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***Extra Medicinam Nulla Salus. Medicine as a Secular Religion*¹**

Abstract: Ever since sociology emerged as a scientific discipline, its founding fathers have stressed that modernisation will result in secularisation. The belief in the ‘death of God’ as a *sine qua non* condition for social progress has also been prevalent during the past 100 years and has resulted in the popularity of the secularisation thesis. In contrast this paper argues that religion has not disappeared in the Western World but is being transformed. It is argued that modern medicine reflects the religious heritage of Western culture: its ideology, myths, dogmas, symbols, beliefs, rituals, practices, hopes and fears. Even more, it is a form of secular religion. The analysis is based on functional, phenomenological and cultural approaches toward religion. The paper focuses on three components of the religion of health: 1) its general structure; 2) the morality of health and 3) the Church of medicine.

Keywords: healthism, health as a secular religion, medicalisation, moralisation, secularisation, sociology of health.

Introduction. Where Is Religion?

Nearly all prominent 19th century sociologists argued that social progress will lead to the disappearance of religion in Western societies. The popularity of the secularisation thesis resulted from the positivistic programme of Comte’s sociology. Nevertheless, while Comte was critical of theology, he did not repudiate religion itself. On the

¹ Although the original Latin phrase used in the title: *Extra ecclesiam nulla salus*, which means *outside the church there is no salvation* refers to Christian teaching on soteriology and eschatology, the word ‘salus’ itself also means ‘health’. Thus, by paraphrasing it into *Extra medicinam nulla salus* we do not mean ‘salvation’ in its eschatological meaning used in (Christian) theology. On the contrary, as we view religion as a social phenomenon, we are not so much concerned about its theological dimension. And while from the theological perspective only religion is capable of redeeming humankind, we view salvation as a unique social construct, irrespectively of its ‘reality’. While, as Peter Berger observed (1990 [1997]), only religion can answer questions on the meaning of life and death, from our perspective it does not matter whether people locate salvation in Heaven or on Earth and whether it really exists. Consequently, ‘salus’ refers to ‘salvation’ understood as a utopic promise of ‘eternal’ wellness and healthy body and mind (Barański 2010, 2011: 169–178; Bennet, Carney and Karpin 2008; Borowiec and Lignowska 2012; Conrad 1994; Dubos 1962; Dworkin 2000 [2008]; Hyde and Setaro 2001; Lelwica 2010; Schwartz 1998; Silver 2002; Szczeklik 2012), which are said to be unattainable without medical assistance. The ‘salvation’ people seek from medicine is of a materialistic kind, and the eternal life it offers is that of the flesh not of the soul. Thus, with this title we wanted to reflect both ‘medical soteriology’, i.e. a medical promise of ‘eternal’ health (salus) and happiness and life without diseases and death here on Earth (salus—salvation) and medical monopoly over people’s health. In sum, we will argue that like many other secular projects which aimed to liberate humankind from all misery, such as the eugenic movement, Marxism and communism, national socialism, pacifism or ecologism also medicine promotes a new, secular version of ‘salvation’.

contrary, the founder of sociology believed in social utility of religion. He argued that religion is eternal and no society can last without it as religion assures social stability and cohesion.² According to him, without religion society is doomed to anarchy and bound to fall. Thus, Comte did not aim to liquidate religion, but to establish a new one: Religion of Humanity (Comte 2004; Domaradzki 2005; Śpiewak 2008). The belief in the 'death of God' as a *sine qua non* condition for modernisation was also common throughout most of the last century (Berger 1990 [1997]; Bruce 2002).

However, in the modern world religion does not disappear. And it was Durkheim (2008 [1990]) who was among the first to stress that religion will rather transform itself than diminish; although Jung also said that: "You can take away man's gods, but only to give him others in return" (Rieff 1973). On the other hand, the desecularisation of the world announced by Casanova (1994 [2005]; Mariański 2006) does not mean that traditional religions and churches will revive in their old, institutionalised forms. On the contrary, there can be observed an increased number of individuals who define themselves in religious terms but separate from institutionalised religions and locate the object of their faith in their own selves.³ Thus, for this reason Luckmann (1990) stressed that self-realisation becomes a key motive for individual actions and may adopt a form of the creation of one's own gods. Also, Durkheim (2008: 40 [1990: 410]) foresaw a substitution of traditional religions by new, private forms.⁴

Nevertheless, transformations of religion are not linear and cannot be easily predicted as "reflexive modernisation" makes many scenarios possible: secularisation faces desecularisation and privatization meets deprivatization, and new spiritual phenomena emerge. While pluralism may produce religious diversity (Berger 1990 [1997]), at the same time it may be a source of religious revitalisation (Casanova 1994 [2005]; Mariański 2006). Indeed, on the religious market many alternative worldviews arise. As a result, church-oriented religiosity becomes only one of the options. Hence, while modernisation weakens religion, it also enables new forms of its manifestation. Another consequence is a dislocation of the sacrum, which results in the replacement of 'great' transcendence by 'intermediate' (nation, race or classless society) and 'low' transcendence (health, autonomy, sexuality and 'me-ism') (Luckmann 1990). Constant search for individual and collective identities results in the creation of different ideologies and worldviews which take the forms of secular religions: nationalism, socialism, terrorism, anarchism, ecologism, consumptionism, healthism, sport, fashion, science or human rights (Gil Calvo 1994).

² Also Durkheim (2008 [1990]) distinguished four functions of religion for society: 1. disciplinary, 2. cohesive, 3. vitalization and 4. euphoric.

³ This new type of spirituality is characterised by its total lack of reference to transcendence. It is not only private, but also interior and is expressed by constant searching for one's 'true' or 'perfect' self (Libiszowska-Żółtkowska and Grotowska 2010).

⁴ At the same time, it would be a mistake to assume that the processes described are either universal or necessary. On the contrary, while both secularisation and privatization of religion are more common in the Western part of Europe, in many parts of the world, including Poland, religion is still strong and performs a key role in society (Casanova 1994 [2005]; Mariański 2004; 2006; 2011; Wójtowicz 2005). Nevertheless, some researches demonstrate that such phenomena also occur, although in somehow different way, in Central and Eastern Europe, especially in terms of changing attitudes toward the Church and its moral teaching (CBOS 2009; Libiszowska-Żółtkowska 2000; Libiszowska-Żółtkowska and Grotowska 2010).

All in all, it is argued that despite common belief in the rationality of Western civilization, people are still, by nature, *homo religiosus*. And although they may be acting unconsciously, they convey their sighs, desires and faith towards other objects: secular ideologies, sport events, rock concerts, movie celebrities, Mother Earth, humanitarian associations, etc. But it seems that it is modern medicine in particular that reflects best the religious heritage of our culture: its ideology, myths, dogmas, symbols, beliefs, gestures, practices, hopes and fears. Although it presents itself as rational, i.e. scientific, objective and neutral, its organisation and functioning are typical of religion. Thus, while defining itself as a secular enterprise, medicine is deeply waterlogged with the spirit of the old religion. Even more, for many, medicine becomes a new, secularised religion (Berger 1991; Clerc 2004; Dworkin 2000 [2008]; Szasz 1977; Szczeklik 2012; Tatoń 2003) and takes up its social functions. It is present in people's life from the womb to the tomb, provides a response to the same fears and angsts of humanity as the Church, and the pursuit of 'eternal' health, youth and beauty has substituted the religious zeal for salvation. Medicine's war on diseases and death is similar to a religious war against sin, as viruses and bacteria have replaced devils and demons, and the structure and functioning of the World Health Organization (WHO) is similar to that of the Church. Physicians have replaced priests and old, religious morality is being substituted by a new moral code: healthism; even though the object of faith and its expression are different, their religious nature persists.

Sociology, Religion and Health

The links between religion and health can be traced back to Durkheim's study on suicides. Nevertheless, it was Parsons (1964 [1969]) who laid the foundations for a sociological theory of medicine. Also today, there is an increasing number of both literature and research on the spiritual dimension of health and the role of spirituality, religiosity and religion in health care (Antonovsky 1987; Chuengsatiansup 2003; Cockerham 2010; Doktor 1994; Głaz 2006; Heszen-Niedoжек 2003; Idler 2010; Kinsley 1996; Koenig, H. 2008; Koenig, King and Carson 2012; Libiszowska-Żółtkowska, 1998; Puchalski 2001; Tulli 2009). It is not surprising as health is an important value in each religion and churches are active in the field of health and illness. And as both phenomena were formerly defined and interpreted in religious terms, medicine derives from religion and magic: nurses are former nuns, and shamans and witches were the first healers. It was the Church that organised the first shelters for the sick, the dying and those in need. Each religion organises therapeutic movements and self-help groups which offer therapy, support and financial, medical, psychological and spiritual help for the sick, the disabled, the addicted, the elderly, etc. But despite vast tradition of the sociological examination of religion as a health resource, rarely does sociology analyse medicine in terms of sociology of religion, which enables to see it as a form of secularised religion.

Of course, the definition of religion is an issue of serious debate rising from the very beginnings of sociology (Berger 1974). Despite these discussions, for the purpose

of this paper a functional approach toward religion will be applied.⁵ Thus, we will emphasise not so much the content of religion but its function for society. We will focus on what religion ‘does’ rather than on what it ‘is’. Religion is treated here as a human enterprise, a social construct which cannot be separated from a social group.

This approach can be seen in the writings of some sociologists who analyse the role of religion towards health: 1. the explication and creation of meaning to health, illness, suffering and death; 2. the normative and control, as religion regulates individual and collective behaviours toward health and illness; 3. the caring and charity, when it helps those who suffer in hospitals, hospices and shelters; 4. the therapeutic, when religion provides spiritual support to those in need; 5. the healing, when it propagates the healing power of praying, sacraments and charismatic healers (Libiszowska-Żótkowska 1998: 45–46; Domaradzki and Wierzejska 2008).

These functions are the starting point for our analysis and one can notice that while there are many examples, both in the past and present, of complementarity and cooperation between both institutions in the health issue (Tulli 2009), at the same time not only does modern medicine perform these functions but also increasingly takes them over from religion and monopolises them. This trend is also exemplified by the fact that an increasing number of individuals tend to justify their behaviours not so much by reference to traditional morality based on the notions of ‘faith’, ‘right’ and ‘wrong’ but (good) ‘health’. In consequence, constant proliferation of ideology of healthism (Borowiec and Lignowska 2012; Crawford 1977; Skrabanek 1994) and moralisation of health is accompanied by a tendency to question the authority of the Church on many moral issues, such as abortion, in-vitro fertilization, homosexual marriages, etc. which, by many, are explained and justified by reference to medicine and not religion.

Consequently, it seems legitimate to analyse medicine as a type of secular religion, not only in functional terms, but phenomenological and cultural ones as well. In an attempt to achieve this goal, the paper emphasises the following three components of religion of medicine: 1. its general structure; 2. the morality of health and 3. the church of medicine.

At the same time, we do not claim that medicine is a ‘real’ religion, nor that it will necessarily substitute religion and that the latter is disappearing. Neither do we intend to see this transformation as a deterministic or global process. On the contrary, our point is that while medicine and religion continue to cooperate in the field of health, at the same time, for some people, medicine substitutes religion or, simply plays an analogous role. Thus, the process described should not be viewed as an ‘either-or’ dilemma, as both processes: cooperation and substitution are not mutually exclusive

⁵ At the same time, we are aware of the limitations of this approach, as if one finds another institution that performs the same function as religion does, one can ask if there is any difference between religion and, say, political ideologies, science and pop culture. Nevertheless, as sociologists of religion agree that religion (as a phenomenon and as a concept) is a social construct, we find the functional perspective useful since it enables to conceptualise as quasi-religions other social phenomena. This does not mean that medicine is a ‘real’ religion, but that it is useful to look at medicine in this way. In an attempt to do so, we use a theoretical concept of the manifest and latent functions proposed by Merton (1968: 73–138 [2002: 93–152]).

and may occur simultaneously. Nevertheless, while there is an on-going debate on secularisation of religion, we will focus instead on ‘sacralisation’ of medicine and ‘moralisation’ of health. Thus, we will focus here on the extra medical dimension of medicine, i.e. we will analyse it not so much as a health care system but as a unique type of knowledge, ideology and social practice.

Medicine as a Secular Religion

In *Birth of the Clinic* Foucault (1963: 36 [1999: 35]) stressed that the French Revolution gave birth to two great myths: 1. that a nationalised medical profession can replace the clergy, and 2. the myth of a total disappearance of diseases. Consequently, health became a public issue (Lupton 1997) and previous forms of social control (religion, law and family) have been substituted by the authority of medicine. As secularisation lead to medicalisation (Conrad 1992: 213), medicine transformed into a dominant form of regulation of social life (Zola 1972): it defines, normalises, disciplines and controls people’s lives. It is a source of power and is strictly related to the policy of the government and becomes a basis for biopolitics. In this way, medicine has substituted the Church, alchemy has transformed into (bio)chemistry, the mind has dethroned the soul and sin is redefined into disease. Health itself constitutes the most important social value and core for individual and collective identities. Moreover, the zeal for health constitutes a new imperative which takes the form of social and political movement (Borowiec i Lignowska 2012; Crawford 1980; Lupton 1997). Even more, health is being sacralised and a “new gospel of health” emerges (Berger 1991; Dworkin 2000 [2008]). Thus, *homo religiosus* transforms into *homo medicus* (Means 1963).

The quasi-mystic character of health is revealed in WHO’s definition of health, according to which: “health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” By emphasising the complexity of health, WHO stresses its three dimensions: physical, psychic and social. Nevertheless, it also includes: emotional, intellectual, environmental, reproductive and spiritual health (Chuengsatiansup 2003; Kinsley 1996, Koenig 2008, Koenig, King i Carson 2012). But, such an inclusive approach makes health an *a priori* category, which is difficult to define and measure. As Skrabanek (1994: 42) observes: if health is more than “the absence of disease or infirmity,” it is rather an unrealistic ideal, a “super-health.” Moreover, by stressing the multidimensionality of health, WHO blurs the concept. As a result, health’s character becomes numinotic (Otto 2004 [1999]): the unknowability of health makes it similar to the religious sacrum: its mystery both terrifies and fascinates. Health is a force which is hidden from people in their genes and the neural network of their brains. Consequently, health and its lack fills individuals with angst and fright. Simultaneously, it is an object of their sighs. The *maiestas* of health poses its *tremendum fascinans*.

Moreover, such an inclusive definition enables medicine unlimited expansion and control over endless dimensions of social life and makes it truly catholic (which etymologically means ‘universal’, ‘general’). Thus, medicine becomes omnipresent

and omnipotent. It is a new canopy. It decides on one's employment, capability of getting married and having children; gives the right to abortion and child custody, decides who, when and how can die and if a person is fit to stand trial. Medical authorities influence personal decisions on feeding habits, sexual conduct and accepted stimulants. Doctors control birth, prenatal, postnatal and paediatric care; not only conception but also infertility, reproduction and sexual activity itself are also subject to their power. Medicine defines when life begins and if, at all, it should begin. Like the Medieval Church, it creates a ubiquitous network: it delivers public hygiene, coordinates treating people, centralises information, normalises knowledge, teaches healthy lifestyle, and legitimises (health) policy and individual choices, which results in an enduring medicalisation of crime (theft, rape, murder), sexual perversion (homosexuality, masturbation, sex addiction) and deviance (substance abuse, eating and learning problems, misbehaving), as well as the ability to perform social roles (military service, obtaining a driving license, employee suitability) and natural physiological processes (childbirth, ageing, menopause, erectile dysfunction) (Blech 2006; Conrad 2007; Conrad and Schneider 1992). Thus, it transforms the world into a clinic (Wieczorowska 2008; Barański 2010; Gałuszka 2008).

Furthermore, as a secular symbol of grace (Leichter 1997: 359) and synonymous with 'good' and 'moral' (Martin 2006), health has become a basis of individual and social identity ('we'—the Healthy) and distinction ('they'—the Ill). It helps to manifest a shared system of values and lifestyle and thus strengthen collective group identity, integrity and sense of worth. The concern for health has turned into a new way of self-discipline, perfection and the seed of the ultimate and universal 'truth' (Conrad 1994; Borowiec and Lignowska 2012).

This transition in the perception of the world is best expressed by genetic discourse and the biotechnological revolution, as the Human Genome Project, which sequenced the entire human genome has changed the way people perceive the world. As Watson himself said: "We used to think our fate was in our stars. Now we know, in large measure, our fate is in our genes" (Alper and Beckwith 1993: 511). In consequence, the gene has become a sacred symbol and icon of biomedical civilization (Myers 1990). The essence of humanity is no longer constituted by immortal soul but owes it to the mystic powers of the genome (Nelkin and Lindee 1999: 2). Thus, genetic essentialism reduces human 'true' self to a molecular structure, which is written down in one's genes and is as immortal as the Christian soul. Viewed as independent from our bodies, it is the genome that gives people life and, like the Christian soul, carries in it seeds of good (health) and evil (disease). As a result of this "molecular optics" individuals increasingly define themselves in biological terms: a chemical imbalance of serotonin (depression) or dopamine (ADHD) levels, carriers of gene mutations (BRCA1 and BRCA2 for breast and ovarian cancer or *htt* for Huntington disease), or possessors of an elevated blood sugar level. Consequently, people become "somatic individuals" (Novas and Rose 2000). Genes also become a basis for "biosociality" (Rainbow 1996: 91–111) as biology defines collective identities. Hence, "the molecularization of life" (Braun 2007) extends medicalisation, leading to the genetisation of society (Lippman 1991: 18–19).

Attributed with mystic powers genes are said to determine people's fate and ensure immortality and thus constitute the "DNA mystique" (Nelkin and Lindee 1999). Debates concerning the manipulations of the human genome confirm its sacred status which is reflected by such religious metaphors as the "Book of Life," the "Holy Grail" or the "Code of Codes" (Kevles and Hood 1992). Consequently, genes become the core of a new moral order: they determine the way people think, how they feel and behave. They influence intelligence, emotions, physical appearance, health, aggression, free will and religiosity (Hamer 2004).

Faith in the magical force of human genes becomes a dogma on which the religion of health is founded. It is a fundamental and universal law that, as the old God, possesses ultimate causative powers. Genes determine what we are, what we will become and how we will end up. As medicine claims that people's fate is written down in the genes, neurogenetic determinism (Alper and Beckwith 1993) turns into a new type of biological predestination: no matter what people do, their destiny is already settled: either on salvation (health and life) or on damnation (disease and death) (Leichter 1997: 359). A medical variation on the Protestant doctrine stresses that an individual's health is not determined by one's virtues and choices or social circumstances but their genetic material. *Sola Genetica* not *Fide* would a modern Luther say. Genetic tests help to recognise one's fate. Thus, like in Protestantism, individuals are obliged to live virtuous and ascetic, i.e. 'healthy', lives (Borowiec and Lignowska 2012; Crawford 1977; Skrabanek 1994) and look for signs of their destiny, i.e. genetic markers.

Like the traditional confessions, the new religion preaches that people when born into the world are corrupted and need the protection of a salutary institution—the church of medicine. According to the theology of medicine, newborn humans are weak and exposed to the impact of new devils: viruses, bacteria and microbes. For this reason, just after delivery, which takes place in the new religion's new churches, individuals are subjected to new purification rituals (Gajewska 2012; Domańska 2005; Nowakowska 2010). As medical demonology stresses that the world is ruled by omnipresent demonic viruses, bacteria and genes that spell doom for people, the role of modern priests is to lead humanity toward salvation and eternal health. Thus, vaccinations substitute for baptism and introduce the newborns into the community of the medical church and protect them from the primal evil of infection. And as medicine accompanies individuals till the end of their lives, it constructs a feeling of absolute dependence (Otto 2004 [1999]) similar to that preached by religion. Consequently, it is no longer the confirmation but medical examinations, such as the first gynaecological examination, that affirm one's maturity. Instead of receiving the Holy Communion people take medications and the sacrament of penance is being replaced with (psycho)therapy. The ill and dying do not meet a priest to receive the anointment of the sick but they go to a doctor and seek (palliative) treatment (Bogusz 2012). The new priests do not study holy books in seminaries but at medical universities where they receive ordination. Marriage is more related to fertility clinics and family therapies than the sacrament of matrimony.

The religion of health has its own dogmas, which rest on epidemiology. The salutary force of vaccination, the belief in the negative effects of 'passive' smoking,

the effectiveness of mammography, the harmfulness of cholesterol, the revelations of sociobiology and new genetics are just a few of them. The faith in body mass index and the existence of mental illness is unquestioned, like the Christian belief in the Holy Trinity. And like in the Church, there is a rule of infallibility: any attempt at questioning these dogmas meets with an anathema and excommunication. *Extra medicinam nulla salus* preaches the new religion. There is nor can be any alternative to medicine. Consequently, the medical heresies which question the truth of the new gospel of health: the anti-vaccination movement (James 1988), AIDS (Duesberg 1996) and cancer (Efron 1984) denialists, the critical psychiatry (Szasz 2003) and alternative medicine (Piątkowski 2008) are the source of the same fears as Medieval witches, quacks and sects and are persecuted and punished alike.

Health is the sacrum of this new religion (Dworkin 2000 [2008]), and death is the ultimate enemy, a profanity and taboo. As biomedicine suppresses the vision of death, fights suffering, pain and diseases, these phenomena become a by-product of medical progress and pose a threat to medical utopia which denies and isolates them as if they were a curse (Illich 2002). At the same time, medicine artificially sustains life and thus tries to postpone the fear of death and maintain an illusion of eternal life, as it helps to sustain people's dependence from physicians.

Finally, both religion and medicine aim at salvation and eternal life. But concern for one's soul is replaced by concern for the body, posture and youthfulness. The persuasive force of the new religion lies in that it gives hope for a better tomorrow and locates uncertain promises of traditional religions in the present. The New Garden of Eden is just round the corner. All one needs to do is convert and follow the new medical morality: eat healthy food, be fit, take care of hygiene, avoid alcohol and drugs, use condoms and preventive medicine and think positively. This ethos of activity constitutes a new form of intermundane asceticism and becomes a secular surrogate of salvation (Borowiec and Lignowska 2012; Conrad 1994; Melosik 1999, 2001). Anorexia nervosa is just its most extreme form (Lelwica 2010).

Since just medicine is based on religious fears of death, suffering, the unknown and life itself, like religion, it provides answers to issues that bother humanity: questions of the sense, nature and origins of life and the genesis of evil. It is a new theodicy. It also strips individuals of the responsibility for the choices they make. Religion achieves this by the sacralisation of morality and medicine by its medicalisation. The latter also offers a utopian vision of eternal life without misery, disease, pain and death (Schwartz 1998). Cryotherapy, transplantology, gene therapy, genetic engineering, a new generation of cytostatic and psychiatric drugs, AIDS drug treatment, etc. draw the future of Huxley's *Brave New World* of eternal good health (Barański 2010, 2011: 169–178; Hyde and Setaro 2001; Bennet, Carney and Karpin 2008; Dubos 1962; Silver 2002).

All these truths are revealed in the medical holy books: WHO's *International Statistical Classification of Diseases and Related Health Problems*, and the *Diagnostic and Statistical Manual of Mental Disorders* by the American Psychiatric Association and many guide books on beauty, fitness, diet, self-relaxation, coping with stress, etc., which, while classifying all human diseases, reflect the truth about life. To achieve salvation promised by medicine all one needs to do is follow the 'right' ascetic prac-

tices. Thus, individuals bow their bodies and fall on their knees in gyms, fitness clubs, sanatoriums and clinics that replace the old churches, chapels and sanctuaries.

The New Puritanism and the Morality of Health

In order to create a social utopia and perfect individuals medicine frames health as an autotelic value and establishes its own morality which determines one's moral character (Barański 2011: 169–178; Borowiec and Lignowska 2012; Conrad 1994; Brandt and Rozin 1997; Martin 2006; Metzl and Kirkland 2010). Consequently, medicalisation leads to moralisation, i.e. the “acquisition of moral qualities by objects and activities that were previously morally neutral” (Rozin 1997). And although the stigma attached to many diseases has been secularised, disease's moral metaphor of evil endures (Sontag 2009 [1999]). Still, it is associated with a moral weakness of character and becomes a source of blame and stigma. On the other hand, health provides a person with a sense of accomplishment and self-worthiness. It is seen as the fruit of hard work, prudence, self-discipline and moral purity (Lupton 1997).

Thus, in the name of health, millions of people all around the world practice modern asceticism: they exercise in gyms, jog and diet, control the number of calories, weight and medical indicators and study relaxation techniques; they do not use tobacco, alcohol or drugs and engage only in safe sex (Borowiec and Lignowska 2012). The imperative of control stresses that health, like salvation, is a matter of self-determination and will (Conrad 1994). Consequently, this Protestantisation of health shifts the responsibility for health to individuals (Crawford 1977). As health becomes synonymous with one's moral status, people are obliged to undergo a total transformation of their self via: physical training, hygiene, weight and product control ('healthy', 'natural' and 'light' food), constant health education, self-observation and periodic check-ups. The pursuit of health, bodily fitness, mental wellness and healthy lifestyle reflects what it means to be a moral person (Conrad 1994). Although medicine transforms the notions of 'good' and 'badness' into 'health' and 'sickness' (Conrad and Schneider 1992), it still attaches a stigma to behaviours that violate the social norms religion used to condemn. Thus, disease is a secularised version of sin: pride and envy are narcissism, greed is kleptomania or 'acquisitive desire disorder'; lust is a sexual disorder; envy is mania and psychosis; gluttony is obesity; wrath is antisocial personality disorder; sloth is dependent personality disorder and depression (Martin 2006: 3). Also, such 'sinful' behaviours as: theft, rape, murder or addiction are redefined as 'disorders'.

This change is strictly related to the new moral commandments based on health promotion which constitute the new decalogues of health: 1. 'Thou shalt have no other gods before medicine and shalt not use quacks'; 2. 'Thou shalt not call for a doctor in vain'; 3. 'Remember your periodic check-ups'; 4. 'Honour your physician'; 5. 'Thou shalt not harm your health nor of others'; 6. 'Thou shalt practice safe sex'; 7. 'Thou shalt not give bribes'; 8. 'Thou shalt not sue your physician'; 9 and 10. 'Thou shalt not desire thy neighbour's' healthcare insurance'. Yet another version was presented in 1992 by

the American Institute for Preventive Medicine and included: 1. stress management; 2. safe sex; 3. no smoking; 4. avoiding secondhand smoking; 5. developing a social support network; 6. being active; 7. controlling the consumption of cholesterol and saturated fat; 8. limiting the intake of red meat, eggs and cheese; 9. moderate alcohol usage; 10. having a sense of purpose (Powell 1991).

Not surprisingly, the new moral code appeals to the same virtues Catholicism does and both are theological: there is faith in the healing force of medicine, hope for a cure and love toward medical personnel; and there is human prudence, justice, fortitude, and temperance which are the basis for the imperative of control. Together they form the ethos of healthism (Borowiec and Lignowska 2012; Crawford 1980; Skrabanek 1994).

As a result, 'immoral' behaviours (overeating, smoking, drug abuse, lack of hygiene, unprotected sex or missing preventive examinations) and 'devil' products (nicotine, alcohol, sugar, salt, fat, eggs, coffee, red meat, sweets and junk food) meet with stigmatisation and condemnation. The best example is the antismoking crusade (Sullum 1999) launched in many European countries, including Poland, where legislation outlawing smoking in public places was established in 2010. Individuals who engage in such 'unhealthy' practices are accompanied by a feeling of anxiety, guilt and shame, while those ascribed with good moral status (fruits, vegetables, fibre and biblical fishes, water and wine) cause fulfilment, euphoria and feelings of strength (Conrad 1994). Violation of the new morality is accompanied by contrition, the resolution of sinning no more, penance and conversion. Although the confessional booth has been replaced by the therapeutic couch, people hear similar moral commands: 'Jog!', 'Diet!', 'Be fit', 'Take care of yourself', 'Quit smoking', 'Stop drinking', 'Reduce weight', 'Do your check-ups'. Also, here deviations require a consultation with an expert, therapy and penance: from self-flagellation and physical tortures in fitness clubs, to studying medicine's holy books on diet, coming out from addiction and mortification: not having chocolate, a beer or sex. The 'sinner' must confess their wrongs, regret, desire to change and go to therapy. Since people are weak, they need constant medical guidance, which results in dependence from the exterior authority of the church of medicine. Without its guidance individuals are incapable of fighting diseases and regaining health. Consequently, the new church enacts new regulations, laws, taboos and orders which direct individuals to the promise of 'eternal' healthy.

New Puritanism is based on medical dogmas that emerge from an epidemiology which stresses 'risk factors'. The category of 'risk' itself helps to attach moral meaning to the epidemiological dogmas which mobilise the state policy and enable social control of entire populations, which is exemplified by the epidemics of plague, cholera, AIDS, obesity and smoking (Lupton 1997). While medicine claims to be value-free and based on scientific facts, its latent premises are deeply moral. Thus, it is now much easier to criticise people's unhealthy behaviours (overeating, smoking, unsafe sex) than one's moral choices (sexual preference, divorce, extramarital sex) unless the latter can be formulated in medical terms and thus constructed as a (public) health threat.

This new morality is led by its virtuosos and carriers of medical culture—health promoters and gurus of fitness, who promote a "lifestyle correctness" (Leichter 1997)

which serves as an instrument for better health but which is also an important tool for social distinction as health becomes a commodity, and taking care of it is a way of “conspicuous consumption.”

The Church of Medicine

The structure of this new religion is similar to that of traditional religions, as WHO is similar to the Catholic Church.⁶ Both are highly bureaucratic, hierarchical and lack transparency; they are centralised and possess a worldwide network of local departments. To maintain their integrity, both organise synods and congresses guarded by special associations. Both are ruled by their own juridical systems and claim monopoly over its services. And just as before the Reformation laymen were not supposed to communicate with God without an expert as a mediator, individuals today should avoid self-treatment and should follow their medical leaders. For this reason, Szasz (1977: 40–41) postulates “medical reformation,” which aims at the liquidation of medical intermediation between a person and their body and the demonopolisation of medical practice.

The new church defines itself according to the creed similar to that of the Catholic Church as: ‘one, holy, catholic and apostolic’. Holding a monopoly over health, disease and the human body, medicine aims to control every dimension of everyday life (Niebrój 2002; Zola 1972; Conrad 1992). It is a new canopy. WHO intends to be catholic, i.e. inclusive and universal. It is a global enterprise and makes no distinctions on the basis of race, gender, nationality, age, profession or confession, and as for medicine: “There is neither Jew nor Greek, there is neither slave nor free, there is neither male nor female” (Ga 3, 28) for all are one in medicine. By medicine, with medicine and in medicine everyone can be saved. Finally, the missionary zeal of medicine aims to spread the gospel of health throughout the entire world. It achieves this goal via crusades, such as vaccination programmes for the Third World or educational campaigns. Even their direction is the same. Moreover, the new church believes that medical crusades are done for people’s good even if they must be enforced. And while the policy of (mandatory) vaccination takes a peaceful form, it was quite the opposite with the temperance and hygiene movements (Lupton 1997). The former ended in prohibition and the latter gave birth to the eugenic movement. Also anti-smoking and planned parenthood crusades take a similar, oppressive character (Sullum 1999). In the name of health, the new church persuades, converts and, if needed, forbids and punishes.⁷

⁶ In further analysis we draw from Weber’s church-sect theory (Weber 1973 [1999]).

⁷ Except for the law forbidding smoking in public places in Poland, such a policy was exemplified by a project of the former Polish minister of health Ms Ewa Kopacz who wanted to force obligatory cytology and mammography screening tests for all employed (sic!) women. Even though, such legislation did not finally come into existence it shows that modern medicine is not only a health care system which focuses on helping the ill, but also a political tool of domination, surveillance and social exclusion. While such a preventive action might benefit many citizens, it also provokes many controversies, as one might ask: Why prevention should include only those who are employed and insured? Will it not create a risk of

The church of medicine has its own saintly patrons, the most prominent being Hypocrites who founded a new religion and its sacred oath and originated a new era of humanity. Then comes Paracelsus, the father of toxicology, who promoted herbal medicine, iatrochemistry and pharmacognosy. Next, Pasteur, the father of vaccines, who, like Moses, shepherded humanity away from the captivity of infectious diseases, led it towards the promised land of health and provided it with the tools for its salvation⁸ (Clerc 2004: 7). There is Freud who founded a new sect within medicine—psychoanalysis (Cioffi 1998 [2010]; Rieff 1973) while Watson and Crick revealed to humanity the sacred mystery of life. Among these saints there are also martyrs, like the promoter of jogging Jim Fixx, who died of heart attack while running, or Rosalind Franklin, who died of cancer caused by her exposure to X-ray radiation.

Physicians themselves represent the modern clergy, as their unique and superior status is distinguished by external symbols (the cassock has only changed its colour). Like priests, they exercise a special power which derives from their monopolistic status. They are like the prophets, followed by a number of devoted apostles: nurses, midwives, dieticians, etc., and share the same sacred vocation and are educated in new seminaries. Their knowledge is not easily accessible to laypersons as it is expressed in mysterious Latin. And neither medical esoteric wisdom and dogmas nor the authority of the new clergy can be questioned. Moreover, a physician, like a priest combines the roles of the judge and moralist, ethicist and politician (Szasz 1977: 1–17) and thus becomes the agent of the State. This alliance of the throne and medicine began during the French Revolution (Foucault 1963 [1999]) when doctor Guillotin used a special device to execute convicts (Szasz 1977: 14). Today, they report on births and deaths, control deviancies and legitimise the social control of citizens.

Yet another way in which the new church influences society is through its symbolic power as health has become a state-sponsored ideology (Crawford 1977; Cylkowska-Nowak 1999; Lewontin 1992; Niebrój 2002; Tesh 1996). As medicine operates a pseudo neutral ‘scientific’ language which is not explicitly related to the power of the State, it seems to be objective and politically neutral. Moreover, medicine presents itself as acting for people’s good and thus masks the real—political—dimension of its interventions. And it has managed to succeed: most people do not see it as a form of dominance, surveillance and as a threat to their freedom. They do not see the coercive and hazardous dimension of medical practices. On the contrary, as they are performed in the name of health, they are perceived as something natural and sought after. Thus, the Medieval principle of *Dictatus Papae* has changed and now integrates the State with medicine, with just new forms of simony: state-sponsored scientific grants. Consequently, a confessional state is replaced by a therapeutic state (Polsky 1991) and medicine becomes a modern inquisition.

Finally, in the structure of the new church, self-help groups and organizations of patients play an analogous role to that of religious convents. In their missionary zeal, they educate, spread knowledge about diseases and faith in the curing power of

discrimination? Does it violate civil liberties of individual freedom? Will those who do not undergo such tests have to pay for their treatment in case they fall ill?

⁸ In French, Pasteur means ‘shepherd’.

medicine and raise funds for its activity. Needless to say all such groups are united under WHO's papacy.

It is significant that while the faith in the authority of religion and its priests is decreasing and people openly question the Church's doctrine on the origins and beginning of life, on moral issues like abortion, euthanasia, IVF or sexual behaviour, there is a growing tendency to believe medicine and physicians when they speak on the same issues (*Gazeta Wyborcza* 2012). The latest example of such 'bioethicisation' of moral discourse and moralization of health issues in Poland is reflected by the recommendation of the Polish Bioethical Committee to legalize pre-implantation genetic diagnosis (PGD) (Komitet Bioetyki PAN 2012). Meanwhile, as Berger (1991: 27) observes, lay confidence in medicine is not as much an act of rationalism as of faith. Thus, doctors turn into gods. They create life in laboratories, decide when it begins and ends, who and when can conceive and terminate life. Doctors possess the monopoly power of "making live" and "letting die" (Foucault 1995 [1998]). Furthermore, like priests, physicians work miracles when on the hospital altar they convert the ill and dying into the healthy. Medicine cures, prolongs, creates and saves lives. Via IVF, it gives hope to the modern Sarah and Elisabeth. The genetic tests, like the old prophets, predict the future and through abortion parents, like Abraham, sacrifice the immolations of their beloved children. Transplantology heals broken organs, while vaccinations, antibiotics and chemotherapy, like Jesus, cure of lethal diseases. And like priests, physicians have the same obligations: fidelity to their sacred vocation, and confidentiality of information, both of which are guarded by bioethical boards and medical tribunals.

Closing Remarks

Despite the popularity of the secularisation theory, religion has not disappeared into the darkness of the past as new gods emerge. Although it was medicine that first used magic, nowadays it is transforming into magic itself. Another enchantment of the world is taking place. As Berger (1969: 65–90) observed, pluralism and fragmentation of the world make people look for new "signals of transcendence" i.e. prototypic human gestures which express the essential dimensions of their existence and order reality by attaching it with meaning and sense.⁹ Each century has its own signals of transcendence. Modern *homo medicus* finds new ones: medical practices and health behaviours which constitute a basis for the new faith in health (Borowiec and Lignowska 2012; Conrad 1994; Melosik 1999, 2001). As this object of new religion is truly transcendent, i.e. it enables individuals, groups and society to affiliate to a transnational community, medicine becomes a meta-religion, it unites all people, including believers of the old faiths (Clerc 2004: 51).

All in all, morality does not disappear but is transformed (Luckmann 2001) as the direct moralisation of religious communication is replaced by the indirect moralisation

⁹ Among them he includes: order, play, hope, damnation and humour.

of medical discourse. Just as society is more and more reluctant to accept moral homilies or lectures, there is less and less aversion toward the moral message of medicine. Thus, just as secularisation provokes medicalisation, the latter generates the moralisation of health. And while it would be a simplification to assume that either 'sacralisation' of medicine or secularisation of society are universal processes, as they are much more common in the West, to some extent they are also present in other parts of the world, including Poland, where in many fields medical authority takes up the leading role. Although the main focus is being put on the medicalisation of the pregnancy and delivery (Domańska 2005; Gajewska 2012; Nowakowska 2010) there is an increasing interest in other areas as well, including ageing (Nowakowski and Nowakowska 2010) and dying (Bogusz 2012), the body (Barański 2011) and emotions (Barański 2010). The process described is further exemplified by the growing ambivalence toward the moral teaching of the Church and medicalisation of the moral discourse on feeding habits, substance abuse, sexual conduct and reproduction, including contraceptives, abortion, IVF and PGD (CBOS 2009; Komitet Bioetyki PAN 2012). Thus, although the dominant institution changes, its structure, dynamics and mechanism of control are the same. Nevertheless, the very idea of a 'right to health' legitimises the coercive practices of biomedicine. Hence, paraphrasing Skrabanek (1994: 11), one may ask "Is a healthy slave happier than a dying free man?"

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