Introduction

Why Against Health?

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How can anyone take a stand against health? What could be wrong with health? Shouldn’t we be for health?

On behalf of the authors, let me reply to these questions by proclaiming that we believe that anyone who feels ill before, during, or after reading this book should seek immediate medical attention. We believe in the germ theory of infectious illness. We believe in penicillin. We believe that physicians should wash their hands between patient visits. We are optimistic about the promise of stem cell research. We believe that the transition from the rigid sigmoidoscope to the lower abdominal MRI represents indisputable progress. We are for bike helmets, sunscreen, and enteric-coated tablets, and we are against the swine flu. Perhaps most of all, we believe that disparities in incidence and prevalence of disease are closely linked to disparities in income and social support. We believe that documents such as the Department of Health and Human Services’ “Healthy People 2010” prove beyond doubt that access to health care and availability of adequate health insurance remain unattainable goals for many Americans. We believe that such disparities need to be rectified, and we stand firmly behind recent expansions in healthcare coverage.

At the same time, we believe that defining the mission of this book solely as a call for redistribution of healthcare resources is to miss part of the point. That is because arguments supporting the reallocation of resources understandably assume that health is a fixed entity that can be transported from one setting to another. The rich have health, for instance, and the poor do not. While valid, such claims overlook the ways in which health itself is part of the problem that we mean to address.

As recent political debates in the United States have demonstrated, “health” is a term replete with value judgments, hierarchies, and blind
assumptions that speak as much about power and privilege as they do about well-being. Health is a desired state, but it is also a prescribed state and an ideological position. We realize this dichotomy every time we see someone smoking a cigarette and reflexively say, “smoking is bad for your health,” when what we really mean is, “you are a bad person because you smoke.” Or when we encounter someone whose body size we deem excessive and reflexively say, “obesity is bad for your health,” when what we mean is not that this person might have some medical problem, but that they are lazy or weak of will. Or when we attend town-hall meetings or Tea Party mosh pits and reflexively shout down other people for not understanding health care, when what we mean is that these people must be principally or politically misguided. Or even when we see a woman bottle-feeding an infant and reflexively say, “breastfeeding is better for that child’s health,” when what we mean is that the woman must be a bad parent. In these and other instances, appealing to health allows for a set of moral assumptions that are allowed to fly stealthily under the radar. And the definition of our own health depends in part on our value judgments about others. We see them—the smokers, the overeaters, the activists, and the bottle-feeders—and realize our own health in the process.

I have developed a strategy to help answer the question, why against health? When I am posed this question by friends, relatives, or even patients, I reply by asking my interlocutors to, for one day, pay attention to the uses of health in their daily lives. Where does the term appear? I ask. To what means and to what ends? This brief exercise is meant to complicate assumptions about health as a transparent, universal good. Instead, even the most cursory examination of health in daily conversation, email solicitation, or media representation demonstrates how the term is used to make moral judgments, convey prejudice, sell products, or even to exclude whole groups of persons from health care.

For instance, if after reading this book you walk to the nearest newsstand in search of health-themed magazines, you will undoubtedly find such popular periodicals as Health, Healthy Living, or Men’s and Women’s Health. It will not take much browsing time to realize that these publications share the common assumption that health is intimately connected to, and ultimately defined by, a person’s appearance. These and other magazines commonly promote the message that healthy appearances embody a set of norms that are at once wholly mainstream and impossible to attain.

A recent issue of Health asks readers to consider whether, in the name of “beauty,” they would consider having plastic surgery on their toes, or
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whether they would consider getting facials on their “fannies” to reduce cellulite. The magazine opines on such topics as “the best jeans for your body,” “secrets to a good hair day,” and “in search of the perfect bra,” while inviting readers to share their weight-loss stories by divulging secret tips and by submitting before and after photographs that illustrate how their health has changed since their weight loss. Men’s Health meanwhile subdivides health into the categories of Sex, Fitness, and Nutrition and instructs readers on ways to obtain buns of steel or build “razor sharp abs” in an effort to “get noticed,” and then get laid, by the girl next door.

Calling such language sexism or cultural narcissism would mobilize a particular critique. But calling it health allows these and other magazines to seamlessly construct certain bodies as desirable while relegating others as obscene. The result explicitly justifies particular corporeal types and practices, while implicitly suggesting that those who do not play along suffer from ill health. The fat, the flaccid, and the forlorn are unhealthy, the logic goes, not because of illness or disease, but because they refuse to wear, fetishize, or aspire to the glossy trappings of the health of others.

You might also log on to your computer only to be accosted by spam emails or pop-up Websites advertising a wide variety of tumescents that promise “sexual health.” You might learn that information about erectile dysfunction (ED) “can be an important first step toward better sexual health,” and that the second step involves ingestion of prescription Cialis™: “With Cialis you can have the option of being ready fast . . . or have up to 36 hours to relax and take your time.” Or you might be directed to the Website of the “non-prescription all natural supplement” Ezerex, which promises a “rock-hard erection” in just twenty-five minutes: “Ezerex is made to act FAST like a prescription, but without all the unhealthy side effects!” The site further explains that the supplement “should be taken as part of a healthy lifestyle” and offers testimonials from men such as “David W.,” who exclaims, “I don’t have an ED problem but I do have a girlfriend who is 20 years younger than I am and she has an endless appetite for sex. I needed an edge and some extra help to keep up. Ezerex is her new best friend! Thank you.”

Calling such claims phallocentrism might mobilize a particular critique. But calling them health allows the Websites to construct social physiologies in which health is marked by the ability to stand at osseous attention for seemingly unhealthy periods of time, while unsubtly suggesting that the inability to do so indicates some sort of disease.

A different notion of health appears when you turn on your television and see public health advertisements that implore you to stop smoking by
appealing to the health of your children. One recent Michigan campaign shows children left alone in homes or in cars, where they are helplessly left to breathe the second-hand smoke of their parents. The children speak dejectedly into the camera about the impact of their passively attained nicotine habits. “I smoke while I’m watching cartoons,” says one girl in front of a television. “We smoke on the way to school,” add two sisters trapped in a car. “When you smoke around your kids,” the narrator explains, “it’s like they’re smoking.”

Calling such appeals moralism might mobilize a particular critique, and to be sure, the ads importantly confront the pernicious effects of second-hand smoke. But calling them health allows these campaigns to make a much wider set of assumptions about people who smoke as being irresponsible or negligent parents, parents who leave their children alone in cars or slowly kill them via their own solipsistic addictions. Pleural health is closely aligned with decency in this formulation, while the disease of smoking decays the body as well as the soul.

Finally, you might be sitting in an airport where, in lieu of an explanation for your flight delay, you are handed a complimentary copy of the Wall Street Journal, which contains the front-page headline, “Lighten Up: Pepsi Sales Force Tries to Push ‘Healthier’ Snacks in Inner City.” According to the article, sales representatives for PepsiCo, Incorporated began a multimillion-dollar campaign to promote Baked Cheetos, Doritos, and Ruffles in the “inner city.” “32% of adult Americans are obese,” the article reads, and in response, PepsiCo hopes to encourage “inner-city African Americans and Latinos” to forgo the 25-cent packs of Flamin’ Hot Cheetos and Nacho Cheese Doritos known fondly as “quarters,” and to instead select lower-fat (and higher cost) offerings produced by the same company.

Calling this approach racism or capitalism or any number of other -isms would mobilize a particular critique. But calling it health allows for a language of betterment that skillfully glosses over the structural violence done to minority and lower-income Americans, while at the same time suggesting that social and economic misfortune results from poor food choices. Calling it health also enables troubling slippages between the health of individual bodies and the health of economic ones, inasmuch as consumption of the very foods that (dubiously) help minority populations slim down also produce portly profits for PepsiCo Incorporated.

The aim of this book might be divided into two parts, the first of which is exponentially easier than the second. First, we mean to unpack health and to explore the ideologies, structures, base pairs, and blind assumptions
involved in its construction. Numerous theoretical tools hang at the ready in this regard. For instance, health might be critiqued through the work of the famed sociologist Erving Goffman as a type of *stigmatizing rhetoric*, defined in moments of “mixed encounter” in which marks of difference based on size, color, or ability create groups of normals and, by exclusion, groups of others. From a Goffmanian perspective, affirmation of one’s own health depends on the constant recognition, and indeed the creation, of the spoiled health of others.7

The work of the philosopher Ivan Illich similarly assists in critiquing health as a potentially *colonizing rhetoric*. Illich is arguably best known for his 1975 book *Medical Nemesis*, which argued that the medical establishment posed a “threat to health” through the production of clinical, social, and cultural “iatrogenesis.”8 In the 1980s, Illich expanded his critique to include the very definition of health itself. In a series of lectures titled “To Hell With Health,” Illich bemoaned the negative effects of excessive preoccupation with health and the countless American industries that gained financially from promoting such preoccupation. “To hell with health,” he is reported to have said. “It is the most cherished and destructive certitude of the modern world. It is a most destructive addiction.” Illich did not mean that people need not seek relief from ailments and illnesses. Rather, he argued that American society promoted a definition of health based on an unattainable ideal, one that made no room for suffering, aging, dying, or other natural processes.9

So too, the scholarship of Talcott Parsons, Irving Zola, and a number of other medical sociologists casts health as a *normativizing rhetoric*. Zola, for instance, championed the phrase “temporarily abled bodies” as a way to challenge dominant notions of health, and critiqued the “socio-political consequences of medical influence” in determining matters of corporeality, ability, and, ultimately, normalcy.10 And, of course, French sociologist Michel Foucault canonically promoted understanding health as a *discourse of power*, a discourse that is productive rather than repressive. From a Foucaultian perspective, American society’s incessant talk about health produces and regulates itself and its subjects, while making it increasingly difficult to get outside of health. Such biopower subjugates utterances that we do not agree with and utterances that we do, both of which serve to remove us ever more from the possibility of real resistance.11

More recently, Adele Clarke, Peter Conrad, and a number of other academics and social critics demarcate health as a paradoxically *medicalizing rhetoric* that propagates various forms of medical profit or influence in an often inverse relation to human betterment. Early medicalization literature
claimed that categories of health atherosclerotically narrowed when categories of disease expanded like an angioplastician’s balloon. Clarke and colleagues track a more complex process of “biomedicalization” whereby biomedicine and technoscience conspire to define health as a moral obligation, a commodity, and a mark of status and self-worth. “In the biomedicalization era,” they write, “the focus is no longer on illness, disability, and disease as matters of fate, but on health as a matter of ongoing moral self-transformation.” Relatedly, public health scholar Deborah Lupton details ways in which public health policies “regulate” bodies by promoting definitions of health that represent “moral imperatives.”

Finally, growing numbers of practitioners from within medicine and public health, as well as members of patient activist groups, critique health as a problematically consumerist rhetoric that reflects social and economic norms under the guise of scientific information. In his erudite essay written in defense of smoking, musician and social activist Joe Jackson maligns anti-smoking “hysteria” through claims similar to ones that appear in this book. “We have become not only excessively reverent towards doctors and scientists, but increasingly willing to allow them to dictate our lifestyles and laws,” Jackson writes. “Health is seen as an unqualified good. Who can be against ‘health’?” Meanwhile, physician H. Gilbert Welch argues that true health-care reform will only take place when America moves away from definitions of health that profit the “medical-industrial complex” of health professionals, pharmaceutical companies, biotechnology firms, manufacturers of diagnostic technologies, surgical centers, hospitals, and academic medical centers. “In the past, people sought health care because they were sick,” Welch writes. “Now the medical-industrial complex seeks patients.” In this system, “if health is the absence of abnormality, the only way to know you are healthy is to become a customer.”

Engagement with these and other critiques of health forces a set of questions central to the intentions of this book. Are present-day notions of health merely extensions of that-which-came-before, or are different forces at play in our current biopolitical age? If the latter, then who are the new actors and agents? Who are the new victims and beneficiaries? Should the aim of critique be, as Illich once suggested, “liberation” from medical authority? Or is medical authority even relevant in an era when pharmaceutical companies appeal directly to consumers, insurance companies set parameters of healthy living, and most people obtain medical information from infomercials, talk shows, package inserts, and the Internet? What new selves and citizens are created by this health rhetoric, and what non-selves and non-citizens are...
constructed and then left out? Whose agendas are met by these new configurations, and whose are thwarted or replaced? Who are the new mortals, elitists, conservatives, liberals, structuralists, activists, and immigrants? And why?

This part, the theoretical part, comes relatively easily, and indeed any critique of health risks forming the very consensus that we are trying to work against. The much more difficult task is to ask what we should do about it. Where does a critique of health take us if we wish to be taken forward? What new possibilities and alliances arise? What new forms of activism or coalition can we create? What are our prospects for well-being? In short, what have we got if we ain’t got health? Answering these “what to do” questions requires an emphasis on the concrete at the expense of the abstract, for if health is to be critiqued as too ideological a concept then surely we must hold resistance to this same standard. And address them we must, if we are not only to critique health, but to propose a viable set of alternatives.

What follows, then, is an attempt to distinguish a growing scholarly movement that regards health as a condition of ideology as well as longevity. Our analysis is in no way exhaustive, nor does it represent a uniform agenda of any sort. Rather, we highlight central lines of inquiry, debate, and even disagreement in an attempt to provoke further discussion. The authors represent opinion leaders from disciplines including medicine, law, bioethics, history, gender and LGBT studies, African American studies, disability studies, and literary studies, among others. Many of the chapters focus on constructions of health in the United States, although each author writes in awareness of the globalizing ways in which U.S. health is built on, and then often effaces, its connection to economies, clinical trials, lives, deaths, and side effects taking place beyond American shores. For the sake of overall coherence, each author has been asked to address the same question: Why against health?

The chapters appear in four thematic groupings, each of which addresses a specific avenue through which health is ideologically produced. Part I, “What Is Health, Anyway?” explores the basic problems involved in defining health. The section begins with a provocative challenge to modern-day notions of health by literary studies scholar Richard Klein. Taking his cue from Epicurean philosophers, Klein argues that present-day America is so strongly “in the clutches” of biomedical definitions of health that it loses sight of alternative approaches to well-being, namely those that emphasize the centrality of pleasure. Complicating Klein’s celebration of indulgence, cultural theorist Lauren Berlant rejects seeing obesity as a disease of irresponsibility and

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focuses on two other factors: the exhausting effects of the laboring day and the mental health effects of eating to pause, to rest, and to suspend vigilance. Part I then concludes with medical anthropologist Vincanne Adams’s critical analysis of the processes by which the notion of “health” in Global Health Sciences holds a tyrannical relationship to problems within the actual practices of global health.

Part II, “Seeing Health through Morality,” considers the moral valences and assumptions embodied by particular constructions of health. Legal scholar Dorothy Roberts begins by unpacking the ways in which the rhetoric surrounding the production of pharmaceuticals designed to treat diseases in particular racial and ethnic groups stealthily supports a neoliberal shift of responsibility for public welfare from the state to the private realm of family and market. Communication studies scholar Kathleen LeBesco then presents a sharply contrasting view to Berlant’s in Part I, arguing that the obesity epidemic is no epidemic at all, but rather an illustration of the “moral panic” surrounding a host of wider, cultural anxieties about identity, subjectivity, and rights. Finally, women’s studies professor Joan Wolf explores medical and moral debates about whether breastfeeding is better than formula-feeding for babies. “I am not against health,” Wolf writes, “but I am opposed to seemingly well-meaning advocates, including the government, presenting health as much simpler than it actually is.”

Part III, “Making Health and Disease,” anatomizes specific ways in which categories of health and illness are socially, historically, or politically produced. Chapters in this section particularly address how politics, corporate forces, special interests, and surprisingly shaky notions of consensus impact popular and medical definitions of mental health and its discontents. Bioethicist Carl Elliott critiques the shocking ways in which pharmaceutical company–driven marketing and propaganda campaigns shape psychiatric beliefs about disease. Literary scholar Christopher Lane then uses the strange, troubling history of passive-aggressive disorder to tell the story of how the number of official psychiatric diagnoses has “skyrocketed so dramatically that half the country is now said to suffer from at least one of them, and there’s scarcely a quirk or trait left that couldn’t be designated a new symptom.” Cultural critic Lennard Davis tackles changing definitions of obsessive-compulsive disorder. Davis argues that psychiatry’s exclusive focus on symptoms serves to flatten out understandings of mental distress. Anthropologist Joseph Masco concludes the section by shifting focus from clinical realms to political and historical ones. Masco adroitly shows how instant mass death, nuclear obliteration, and radiation-induced disease became normalized
threats in the aftermath of the Second World War, producing new anxieties, new concepts of healthy life, and new relationships between citizens and the state.

Chapters in Part IV, “Pleasure and Pain after Health,” actively refute or rearticulate basic formulations of health. Disability studies scholar Eunjung Kim’s focus on individuals who understand their absence of sexual desire as an asexual identity or orientation, not as lack or dysfunction, leads to a broad discussion of the centrality of sexuality to Western notions of healthy bodies. Anthropologist S. Lochlann Jain then unpacks the paradoxes of cancer culture. Jain argues that marches for hope, research funding and direction, pharmaceutical interests, survivor rhetoric, and hospital advertisements overlap to form a broad hegemony that restricts the ways that cancer is talked about in the United States, while at the same time paradoxically constructing cancer as an individual problem, not a social or public one. Literature professor Tobin Siebers, also writing from the perspective of disability studies, then offers a political account of how pain triggers powerful emotions, opinions, and judgments. “I speak in the name of pain,” Siebers explains, “to reveal that the fear of pain is one of the most pervasive and insidious justifications of disability oppression.” Finally, legal theorist Anna Kirkland concludes Against Health by summarizing the book’s main arguments and asking, “What next?”

Once again, this book’s stand against health is not a stand against the authenticity of people’s attempts to ward off suffering. We instead claim that individual strivings for health are, in some instances, rendered more difficult by the ways in which health is culturally configured and socially sustained. As we now turn to explore, health is a concept, a norm, and a set of bodily practices whose ideological work is often rendered invisible by the assumption that it is a monolithic, universal good. Sometimes, to be sure, this ideological function works for the betterment of many people by promoting herd immunity, longevity, happiness, or calm. Other times, ideology obfuscates the ways in which the good health of some persons depends on the ill health of others, or promotes purely political agendas under the guise of passion or concern. We hold that the conversations that doctors, patients, consumers, activists, pacifists, protesters, or policymakers have about health are enriched by recognizing that, when talking about health, they are not all talking about the same thing. And that articulating the disparate valences of “health” can lead to deeper, more productive, and indeed more healthy interactions about embodied expectations and intersubjective desires.
NOTES

6. We acknowledge, however, that more often the opposite association exists in capitalist societies. Wal-Mart Stores, Inc. grows more profitable by denying health care to its workers. And the stocks of tobacco corporations rise when the class action lawsuits of wronged individuals are thrown out of court, thereby allowing the production of more cigarettes. Inasmuch as Wal-Mart or tobacco shares rise in an inverse proportion to the health claims of workers or consumers, the health of economic bodies depends inversely on the health of individual ones.
10. See Irving Zola, “In the Name of Health and Illness: On Some Socio-Political Consequences of Medical Influence,” Social Science and Medicine 9, no. 2 (February 1975): 83–87. See also Irving Zola, “Bringing Our Bodies and Ourselves Back In: Reflections on a Past, Present, and Future ‘Medical Sociology,’” Journal of Health and Social Behavior 32, no. 1 (March 1991): 1–16. We might also call on the work of the philosopher Louis Althusser to define health as an interpolating rhetoric that hails and defines patients and doctors both. This perspective helps deconstruct moments when, for instance, patients come to doctors’ offices requesting advertised brand-name medications by name after having been hailed by drug advertisements. Such moments represent consumer empowerment, to be sure.
But the empowerment comes at the cost of entry into a symbolic order that precludes awareness of generics, herbal remedies, holistic medicines, and other alexiterics that are thereby metabolized as outside the economy of health.


