

From:

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Between Self-Determination and Social Technology
Medicine, Biopolitics and the New Techniques
of Procedural Management

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The book critically examines how concepts such as self-determination, participation, ethics, or dialogue, developed not least by the feminist movement and directed against repression, heteronomy and professional paternalism, have been integrated into new contexts and transformed into new social technologies. Crossing a variety of fields from birthing, genetic counselling, living wills, hospital ethics, to population policies and politics of biomedicine, it shows that medicine and medicine-related policies and practices form crucial arenas of these transformations. What we see emerging is procedural management as a new set of social techniques.

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Preface

We're free. That's the message in a bottle that floated off from the Movements of the 1960s. People who know themselves to be free people can stop unjust wars, win the vote for those excluded from democratic practices and full social participation, and reduce the power of people who had claimed authority on the basis of technical expertise.

Restructuring the medical encounter became emblematic of the possibilities of a freer life in institutions. The women's movement in particular took aim at the godlike physician—the doctor who, in the best interests of his patients, decided what needed to be done and did it, but who, also in the interest of his patients, did not speak—and toppled him. Armed with information and supported by free and open talk among friends and colleagues, women—eventually, all patients—demanded and won a seat at the medical decision-making table. The victors asserted that the power of medical authorities had been properly reduced or that, at least, power had come to be shared between interested parties.

Beginning around 1970 the structure of the medical encounter changed. Very quickly, medicine adopted the principle of informed consent, which was premised on the notion that a patient had to be told all the facts of her situation and all options for treatment so that she, not the physician, could be the principal decision maker about what medicine could do to her body, herself. Medical ethics was no longer just an internal code by which physicians might regulate themselves but became subject to public discussion about the proper role, place and function of physicians. Medical practices became matters of public policy. Medicine's object, the disease, the disability and the body that carried It, became a subject, a She or a He, a person who spoke, contended, thought, desired, felt, a person who angered,

experienced pain, who changed, who wondered not just how, objectively, one dies but what it means to die, and what it means to live. People, especially free ones, are messier than objectified, medicalized bodies. Medicine changed to accommodate “the patient as a person.”¹

But now we have this remarkable collection of thoughtful empirical studies of the structure of medical practice that should make us wonder if, almost a half century after the Movements, we are truly free. Ranging from the intimacy of the genetic counseling session through the knot of legalities that emerge as we move from the human condition of “having to die” to the medico-legal problems of “planning my death” and on up to the level of National Ethics Committees and Boards, these studies paint a challenging, even perverse image of this so-called free individual. The new subject of medical practice not only *can* talk; she *must* talk. She not only is capable of making decisions; she must follow medicine-designed decision-making procedures, “social technologies that ... avoid disruption, absorb disturbances, and allow for things to smoothly go on.” At the national level citizens must engage in debates about ethics because public debate is *the solution* to ethically conflicted problems; public debate gives people a sense of participation in political discussions, but the discussions are socially designed so they do not interfere with the progress of science. We’re not free. We revel in thinking that we are, but in fact we are well managed. We can say anything as long as we stick to the script, the preformed guidelines for proper speech. We’re free as long as we don’t say or do anything that matters.

This volume details how our interactions with modern medicine, public officials and with one another have been structured and refined to make us behave. New procedures forbid real talk, real conflict, any form of immoderation, silence, all the juiciness and earthiness of our humanity out of which the Movements flowered. We cannot disrupt scientific progress by

1 The first chapter of Tinsley Harrison’s new medical textbook, *Principles of Internal Medicine*, was “The Patient as a Person.” This was the first time medicine had thought of the patient as a person. Harrison’s revolutionary manifesto said, in part, “the art of medicine is not confined to organic disease; it deals also with the mind of the patient and with his behavior as a thinking, feeling human being” (Harrison 1950, 4). It is worth noting that this was published in 1950, ten to twenty years before the revolutions of the Movements.

doing, as Bill McKibben put it, “an unlikely thing: we need to survey the world we now inhabit and declare it good. Good enough” (McKibben 2003, 109). Were we able to start there, we might imaginably push on toward the recovery of the Enlightenment ideal that “the only ethical human condition is the mutual, shared, respectful, civic recognition of human interdependence” (White 2004, 163). We would not spend our time talking with genetics expert trained to speak only in risk probabilities; we could find friends with whom to talk about how best to live in the great hope of expecting a baby. We would not wrap ourselves in the expert-granted “personal autonomy” to make, in advance, personal decisions about “my death” and fuss over the details of our living wills and final instructions; I could reflect on “my trust in my relatives and others around me, my faith that they will do what is right, [on the fact] that I can feel cared for as a human being”.² I probably would not worry about the details of research on stem cell lines, pre-implantation diagnosis, or the latest efforts to control population growth; I might join with others to imagine what liberation, equality, enfranchisement and the like might mean in these times. A world that we declare “good enough” in scientific terms has a chance of being better in human terms.

This book says, “We’re not really free, but we could try to be”. It’s a generous invitation.

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2 From “Planning Death,” this volume.

Between self-determination and social technology. Medicine, biopolitics and the new techniques of procedural management

An introduction

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Doctor's attitudes toward patients are terribly condescending, especially toward women. You aren't supposed to read the record of your own body, and you are scolded like a child if you do. Doctors withhold information that you are dying. They withhold information that you might have a difficult pregnancy or childbirth. In playing God, their attitude is that you must have complete confidence in them to make all of your decisions for you. Why should they make your decisions?

(Boston Women's Health Collective 1970: 182)

Forty years have passed since a group of women, who called themselves "the doctors group", published the first edition of *Our Bodies, Ourselves*. What angered them was the experience of a double silence; the silence of doctors toward them, as denounced in the quote above, but also the experience of being silenced, of not being entitled to speak about their own bodily experience, not being taken seriously, and not being listened to. The first silence was one rife with knowledge and hubris: knowledge withheld from those whom it intimately concerned. Doctors, the women felt, were withholding knowledge about a patient's body, pregnancy, or imminent death, knowledge deemed too complicated and dangerous for those whom it con-

cerned. Decision-making was left to those who could deal with that knowledge and who knew what they were doing, namely, the doctors. On the other side, there was a silence rife with ignorance and shame: ignorance that prevented them from posing questions, discussing options and insisting on making their own decisions, and shame about menstruation, masturbation, unwanted pregnancies, illegal abortions, post-partem depressions, and other manifestations of having a body, specifically a female one. Against this ignorance and shame, the group deployed a process of collective learning and talking, acquiring knowledge and sharing experiences, emotions, and ideas: “The process of talking was as crucial as the facts themselves” (Boston Women’s Health Book Collective 1973). This process became a model for feminist self-organization and arguably for a great many other social innovations in the following decades.

The book was highly influential, but not everything has changed. The experience of not being listened to, not being taken seriously, not being sufficiently informed, not daring to ask or not getting answers to one’s questions is certainly still common in the medical context. There is still a general sense that the field of medicine, from medical practice via medical research to the politics of health and biomedicine, is a domain where experts reign supreme, exercising a paternalist type of rule, claiming to know what is best for the patient or the public, telling them what to do and what not to do, and making decisions while scarcely consulting with the persons concerned. Medical institutions are still widely experienced as a realm of heteronomy and alienation, a realm where people have to struggle in order to understand what is happening to them. People still often feel they are not allowed to express their wishes and fears, make themselves heard, and engage experts in dialogue rather than passively await their decisions. Self-determination, patient autonomy, participation and dialogue are still the watchwords of the struggle against medical domination.

At the same time, we have seen an explosion of discourse in relation to just about all practices and processes that in the 1970s were a matter of ignorance and shame, such as menstruation, masturbation, pregnancy, abortion, and death. These have now been joined by infertility, breast cancer, HIV, transgender, lesbian motherhood, reproductive technologies. Today, it has become an established norm that patients have to be informed, and that citizens need to be medically educated, if not genetically literate. Life has become a series of occasions for decisions that, as nearly everyone would

agree, should *not* be taken by medical experts, but by the individual subject. We as individual subjects should decide whether, where, when and how we want to give birth, undergo breast cancer screening, cervical cancer vaccination, or genetic testing, which pregnancy we wish to abort and which we want to carry to term, which organs we want to donate, and even when, where and how (although not whether) we want to die. While people still experience medical paternalism, paternalism has become a pejorative term and self-determination a legitimate claim.

In 2007, an article in the *Journal of Health Services Research & Policy* hailed the changes incited by *Our Bodies, Ourselves*:

The Collective, along with other self-help health and consumer groups that emerged in the late 1960s, played a critical role in transforming patients from passive recipients of health care into active consumers. Today's concept of shared decision-making in health care is firmly rooted in the principles and practices of health communication set forth in *Our Bodies, Ourselves*. Scholars now debate which patients prefer being active decision-makers and even ask if passive patients should be urged to take more active roles in decision-making. These controversies reflect the diffusion of models of doctor-patient communication and relationships that the book set out to create over three decades ago. (Ruzek 2007: 182)

In short, the norm of “the doctor knows best” has been replaced by the norm of shared decision-making, the figure of the ignorant and docile patient by the informed and active consumer, and the commandment to keep silent by the commandment to talk. Yet, if we are supposed to talk, what is to be our language? If we are supposed to be informed consumers, what menu are we supposed to choose from? And if we are supposed to make decisions, what if we do not want to decide? If communication takes us on the road to liberation, what are the terms on which communication takes place? And what is the meaning of the liberation we are thereby offered?

If we take a second look at *Our Bodies, Ourselves* of 1970, we find that some things apparently got lost in transformation. The kind of liberation the group had in mind did *not* equate to consumer choice, shared decision-making, and health communication. Their ideas had something to do with social and political change and social justice, and not just with models of communication:

The factors in our society which produce a great amount of sickness are not dealt with by the medical establishment. In fact, bad housing, poor nutrition, poor sanitation, pollution, and dangerous working conditions are not dealt with by any establishment. The diseases resulting from these factors are obviously suffered mainly by poor people who have no control over them. (Boston Women's Health Collective 1970: 179)

The idea that one has to have control in order to be liberated has endured, but it has been detached from the political meaning it carried in the movement context at the time. Having control is certainly important today, particularly in the medical context, but the struggle for control, so the common understanding, is the struggle against doctors who prescribe medication without explaining it properly or who refuse to accept your living will; it is not the struggle against poverty, dangerous working conditions, or pollution. Today, to speak of bad housing or poor sanitation in relation to liberation would sound somewhat outmoded. Some readers would intuitively respond that these social problems have been solved or at least dramatically mitigated. However, this is unfortunately not the case—or, at the very least, it depends where you look. Similarly, to speak of power, class, race, or the profits made in the health sector, like the Boston women's group did, would seem rather inappropriate for today's active consumer.

William Arney and Bernard Bergen (1984) have provided us with a different view on the changes in modern medicine since the 1950s. They also register the entrance of the speaking subject into the medical setting, that is, the patient speaking about her- or himself, and thereby contributing to the therapeutic process rather than obstructing it. Arney and Bergen describe the new vision of patients as partners or participants, as proclaimed by medical textbooks in the 1950s and 1960s. However, they refuse to celebrate these changes as marking a transition from oppression to liberation, from medical domination to self-determination, from depersonalized medical care to the humane recognition of the person, or from authoritarian to egalitarian relations. Drawing on Foucault's critique of the repression hypothesis and his insight that speaking the truth about oneself is not an act against power but within power, they insist that "the person does not dissolve the activity of power as he or she begins to speak" (Arney and Bergen 1984: 5). Power is not just domination and exclusion; today it also works through *inclusion*. Thus, Arney and Bergen argue that "[w]e may have to

suspend the seemingly self-evident idea that to study power we must focus on exclusionary practices” (Arney and Bergen 1984: 6). This view generates a new set of questions. If we are invited to participate, in what do we participate? On whose terms, in which terms, in which setting, within which framework? If we are invited to talk, in which language? If we are supposed to take decisions by ourselves, what does it mean to decide? And what does it mean to render things decidable at all?

Today, we maintain, the changes pointed out by Arney and Bergen go beyond the scope of the medical encounter. The contributions to this volume show how the incitement to talk, the invitation to speak about oneself, to search for, to express and to share one’s preferences, anxieties, views and values has been cultivated in different settings and incorporated into a wide range of practices and institutions, from labor wards to living wills, from counseling services, ethics committees and public participation arrangements, to regulation processes or policy debates. Today, in many settings, not only patients talk about themselves, but also professionals, citizens, and at times even experts and policy-makers. They all are constructed as partners in communicative procedures that require them to participate by means of speaking about themselves. If Foucault traces the speaking subject from the confessional to psychotherapy, and Arney and Bergen follow her from there to the medical encounter, today we also find her in the consulting room, the ethics committee, in public consultations, and parliamentary debates—or at home discussing with her children how to fill in the form of her living will. Part of this development may be understood as a consequence of the transformations described by Arney and Bergen, namely that medicine transcends the boundaries of the doctor-patient dyad by taking over, or being charged with, novel responsibilities from managing chronic disease, via prevention or containing health care costs, to recruiting medical subjects or procuring organs for transplant. Medicine takes on the logic of systems, turning both doctor and patient, along with other professionals such as midwives, nurses, counselors, or pastors, into team members and participants in systemic processes. Team members, to some extent, have to speak a common language, but what language is it? What can and what cannot be said in this “proper talk” (Braun/Moore/Herrmann/Könniger 2010)?

The systemic turn in medicine is not the only strand that has led to the proliferation of practices of speaking-about-oneself. Another strand goes

back to the new social movements of the 1970s and 1980s, such as the feminist, gay, disability rights, or the environmental movements, which questioned expert authority, demanded self-determination, institutional transparency, citizen participation, and attention to the value dimension of policy-making. Interestingly, many institutional innovations that incorporate the speaking subject, such as non-directive counseling, shared decision-making in peer committees, or public consultations on contested policy issues, have evolved in issue areas for which medicine claims competency, such as dying or withdrawal of treatment (see the contributions by Isabella Jordan and Helen Kohlen in this volume), giving birth or being pregnant (see the contributions by Marion Schumann and Silja Samerski), political controversies on genetic technology and reproductive medicine or other contentious medical technologies in the political arena (see the contributions by Svea L. Herrmann, Sabine Könniger, and Kathrin Braun and Susanne Schultz), or contraception and population policy in the context of development policy (see the contribution by Susanne Schultz).

If this observation is correct, it may have to do with the fact that the body is still at the intersection between the personal and the political, at the point where processes of subjectivation and processes of government meet. On the one hand, we experience our body as the most personal thing to us. Decisions about our body, we feel, should be a matter of personal autonomy and not of doctors, experts or policy-makers' authority. This is the more so when it comes to moments in life we experience as deeply personal and often difficult, such as being pregnant, giving birth, trying to conceive a child, or facing death. On the other hand, the body and the "facts of life", such as health and disease, fertility and infertility, conceiving or not conceiving a child, aging and dying, are located where Foucault saw sexuality, namely at the intersection between the individual and the population, the techniques of discipline and the mechanisms of regulation, anatomo-politics and biopolitics (Foucault 2002: 250f.). For politics today, matters of health and illness, reproduction and mortality are no less important than for classical biopolitics in the 19th and early 20th century, for they are still linked to matters of economic productivity, social welfare, public finances, or political conflict, and as such they are in need of government and steering. For these reasons, as Foucault has shown, medicine has been critical for articulating the formation of governmental technologies, knowledge and subjectivities, from the emergence of the modern state up to the present. In

contrast to the era of classical biopolitics, however, social engineering is no longer considered a legitimate technology for governing the living, as it had been in the first half of the 20th century. In the first part of the 20th century, one could say, two historic novelties, which Foucault inspected in *The Will to Knowledge* (Foucault 1980), still existed largely in separation from each other, namely the migration of confession practices into the therapeutic setting and the emergence of a novel type of power regulating, managing and enhancing the life processes of the population. Foucault dealt with these two phenomena in separate chapters. True, they were articulated through sexuality, forming the link between the individual and the reproduction of the population as well as the site of knowledge production, truth telling, categorization and normalization. Yet they occurred in different institutional contexts and on different social levels. Confession practices, soul searching and subjectivation took place on the micro level and mainly in the context of psychotherapy, whereas this new type of power Foucault named biopower was located at the macro level, exercised by state actors through public policies, and supported by experts, professionals, charities and other intermediaries. The appearance of the speaking person, with her respective practices of soul searching and subjectivation, was confined to the micro level, and even here more specifically to dyadic settings that still bore some resemblance to the penitent-priest relation. Even the ordinary medical encounter between doctor and patient, as Arney and Bergen showed, gave no appropriate environment for the person speaking about herself. Way into the 1950s, it did not give rise to self-technologies in form of introspection and truth telling. Looking, not listening, was the usual way of finding out what was wrong. The doctor was the one, who had the relevant knowledge to interpret the signs of disease on, or in, the patient's body, the patient had to show those signs and follow instructions, and ideally disease would go away. Likewise, at the level of biopolitics, the population, in its size, composition, health, birth rate, death rate, productivity, proclivity to alcoholism, crime, or other deviant behavior, was the target of governing and steering, exercised top down, through the application of expert knowledge, transformed into provisions and measures to be followed (ideally) by the target groups, such that social problems would go away. In the 20th century, biopolitics has largely taken the form of social engineering in this sense: identifying a "social problem", making a decision upon the means of intervention, applying appropriate expert knowledge, imple-

menting schemes and programs—everything in a top down manner, and ideally solving the social problem. Within this model there was no room, nor need, for speaking subjects. Medical knowledge and medical professionals have been prominently involved in this type of biopolitical social engineering, designing and implementing policy schemes for hygiene, eugenics, and so on. In short, while the speaking subject made its appearance in the therapeutic setting on the micro level, medicine and biopolitics for decades remained a paternalist, expert-led, top down affair. Technologies of the self were linked to but not integrated with technologies of government.

The contributions to this volume suggest that since the 1960s, and in a variety of fields, we have seen the mutual assimilation and integration of self-technologies and governmental technologies. In the course of this integration, the figure of the speaking person has hugely expanded her range of activities, moving from the narrow, dyadic, therapeutic setting, via the medical encounter, the clinic, or the ethics board, further into the political realm. Self-examination, self-expression, and self-determination have become widely accepted norms and values both in relation to an increasing range of issues of “delegated biopolitics” (Memmi 2003), such as abortion, preimplantation genetic diagnosis, embryo research, or medically assisted suicide, and in relation to a plethora of arenas and institutional settings. The range of arenas where it is considered acceptable, and even virtuous, to examine one’s feelings, to express them as authentically as possible, and to make decisions on the basis of them has expanded greatly compared with the 1950s and 1960s. However, the studies assembled in this volume also show that when claims to self-expression and self-determination are incorporated into new institutional contexts, this has certain implications, such as the requirement to use a certain language that allows for addressing some things but not others, the requirement to accept certain terms of participation upon entering the communication (for instance about which issue is at stake and which is not), and to accept certain new norms and standards that have replaced older ones. New types of expectations and necessities emerge, like the expectation that one plans ahead for one’s death or calculates whether or not to abort a fetus on the basis of statistical probabilities. We know from the growing body of governmentality studies, that the self is increasingly engaged in new technologies of government, particularly through new choices, new freedoms but also new responsibilities brought

about by technoscientific developments in genetics, reproductive medicine, neuroscience, pharmacology and other medical fields (Lemke 2004; Rose 2007). The studies presented here add to this field. However, the focus of this book is not specifically on the production of a neoliberal subjectivity in and through techno-scientific advancements. It focuses on forms of interaction rather than individualization, and on changing social practices rather than techno-scientific developments and their implications. Many of the changes examined here, such as the invention of ethics committees or living wills, were *not* induced by technoscientific developments, although public discourse gives the impression that they were. We do not intend to sustain this belief, for to do so would mean, even if unwillingly, subscribing to technological determinism.

Also, our interest is very much on the dark sides of these transformations, on what gets lost and what cannot be said and done, and on the new burdens, norms, demands and impositions that emerge. We think something else is going on in relation to medicine and biopolitics besides the responsabilization of the individual, although this is an important part of the story. We think that new forms of interaction have evolved that to some extent incorporate the notion of self-determination and participation and that operate as new social technologies for managing different types of conflicts and crises. These are social technologies that, unlike technologies of classical social engineering, cannot operate *without* the speaking person being actively involved. Also, unlike medical or expert paternalism, they do not consist of telling people what they must and must not do. These new social technologies are procedural rather than prescriptive and directive. What does that mean, and what is the difference? In order to understand what is new, it may be useful to compare the concept of social engineering to the concept of procedure.

In *The Open Society and its Enemies*, first published in 1944, Karl Popper conceptually differentiates piecemeal social engineering and utopian social engineering, defending the former against the latter. For Marx, he argues, capitalism subjects everyone, workers and capitalists alike, to its immanent laws. Capitalism is a machinery that works blindly and makes everybody blind (Popper 2003: 123f.). Therefore, Popper argues, according to Marx, there can be no way of rationally improving the system: “Social engineering is impossible, and a social technology therefore useless” (Popper 2003: 124). People will not be better off until the system has been re-

placed by a better one. Piecemeal social engineering, in contrast, is more realistic, less problematic, and, in Popper's view, definitely possible. It seeks to fight the greatest social evils through rational, science-based political interventions such as tax systems, social insurances, police forces, educational systems and the like. Piecemeal social engineering basically means rational planning, exercised by governments, informed by social science, and applied to social institutions. It presupposes a clear, substantial idea of the problems at stake and what needs to be changed.

In the 1960s, the term social engineering became linked to a growing discourse on "social problems", mainly in the US. Social problems could be anything from war and poverty to pollution, traffic, alcoholism or the growth of the "world population". Within this discourse, the "social engineer" does not tackle institutions, such as tax or social insurance systems as in Popper, so much as individual behavior. Social problems, within this discourse, are caused by inappropriate human behavior and the key to solving them is to alter human behavior. The job of the social engineer is to bring people, for instance, "to have fewer babies, or to drive more carefully or to refrain from disliking blacks" (Weinberg 1991: 42). Thus, it presupposes the idea of governments as coherent subjects who have both the capacity and the right to identify social problems, set policy goals, and use top-down interventions to achieve them. Above all, it implies the idea that governments are entitled to set substantial policy goals. At each stage of this process, they are to be supported by reliable, readily applicable social science knowledge that allows for rational planning.

Yet, almost at the same historic moment when the idea of social engineering becomes popularized, it also becomes problematized. Questions arise whether social engineering, with its substantial goals and its centralized schemes, is compatible with individual freedom. What are its costs, and does it work at all? It turns into a polemic concept mobilized by those who fear for their financial resources or their liberties or both, endangered by patronizing governments. Now "social engineering" has become a pejorative term. It has taken on the meaning of illegitimate and expansive government intervention. Certainly the classic model of social engineering has not disappeared completely. In those parts of the Western world, however, that subscribe to advanced liberal strategies of government, which have been on the rise since the 1980s, it has largely been replaced by ideas of "government at a distance" (Rose and Miller 1992). We think that in these

contexts, governing through procedure has become an important technology of governing at a distance across different social realms and levels. Although the concept of procedure may have a technicist or bureaucratic, impersonal ring to it, the speaking subject is in fact at the center of governing through procedure. In order to understand this concept, it is useful to turn to a sociologist who has described the functional logic of procedures, even if in a different context than ours, namely Niklas Luhmann. In his *Legitimation durch Verfahren*, first published in 1969, Luhmann (1983) analyzes what kind of legitimacy is created through modern decision-making processes by courts, parliaments and public administrations, and *how* it is created. He argues that in these processes legitimacy is derived specifically from the organization of decision-making as procedure. One does not have to subscribe to the view of social theory as systems theory in order to make use of this analysis. While Jürgen Habermas has accused Luhmann's systems theory of *operating as* a social technology, we think his concept of procedure can be useful in order to *analyze* a new type of social technology. Luhmann, Habermas argues, excludes questions of practical reasoning, that is normative questions, from his conceptualization of the social order (Habermas and Luhmann 1985). In doing so, Habermas says, Luhmann re-frames practical questions as technical questions and depoliticizes them, thereby protecting the existing social order from being challenged in public discourse. However, sometimes refraining from taking a normative stance can actually be quite useful for developing a critical stance, as Foucault (who has been the target of a similar critique by Habermas) has shown.

Now, what is a procedure? In order to understand the specificity of procedure, one may start with what a procedure is not. For instance, a procedure is not a rule or a set of rules. Although procedures are mostly regulated by a legal framework, they are not identical with it. Rules exist; they may be formal or informal, be enforced or suspended, applied or ignored. Procedures take place. Their form of existence is a temporal one; they can only exist as practices in time. Further, procedures are not rituals. Oftentimes, procedures may have strong ritual elements, but this is not what makes them procedures. A ritual is a fixed sequence of actions within which only one action is correct at a time; there is no choice among different equally possible options. In a procedure, by contrast, the outcome is uncertain. If it is not, it is a ritual and not a procedure. It is the uncertainty of the outcome and the existence of choices that motivates people to partici-

pate in a procedure at all; if the outcome was clear, there would be no point in participating.

In *Legitimation durch Verfahren*, Luhmann looks at legislative procedures, court trials, and bureaucratic procedures, that is, those procedures that in modern societies generate, interpret or implement the law. His aim is to reconstruct the problem to which these procedures are the solution. Note, that the question is not which particular problems are solved within particular procedures, but rather which problems are solved through procedure as such. In the case of the above mentioned type of procedures, namely those that generate, interpret or implement the law, the problem is to generate the legitimacy of the law under conditions of modern uncertainty, where legitimacy means the general willingness of people to accept, within certain limits of tolerance, the law as binding, regardless of whether it benefits their interests or is in line with their values or convictions, or not. Thus, legitimacy is not synonymous with consensus; the problem is how to secure legitimacy under conditions where consensus is unlikely. Due to the disappearance of natural law and its constraints, but also, one could add, to the growth of new options opened up through technoscientific developments, the range of possible alternative courses of action has greatly increased. Procedures are forms of interaction that, following Luhmann, serve to render things *decidable* and absorb the frustration and potential anger of those whose view did not prevail. They eliminate alternatives, neutralize energies, and dampen conflicts (Luhmann 1983: 4).

The point, thus, is not to create consensus, or to make the *right* decision, nor even to make *good* decisions. Procedures as such are not about the quality of the outcome, since there is rarely an uncontested way to assess outcome; they are about manageability. Procedures can be understood as social technologies for dealing with matters of uncertainty, conflict, or crisis in a way that avoids disruption, absorbs disturbances and allows for things to smoothly go on. This is not to say, however, that procedures always function the way they should and achieve what they are supposed to achieve, nor that without them, we would necessarily see an eruption of open protest. But it may explain why we see all sorts of procedures emerging in different contexts, some for decision-making, some just for deliberation, consideration, evaluation, argumentation or other speaking practices, even if people are not necessarily convinced that this leads to better outcomes, or any outcomes for that matter, let alone to a more efficient way of

achieving those outcomes. Procedures serve to achieve manageability, not particular outcomes. But how do they achieve manageability? Referring to collective decision-making procedures, Luhmann argues that they consist of building a decision-history within which each single step turns into a fact that as such narrows the scope of possible subsequent steps. The UK Human Fertilisation and Embryology Authority, for instance, has a tool called a “decision tree”. There are decision trees for different sorts of questions, for instance a “PGD decision tree” (HFEA 2010), or a decision tree for clinic staff (HFEA 2009). They all provide a scheme of “ifs” and “thens” that are meant to provide guidance for decision-making on different sorts of issues. While the decision tree is a highly standardized, computer program-like procedure, it is important to note that it is *not* a computer program. Decision-making is not left to software. These schemes, on the contrary, are tools for clinic staff (for instance) to organize their interaction with patients, or for members of the licensing committee to make a collective decision on whether or not to grant a clinic a license to perform preimplantation genetic diagnosis (PGD). A decision tree is a technology of interaction, not an electronic technology. Its purpose is not only to generate a decision—for that could be done by a computer program—but also to render issues decidable in a way that both clinic staff and patient, both license committee members and clinic, and in case of the latter, maybe even the general public, will feel committed to—even if they don’t necessarily like the outcome.

Speaking is key to generating this commitment. The properly operating procedure will provide the patient, the staff, the committee member, and sometimes also the member of the public with an opportunity to speak. Through expressing herself, her thoughts, opinions, sometimes her beliefs, values or feelings, she participates in narrowing down the scope of possible future actions. Her utterances become part of the decision-making history, and they enter that history as facts she cannot easily undo. If she wants to be taken seriously, she needs to be credible and authentic, which means she has to be true to what she said before. If she missed the right moment for uttering protest, she cannot make good for it later; belated protest rings hollow and is easy to rebut (Luhmann 1983: 45).

Aside from binding participants to their utterances in the past, and thereby eliminating alternatives, Luhmann suggests that procedures also serve to fulfill expressive needs, such as letting out anger, or pride, or presenting oneself as a good, moral person. Thus, while the expected outcomes

may lie in the distant future, the opportunity to speak may fulfill more immediate needs (Luhmann 1983: 124).

What happens is that upon entering into a procedure, the person accepts the terms on which the procedure takes place. To become a participant is to accept its rules, its setting, its remit and the like. Second, upon participating, the person binds herself to the history of her own expressions, to what she has or has not said at a certain moment in time. One effect is that for her it becomes hard to sustain fundamental opposition to the terms of the debate once she has subscribed to them. Another effect is that if she does not agree to the outcome but still sustains an attitude of opposition, conflict or anger, it is easy for society to ignore her. If she does not adjust to the new situation, she will just be the notorious grumbler.

Not all of the procedures examined in this volume are decision-making procedures, and few are as standardized as the “decision tree”. We think there is a wide variety of procedures that serve as social technologies for rendering issues manageable, some more rule-based, some more informal, some more standardized, others more flexible, some restricted to a dyadic setting, such as genetic counseling, some to a restricted group of peers, such as ethics committees, some open to a diffuse public, such as public bioethics debates. What they have in common is that they make it hard for participants and non-participants to sustain conflict and opposition. For non-participants, the fact that mechanisms and procedures of ethical debate, shared decision-making, exploration of preferences and so on are in place, means that they *could* participate, if only they seriously wished to, or that, when the moment comes, they *will* be asked for informed consent, or that their case *will* be brought to the respective ethics committee. So, we can be reassured that there are proper procedures in place to take care of crisis when it occurs. Whether this is the type of care we actually need or wish for ourselves and those we love is another question, and one that becomes much harder to address once the proper procedures are in place. Being the active consumer, you can opt not to buy certain prenatal tests, but it is much harder to say that society does not need this type of test at all. You can get a lot of support from churches, charities, or call centers to fill out your living will, but you cannot wish just to give yourself into the hands of people you trust when you die. You can actively participate in public bioethics debates but if in this context you insist on talking about poverty, power, capitalism, or unequal health care you will most likely be told not to change the sub-

ject. This is not to say that self-determination, shared decision-making, participation, or ethical debate are *just* social technologies, and certainly not that they are novel, more insidious means of manipulation. Yet, we think, someone has to be the killjoy and question whether they really give so much cause for celebration, detached as they are from the struggle for political and social change.

The contributions to this volume pose this question, each on the basis of detailed empirical research in their field. In the first contribution, Marion Schumann has traced the emergence of the speaking person in the labor ward back into the 1950s. Using contemporary archive material, medical journals and books, as well as sources from the German women's magazine *Constanze*, she examines the transformation of obstetrical concepts in the Federal Republic of Germany between 1950 and 1975. Beginning with the traditional model of midwives assisting women giving birth at home, a practice that was still widespread in the early 1950s, she analyzes two scientific methods of childbirth that have been established in the clinic at different paces: technologically monitored and preventively calculated "programmed childbirth," and the so-called gentle, or "natural" childbirth model of Dick-Read. What emerges from this study is the "internal" connections between these two models, in that both show the predominance of thinking in terms of planning in the 1960s.

Isabella Jordan examines the transformations in dealing with death since the 1960s. Since then, she argues, the dying have increasingly been professionally cared for by clinical institutions. Developments in intensive care have raised the possibility of extending lives. The public debates in Germany since the 1970s on "euthanasia" on the one hand and on terminal care on the other both focus on "self-determination in the final phase of life" and the question of how it could best be achieved. They evoke peoples' alleged "fear of high-tech medicine" as well as their alleged demand for self-determination, suggesting the latter be the best solution to the former, in order to avoid "sustaining life at all costs." Based on document analysis, the contribution examines the development of the death debate in Germany. It traces how what were initially contrary demands for "euthanasia" on the one hand and terminal care on the other have in recent years converged in the demand for living wills. It shows that while the demand to plan or arrange one's own death is becoming more pronounced in public

debates, everyday social and caregiving aspects based on responsibility and trust are being thematized less and less.

Silja Samerski investigates the concept of individual self-determination more closely in the context of genetic counseling. Based on an empirical study of genetic counseling in Germany, this contribution frames counseling for “self-determination” and “autonomy” as a new technique of social engineering. She argues that in the 20th century self-determination was a major goal for female activists struggling against cooptation of female fertility by the state, whereas today, counseling services in medicine impose “autonomous decisions” upon patients. Taking the example of prenatal genetic counseling, she shows that professionally taught self-determination creates several paradoxes. First, it is service dependent. The act of deciding is identified with selecting from a menu of service options. Second, it is mediated by technoscience. Clients are supposed to choose technical procedures, mostly ultrasound or amniocentesis, and base their decision on scientific constructs such as chromosome numbers and probability curves. Third, it is compulsory to choose because even rejection of the whole procedure will be interpreted as a choice, namely, for the no-test option with its associated risks. Therefore, this new kind of self-determination requires services offered by professionals, schooling in technoscience, and decision making between risk-laden options.

Helen Kohlen’s contribution looks into shared decision-making and shifting responsibilities in hospital ethics committees. She shows how bedside ethics gave way to bioethics and how institutionalized committees have played a decisive role in this transformation process. The key questions here are: What makes people call upon experts of bioethics in hospital committees, and what are the consequences of collective decision-making and a rationalistic framework for resolving “patients’ cases”? Bioethics, understood as a contested discipline and practice whose historical traces and proper tasks are not at all clear, has nonetheless grown rapidly as an interdisciplinary enterprise in the US since the 1960s, when bioethicists were called upon to serve as expert consultants in numerous medical, legal, political, educational, and industrial areas. In the 1970s, the “Case of Karen Quinlan” drove the idea of decision-making by local committees forward. Gradually bioethics moved into the medical field while ethics committees became the standard organizational form for discussions on patient care review and engagement in a collective decision-making process, the formula-

tion of new rules and policies and the education of health care professionals on how to cope with ethical dilemmas. Medical morality gave way to bioethics by adopting not only its interdisciplinary approach, but also its rational analytical style and a technical procedure of principle-based ethics. The responsibility that once belonged to the authority of the medical profession, rooted in the Hippocratic oath, has shifted into a collective process of decision-making by a team of (bio-)ethics experts, physicians, lawyers, nurses, chaplains and social workers.

Moving to the arena of public debate, Svea Herrmann analyzes the political conflicts on embryonic stem cell research in the UK and in Germany in the late 1990s. She argues that public ethical debate, here, worked like a kind of “speaking cure for conflicts”, arguing that problematization in terms of ethics underpinned a constant call for the stimulation of public discourse and the invitation of more and more participants in it. At the same time, these ethical debates did not counter a preexisting commitment to scientific “progress.” On the contrary, in both countries, public discourse, especially a discourse in terms of ethics, was a medium in which an imperative of scientific progress, on the one hand, as well as actual or possible concerns or opposition towards scientific endeavor, on the other, could co-exist. Ethical problematizations of these issues created a discursive space for the articulation of anxiety or conflicts and the formation of an ethical viewpoint, without, however, challenging an imperative of scientific progress. In face of new research options public participation in ethical debate was directed at the formation of a personal ethical perspective or at personal decision-making according to individual moral conviction rather than at political contestation of scientific progress. Thus, public ethical debates followed and worked in favor of liberal and individualistic market logic.

Kathrin Braun and Susanne Schultz also examine science policy controversies. They focus on the government of preimplantation genetic diagnosis (PGD) in the UK and argue that the mode of government that has emerged here differs from classical modernist statecraft in many crucial respects. It is a pragmatic, flexible, procedural mode of governance, which ranges from counseling processes among patients, clinics and the regulating authority, the Human Fertilisation and Embryology Authority (HFEA), via deliberation processes within the HFEA, to processes of debate organized through public consultations. This new mode of government, the authors argue, is characterized by incremental decision-making rather than by gen-

eral rules, elastic and temporary categories rather than fixed ones, non-parliamentary bodies rather than parliament, and an emphasis on personal experiences, values, and emotions rather than universal principles. In effect, however, it is permissive and open to a gradual expansion of technoscientific practices. It does not per se give more room to political contestations, since it maintains an overall non-antagonistic constellation. Acknowledging uncertainty and incorporating extrascientific actors as well as extrascientific forms of knowledge are compatible with a permissive, pro technoscience stance.

Sabine Könniger also examines the social technologies of bioethics, but on the level of technoscience policy. Since the 1980s, she shows, we see the emergence and proliferation of ethics procedures and institutions, such as national ethics councils, in scientific governance in Western countries, mainly in the field of biotechnology. Although it seems self-evident that issues in biotechnology and medicine are ethical issues and that ethics bodies are therefore necessary, the discourse on nanotechnology shows that there is a process that goes beyond the linking of ethics and biotechnology: Not only the number of publicly sponsored procedures and bodies increases, but also the number of issues. Thus, we see a “new” proliferation of ethicpolitics. Based on an analysis of key documents, expert interviews and participant observations, the chapter examines the development and meaning of ethicpolitics in France, tracing back bio- and nanoethics discourses by identifying the shifts, differences and parallels in the ways they were problematized. On the example of the French National Ethics Committee, Könniger shows that nanotechnology became an ethical issue through being framed as a health issue and as an individual problem. Second, she argues that ethicpolitics is flexible in that it frames the way the discourse is performed, rather than providing substantive normative orientation for action or the shaping of bio- or nanotechnological developments.

Moving from the level of national public policy to international politics, Susanne Schultz investigates the articulation of demographic aims and gender policies in international population programs. She questions the claim that we live in an age of a “new biopolitics,” marked predominantly by a regime of individualized self-responsibility and biological citizenship. This, she argues, is a one-sided view that overlooks the continuity of “old biopolitics,” characterized by state-led and coercive practices and a focus on the administration of populations, outside the Western industrialized coun-

tries. It is true, she argues, that since the United Nations' Conference on Population and Development in Cairo 1994, the figure of the docile, receptive addressee of international population control policies has been replaced by the figure of the autonomous woman in the developing world who claims and responsibly manages her own "reproductive health". While such a shift towards self-determination, empowerment and women's reproductive autonomy, *has* taken place, Schultz shows, it operates not as the antithesis but rather as the new vehicle of a neo-Malthusian demographic rationality that seeks to reduce the number of the poor in the non-Western World. The new individualizing concepts, she shows, are articulated with demographic goals through an anti-natalist bias.

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