Dr. Thomas Lemke:

A New Understanding of Health and Disease

In this introductory talk, I come back to the argument of a paper I wrote about a year ago on a new understanding of health and disease.[1] In my paper I did concentrate on four lines of development in medicine. When I recently reread the text I realized that there was something missing in the account I gave in my original paper. What was missing is the question: Why does health occupy such a prominent place in contemporary society? This is far from being self-evident; and I think that there is something more that health which is here at stake. So what I suggest to do now is to offer some additional perspective on the question that shall occupy us this afternoon, namely how to understand health and disease and the line that separates them today. But let me start by repeating the main lines of my original paper by distinguishing four poles – or parameters – to account for current developments in medicine: virtualization, individualization, socialization and naturalization.

The *virtualization* of medicine comprises two aspects: the quantitative expansion and the qualitative transformation of medicine. Today, medicine encroaches on areas that previously were not considered to be medically relevant. Medical research attempts, for example, to attribute dyslexia or homosexuality to presumably "sick" deviations from a "normal" genome or an "average" brain. Some time ago, the *British Medical Journal* (Vol. 324, pp. 883-885) published a list of so-called "non-diseases." The definition given for a non-disease is "a human process or problem that some have defined as a medical condition but where people may have better outcomes if the problem or process was not defined in that way." The readers of the journal put "aging" on top of the list, followed by work, boredom and bags under the eyes.

Is aging thus in need of therapy; is boredom a clinical phenomenon? Is a lack of intelligence, a lack of beauty or too many freckles of medical relevance? From sports medicine to plastic surgery, from impotence problems to shyness and failure in school, it seems that, nowadays, every lack and excess can be perceived and treated as a medical problem. As a consequence, medicine increasingly

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[1] Thomas Lemke, „Gesunde Körper – kranke Gesellschaft? Medizin im Zeitalter der Biopolitik, in: *Zeitschrift für Biopolitik*, 2. Jg., Nr. 2, 2003, S. 67-71.

encompasses traits and distinctive behavior, which previously had been external to the field of medicine.

The expansion of the concept of disease goes hand in hand with a new understanding of health. The aim of medicine changes: therapeutics that is insofar reactive as it presupposes a prior existing disease is more and more replaced by the active prevention of diseases. Medical practice focuses on the diagnosis of dispositions, susceptibilities and risks for diseases. The medical interest shifts from the treatment of concrete physical or psychological conditions to the prevention of potential diseases prior to their outbreak. Virtualization refers to the fact that healthy individuals are now labelled risk persons in need of medical surveillance; at the same time these risks do themselves occupy some kind of virtual status: they could only be made visible by complex technological means and a visualising apparatus.

This touches on the second relevant parameter – *individualization*. Individualization designates a complex ensemble of different tendencies. For one thing, individualization refers to a vision of a personalized medicine, which permits pharmacological interventions adjusted to the individual genome. Instead of working from a human “standard genome” – “the human genome” – medical research now starts from the assumption that individually variable genetic profiles are responsible for different drug effects or developments of illness.

Secondly, individualization means that current medical research, in its search for the causes of illness, focuses on the individual body. This perspective systematically ignores the physical, biological or social context of the origin of a disease. The underlying assumption is that the explanation for illness and health can be found in the human brain or genes. According to this perspective, disease cannot be blamed on harmful environmental substances and industrial contaminations, societal power relations and exploitation structures, but on the individual him- or herself. What is responsible for the disease seems to be an error in the molecular text or in the neurobiological circuits.

Finally, individualization is associated with the continual reference to self-determination, informed consent and patient autonomy in clinical practice. While these concepts were brought up in the 1970s and 1980s by the anti-medical and feminist movements to counter the scientific establishment and the paternalism of doctors, self-determination now seems to become a resource to expand and legitimize medical practice. Today, the individual free will seems to become the

determining criterion, the basis and border line for medical intervention. In general, this perspective does not take into account how this will is being socially shaped, how it is governed by normative imperatives and how it is subject to material restrictions.

Seemingly paradoxically, the trend towards individualization is being supplemented by an increasing *socialization*. The point of reference as well as the ethos of medicine is object of a transformation. Increasingly, the old Hippocratic ethics is replaced by utilitarian concepts. There is an growing acceptance of health economic calculations and cost-benefit relations in medical practice, while notions of "donation" and "solidarity" are given up in favor of "customer relations" and "contractual relations." E.g. there are debates about financial incentives and material compensations for people who voluntarily donate an organ for transplantation and medically relevant body substances can be patented and sold.

Another aspect of this trend towards a "social medicine" is the fact that genetic knowledge is no longer just relevant for the individual him/herself, but also for his/her progeny. Thus, family relationships are imbued with a new – medical – importance. What arises are concepts of "genetic responsibility" and new, hitherto unthinkable rights and claims: the right to be informed by one's relatives about alleged genetic predispositions, the right not to be born or to be born healthy.

Criteria of health and disease, life and death and the drawing of boundaries between bodies become a matter of societal conventions, political regulation and bioethical counseling. Demands for the protection of privacy and bodily integrity appear in a new light. They are no longer taken for granted, but become something relative, open to consideration and subject to interpretation and evaluation.

It is already possible to perceive the first contours of a "social responsibility" of the body. One example might be a child that has been selected by means of PGD in the US to heal the disease of its already born brother. There are two aspects to this new form of responsibility. On the one hand, if in some bodies reside the mean of well being for others, isn't is irresponsible and, in the final analysis, immoral not to consent to the transplantation of one's organs or the donation of one's body substances? On the other hand, to what extent does the access to organs presuppose certain social qualifications and proof of "responsibility," such as a responsible lifestyle, drug abstinence or social prestige?

Finally, the *naturalization* of medicine is characterized by a paradoxical tendency. On the one hand, technological options and medical innovations increase decision-

making options and individual choices by rendering problematic traditional, seemingly universal notions of “normal” and “natural”. On the other hand, this production of contingency intertwines with processes of social closure and strategies of (re-)naturalization. Medical-scientific progress is often seen to be something that follows its own internal and irreversible dynamics, a goal-oriented development that, in principle, is external to societal interventions. The frequently cited formula “what can be done, will be done” implies this inevitability of scientific-technical processes. Societal debates, economic interests and political strategies are thus rendered invisible. The expansion of contingency and new potentials for decision-making become tied up with ideas of inevitability and fate; the socialization of nature goes hand in hand with a naturalization of society.

Now, after describing these four heterogeneous and conflicting lines of development – virtualization, individualization, socialization and naturalization – let me propose to have a closer look on the social and political context in which they take place. I think that this context is necessary to understand why health in the terms that I just described occupies such a central place in contemporary societies. This was not always the case, and I think it is far from being self-evident. Again, I shall only present a very brief and inadequate sketch that hopefully proves useful for stimulating the debate even or especially if the picture remains incomplete or distorted.

My thesis is that this transformation of medicine is part of a larger social process and I invite you to analyze three aspects of this process that seem to me relevant here: Health is conceived as a matter of choice, a moral competence and a social capital.

1. Choice:

Let’s start with the conception of health as choice that marks a significant historical transformation. In the past, health has most often been assimilated to a form of unawareness. To be healthy meant to be able to live without noticing the body, without perceiving it as a source of interference with daily activities. In the well-known words of the French surgeon René Leriche, health is ‘life lived in the silence of the organs’. The negative description of health as the absense of disease is no longer accepted by now. The rather passive conception of health that is marked by a lack of reflexivity is more and more replaced by another conception that stresses an active feeling of well-being, that has been unthinkable before: Health is redefined as

wellness, it is not something that just happens but a matter that must be pursued and that could be achieved through adequate measures. Health is no longer silent, it is something to be talked and thought about, a matter of reflection and consciousness.[2] As a consequence, health is not simply missed or enjoyed like in the past, but it seems to be the object and result of choice. Health is a matter of management and control, of prudence and prevision. Notions and programs of health promotion, disease prevention or disease management imply that health is something more than a physical ability or an actual state: it is also an explicit sign of dynamics, balance, adaptability and initiative. In this light, health does not refer to subjective luck or individual misfortune, quite on the contrary, it is an objective witness for his or her ability or inability to act as a free and rational subject. But if health is reframed as a matter of choice the same is true for disease. Since autonomy and self-determination are prerequisites for health, a lack of will or an insufficient self-governance are already the first symptoms of a disease that finally resides inside the subject. As the medical sociologist Monica Greco points out, in this perspective every disease can be finally be conceived as a disease of the will, "a failure of the self to take care of itself": "The mastery of the self is thus a prerequisite for health; the lack of self-mastery, accordingly, is a 'disease' prior to the actual physical complaint, whose symptoms are detectable as behavioural, psychological and cognitive patterns".[3]
If disease is a pathology of the will, health is a propriety of the willing. This bring me to the second aspect: health as a moral competence.

2. Competence

If health is something that can be achieved by sufficiently motivated individuals, if they work hard enough on themselves, the question comes up: who is to blame, if an individual gets ill. If health is something that is the result of a "will to be well", disease seems to be the side-effect of a lacking, insufficient or misguided will. Body and health are not simple biological or medical facts but filled with ideas and values about what it means to be a good citizen and a respectable and responsible person.

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[2] Monica Greco, „Wellness", in: Bröckling, Ulrich/Krasmann, Susanne/Lemke, Thomas (eds.), *Glossar der Gegenwart*, Frankfurt am Main (forthcoming).

[3] Monica Greco, "Psychosomatic subjects and the "duty to be well": personal agency within medical rationality", in: *Economy & Society*, Vol. 22, 1993, pp. 357-372 (here: p. 361).

Again, let us note the historical difference. While in the 1960s social movements claimed health as a social right, it seems that today it is more and more becoming a moral obligation. The unhealthy are explicitly or implicitly confronted with the intriguing question why they became ill: Did they eat the right food? Did they do the recommended exercises? Did they smoke or consume alcohol? In this perspective, health signifies the product of a right life-style and a correct decision making. A health that is chosen rewards those that achieve it. Those who choose health belong, by doing so, to the ones that are chosen. Today, health symbolizes a "secular state of grace".[4] As an observer remarks: „In many ways the Church has been replaced by the gymnasium as the edifice which represents the kind of moral perfection that individuals are encouraged to aspire to in contemporary times".[5]

It follows, that health is not only the product of a successful and prudent behaviour, it is also a symbolic resource to distinguish healthy from unhealthy, responsible from irresponsible bodies. The pursuit of health is an arena for the display of responsibility and self-discipline. In this light, the ill are not only ill, they are also morally questionable, since they are a visible manifestation of a form of irrationality.

To be and to stay in good health is important in a double sense. Firstly in strictly material terms, disease – apart from being a physical or psychic harm and burden – is also a financial risk. This is especially true in a time in which social expenditures are cut down by the dismantling of the welfare state. But health is secondly important in symbolic terms, since health signifies a central attitude towards oneself and others, the pursuit of health displays a moral capacity, it establishes social borderlines by defining acceptable life-styles. And the symbolic dimension may have quite material consequences. For example, in many enterprises it is regarded as a job qualification not to smoke, to care for one's health, to engage in fitness practices etc.

This brings me to my last point: Health is also a social capital.

3. Capital

Speaking of health as a capital, let me first stress the economic impact of the health sector. For example, the US health sector has more than tripled in size over the last

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[4] Howard M. Leichter, "Lifestyle Correctness and the New Secular Morality", in: Brandt, Allan M./Rozin, Paul (eds.), *Morality and Health*, London und New York, 1997, pp. 359-378.

[5] R. Galvin, "Disturbing Notions of Chronic Illness and Individual Responsibility: Towards a Genealogy of Morals", in: *Health*, Vol 6, 2002, pp.107-137 (here: p. 129).

50 years from 4 percent to 13 percent of the Gross National Product (GNP), and it is anticipated to exceed 20 percent by 2040.[6] Similar trends are visible in other industrialized countries. Again, this development is not covered by the quantitative dimension alone. There is also a qualitative transformation to be noted. Today, medical services are more and more understood as products and patients are viewed as consumers of these products. In this perspective, health is a question of money and investment. It depends on how much one is willing or capable to pay.

I think we have to link the increasing economic significance of the medical sector to something that we might call the dissolution of what was traditionally understood as "the social". The retreat to a purely personal preoccupation with the body and its health is the result of a crisis of the collective body. The failure of the social revolutionary projects of the 1960s and 1970s together with the economic crisis that began in the 1970s led many people to rely on themselves. Strategies of individual self-improvement replaced visions of social progress. Dominated by anonymous political forces and economic interests, individuals affirmed their power on something that they obviously could control: their bodies. Rising unemployment and the competition for social positions, the dequalification of traditional professional activities and the imperative of flexibility and mobility increased social insecurities and personal anxieties. This was met by efforts on the side of the individuals to strengthen bodily power, to build up resistances and to improve personal fitness and endurance.

In contemporary society, disease as a loss of control and a display of dependency is may be more a problem than ever. As this society permanently calls for autonomy, sovereignty and self-reliance, disease becomes the other side, the dark side of this vision of a rational, autonomous and independent subjectivity. Since there is no outside and no other side of this autonomy, even dependency is conceived as a result of an autonomous choice (or the failure of choice). The unhealthy are not only a problem in medical or financial terms; by their very existence they negate the technological vision of a society without disease.

But since health is no longer a state but a process without end, disease is everywhere. The more individuals get healthier compared to the past, the more they are preoccupied with the possibility of disease. Always confronted with the unhealthy other, the healthy person is assured and anxious at the same time. While assured

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[6] Adele E. Clarke. et al., "Biomedicalization: Technoscientific Transformations of Health, Illness, and US Biomedicine", in: *American Sociological Review*, Vol. 68, 2003, pp. 161-194 (here: p. 163).

not to be one of them, he or she knows that this is only true for the moment, since health risks and dangers are hiding everywhere and discipline and prudence are necessary at all times to stay healthy in order not to become one of them: those who failed.

Let me conclude on this point. My intention was to outline some important lines of development and transformation in the medical system and medical thinking. At the same time I wanted to stress that there is more at stake than health or questions of health and disease. My purpose was to draw your attention to the moral and symbolic dimensions of health while I deliberately concentrated on some discomforting and troubling social implications of these transformations. My account is certainly insufficient or may even be regarded one-sided in some respect but as I said before: My hope is that even in its partiality is may provide some good ground for further debate. So I’d like to thank you for your attention and invite you to comment and criticize my account.