Original article

Health and disease as normative concepts

Dirk Lanzerath[a]

a Deutsches Referenzzentrum für Ethik in den Biowissenschaften Bonn

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«Health» and «Disease» may be grasped in terms of basic categories of human existence – as practical terms both in day-to-day dealings as well as in existential concepts of living which exercise an elementary influence on our individual and our social intra-activity and interactivity. The relationship between doctors and patients provides an inferential platform for this normative dimension of these concepts. This background leads to the assumption that disease and health cannot exhaustively be accommodated within the scope of a theoretical, scientific description of certain natural states. Rather, the normative factor of disease and of the physician-patient relationship amplifies the concept of disease in such a way that it uniquely specifies, legitimises and circumscribes medical activities – against models which are driven by market and look at patients merely as clients and consumers. In contrast to a purely technicistical attitude, the physician helps the patient towards a better understanding of his experience of illness. Such a practical concept of disease can help to ensure that medicine remains accountable, the relationship of confidence between the physician and the patient is stabilised and the innovative possibilities of modern biomedical research in terms of diagnosis and therapy can be exploited without the associated risks escalating, without medicine degenerating to become mere ‹anthropotechnology› and medical technology becoming a mere comparison of the consequences of different technological solutions.

Keywords: health, disease, enhancement, physician-patient-relationship, medicalisation

Introduction

Medicine, *science* and *society* are currently undergoing a structural change which, amongst many other things, includes a reappraisal of the concepts of ‹disease› and ‹health›, as well as the aims of medical treatment. *Medicine* is increasingly no longer seen as a practical science oriented towards given objectives, but rather as an applied natural science without specifically defined goals. The predominant paradigms of the *sciences* are, from a methodological point of view, of a natural scientific nature with a bias towards a scientistic approach to nature. This induces a close linking between theory and application, which is almost indiscernible. *Society* is influenced to a significant extent by empirical scientific explanatory models and economically motivated decision-making processes which lead to a poorly reflected pragmatic paradigm of acts and explanations of the world.

The purpose of the present paper is to shed light on the consequences of this structural change for physician-patient relationships and to illustrate the benefits of avoiding an exaggerated limitation of our understanding of ‹disease› and ‹health› confined to a scientistic description of organic dysfunctionality or functionality as the case may be. Instead, they may be grasped in terms of basic categories of human existence – as practical terms both in day-to-day dealings as well as in existential concepts of living which exercise an elementary influence on our individual and our social intra-activity and interactivity.

‹Disease› and ‹Health› as states of contingent human existence

Diseases as natural states between description and evaluation

Current specialist literature is characterised mainly by two different interpretative approaches to our understanding of disease and health: a naturalistic one and a conventionalist one.

a) The naturalistic approach

In the nascent period of scientific medicine, recourse to nature represented an important step towards excluding the realms of magic or charlatanism, so that correct diagnosis and prognosis became possible, and with them the likelihood of adequate therapy. To this day, medical practice invokes natural scientific methods and biomedical techniques to obtain data concerning a patient's nature with the aim of drawing up a diagnosis and then adopting therapeutic or palliative measures as the case may be. This poses the fundamental question as to whether disease and health are states which can be ‹read off› a person's current natural disposition and then used to document the organism's functionality or dysfunctionality. In keeping with such a view, ‹illness› is considered to be a purely *natural scientific and theoretical* concept. [1, 2] When an organism is no longer able to react adequately to environmental conditions, it becomes *dysfunctional*, i.e. ‹ill›. This applies equally to nonhuman organisms.

With regard to the term ‹disease›, such a naturalistic perspective suggests that natural scientific methods provide an objective means of grasping the phenomenon for which it stands. On this basis the observer is in a position to perform an exact evaluation as to whether not only cancer or diabetes, but also for instance homosexuality, nicotine and heroin addiction, perhaps even criminal behaviour, etc., are to be seen in terms of biological dysfunction or not. This is exemplified by the current debate in child and adolescent psychiatric circles as to whether an attention deficit hyperactivity dis-

order (ADHD) is truly to be classified as a disease or rather as a social phenomenon arising from deficits in the domestic environment or western education systems – and therefore requires social rather than medical solutions. [3,4] If illnesses were conditions essentially susceptible to scientific investigation and reliably to be associated with the corresponding natural concepts, then they could be classified as being either ‹pathological› or ‹not pathological› through implementation of the appropriate scientific methods. It is not the present intention to shed any doubt upon the possibility, in principle, of investigating diseases with the aid of natural scientific methods. However, there are good reasons to support the assumption that the concept of disease cannot exhaustively be accommodated within the scope of a theoretical, scientific description of certain natural states. The following pages provide corroboration of this view.

b) The conventionalist approach

The opposing approach [5, 6, 7] is based on the assumption that nature is not able to set standards or norms – but that just this is implicit in the terms ‹disease› and ‹health›, terms which are subject to *implicit value judgements* which can only be grasped within a specific sociocultural context: ‹disease› and ‹health› are seen as reflecting our negative or positive evaluations of physical or psychological states and are thus themselves the constitutive factor determining disease or health. If one were to pursue this thought further, then it could prove to imply that sociocultural paradigms represent the only constitutive characteristic of illness. This, in turn, would mean that the concept of disease represents no more than a certain convention within the social fabric.

The concept of disease as being a matter of sociocultural value judgement may be challenged on the basis that, in view of the diversity of diseases, cultural aspects are at most of peripheral importance; in general a broad consensus is to be expected in respect of the evaluation of most diseases. Those who maintain that the concept of disease is exclusively a question of value judgement interpret this basic agreement such that it by no means provides evidence for the lack of such normative judgements, but that, on the contrary, it can be accounted for by the existence of widely accepted conventions and norms. [8] Naturalistic interpretations, on the other hand, work on the assumption that such concurrency is intrinsic to the human species, so that diseases can be ‹read off› as biological dysfunctionalities in the human constitution.

It goes without saying that in respect of the concept of disease, the references to nature and value judgement are axiomatic. However, their relationship to one another remains to be clarified. Such clarification need not necessarily be bound to a decision in favour of a naturalistic view, which sees diseases as being phenomena that can be objectively ‹read off› natural circumstances, nor of a view based on *axiological relativism* or *conventionalism*, in which the concept of disease is assigned to conditions according to arbitrary value patterns or pure convention [9].

The experience of disease and health: The elements of self-interpretation

The opinion presented in this paper as to the way concepts of disease and health function is to be approached initially via the patient's own experience and via the physician-patient relationship.

The assessment of a condition as constituting a disease in the context of an individual's mode of living may – according to the severity of the disease – confront the person concerned with questions as to the *meaning* of his or her existence. Such a confrontation is involved with the contingency of that person's own way of life, and even within the negative context of the illness it may prove to be of positive value. The loss of control over one's own body, parts of it or indeed one's entire existential situation which frequently accompanies the experience of illness often gives rise to a sense of complete insecurity in respect of the present and the future. Jean Améry describes the associated «expectation of assistance» and «certainty of assistance» as being one of the «fundamental human experiences» [10]. Precisely this basic sense of insecurity and helplessness, which can develop into a state of existential *Angst* (Heidegger) [11], renders the patient incapable of regaining command of his or her situation. The dependency of assistance results in a need for a specific social and hermeneutic interaction. Thus the point of view of *the other* (Sartre) [12] is an important factor in respect of the evaluation of one's own condition of illness. A person is healthy if, with or without deficits to his corporeality that are evident or perceptible to him, with or without the assistance of others, he finds, develops and maintains balances which provide him with the basis for an existence oriented towards the fulfilment of his personal dispositions and concept of life, as well as the achievement of life aims to the extent that he can say: *my* life, *my* disease, *my* death [13].

Perhaps more than any other condition, being ill reveals to us the simultaneity of identity and nonidentity with one's body and corporeality: If I fall ill, my body becomes foreign to me; it is *my body* that makes me ill, but at the same time *I* am the one who is ill and who cannot simply become separated from my infirm body because *I am* my body. At the same time a human being is his body only in respect of *embodiment*, i.e. when the person engages in speech, religion, laughing, crying etc. [14] The corporeal aspect *is* never fully accomplished, but is rather in a permanent state of renewal or *materialisation*, i.e. the anthropological process of *embodiment (Verkörperung)*. If we are only able to grasp this relationship between man and his body and corporeality in linguistic, cultural and social acts when we interpret him as a person, namely as an ‹I› which forms an indivisible *unity of self and body*, and yet has a correspondence with both, then this aspect of the

conditio humana gives an explanation for the corresponding relationship between a person and a person's state of health or illness. They cannot be described just as biological functions or dysfunctions. Rather the person-body-interlacing illuminates in a symbolic and existential modus that the process of embodiment is always – explicitly or implicitly – accompanied by an awareness of its anthropological counter-possibility: *disembodiment* [15]. As disembodiment is a part of embodiment, so do illness and death belong to life.

As a counterpart to the concepts of disease and illness, which so effectively reminds us of our body's existence, there is the concept of health. Health is a condition which frequently remains foreign to our conscious awareness; we simply overlook it. Being healthy means being freed from limitations and problems which could induce us to engage in self-reflective activity. Thus Gadamer [16] refers to the «*hiddenness of health*», and Leder [17] to health as a «*tacit background*». A healthy person can plan his work, his leisure and his social activities with considerable autonomy. Generally, individual intentions can be fulfilled. For an ill person this is only possible to a limited degree. «The state of health, bodily and psychic, that allows for such engagements usually remains the tacit background. […] To be healthy is to be in a state of relatively unproblematic wholeness» [18]. The absence of this experience always remains implicit in our daily lives. This represents the ambient status for that which Maurice Merleau-Ponty [19], following Edmund Husserl, refers to as the «physical ‹I can›». When it is healthy, I do not need to give consideration to my body – I am not even aware of it. My healthy body is my «calm and loyal servant», and there is no need to spend more time thinking about it than about my own mortality. It also releases me from the necessity to engage fully with the world outside my frame and is associated with a loss of a sense of contingency. Only when illness befalls us are we reminded of the insecurity of the world of which we are a part [20]. When we generally work towards a future life in accordance with self-determined goals [21], a current illness makes us feel that the way to the future is blocked. Illness can keep us nailed down to the here and now. Such a spatial and temporal disintegration also affects our relationship with others. When healthy, we are integrated in the activities and experiences of those around us. But even just a period of pain may have the effect of putting distance between ourselves and others, for that special experience cannot, initially, be shared by another: The person affected – depending on psychological states, social relationships and the kind of disease – may not find the words to express it, for the capacity to ‹co-suffer› is limited. In such a situation the motivation to socialise may be lacking; we rather have a need to hide which we express thus: «I don't want you to see me in this state.» Those who are healthy tend to avoid the world of the ill, because such a confrontation carries with it a reminder of one's own contingency, vulnerability and mortality. For illness brings our «advance towards death» («Vorlaufen zum Tode») to the forefront of our consciousness [22] thereby preventing us from being able to forget our finiteness. Therefore, in this quite positive respect illness is constitutive for the *world* of humans and their existence [23]. That which is present as sympathy, i.e. the human capacity to share suffering among beings of the same kind, and which articulates itself in a desire to listen, touch and care for, can be of great service in the alleviation of suffering and acknowledgement of the helplessness of those who are ill.

In this context, particularly serious illnesses prompt questions such as «why did it happen?», «why now?», «why me?» Suddenly, the world we have created collapses: historically, many cultures have seen disease as the punishment of God or the gods. [24] However, even in a modern society illness may motivate the individual to search his conscience and begin a search for meaning. «Illness, then, is not simply a biological event; it is also an existential transformation. One may be stripped of one's trust in the body, reliance on the future, taken-for-granted abilities, professional and social roles, even one's place in the cosmos» [25]. One's whole life may be transformed by the experience of illness, resulting in a rearrangement of the *priorities* of one's aims in life. Of course this is not always the case, and it depends on the nature of the disease, the patient's individual psychological state and his or her social environment. In respect of the experience of contingency, chronic illnesses deserve special attention, for they represent not an acute, transitory stage, but must be borne over a long period of time. This puts greater demands on the individual concerned than temporary discomforts. They put the task, which devolves upon mankind by its nature more sharply into focus.

One the one hand, the experience of health and illness shows us that health cannot simply be regarded as a condition which is the opposite of illness, but rather that the two complement each other. On the other hand, we see that the concept of disease in this context includes a curiously dialectical structure consisting simultaneously of *destructiveness* and *constructiveness*, of existential *suffering* and of existential *opportunity*.

By way of an intermediate result, we may establish that *only partial aspects both of the naturalistic as well as of the conventionalist approach can be accommodated*. For disease and health can be described in terms of individual states and experiences which affect man's ‹nature› and are bound up with the self-interpretation of the person concerned. However, access to human nature cannot be comprehended in a purely theoretical, scientific manner, but on the contrary the evaluative, practical moment is an essential part of the task. The following passages elucidate the great extent to which social aspects play a role in this interpretation of our own nature.

Health and disease: relational terms in the sociocultural complex

If one comprehends the concept of illness as being part of the process of self-interpretation, then this must include elementary social attitudes, for self-interpretation cannot take place without a social context. In this respect precisely these contingent and externally determined factors may have a decisive role to play in a patient's ‹selection› of symptoms: which ones are to be communicated to his family and physician; which are to be instrumentalised to prove ‹that there's nothing to worry about›; which are to be denied? They can also represent crucial factors which determine when, how and where a patient seeks and accepts help. Lifestyle, culture, traditions, legislation, etc. can therefore exercise considerable influence on individual interpretations of illness [26].

This social relevance is of fundamental significance not only for the disease and its interpretation, but also for the practical dimension of the concept of disease itself and its place in a health care system. The anthropological dimension of mutuality encompasses the aspect of social caring which identifies man – in classic terms – as a *zoon politikon* and finds its expression in the exercise of medicosocial responsibility within those health care systems.

Each social role within a community carries with it implicit expectations, as in the form of obligations, for instance. To take the role of the patient as *one in need of assistance* seriously means that its social efficacy is bound up with a society which accepts this role and sees in it an obligation to provide care. One of the socially biased functions of medicine is to champion this acceptance of the patient's role and to give it concrete form. Seen in this light, the healing professions are by no means ethically neutral instances within the context of social regulation and control [27, 28]. Bearing this in mind: if the physician is expected to be the advocate of patients' interests, this can only be realised in a society which provides an appropriate framework and itself takes its obligation to care for its weaker members seriously – not least because the *conditio humana* makes a potential patient out of every single one of us. At the same time medicine and its actors contributes techniques and offers to shape society, and in this sense medicine itself has normative impacts.

There is a broad basis of consent that health constitutes a fundamental asset for all members of a society. This status is amplified, as demonstrated by Nordenfeldt [29], by the tendency not only to strive for it for its own sake, but also because it represents a prerequisite for the achievement of self-determined aims in life. Only on the basis of robust health is it possible to architect a fulfilled life; on a more banal level improvements in general health increase the productivity of an economic society and thus the provision of goods for all of life's requirements. But the interpretation of «health» and «robust health» depends on ones own capacity of embodiment and the personal explanations of this specific condition. Even disabled persons may feel healthy [30]. Thus the normative function of the concept of health is already defined in that it encompasses all those physical and psychological conditions without which man does not have the capacity to be a morally active subject. And if we see the latter as being a categorical asset – the seat of self-esteem – then health, as representative of that psycho-physical equilibrium which is a prerequisite for existence as a subject, is necessarily in itself worthy of care and protection. It is not merely an instrumental asset, albeit not the highest, but one which is fundamental to human existence. As a fundamental, individual asset we see it as one of the elementary or primary assets. And to the extent that we have come not only to acknowledge the special character of this asset, but through the art of medicine have also developed effective ways of maintaining or restoring it, health has advanced to become a social asset and the subject of state-supported, i.e. of political activity. In concrete terms this means: Health care for all, reliable provision of such, fair access and an attempt to find a balance between existing individual variances can be regarded as a basic framework for a just social structure [31]. There is a need here to provide opportunities for individual physician-patient relationships and an individual medical indication [32]. Consequently, I should like to devote some attention to the significance of the physician-patient relationship in respect of the interpretation of illness and health.

The patient and the physician

However provocative the thought may appear at first, the primary judgement as to whether a person is ill or not is not made by the physician within a physician-patient relationship. On the contrary, the important thing is, at first, the opinion of the patient who seeks help from the physician. And from the patient's point of view the *perception* of the disease is not restricted to the sensory realm, but also contains a *reflective* component. The condition which is interpreted as ‹illness› is subjected to assessment in that the patient devotes his attention to it and seeks to integrate it into his concept of life. However, this individual evaluation remains on a superficial level of reflection, because the patient generally lacks the information which should accompany such a process, namely specialist medical knowledge. The patient is frequently in need of medical support even at this early stage, when he simply wishes to understand his condition. From the physician's point of view, the central professional component of an anamnesic talk between the physician and the ill person (through which the latter becomes a patient) should be an *explanatory description* of the condition involved.

It then becomes the common task of physician and patient to conduct a new evaluation of the disease, which

then provides the basis for preventative, therapeutic or palliative measures. The physician helps the patient to objectivise his self-assessment by putting the experience of ‹being ill› into perspective with the aid of pathological findings, laboratory results, etc. This in turn gives rise to subsidiary processes relating to the experience of ‹being ill›. The reduction of the person and his transformation into a set of diagnostic capacities can indeed be regarded as a necessary and desirable process, a prerequisite for that schooled thought and strictly ordered investigation which make up a medical assessment [33]. In the context of the physician-patient relationship, subjective awareness is to be raised onto another level through the generation of a pool of empirical data. In this way the concept of disease is transformed into an *operable quantity* for future medical activities. Frequently, however, the opposite happens: subjective perception is the sole basis for a judgement; the pathological or pathoanatomical findings are acknowledged only as ‹facts› – and in this sense as disease – but precisely the findings, the pathological condition or the biological dysfunction are not identical with the illness. [34] In this sense illness can be seen as the concept, which constitutes disease, when a dysfunction turns out to become a practical problem.

Such communication problems between physician and patient have manifested themselves in various forms throughout the entire history of medicine [35]. They can be attributed to the *incommensurability* which exists between the patient's world of *everyday language* and the physician's *technical language*, at first only to be comprehended within the context of this *subsystem*. However, the longer the process of communication between the physician and the patient continues, the more the patient is rendered capable of interpreting his illness with the help of medical terminology. The necessary interpretation of the pathological findings which the physician undertakes on the basis of current medical scientific knowledge must be translated into the everyday interpretation of the dysfunction experienced by the patient, so that the latter can begin to comprehend the illness as *his illness*. For Gadamer [36], the purpose of the talk between the physician and the patient is to ‹humanise› the relationship between two «fundamentally differing» levels. The patient is dependent on an expert interpretation of the empirically available findings. The communication between the physician and the patient must serve to improve the latter's understanding of his disease. For both, the aim is to achieve a productive ‹*meeting of the horizons*› [37, 38]. However, this does not mean that the patient should or wishes to obtain a scientific explanation of his physical symptoms, but rather to come to an understanding of *his* personal situation which is the context of *his* illness. The process of communication expresses the significance of the illness within the patient's own specific biographical situation [39].

Successful communication between the physician and the patient is dependent not only on the skill of the physician, but on the patient's efforts as well. For without a will to recover on the part of the latter the physician's endeavours will be of little avail [40]. In this way *practical communication* between the physician and the patient leads to the development of a *practical concept of disease*, in other words a *practical concept of action* which is associated with expectations on the part of both participants. The dialogue is characterised by mutual answerability and solidarity. Thus active engagement *with* the other person and *treatment of* the person are not only connected with physical action, but already commence with the *words exchanged* in a face-to-face relationship [41]. This latter includes not only confidential treatment of all the data involved and the physician's professional discretion, but a fundamental trust which can only be ensured within a framework of carefully defined medical aims.

The old and new standards of medicine: enhancement and economisation

On the basis of this brief sketch of the roles of the individual and society for an understanding of disease and health, the aim is now to address medicine as a social subsystem with a traditional orientation towards the concepts of disease and health. However, modern medicine is undergoing a fundamental structural change at present, and this has dramatic consequences for our view of disease and health as well.

Medicine has evolved to become a highly organised and highly specialised apparatus. It still remains in essence a combination of art and science, but modern developments in science and technology have allowed it greatly to extend its scope of operability – and therefore also of its responsibility, as the examples of transplant technology, in vitro fertilisation and human genetics amply underline. This has led not only to a shift in the manner in which knowledge is accumulated, but also to new dimension of capability in respect of the way in which we can intervene – for instance in individual genomes. We speak less and less of the ‹natural limits›, and nature itself becomes more and more an object, which can be investigated and manipulated.

The significance of scientific research and its technological implementation have encouraged a tendency to subsume medical activity into scientific and technical categories, with corresponding effects on the way the discipline of medicine regards itself as well as the structure of its realm of influence. Whereas science and technology can be characterised as being essentially ‹open-ended›, medical researchers have tended to adopt a goal-oriented approach to date. However, now that such clearly defined aims are no longer always available as a matter of course, the areas of activity are widening in scope and also the pressure to take deci-

sions is increasing, medical activity has entered a phase of significantly greater uncertainty.

In view of the expansion of medical capability, the traditional aims of medical activity (healing, prevention, palliation) are being supplemented or replaced. Increasingly, the focus of medical decision-making and activity is being directed towards the question of ‹medico-technological feasibility›, and medicine itself is degrading to the status of ‹anthropotechnology›. Since the Early Modern Times and in particular since the Age of Enlightenment, when nature becomes a mere object to design, the human drive to ever greater performance, to overcoming limitations, has fuelled the fantasy that human endeavour has, in principle, no boundaries. Considerations of health represent no exception to this rule, with the result that contingency and mortality – the primeval attributes of human nature – are pushed to one side. The blind faith of masses of people in medico-technological potential is leading man towards the complete *medicalisation* of his way of life, to the extent that even social problems are considered to be, essentially, solvable by medical means [42].

The influence of science on medicine – which undoubtedly has its positive aspects, but also carries with it the risk of making medicine appear simply to be another applied science – is causing the dissolution of traditional medical teleology and pushing medicine along a path which is transforming it from a *techné* to a technology. In principle, such a technology is available to anyone for any purpose. Discussions abound concerning the aims of such a modern ‹medical service industry›: improving the quality of life, achievement of a ‹perfect› state of health, etc. The desire for ‹improvement› *(enhancement)* of human nature is fuelled by utopian visions of a society freed from suffering [43].

Inspired by biotechnological and medical techniques – and beguiled by visions of ultimate human fulfilment – we strive for some kind of ‹second health›. Following the Aristotelian concept of ‹second nature› it has to be considered how artificial our naturally given state may become without feeling mostly manipulated and inauthentic. Our increasing knowledge concerning the physical and psychological states immanent to human nature insinuates the possibility of achieving ‹human perfection› at the end of the road towards improving the quality of life by means of conventional surgery, genetic manipulation or medication. Examples of this are to be seen not merely in certain areas of cosmetic surgery or the practice of prescribing antidepressants as lifestyle medicines, but also the use of anabolics or amphetamines in sports medicine. Public discussion of doping generally revolves around the question of unfair competition; equally worth debating is the *quo vadis* in respect of medical activity [44].

Whereas the enhancement discussion appears somewhat utopian, health services are at the same time being subjected to profound upheavals motivated by economic concerns. The present circumstances could hardly be less favourable from the point of view of avoiding the confusion of economic and medical criteria. As a senior consultant wrote in the *Deutsches Ärzteblatt*: «Has a senior consultant, when he reads in the news about the record profits made by his clinic group, grounds for self-congratulation – or should he remonstrate with himself for failing to divert more funds towards the care of his patients?» [45] The economisation of medicine and the difficulties involved in allocating scarce resources result in curious ‹extras›, both for general practitioners as well as clinical staff. So-called individual health services are to provide for economic survival of practices, and aesthetic surgery is to provide for economic survival of clinics. The broader the social consensus in respect of treatment that is not immediately relevant from the point of view of maintaining health, the less scope there will be for sanctions on the basis of professional ethical grounds. The economisational tendencies in medicine and the raised expectations of society appear to promote an increasing preparedness to integrate novel treatments into taken-for-granted medical practice. This leads to a «new language» in medical schools [46].

The proliferation of medico-technological services is transforming ‹patients› into ‹customers›, doctors and nurses into ‹providers› [47]. The new kind of ‹medical› service provision can be conveniently regulated through supply and demand – with the result that the physician-patient relationship of *mutual confidence* anchored in a tradition of medical teleology is being replaced by a straightforward, individual *contractual* relationship [48]. It remains a moot point as to whether society is truly well served by physicians who see themselves only as service providers, and how this can be reconciled to the physician's role as a guarantor.

As a component of society, medicine is of course subject to socio-ethical evaluation and political and economic calculation. A huge range of tastes, desires and fantasies exercise an influence on medical aims and priorities. Social aims and medical aims are intricately related and each demands acknowledgement in its own right. The question as to whether such a thing exists as a medical teleology that can be applied universally, i.e. to all cultures, is heavily influenced by one's own opinion in respect of medical treatment and the universal experience of illness immanent in human nature. But only when the concepts of ‹disease› and ‹health› are brought sharply into focus does it make sense to reflect on them in an ethical context. This all the more, in an era in which, traditional medical structures and activities are being put increasingly into question.

Conclusion

In contrast to other terms – which can also be of a normative nature, but are extremely open to wide interpretation – the *practical concept of disease* presented

here has the advantage of providing a narrow delimitation of the medical and physician's radius of action, thus rendering it accountable. Developed in this way, the concept allows ‹being ill› to be comprehended as a mode of (human) being in which the communicative aspect of the individual who is conveying his or her situation advances to become an important constitutive component of a state of disease. Accordingly, the role of the physician in his relationship with the patient who is trying to find expression for his self-interpretation includes not merely therapeutic aid in a narrow sense, but also hermeneutic support. In contrast to a purely technicistical attitude, the physician helps the patient towards a better understanding of his experience of illness [49].

If this is to be achieved, the physician-patient relationship must be taken more seriously. This factor amplifies the concept of disease in such a way that it uniquely specifies, legitimises and circumscribes medical activities – against models which are driven by market and look at patients merely as clients and consumer [50]. Such a *practical concept of disease* can help to ensure that medicine remains accountable, the relationship of confidence between the physician and the patient is stabilised and the innovative possibilities of modern biomedical research in terms of diagnosis and therapy can be exploited without the associated risks escalating, without medicine degenerating to become mere ‹anthropotechnology› [51] and medical technology becoming a mere comparison of the consequences of different technological solutions. As a patient one wishes to feel safe, with a desire for appropriate advice and treatment, and not to have the feeling of being mainly instrumental as a means of providing for the economic survival of a practice or hospital.

Conflict of interest: None to declare

Zusammenfassung

Gesundheit und Krankheit als normative Begriffe

«Gesundheit» und «Krankheit» können als grundlegende Kategorien der menschlichen Existenz aufgefasst werden, welche die konkreten Bedingungen des alltäglichen Geschehens wie auch der existentiellen Vorstellungen vom Leben festlegen. Die Arzt-Patient-Beziehung stellt eine Bühne bereit, um die normative Dimension dieser Begriffe auszuloten. Der normative Aspekt der Krankheit wie auch der Arzt-Patient-Beziehung bestärkt vielmehr eine Vorstellung von Krankheit, die lediglich medizinische Aktivitäten benennt, legitimiert und abgrenzt – und zwar gerade von Modellen, die der Marktlogik gehorchen und die Patienten als reine Kunden oder Konsumenten betrachten. Im Gegensatz zu einer rein technizistischen Haltung vermag der Arzt dem Patienten so zu einem besseren Verständnis seiner Krankheitserfahrungen verhelfen. Ein solcher praxisorientierter Krankheitsbegriff kann dazu beitragen, dass die Medizin verantwortungsvoll bleibt, die Vertrauensbeziehung zwischen Arzt und Patienten gefestigt wird und die innovativen Möglichkeiten der modernen biomedizinischen Forschung im Hinblick auf Diagnostik und Therapie ausgeschöpft werden, ohne dass die damit verbundenen Risiken überhand nehmen und ohne dass die Medizin zu einer reinen ‹Anthropotechnik› verkommt und die Medizintechnik zu einem blossen Vergleichen verschiedener technologischer Lösungen und ihrer Folgen führt.

Résumé

La santé et la maladie comme concepts normatifs

La «santé» et la «maladie» peuvent être comprises en termes de catégories fondamentales de l'existence humaine – comme termes pratiques à la fois dans les rapports quotidiens et dans les concepts existentiels de la vie, exerçant une influence élémentaire sur notre intra-activité et notre interactivité individuelle et sociale. La relation entre médecins et patients fournit une plateforme inférentielle pour la dimension normative de ces concepts. Ces fondements conduisent à la présomption que la maladie et la santé ne peuvent trouver leur place de manière exhaustive dans le champ d'une description théorique et scientifique de certains états naturels. Au contraire, le facteur normatif de la maladie et de la relation médecin-patient amplifie le concept de maladie de telle façon à ce qu'il spécifie particulièrement, légitime et circonscrive les activités médicales – en opposition à des modèles conduits par le marché et qui verraient les patients comme simples clients et consommateurs. A l'opposé d'une attitude purement technistique, le médecin aide le patient à une meilleure compréhension de son expérience de la maladie. Un tel concept pratique de la maladie peut aider à s'assurer que la médecine reste fiable, que la relation de confiance entre le médecin et le patient soit stabilisée, et que les innovations possibles dans la recherche biomédicale moderne en termes de diagnostic et de thérapie puissent être utilisées sans escalade des risques associés, et sans que la médecine ne dégénère en simple «anthropotechnie» ou que la technologie médicale ne devienne une simple comparaison des conséquences de différentes solutions technologiques.

Correspondence
Dr. Dirk Lanzerath
Deutsches Referenzzentrum für Ethik in den Biowissenschaften (DRZE)
Universität Bonn
Bonner Talweg 57
D-53113 Bonn

E-Mail: lanzerath[at]drze.de

Eingang des Manuskripts: 16.1.2012
Eingang des überarbeiteten Manuskripts: 26.4.2012
Annahme des Manuskripts: 26.4.2012

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10. Cf. Améry J. Jenseits von Schuld und Sühne: Bewältigungsversuche eines Überwältigten. München; 1966.
11. For Martin Heidegger «Angst» is a basic state of mind which makes aware the contingent existence of humans and enables humans to decisiveness. «Die Angst vor dem Tode ist die Angst ‹vor› dem eigensten, unbezüglichen und unüberholbaren Seinkönnen. Das Wovor dieser Angst ist das In-der-Welt-sein selbst. Das Worum dieser Angst ist das Sein-können des Daseins schlechthin.» Heidegger M. Sein und Zeit. Tübingen; 161986. Para. 50, 251.
12. Jean-Paul Sartre submits in his existentialist philosophy an analysis of «the look». He states that many social relations are created by the way how a person makes them feel about themselves by how they look at another person. Sartre describes it as a state of emotional alienation induced by the judgments of «the others». (Chapter «the look» in: Sartre JP. L'être et le néant. Essai d'ontologie phénoménologique. Paris: Gallimard; 1943.
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