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The Modern Body Image as Ethical Device for Biomedical Enhancement

Abstract (Deutsch)

Die Diskussion hinsichtlich der Legitimität biomedizinischer Verbesserungen am Menschen, kann mit dem Bild, das wir uns– als Einzelne oder als Gesellschaft – vom Körper machen, in Beziehung gesetzt werden. Der folgende Beitrag wirft einen Blick auf die historischen Wurzeln von in der Neuzeit entstandenen Körperbildern und versucht strukturelle Verfahren abzuleiten, die zur ethischen Einschätzung der Möglichkeiten dienen, die wir haben, um die menschliche Natur zu verbessern.

Abstract (Français)

La discussion concernant la légitimité d'améliorations biomédicales sur des humains peut être rapprochée de l'image que nous – en tant qu'individus ou en tant que société – faisons du corps. L'article suivant explore les racines historiques des images du corps qui ont émergé à l'époque moderne et essaie d'en tirer des dispositifs structurels pour une évaluation éthique des possibilités dont nous disposons pour améliorer la nature humaine.

I. The Part and The Whole

The modern understanding of the human body has been significantly shaped by the period at the end of the eighteenth and the beginning of the nineteenth century, during which the traditional images were partly lost and partly modernised. The Hippocratic-Galenic tradition was replaced by the scientific body

concept – physiology[1]. This new area of science – based on a variety of influences, particularly from René Descartes and Julien Offray de La Mettrie – considered the body as a machine that functions according to the laws of physics and chemistry. This body *mechanism* model, which can be explained through mathematical patterns, was joined by a new interpretation of *vitalism*, which had by then been understood scientifically, and which considers the body as having a self-regulating, dynamic balance, without reverting back to teleological-metaphysical patterns. Consequently, the body is also called a "living machine"[2]. This understanding does not reduce the organism as a whole to physical and chemical processes; on the contrary, the organism represents the reason for the functioning of the individual organs. The body is therefore a self-referential system that reproduces the prerequisites for its existence[3]. As opposed to the mechanical idea, which emphasises the parts of the body, this is the emergence of an integrative idea of the whole: the organs serve the organism, whose sole purpose is survival[4]. So, for the time being, we can conclude that there is a tension between the two models, mechanism and neo-vitalism, depending on whether you consider the parts or the whole.

II. Normality and Normativity

The Hippocratic-Galenic tradition, in both interpretations of physiology, was replaced by a scientific concept of the body, which superseded older, dietetic ideas of health[5]. Both the mechanistic and the neo-vitalistic metaphor of the body as a machine prepared the ground for the development of a discourse, which referred less to the telos of 'health' but more to the regular functioning of the organism[6]. Physiology defined normality by means of a statistic scattering or

1 G. Canguilhem, *Die Herausbildung des Konzeptes der biologischen Regulation im 18. und 19. Jahrhundert*, in G. Canguilhem – W. Lepenies (eds.), *Wissenschaftsgeschichte und Epistemologie*, Frankfurt a.M., Suhrkamp, 1979, 89–109.

2 C. Bernard, *Introduction à l'étude de la médecine expérimentale*, Paris, Garnier-Flammarion, 1966.

3 C. Sinding, *Vitalismus oder Mechanismus? Die Auseinandersetzungen um die forschungsleitenden Paradigmata in der Physiologie*, in P. Sarasin – J. Tanner (eds.), *Physiologie und industrielle Gesellschaft: Studien zur Verwissenschaftlichung des Körpers im 19. und 20. Jahrhundert*, Frankfurt a.M., Suhrkamp, 1998, 76–98.

4 J. Tanner, *Weisheit des Körpers und soziale Homöostase: Physiologie und das Konzept der Selbstregulation*, in P. Sarasin – J. Tanner (eds.), *Physiologie und industrielle Gesellschaft*, 129–169, p. 165.

5 Canguilhem, *Die Herausbildung des Konzeptes der biologischen Regulation im 18. und 19. Jahrhundert*, pp. 89–109.

6 M. Foucault, *Die Geburt der Klinik*, Frankfurt a.M., Fischer, [8]1998, p. 52.

distribution curve, which determines the transitions from normal to abnormal[7]. The search for a statistic measure to present individual cases uniformly is, however, not realistic, but a social construction[8]. The differentiation between normal and abnormal phenomena insinuated here could be used *descriptively* on the one hand, and *prescriptively* on the other: descriptively, inasmuch as it enabled categorization and differentiation (something could be characterized as being normal or abnormal); prescriptively, inasmuch as the possibility of treating differentiations as social exclusions could have a disciplinary effect (what used to be considered abnormal had to accept at least the endeavour towards normalisation)[9]. It is possible to interlink the descriptive and the prescriptive dimensions: He who determines what the body is, in principle at least, dictates the way in which to treat one's body.

Defining a 'normal' physiology and determining regular functions and average frequency distributions of physical characteristics or features, became part of an ongoing *normalisation discourse* in society[10]. The interesting thing about this is that deviations from what is considered to be normal may not only refer to the 'below average', but also to the 'above average', i.e. physical characteristics or marks can also be considered as particularly good or particularly beautiful. This actually creates the basis for any discourse on improvement: it is not only about letting a sick body return to health, but about increasing the performance or aesthetic quality of a healthy body. In any case, the difference between what is normal and what is abnormal does not only concern the range of cases or the proportion of the distribution of characteristics and features, it also turns out to be a scheme for the generalisation of expectations. Discourses on normalisation therefore carry the seed of *standardisation efforts*. This blurs the distinction between what is normal and what is abnormal. Where physical characteristics or features are optimised, they may appear normal again one day, so that the standards, which allow the distinction between what is normal and what is abnormal, could change[11].

7 J. Link, *Versuch über den Normalismus: Wie Normalität produziert wird*, Opladen, Vandenhoeck & Ruprecht, 1996.

8 G. Canguilhem, *Das Normale und das Pathologische*, Frankfurt a.M., Fischer, 1977.

9 P. Sarasin – J. Tanner, *Physiologie und industrielle Gesellschaft*, in P. Sarasin – J. Tanner (eds.), *Physiologie und industrielle Gesellschaft: Studien zur Verwissenschaftlichung des Körpers im 19. und 20. Jahrhundert*, Frankfurt a.M., Suhrkamp, 1998, 12–43.

10 D. Lupton, *Medicine as culture: Illness, disease and the body in western societies*, London, Sage, 1994.

11 B. Orland, *Wo hören Körper auf und fängt Technik an? Historische Bemerkungen zu posthumanistischen Problemen*, in B. Orland (ed.), *Artifizielle Körper – Lebendige Technik: Technische Modellierung des Körpers in historischer Perspektive*, Zurich, Chronos, 2005, 9–42.

III. Authority and Authenticity

The question about what is 'normal' physiology in modern times not only arises with regard to the ability to discipline – i. e. the effort to turn bad into good and to make what is good even better – but also with regard to the 'self-image' of the body. The body you have is only accessible through the image you make of it. This image stands for the body that we are not[12]. In the words of Helmuth Plessner[13], this is how a rift develops between the "Leib" that we are, and the "Körper" that we have or, one must add, should have (as shown by the disciplining discourses), or that we want to have (that is the new momentum, which the body creates as an image of the self). One could also say: the identification through one's own body is not the identification with one's own body[14]. Wherever we consider the body, we are dealing with an image formed by society, a body which is formed by coded practices and which only exists within the context of discourses.

The body is part of an interminable social construction of reality. It can never be envisioned purely for itself; in fact, the body is always seen through images fluctuating in society and is, in this case, only one's own if it is conveyed: authenticity is conveyed socially. This implies the discursive framework, which initially provides the subject with its 'individual body' as its 'very own'. The image humans have of their bodies therefore varies throughout history and throughout cultures and takes on various shapes at different times and in different settings[15]. The process of industrialization in particular has illustrated quite plainly the cultural and historic plasticity of the way in which human beings relate to their bodies, and this has led to the formation of a new field of research called "body history"[16]. It was precisely this new, emerging scientific discipline of physiology that was now closely interwoven with economic, political, legal and medical or aesthetic images, which attempted to bring forth industrial advancement through mastery of nature and of the body.

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12 K. Vahland, *Der Kunstmensch als Maß der Dinge: Zu Leonardo da Vincis Utopie des idealen Körpers*, in K. Hasselmann – S. Schmidt – C. Zumbusch (eds.), *Utopische Körper: Visionen künftiger Körper in Geschichte, Kunst und Gesellschaft*, Munich, Fink, 2004, 29–40.

13 H. Plessner, *Anthropologie der Sinne*, in H.G. Gadamer – P. Vogler (eds.), *Neue Anthropologie*, vol. 7, Stuttgart, Deutscher Taschenbuchverlag, 1975, 3–63.

14 N. Luhmann, *Soziologische Aufklärung 6: Die Soziologie und der Mensch*, Wiesbaden, Verlag für Sozialwissenschaften, ^{2}2005.

15 P. Sarasin, *Der öffentlich sichtbare Körper: Vom Spektakel der Anatomie zu den „curiosités physiologiques"*, in P. Sarasin – J. Tanner (eds.), *Physiologie und industrielle Gesellschaft: Studien zur Verwissenschaftlichung des Körpers im 19. und 20. Jahrhundert*, Frankfurt a.M., Suhrkamp, 1998, 419–452.

16 R. Porter, *History of the body*, in P. Burke (ed.), *New perspectives on historical writing*, Cambridge, Polity Press, 1992, 206–232.

This is why no uniform body image exists in modern times. In point of fact, there are a multitude of body images. This plurality of body images has been created within the orientational differences of the modern, functionally differentiated society: there are economic, political, legal, medical or even aesthetic body images which are managed by the respective specialist authorities. Body images have consequently become more autonomous, allowing, for example, aesthetic standards to develop independently from political or economic or, most of all, medical guidelines[17]. This has also allowed beauty and health to produce separate guidelines, which in turn has had an effect on medicine: reducing suffering can refer to healing an illness, removing a disfigurement or a blemish, or increasing the performance of physical as well as mental processes. But both standards can also conflict: restoring beauty or increasing performance can lead to health risks, and the restoration of health can have an adverse effect on beauty, and the question then is: which standard should prevail?

IV. Naturalness and Artificiality

What has led to the distinction between naturalness and artificiality is the diversity of cultural images influenced by physiology that are superimposed on the nature of the body. For even if the human body, according to Friedrich Hoffmann[18] for example, is a machine that works according to natural laws, each human being has created his or her own nature. Therefore it is sensible on the one hand to treat one's own artificial nature with care; on the other hand, nature requires development and refinement, and where this is achieved by reason man then becomes a human being, as Christoph Wilhelm Hufeland emphasises[19]. In fact, the art of medicine is able to enhance nature's achievement, as Pierre Jean Georges Cabanis also states[20]. Therefore, it is essentially reason, or art directed by reason, which turns the mere body into a human being. The body cannot be seen merely as a gift of nature, it is in fact the "result of a discourse which

17 F.J. Verspohl, *Die Entdeckung der Schönheit des Körpers: Von seiner maßästhetischen Normierung zu seiner bewegten Darstellung*, in R. van Dülmen (ed.), *Erfindung des Menschen: Schöpfungsträume und Körperbilder 1500–2000*, Wien – Köln – Weimar, Boehlau, 1998, 139–155.

18 F. Hoffmann, *Gründliche Anweisung wie ein Mensch von dem frühzeitigen Tod und allerhand Arten Krankheiten durch ordentliche Lebens-Art sich verwahren könne*, vol. 1, Halle, Renger, 1715, pp. 105–106.

19 C.W. Hufeland, *Die Kunst das menschliche Leben zu verlängern*, vol. 1, Jena, Akademische Buchhandlung, 1800, pp. 130–131.

20 P.J.G. Cabanis, *Rapports du physique et du moral de l'homme*, vol. 1, Paris, L'Harmattan, 1802, p. 76.

orchestrates naturalness as 'perfect art'"[21]. The room for interpretation between mechanistic and neo-vitalist thought becomes very apparent in these medical-theoretical statements on the relationship between nature and art[22].

V. Discussion

The above-mentioned devices are in a position to structure the ethical discourse on the biomedical improvement of mankind.

1. The co-existence of mechanistic and neo-vitalist ideas presents a reason for putting the part and the whole in relation to each other: the human body is not only an instrument of the person embodied within; according to Hegel, it is also – and even primarily – the "existence"[23] which contains the social appearance of this person. Each *instrumental* attitude towards the body should therefore be embedded in a *prudential* attitude: the degree to which the body changes must be put into relationship with other, more far-reaching aims: aesthetic standards, for example, should be related to health criteria, and vice versa. The far-reaching aims also comprise social ties, so that a prudent approach must also be integrated within a *value*-approach: the standard, according to which a person relates to his or her body and treats or changes it, does not entirely reflect his or her individual desires. A mechanistic view, which is about exchanging individual parts or renewing or improving certain functions, should consequently be incorporated within a holistic view, which encompasses the entirety of the physical appearance as well as social processes and judgements. Changing parts results in a change of the entire person, and this also includes the social consequences of medical interventions to the human body.

2. A biomedical intervention intuitively seems artificial and therefore problematic, especially if it violates the concept of normality in a given culture or at a given time. The term naturalness is, as we have seen, virtually inseparable from the term normality; the term normality, however, is always relative to a certain time and a specific culture. The question then is what you gain from such information. One view is that only those medical interventions necessary to restore or maintain the normal functions typical of the species and the reference class should be carried out, but not those that go beyond restoration or the pure

21 P. Sarasin, *Reizbare Maschinen: Eine Geschichte des Körpers 1765–1914*, Frankfurt a.M., Suhrkamp, 2001, p. 49.

22 R. Porter, *The greatest benefit to mankind: A medical history of humanity from antiquity to the present*, London, W.W. Norton & Company, 1999.

23 G.F.W. Hegel, *Grundlinien der Philosophie des Rechts*, Frankfurt a.M., Suhrkamp, 1986, § 47.

maintenance of these normal functions[24]. Initially, this sounds plausible. However, the question is whether excluding the treatment of psychophysical impairments that do not qualify as being negative diversions of the respective normal functions can be ethically justified, and thus whether also to treat variations that lie within the norm if otherwise this would lead to a disadvantage or even discrimination. Moreover, the idea that is particularly voiced in the context of cosmetic surgery – stating that the core of 'aesthetic' problems lies in 'social' problems provoked by social norms and thus can only be broken down by society itself – points in this direction and prevents us from blindly charging the concept of normality in a normative way. On the one hand, it should be taken into consideration that an aesthetic correction can alleviate discrimination and suffering. On the other hand, this will confirm the aesthetic values and stereotypes responsible for this discrimination and suffering[25]. A compromise, which is able to distinguish between the level of action and the level of regulation, would be the suggestion to take into account both aspects through "conflicting complicity"[26]. Although the aim should be to compensate for the acute discrimination of the individual, it is at the same time important to strive to overcome such tendencies and values.

3. Because modern society, in which the normalisation discourse and the standardisation efforts are taking place, reflects upon itself as a functionally differentiated society, it is taken for granted that it considers one and the same object from different perspectives without giving preference to a specific perspective across society as a whole. Medical decision-making can also be considered economically, politically, or aesthetically, and this may lead to several different judgements on the course of action. The result is the paradox of a symmetry of asymmetries, which has an effect on the traditional authorities or, respectively, on professional expertise: in modern times, the authoritative speaker positions, which also include doctors, are brought together on equal terms, without ceasing to be professional speaker positions[27]. A medical decision, which used to be an authoritative decision, can now be doubted and therefore needs to be well-founded on reasons. In this way you can question

24 N. Daniels, *Normal functioning and the treatment-enhancement distinction*, in *Cambridge Quarterly of Healthcare Ethics* 9 (2000) 309 – 322.

25 S. Bordo, *Braveheart, babe, and the contemporary body*, in E. Parens (ed.), *Enhancing human traits: Ethical and social implications* (Hastings Center studies in ethics), Washington, D.C., Georgetown University Press, 1998, 189 – 221.

26 *Ibid.*, p. 221; see also M.O. Little, *Cosmetic surgery, suspect norms and the ethics of complicity*, in E. Parens (ed.), *Enhancing human traits: Ethical and social implications* (Hastings Center studies in ethics), Washington, D.C., Georgetown University Press, 1998, 162 – 176.

27 A. Nassehi, *Organisation, Macht, Medizin: Diskontinuitäten in einer Gesellschaft der Gegenwarten*, in I. Saake – W. Vogd (eds.), *Moderne Mythen der Medizin: Studien zur organisierten Krankenbehandlung*, Wiesbaden, Verlag für Sozialwissenschaften, 2008, 379 – 397.

whether the decision in favour of or against a certain measure was correct. And exactly this fact characterises the moral ambiguity of the modern age. What is medically necessary and is therefore proposed by the doctor can be challenged or put into question by other authorities, such as lawyers, which necessitates further discussions on what action can be considered as being correct. And even if there was an agreement on this issue, i.e. if there was an authoritative consensus on what is good for the patient, the patient's will may differ from the recommendation he was given. The question then is what counts as the authentic will of the patient? The medium, in which ethical justifications take place, is then no longer authority, but authenticity. What is ethical about this practice is that everything can and must be talked about. Whether ambiguous decisions can be solved by complying with the patient's will remains to be seen. This development, however, increases the significance of the communication with patients. Whereas it used to be sensible to do what the doctor ordered, thus bowing to medical rationality, this is precisely what is being questioned today with reference to authentic decision-making, i.e. subjectivity. Fundamentally, this questions the relationship between authority and authenticity. This is where the aspect of autonomy that is granted to the patient meets the aspect of the doctor's ministrations. Whether a medical intervention that bears medical risk should be carried out – although it improves, for example, the aesthetic situation – can only be decided by the patient following a prior consultation with the doctor[28].

The way in which the body is portrayed through images constructed by society indicates the relationship between authority and authenticity. A number of authors therefore emphasise that biomedical enhancements of human performance can undermine the authenticity of performance when it is attributed to personal achievement. This is particularly relevant in the context of performance rating or when comparing performance, such as in sports or educational or other examinations, where not only the level of performance but also the authenticity of achieving it, are decisive factors[29]. It is important, though, to consider the character of such situations. In zero-sum games, such as in exams or in sports events, this argument is plausible. In positive-sum games, however, through which society increases the performance of its members for mutual benefit, this argument is not convincing. Yet we need to expose the problem that individual types of biomedical enhancement may form human experience and behaviour to the extent that this has a major impact on the personality of a

28 C. Breitsameter, *Autonomie und Fürsorge: Zwei gegensätzliche Prinzipien?*, in C. Breitsameter (ed.), *Autonomie und Stellvertretung in der Medizin: Entscheidungsfindung bei nichteinwilligungsfähigen Patienten*, Stuttgart, Kohlhammer, 2011, 60–78.

29 D.W. Brock, *Enhancements of human function: Some distinctions for policymakers*, in E. Parens (ed.), *Enhancing human traits: Ethical and social implications* (Hastings Center studies in ethics), Washington, D.C., Georgetown University Press, 1998, 48–69.

human being. This may, on the one hand, contribute to a desired restitution of the actual personality that is pathologically covered, or to a further development of the personality; on the other hand, it may result in the deformation of the self. This deformation could lead to the loss of personal identity and autonomy, as well as the self-perception as a self-responsible subject[30]. Medical interventions, which pose a threat to a person's ability to be a self-responsible subject, also present a problem from an ethical point of view when the patient himself desires such intervention. Self-determination over one's own body meets the limits of legitimacy right at the point where it threatens to undo the ability of self-determination.

4. The last structural device that we raised from the historical perspective only delivers a heuristic and not a clear restriction of action. This is because we use a limiting concept when talking about things that are "natural" or "artificial"[31]. Nothing we encounter in our world is purely natural or purely artificial (and the latter not even if the development of the art of imitating naturalness is fully matured). In order to give shape to phenomena within the fluid spectrum between naturalness and artificiality, instead of just considering them as a combined form, it seems practical to distinguish between formation and appearance[32]. A characteristic feature of a body may have been created artificially, but it can appear to be natural. It is also possible for something natural to seem artificial. Naturalness in the sense of phenomenon can be artificial, whereas naturalness in the sense of genesis may seem artificial. Naturalness in the genetic sense can only be preserved, whereas naturalness in the phenomenal sense can be artificially restored where it was lost. Nevertheless, something can only be considered as artificial when compared with something natural (or what is assumed to be natural).

As far as medical interventions are concerned, using nature as a norm seems to be plausible in the phenomenal sense, but only at first glance. For, there are cases in which, for instance, surgical intervention leads to a seemingly unnatural result. This, however, may be more acceptable to the patient than the 'original state' of his or her appearance that had been, for example, marred by an accident and thus 'artificially' impaired. Whereas, if a person is maimed by nature, i.e. since birth, nature will not be the desired standard to use. The term 'nature', particularly in biomedical applications, is a dense term which can serve as a heuristic for the course of action. But it is clear that we require objective reasons

30 M. Quante, *Personales Leben und menschlicher Tod: Personale Identität als Prinzip der biomedizinischen Ethik*, Frankfurt a.M., Suhrkamp, 2002, pp. 287–290.

31 K. Bayertz, *Die menschliche Natur und ihr moralischer Status*, in K. Bayertz (ed.), *Die menschliche Natur: Welchen und wieviel Wert hat sie?*, Paderborn, Mentis, 2004, 9–25.

32 D. Birnbacher, *Natürlichkeit*, Berlin – New York, De Gruyter, 2006.

when formulating restrictions from a heuristic. If this transition is not indicated and justified separately, the result is a naturalistic fallacy.

VI. Conclusion

When observing the development of the body image or, rather, of body images in modern times, four relevant structural devices are evident: the part and the whole, normality and normativity, authority and authenticity, naturalness and artificiality. All four devices initially only represent a type of search guide: not to forget the whole when considering only partial aspects of biomedical interventions; critically reflecting the restoration of normality using suitable norms; combining the authenticity of a desire for improvement with the authority of specialist expertise (but then considering the desire as the last normative foundation); and, finally, clarifying the idea of naturalness and artificiality by using the categories of genesis and phenomenon. In this sense, the above-mentioned devices structure the ethical discourse on the biomedical improvement of a human being: the necessary components of heuristics must be translated into restrictions of action in a reflective and methodically controlled way.