dominates only bodies, but appropriates data", while "genetic maps and demographic information" become "the new rare earths of power" (Leo XIV 2026, §178) — a description that prolongs into the twenty-first century both the biopolitics of the population (Foucault 1976) and biocitizenship (Rose 2007). The same direction is taken by the identification of the "technocratic and post-humanist mentality" that treats the person as "an object to be manipulated or a resource to be optimized" (§172).

There is, however, an ontological tension which intellectual honesty obliges us to name. The encyclical grounds its argument upon a substantialist conception of dignity — "infinite", "inalienable", "neither

acquired nor earned" (§§52–53), echoing *Dignitas Infinita* (Dicastery for the Doctrine of the Faith 2024) — which enters into tension with the relational autonomy defended in the present article (Mackenzie and Stoljar 2000) and with the communicational model of the body proposed by Codoban (2011). We observe, as a personal reflection, that dignity — although deriving, in the Christian vision, from the understanding of the human being as *image and likeness* of the Divinity — is, in its current form, a component of the human condition *post-fall*: it derives from the knowledge of Good and Evil and manifests itself as autonomy, responsibility, and belonging to humanity. Before the fall, dignity was purely existential, owing to the situation of the human being in the neighbourhood and likeness of God. The most consistent convergence with the encyclical concerns the critique of disembodied transhumanism (§232), while the divergence concerns the ultimate foundation of dignity — without, however, this annulling the practical convergence in the diagnosis of contemporary biopolitical power.

7. Fake News, the Instrumentalization of Maternity, and White Supremacy Narratives

Onto the terrain of the medicalization of birth, there grafts a series of pseudo-scientific narratives that are at once dangerous and instructive for bioethical reflection. They issue, for the most part, from the ideological zone of the *White Supremacy* current and instrumentalize maternity as a terrain of racial conflict.

We do not intend to make a moral or axiological judgment concerning far-right biopolitical visions, nor do we intend to scientifically validate or invalidate the claims of the Great Replacement theory. What can be attested is a decline in the birth rate in technologically advanced societies, at least apparently similar across white and yellow populations (without wishing, in any way whatsoever, to touch upon any nuance of racism, but geopolitical localization is not sufficient in this context to permit the use of terms such as "European" or "Asian," "Caucasian" or "Mongoloid"). The cultural criteria and the appetite for individualism of modern society are more probable causes of demographic decline than a hidden agenda of racial replacement.

These narratives are facets of a coherent ideological apparatus — *the great replacement*, the conspiratorial theory of the substitution of white populations through immigration and differential natality, formulated by Renaud Camus (2011) and subsequently amplified in the digital space of the *alt-right* (Stern 2019). Sarah Bracke and Luis Manuel Hernández Aguilar (2020, 680–701) show how this discourse reactivates a biopolitical framework in which demography becomes the pretext for an appeal to eugenic

policies, and the maternity of white women is reconstructed as a patriotic and racial obligation. This "obligation" is wrapped in Christian religious language specific to certain neo-Christian cults that favour White Supremacy.

In the spirit of this pseudo-scientific theory, it might be claimed that caesarean birth would weaken the reproductive capacity of women, thus limiting the natality of the white population. A second claim is that caesarean birth would deprive the newborn of the maternal microbiome, leading to immunological degeneration. The study by Maria Gloria Dominguez-Bello et al. (2016, 250–253) confirms that infants delivered by caesarean acquire a different microbiome and that this difference has been associated with slightly elevated risks for immunological and metabolic disorders. What is not, however, documented is either firm causality, nor any racial differentiation. We therefore have a rhetorical operation through which a real and racially undifferentiated statistical association is over-saturated with a speculative consequence, framed within the logic of the "great replacement".

The third claim is that the increased caesarean rates in the West would represent evidence that medicine is "selectively attacking" the fertility of the European population. This thesis is likewise unsupported: as Boerma et al. (2018) show, the caesarean rate is 4.1% in West and Central Africa, compared to 44.3% in Latin America — differences explained by inequalities of access and by cultural models, not by an "occult strategy" against any race.

The fourth claim, perhaps the most sophisticated, is that the medicalization of birth would form part of a project of "affirmative domestication" of white women: the *trad wife* narrative, according to which the woman loses her role of traditional maternity, becomes docile, placed under the tutelage of an expert system that confiscates her femininity. Alexandra Minna Stern (2019) shows how precisely this narrative is functioning as an ideological interface between the pronatalism of the *alt-right* and contemporary forms of online misogyny. To reduce this complexity to an "anti-white-race" conspiracy is to confuse aggregation with intention.

What must be emphasized is that the "great replacement" narrative is not only racial and biopolitical, but also has a quasi-religious structure. The ideological apparatus sacralizes the maternity of the white woman, transforming it from biographical experience into sacred vocation, while differential natality is converted from a statistical parameter into a duty of eschatological resonance. The *trad wife* current is the clearest expression of this sacralization: religious affiliation is constitutive, and the radical forms exploit the religious register for recruitment (Sykes and Hopner 2024).

This biopolitical apparatus finds a contemporary cultural expression in the tradwife subculture, a community of influencers who promote online a traditionalist domestic femininity. Sophia Sykes and Veronica Hopner (2024, 453–487) distinguish, within it, a spectrum ranging from a conservative variant to an explicitly *alt-right* one, articulated around white supremacy, hetero-patriarchy, and nationalism. In its radical segment, the phenomenon fuses with Christian nationalism: through the reactivation of "purity culture", the sexual purity of the white woman is re-signified as racial purity, and the integrity of her body becomes analogous to the integrity of "the body of the nation" (Moslener 2025).

Samuel Perry and colleagues (2022, 995–1017) document the manner in which nationalist pronatalism articulates itself with Christian nationalism, transforming fertility into a marker of sacral belonging. We are dealing with an ideological resacralization of the maternal body — the "from the secular to the religious" process described by the sociology of religion as a modern form of sacralization (Aguiluz-Ibargüen and Beriain 2025). Codoban's body-as-message is, here, captured: its utterance is no longer left to the subject, but is rewritten as a statement about race, order, and the sacred.

Medicalization is correlated with the pathologization of normal conditions, and the resulting diagnosis can be sometimes stigmatizing, sometimes beneficial. Any biomedical phenomenon is "parasitized" by narratives that superimpose upon it a malicious intentionality absent in reality. The duty of bioethics is neither to reject *ab initio* these narratives, nor to accept them, but to examine them with the instruments of empirical evidence. A bioethics that rejects without examination risks becoming dogmatic; one that accepts without examination risks becoming complicit. The racial narratives that parasitize the debate over the caesarean are in fact biopolitical operations through which a medical fact is transformed into an instrument of political mobilization, invested with the authority of a substitutive sacred (Bracke and Hernández Aguilar 2020); and bioethics cannot remain neutral in the face of this capture without infringing upon its own principles.

8. Conclusions

The present reflection has set out from a double thesis: a bioethics lacking biopolitical awareness remains naïve, while a biopolitics lacking bioethical reflection becomes cynical. Reading Foucault (1976, 1997) and Illich (1976) together, the study has shown that biopolitics is not only a theory of power but also a theory of dependence; that it operates simultaneously at the level of the anatomo-politics of the individual body and the biopolitics of the population; that the medicalization of social life,

described by Conrad (2005, 2007) and Zola (1972), is the concrete infrastructure of contemporary biopolitics; and that any medical phenomenon must be read simultaneously through three filters: the sociological, the bioethical, and the biopolitical. An apparently banal medical act — the signing of a consent form, the prescription of an antidepressant, the scheduling of a caesarean — is, simultaneously, a clinical, an ethical, and a biopolitical decision.

The case study of the medicalization of maternity has concentrated this stratification. The caesarean is, all at once, a public-health benefit (Sandall et al. 2018), an expression of the continuum *too little, too late / too much, too soon* (Miller et al. 2016), a possible form of structural obstetric violence (Sadler et al. 2016), a tension between relational autonomy and distributive justice (Mackenzie and Stoljar 2000; Sandu 2022), a bodily utterance (Codoban 2011), and a terrain of "great replacement" narratives (Bracke and Hernández Aguilar 2020; Stern 2019). Medicalization does not simply desacralize the maternal body, but rather shifts its regime of signification — from the sacred as received dignity toward a communicational regime, and at times toward a substitutive, ideologized sacred. There is no raw medical "fact" anterior to any meaning; there are only bodies that enunciate and regimes of meaning that contest the right to articulate that utterance.

We thus observe a semiotic dyad between the tendency to treat corporeality—the cesarean section, in our case study—on the one hand as an expression of one's own autonomy and of the right of disposal over one's own body, a perspective indebted to the bioethical vision of respect for autonomy, in apparent opposition to the biopolitical vision of duty—toward the race or toward future generations, in our example.

We understand that the duality of the body—seen, on the one hand, as one's own possession and, on the other, as an instrument of social control—is resolved in a Hegelian manner, through the understanding of the body as a semiotic instrument of the expression of the Self (whatever this means for each of us). This idea of the body as a semiotic instrument calls to mind the notion of the social construction of corporeality, which renders the communicating body precisely the third term of the semiotic triad of corporeality. The communicationally constructed body is the agent of the social construction of the medicalization of social life. In turn, medicalization becomes part of a new semiotic triad, whereby the medical act is part of the process of desacralization—through the reduction of the physician's activity from the role of transmitter of divine healing power to that of a professional within the medical sector—and, on the other hand, of the process of resacralization, through the institution of a lay priesthood in the person of the physician, in the soteriological sense discussed in the present study. As such, the medicalization of social life—the expression of

the reading of corporeality as the context for the social and communicational construction of reality—represents precisely the Hegelian synthesis of both the bioethical and the biopolitical poles.

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