THE MEDICALIZING OF SOCIETY -

MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL

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Introduction.

I wish to beg your indulgence for in this series of papers I will not be presenting a definitive well-organized argument but rather a case in progress. To guide you in your patience let me start with a fable heard during a tour of duty at the World Health Organization.

> To test the stamina of all who wish to work on the international scene applicants were asked how they would handle the following 'stressful situation'. The applicants were naturally three women - one English, one American, one French. I am told that a good traditional Dutch Calvinist might resemble the English women. This was their test: 'You have just been shipwrecked and as you make your way towards shore you see that there are dozens of men who have obviously been deprived of female companionships for many months.
> What would you do?'
> The English woman replied first, "I would do the only honorable thing, I would kill myself."
> The American followed quickly, "I would go to the biggest, the strongest, the most powerful of the men and let him take care of the rest."
> The French woman hesitated and then with a shrug said, "I see the problem but I don't see the issue."

I hope as I list problem after problem you will still be able to see the issue.

Some other cautions are however necessary. These refer to the kind of data I will use and my ultimate goal. I draw most heavily on observations made in the United States though similar murmurings particularly in the work of Lady Barbara Wooton have long been echoed elsewhere. For better or worse America is in the vanguard of Western Medicine. And while I would hardly be so pompous as to suggest that where the U.S. rushes in the rest will certainly follow, let us at very least look at America as a case of what can happen - in the view of one Social scientist.

There is still another problem. In the traditional sense of the word, I cannot prove much of what I say. My observations and the way I have put them together are very selective. Thus most clearly I am trying to create a particular perspective or orientation, to call your attention to what I think is a problem of paramount importance in Western society. In other wordt, I hope purposefully to be provocative and in the best sense of the word heuristic and stimulative.

With all these qualifications in mind, let me turn to what I am trying to say.

The theme of this series of papers is that medicine is becoming a major institution of social control, nudging aside, if not incorporating the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts. And these judgments are made not in the name of virtue or legitimacy but in the name of health. Moreover this is not occurring through the political power physicians hold or can influence, but as I shall try to illustrate, is an insiduous and often undramatic phenomenon accomplished by 'medicalizing' much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence.

Although many have noted aspects of this process, by confining their concern to the field of psychiatry, these criticisms have been misplaced (particularly the works of Thomas Szasz, Ronald Leifer, Erving Goffman). For psychiatry has by no means distorted the mandate of medicine, but indeed though perhaps at a pace faster than other medical specialties, is following instead some of the basic claims and directions of the profession (see Freidson's Profession of Medicine). Nor is this extention into society the result of any professional 'imperialism', for this leads us to think of the issue in terms of misguided human efforts or motives. It would be nice to be able to think of the problem solely in terms of a concrete enemy, (the example of Psychology Today's Jan. 1972 article on the mental health industry was cited as well as references to the military industrial complex, leaders of nations etc.), for this allows us to think of the problem in terms of evil men or evil policies embodied in certain men and the solution in terms of eliminating or changing these men.

Yet if we search for the why of this phenomenon we will instedad see that it is rooted in our increasingly complex technological and bureaucratic system - a system which has led us down the path of the reluctant reliance on the expert. My most general purpose then is not to list the 'evils' of medicine but rather set the stage for understanding the implications of the role of expertise which medicine has both sought and had thrust upon it.

Format.

I am trying to build my case thru approximately six interrelated papers. The topics build one upon another as answers to a series of questions.

The first question and the theme of the first essay is how long has medicine's social involvement been going on. Here we will try to set the context for much of what follows, define some terms, trace medicine's involvement with the state, cite its development through certain subspecialties as well as medicine's historical de jure and de facto relations to the preservation of social order.

The second question deals with the issue of why medical science rather than some toher institution has become this "answer" to man's problems.

The third question asks regardless of the length of medicine's involvement is not this involvement essentially a beneficial one.
I call this topic, the Moralizing of Medicine for it has often been claimed that the introduction of medical science into the management of society could only be beneficial because of the supposed objective and value-free nature of its tools and concepts. Thus here we examine the 'amoral' nature of disease as seen in both the operating perspectives of the treaters and the treated.

Our next question asks what means are available for medical science to exercise any moral and social control. This refers to what I call the 'medicalizing of society'. Here we will trace some of the specific mechanisms whereby medicine's scope and concern become extended. The process to be described is not a dramatic one but rather a series of almost taken - for - granted extensions of the relevance of medical science and the concepts of health and illness.

The next question concerns not the means but the actual opportunity - here we contend that the real potential for medical influence is perhaps best seen in an almost statistical sense as we present data for regarding 'illness' and 'illness threats' (and thereby the potential services of medicine) as the norm rather than the exception of daily life. This will

be seen from both the perspectives of the practicing clinician as well as the general public.

Our two final questions deal with the consequences of medical control. We will first become rather concrete and examine some of the underlying and unspoken value assumption of medicine and its practitioners in a number of

socially relevant medical concerns. These will include such problems as abortion, drug safety, genetic counseling, and automatic multiphasic testing. Then we will turn to some more abstract concerns - the way the introduction of medical data may 'depoliticize' issues. We will ask and probably not satisfactorily answer: why is this such an important issue today? Why has society entrusted such power in the hands of experts? What if anything can or should be done about it?

The Historical Trend.

So let us begin. A decade ago Philip Rieff in his book Freud: The Mind of the Moralist claimed that "the hospital is succeeding the church and the parliament as the archetypal institution of Western culture." This shift, one that is not fully complete, has spanned centuries. To understand this phenomenon we have to understand something about the nature of professions.

Now I do not propose to offer any general definition of a profession. But rather I will focus on two rather important characteristics of a profession - its control of its work and its tendency to generalize their expertise beyond technical matters. Everett Hughes states these characteristics rather concisely.

(p. 204 in The Profession of Medicine by Freidson)

> "Not merely do the practitioners, by virtue of gaining admission to the charmed circle of colleagues, individually exercise the license to do things others do not do, but collectively they presume to tell society what is good and right for the individual and for society at large in some aspect of life. Indeed, they set the very terms in which people may think about this aspect of life."

I will return to the first characteristic how a profession gains the exclusive right and license to manage its work a bit later. For now I wish to dwell on the second aspect - what Bittner has stated as its desire to extend its limits beyond its technically and traditionally ascribed and assumed competence to wider more diffuse spheres. To my mind it is not at all clear how much of this they actually seek or find thrust upon it. But in any case it is here that we enter our brief examination of religion, law, and medicine.

The Christian ministry as the prototype of all professions is as good a place as any to start. Ever since Christianity achieved its dominance and institutional integration in Europe in the early Middle Ages, its ministry has been beset by tensions between its limited and diffuse functions. The former involved the specific administrative of the means

of grace to individuals, while the latter involved the functions of prophecy - the direct application of the message of the gospel to the structure of communal life. There was recognition of the danger of this expansion and yet it seemed unavoidable. For the initially strictly personal sense of the teaching of Christianity undermined the tribal organisation of the community. Thus popes, bishops, and clerics were forced not only to formulate but also to aid in the implementation of the Christian concept of social order. In a real sense then, in the Middle Ages and well into the Reformation, all real communities in Europe were religious units as many of their leaders and chief advisers were religious men and alle relationships, enterprises, and occasions derived the interpretation of their meaning and the estimate of their value from a religious framework.

During this period of course lawyers existed and functioned. But no one expected lawyers to be expert on how the affairs of the community should be managed. For ordinary purposes in everyday life, the answers to the questions of who a person is, what he can do, what his duties are, were deeply ingrained in the Christian mentality, built into the structure of Christian communities, and kept alive by an incessant flow of Christian homiletics.

But roughly during the seventeenth and eighteenth century the influence of religious teachings on communal life moved into eclipse. In England, some date this to the 1640's, the Age of Cromwell, when the common law was becoming the law of the land. It is perhaps difficult to pinpoint a single cause, but the culmination is seen in what Aobsbaum called the dual revolution - the Industrial Revolution itself not a single event but one spanning literally centuries and the French Revolution and its concomitants. The old order faded and a new codifier was needed. The seeding had been going on for a long time. Tracts were being written about the nature of man based on a different relationship - it was called the social contract, its legalistic terms not occidental, its espousers of varying persuasion - Hobbes, Rousseau, Mills, Locke. The tool of this transformation of thought are probably best seen in the American and French Constitutions. These documents made it possible to talk about people and human affairs, without religious reference but by involving merely secular terms: justice, right, duty, franchise, liberty, contract etc. In other words, legal terms and ideas became autonomously meaningful and were perceived to have a general relevance for life that coulde be grasped directly. New expressions came into being to reflect this."That no man was above the law" became symbolic of its growing power, at least in rhetoric.

And as once there had been an exclusive search in relegious teachings now there was a strong pressure toward finding in the law the grounds for virtually every form of human enterprise and a solution for virtually all human problems. In America it was well expressed in the colloquialism "There ought to be a law" as it was used in answer to any unclear problem, dilemma, or conflict. Thus as prophecy involved a transcendence of the original mandate of religion, so too did the infusion of legalism into the regulation of politics, economy, kinship, social wellfare and every other social institution and human relationship involve a transcendence of the original mandate of jurisprudence.

Religion, of course, did not die or fade away but turned more inward concentrated on matters of the inner life and left the secular life to law. And flourish it did with perhaps the period 1815 till 1914 being the high point - a time when the Western community ordered merely by legal rational means, experienced a period of unprecedented harmony, peace and wellfare. But two world wars including a war to end all wars, a set of trials in Nuremburg and Jerusalem where men as their defence against charges of genocide involved their obedience to law and authority began to shatter the image. At the same time, despite laws being passed, the poor still seemed poorer, the minorities of the earth still exploited, the consumer cheated. Until the idea of law itself began to be questioned. It was no longer believed that justice was blind but that in fact the law was corrupt if not bankrupt. In America, a relatively new concept began to emerge one almost 'unthinkable' a couple of decades previously the concept of a 'bad law'. An old tactic caught fire again - civil disobedience as an answer to change the law and with it debates under what circumstances it is just to violate the law. Again the interpretive system of values was beginning to crumble. Its too soon to say how complete sory is the fall and on the American scene there is a counter movement - the Nader Raiders. Whether this, however, is a true revival and turning point or merely dying gasps we will leave to a future discussion.

There is another way of stating what has happened. Again relying on Bittner. The ultimate ground of Christian influence, its charisma was The Truth. This does not mean that what was preached was true or not true but merely that it was with reference to its truth - value that the claims of Christian influence were asserted. In an equally fundamental sense, the idea of authority was the basis of the influence of jurisprudence.

Obviously it cannot be said that Christianity did not claim authority; nor can it be maintained that the law neglected questions of truth. However, what in the former was the authority of truth became in the latter the truth of authority. The crisis of the ministry and of jurisprudence consists precisely in the fact that the former could not sustain its truth claims and that the latter is failing in its authority claims.

But again there was another group of codifiers waiting in the wingers - new purveyors of both truth and authority. Medical Science was/is there to fill the vacuum. I use the two terms together purposefully for all they connote.

At first medical science was one of the several orientations providing the tools to argue that man could be understood well enough without assuming the intervention of the "Divine Mechanic" and that there where laws governing men but they were natural scientific ones. While the tools and concrete achievements of medical science were seen most clearly in the bacteriological revolution, its promise of something more seems closely allied to a new motion of meaning - a new goal which started to be articulated in the mid and late 19th century - progress. Medical Science seemed to be the articulater or conveyer of the message of Darwin and Spencer. A social message which incidentaly was much more conforting to an understanding of social order - its rhyme and reason - than say some of the other competing views like those of Saint-Simon and Marx. So too medical science began to articulate progress as well as the meaning of life in new terms. The new codifies carried not the Bible or Blackstone but the Merck Manual Robes remained but changed in color from red and black to white.

And health itself which was always important became no longer one of the essential pillars to the good life, not the means to an end but the end in itself. For according to the World Health Organization health was "a state of complete physical, mental, and social being and not merely the absence of disease and infirmity."

It was no longer part of life but as embodied in this definition was almost life itself.

This relation between what a profession professes and what the society or the most powerful segment of the society needs is not accidental. For the very existence of a viable profession is based on its close ties to the state.
For an articulation of this we again turn to Freidson for he ask not rhetorically.

"What exactly is a profession? What differentiates it from other occupations? The most strategic distinction lies in legitimate organized autonomy - that a profession is distinct from other occupations in that it has been given the right to controle its own work. Unlike other occupations, professions are deliberately granted autonomy, including the exclusive right to determine who can legitimately do its work and how the work should be done. Virtually all occupations struggle to obtain both rights and some manage to seize them, but only the profession is granted the right to exercise them legimately. And while no occupation can prevent employers, customers, clients, and other workers form evaluating its work, only the profession has the recognized right to declare such 'outside' evaluation illegitimate and intolerable.

Obviously an occupation does not 'naturally' come by so unusual a condition as professional autonomy. The work one group commonly overlaps, even competes, with that of other occupations. Given the ambiguity of much of reality, and given the role of tastes and values in assessing it, it is unlikely that one occupation would be chosen spontaneously over others and granted the singular status of a profession by some kind of a popular vote. (The example of the ministry's rise to preeminence was cited.) A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it - an influence that drives competing occupations out of the same area of work, that discourages others by virtue of the competitive advantages conferred on the chosen occupation, and that requires still others to be subordenated to the profession.

If the source of the special position of the profession is granted, then it follows that professions are occupations unique to high civili-

zations for there it is common to fed not only full-time specialties but also elites with organized control over large populations. Further, the work of the chosen occupation is unlikely to have been singled out if it did not represent or express some of the important beliefs or values of that elite - some of the established values and knowledge of the civilization. Further more, since it is chosen by the elite, the work of the profession need have no necessary relationship to the beliefs or values of the average citizen. But once a profession is established in its protected position of autonomy, it is likely to have a dynamic of its own, developing new ideas or activities which may only vaguely reflect and which may even contradict those of the dominant elite. The work of the profession may thus eventually diverge from that expected by the elite. If a profession's work comes to have little relationship to the knowledge and values of its society, it may have difficulty surviving. The profession's privileged position is given by, not seized form, society, and it may be allowed to lapse or may even be taken away. It is essential for survival that the dominant elite remain persuaded of the positive value, or at least the harmlessness, of the profession's work, so that it continues to protect it from encroachment." (Examples cited on the position of academics + reference to certain groups being called unprofessional.)

From this perspective we can understand much of the criticism of the young when they accuse <u>all</u> the professions of being merely the creations and tools of the Establishment.

So lets look briefly at medicine in this light.While medicine had existed since recorded history, most historians date its modern form to its affiliation with the medieval university (Shryock, Sigerist, Freidson).

During this time as medicine began to reestablish itself it also began to reassert certain claims for autonomy and the need for some form of licensure. I use the terms reestablish and reassert for one reading of history might give the impression that these powers were merely in abeyance. This claim might be based on the view of 'primitive medicine' cited by Sigerist (p. 161, History of Medicine, 1951, Oxford University Press).

> "The medicine man is concerned not only with the people's health but with their entire welfare, ranging from crops to victory in war. It is his function to avert evil that may threaten the individual or tribe in any form, to propitiate the spirits for the benefit of his people, and also to destroy the enemy. He is, therefore, priest, sorcerer, and physician in one. He is, moreover,

> very often the chief of the tribe, the king who rules over the people.
> And in addition he frequently is the bard of the group, who knows the stories and songs that tell of the origin of the world and of the deeds of the tribe and its heroes in a far remote age. He thus fulfills another function, one that is very important in a scriptless society."

There are many doubts that the medicine man held such an exalted role in all societies (Freidson) but in any case let us return to medicine in the eighteenth century. For as medicine began to also reecho some ancient truths as the relationship of man and his social environment, a call for doing something about this was being articulated. It is during this period that George Rosen dates the first recorded murmurings of 'social medicine'. For me the most important part of such statements was their statements pointing to the import that medicine could have for the State.

(De mortis artificum. Diseases of workers - tr. by Wilmer Cave Wright, Univ. of Chic., Pr. 1940 (esp. p. 5-11, 347, 449).

Bernardino Ramazzini wrote in 1713:

> "It must be confessed that many arts owe the cause of grave injury to those who practise them. Many an artisan has looked to his craft as a means to support life and raise a family, but all he has got from it is some deadly disease.... Therefore, medicine, like jurisprudence should make a contribution to the well-being of workers and see to it that, so far as possible they should exercise their callings without harm."

In other words we have here some talk about occupational medicine and man-made disease though it may take a century or two for the thoughts to be translated into concrete action. As Rosen points out such ideas were not isolated but formed part of new philosophy of government sweeping across Europe. It was a system of thought commonly known as mercantilism or cameralism, whose "supreme aim was to place social and economic life in the service of the power polotics of the State." Rosen states it as follows: (p. 20 in F,L,R)

> "In England and on the Continent a central question was: What policy must the government pursue in order to increase the national wealth and the national power? That industry was one of the chief means by which a country could attain wealth was evident. Consequently, labor - one of the most important factors of production - came to be regarded as an essential element in the generation of national wealth. Obviously, any loss of labor productivity due to illness and death was a significant economic problem."

And so across Europe, prominent men and government officials began to write about the more direct wedding of the health of the people to the wealth of the nation.

Von Seckendorff who held administrative posts in the ducal courts of Gotha and Sachen-Zeity advocated a government program concerned with the maintenance and supervision of midwives, care of orphans, appointment of physicians and surgeons, protection against plague and other contagious disease, use of tobacco and spirituous beverages, inspection of food and water, measures for cleaning and draining towns, maintenance of hospitals and provision of poor relief. Von Justi writing in 1756 advocated even more direct intervention of the State. Thus he advocated that people who suffer from hereditory diseases or who are unable to procreate should not be permitted to marry, that vice should be treated severely since it diminishes fecundity and discourages marriage; and that dissipation and disease should be prevented when at all possible.

The voices were there. But frankly they seem relevant mostly for historical precedence. For despite the high status of some of these spokesmen, they seemed to have relatively little substantive import. no great waves of legislation protecting the safety of workers on providing more adequate medical care followed in their wake.
The time was not ripe. But why it was not ripe is worth a brief digression. At least one reason was that the remedies required too much social interference in the affairs of men. Where the faults of 'industry' and general provision of services was referred to this meant the affairs of 'prominent' men. But perhaps most important was the fact that while the concern with human life was admirable, in a commodity sense human life was probably just not <u>that valuable</u>.
For when workers died there was certainly a ready supply available elsewhere. Given the work required it could be not only other men but slaves, very young children, and women. But ist not merely an issue of numbers but of skills. For until the late 19th century, the work of industry was largely done by unskilled labor. Thus while if he or she had to be replaced it was unfortunate but he could be replaced by virtually anyone It was when labor itself became more highly skilled, when direct replacement takes more time and money, then and only then does it become worth it to invest in making the current employee more healthy - his working conditions more safe and sanitary. (To be sure organized labor, public health and general humanitorionism, pushed for such goals but self-

interest made a favorable response inevitable).

Because of the general unease generated by the many implications of the statements of the precursors of social medicine, the bacteriological revolution was welcomed with a sigh of relief. As Emil Behring declared in 1893:

> "the study of infectious disease could now be pursued unswervingly without being sidetracked by social considerations and reflections on social policy."

There was a dying gasp in America reflected in the founding in 1910 of a section of the American Public Health Association. The keynote for this period was struck by Herman Biggs.

> "Disease is largely a removeable evil, it continues to afflict humanity not only because of incomplete knowledge of its causes and lack of individual and public hygiene but also because it is extensively festered by harsh economic and individual conditions and by irreched housing in congested communities. These conditions and consequences the diseases which spring from them can be removed by better social organization."

The spirit was short-lived and the section disappeared from the Association within a decade.

While some of the more global aspirations of medicine may thus be said to have gone 'underground', nevertheles the nature of the work and the tools necessary to do their work bound two specialties to the State- public health and psychiatry.

Public health was always committed to changing social aspects of life from sanitary to housing to working conditions. Moreover it often used the arm of the state (i.e through laws and legal power) to gain its ends (e.g. quarantines, vaccinations). Psychiatry's involvement in society is a bit more difficult to trace but taking the histories of psychiatry as data, then one notes the almost universal reference to one of the early pioneers a physician named Johan Weyer. His and thus psychiatry's involvement in social problems was in the objection that witches ought not be burned; for they were not possessed by the devil but rather bedeviled by their problems - namely they were insane. From its early concern with the issue of insanity as a defense in criminal proceedings psychiatry has grown to become the most dominant rehabilitative perspective in dealing with society's 'legal' deviants. Psychiatry like public health has also used the legal powers of the state in the accomplishment of its goals (i.e. the cure of the patient) through the legal proceedings of involuntary commitment and its concommitant removal of certain rights and privileges. (The film The Devils was cited as a more direct involvement of medice in social control. K. Jones was cited showing other medical, i.e. non-psychiatric concern in criminal matters).

This is not to say, however, that the rest of medicine has been 'socially' uninvolved. For a rereading of history makes it seem a matter of degree. Medicine has long had both a de jure and a de facto relation to institutions of social control. The de jure relationship is seen in the idea of reportable diseases wherein if certain phenomena occurs in his practice the physician is required to report them to the appropriate authorities. While this seems somewhat straightforward and even functional where certain highly contagious diseases are concerned, it is less clear where the possible spread of infection is not the primary issue e.g. gunshot wounds, attempted suicide, drug use and what is now called child abuse. (Oct. 4th 1971 London Times example of the implications of VD as a reportable disease.) The de facto relation to social control can be argued through a brief look at the disruptions of the last two or three American Medical Association Conventions. For there the American Medical Association - and really all ancillary health professions -

were accused of practicing social control (the terms of the accusers was genocide) by 1) whom it has traditionally treated with what - giving better treatment to more favored clientele, and 2) what it has treated - a more subtle form of discrimination in that with limited resources by focussing on some diseases, others are neglected. Here the accusation was that medicine has focussed on the diseases of the rich and the established - cancer, heart disease, stroke, and ignored the diseases of the poor such as malnutrition, and still high infant mortality.

My contention of course is that I have not been citing isolated examples but that rather they reflect some of the inherent conflicts in the practice of any profession. For the profession by its nature will also reflect some of the basic conflicts of the state. During the upheaval-revolutions of 1848 there was an articulation of one of these conflicts. D.O. Evans reports that there was in the air

> "a recognition that the good of Society, the welfare of the individual and the interests of the State are not necessarily identical and that it is therefore necessary to study how these may be coordinated for the greatest benefit and to substitute social questions for political questions."

And one of the recognized pioneers of social medicine or at least the one who created the term social medicine Jules Guerin appealed to the French medical profession to act for the public good, to help create the new society for which the French revolution had opened the way. For he felt that social medicine was "the key to the most important issue of our period and that the medical profession profession was the most appropriate group to mediate between the state and the individual.

Some 125 years later, the conflict is still recognized but there is at least some doubt that the physician holds the key and that rather that he is the man in the muddle, not so much the mediator but the pawn.

I will let Dr Keith Hodgkin articulate this recognition(Proc. Roy. Soc. Med. vol. 63, nov. 1970, 1131-1195 - Dr. Keith Hodgkin "The General Practitioner and Industrial Absenteeism"). "Industrial absenteeism is an emotive subject because individual action is at variance with the needs of the community."

A century ago an individual worker was considered so unimportant that a family might starve if a breadwinner absented himself from work for ANY reason. Nowadays by contrast it is possible for anyone to absent himself without danger of social repercussion. Our modern democratic Society wisely tolerates a wide variety of individual actions; many of

these are selfishly motivated and some are antisocial. If antisocial individual behaviour affects the sommunity adversely, the community shows its disapproval by creating and then enforcing laws. In a democratic society the interests of the individual (the defence) are argued against the interests of the community (the prosecution) in front of a judge and jury.

Industrial absenteeism in our competitive society creates just such a conflict between the interests of the individual and the community; yet we find a single GP expected to judge an individual's motives and act as defense, prosecution, and jury rolled into one. Such a role is in direct contradiction to that of personal doctor and cannot be fulfilled justly by one individual.

"Society expects the GP to assess and correct the motivation as well as the illness of the individual absentee."

What is striking to me about this statement is a few things - the recognition of the dilemma of the position in which the physician is placed, the emphasis on his role not his character, and the fact that this phenomenon is articulated in a Western non-communist country by a physician. The latter is particularly important for it illustrates that, perhaps, too much has been made in emphasizing the relationship between the state and the doctor and the individual in places where ideologically the physician is supposed to serve the State (i.e. the Soviet Union). The dilemma obviously goes deeper and though affected by circumstances in which it finds itself has features which cut across all countries. (Incidentally - Freidson argues this position re the issue of autonomy of professions.)

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II. THE PROMINENCE OF MEDICAL SCIENCE AS AN 'ANSWER'

To man's dilemmas

A concern that has been voiced many times in these discussions is why medical science has risen to such prominence as an institution of social control, as major codifier of meaning and morality in the 20th century.

This 'why' has several different levels, so let me try and comment - speculate briefly on each.

First there is a why of the where - why is this phenomenon reflected in the United States more clearly than elsewhere.

Perhaps it is necessary to state almost a truism, that modern medicine has never succeeded or been accepted in any country just because it works, just because it is better in some way than the existing method nor even if it can be shown to significantly reduce mortality or disability. This is amply demonstrated in the many case studies of western public health programs introduced into non-western countries (see Ben Paul, editor Health, Community and Society).

Thus we can more easily understand the acceptance of medical science - health in the United States by noting its fit with at least three central values, which have been dominant almost since the creation of that nation (Talcott Parsons).

The first of these can be labelled activism - a continual emphasis on mastering the environment, man over nature rather than either adjusting or submitting to it. In the U.S. there was no river that could not be dammed, no space that could not be bridged and ultimately no disease that could not be conquered. The idea of conquest is an appropriate one as the U.S. waged successive 'wars' against polio, measles and now against heart disease, stroke, cancer. A second might be called worldliness which consists of a general preference for practical secular pursuits over more esthetic, mystical, or theoretical ones.

This phenomenon was no doubt aided by the absence of any state or institutionalized religion. Thus medical science at least had no formi-

dable institutionalized opponent as in other countries. Finally there is the American valuation on instrumentalism - an emphasis on means and movement without having a specified goal. It is probably not accidental that some of the clearest debates as well as the most ultimate acceptance and implementation of Darwinism took place in the United States. Thomas Kuhn comments on the resistance to Darwinian theory help explain this.

> "When Darwin first published his theory of evolution by natural selection in 1859, what most bothered many professionals was neither the notion of species change nor the possible descent of man from apes. The evidence pointing to evolution, including the evolution of man, had been accumulating for decades, and the idea of evolution had been suggested and widely disseminated before..... All the well-known pre-Darwinian evolutionary theorists - Lamark, Chambers, Spencer, and the German naturophilosophen - had taken evolution to be a goal-directed process. The 'idea' of man and of the contemporary flora and fauna was thought to have been present from the first creation of life, perhaps in the mind of God. That idea or plan had provided the direction and the guiding force to the entire evolutionary process. Each new stage of evolutionary development was a more perfect realization of a plan that had been present from the start.
>
> For many men the abolition of that teleological kind of evolution was the most significant and least palatable of Darwin's suggestions. The Origin of Species recognized no goal set either by God or nature. Instead, natural selection, operating in the given environment and with the actual organisma presently at hand, was responsible for the gradual but steady emergence of more elaborate, further articulated, and vastly more specialized organisms. Even such marvelously adapted organisms as the eye and hand of man - organs whose design had previously provided powerful arguments for the existence of a supreme artificer and an advance plan - were products of a process that moved steadily from primitive beginnings but toward no goal. The belief that natural selection, resulting from mere competition between organisms for survival, could have produced man together with the higher animals and plants was the most difficult and disturbing aspect of Darwin's theory. What could 'evolution', 'development', and 'progress' mean in the absence of a specified goal? To many people such terms suddenly seemed self-contradictory."
> (The Structure of Scientific Revolutions, p. 171-172.)

It is almost as if the species of which Darwin was speaking was the Homo Americanus.

In the U.S. this instrumentalism was also reflected in an emphasis on 'doing' - on doing something, almost anything. Doing nothing in a difficult situation was interestingly enough an item on a popular psychological test diagnostic of neuroticism. Sometimes the emphasis

on movement becomes so great that speed itself is emphasized - sometimes for no logical reason. Where else but in America could a selling point of a TV-set be that it goes on 30 seconds faster than its nearest competitor. (An anecdote re Piaget was also told.)

Such a value context seems ideally suited to the early developments of science in general and medical science in particular. This does not mean that medicine cannot attain equal stature either in general or as an institution of social control in other settings. Where there is a different socio-historical-cultural context, where other values are dominant we expect this to have an effect - just as we know that Roman Catholicism seems to have different forms and emphasis in Ireland, Italy and South America. The questions to be answered is whether such differences will be sufficiently strong to mean that it will not happen here (wherever here may be) or that the form and content will in some very important ways be altered.

The second 'why' is the 'why of when' - when medical science took hold. Again there is no single event and again we have to get historical. In the mid-1800's, perhaps as a counter-movement to the wave of legalism introduced in the American and French constitutions. I say counter-movement for in a certain way these documents and obviously the demand of abortive revolutions of 1840 went "too far".

For in addition to other ways of defining man's life, its meaning, his relationship to others it used some rather heady concepts like individual liberty, freedom, and perhaps most difficult to take equality. The words sounded good but surely it was not meant to be practiced. Surely some people were 'more equal' than others. So theories and writing began to appear in many field trying to explain some of the 'given' inequalities of man. Amongst the more popular - all done up in the wrappings of scientific measurements and figures was the PHRENOLOGY movement and then a text which meant thru many editioned, several in the U.S. - de Gobineau's The Inequality of the Races. But all were relatively short-lived. (Some detail on both of these movements was given.)

One figure, one theory did, however, make it not only as an accepted scientific theory, but as a guide for social action - a theory which in a relatively short time reached what Bertrand Russel calls the 'cult of common usage'. This was the theory of evolution, the work of Charles Darwin. It had an enormous appeal. For though the idea of evolution was not new, the process by which he postulated it taking place was - a competition, the survival of the fittest. What was appli-

cable to flora and fauna was seen also to be relevant for man. For whatever else it implied, it seemed to be an easy step to say that what is here today is here because it is in someway better. This was applied not only to civilizations but ultimately to man vis-a-vis other men, the people who at this point time were on top were there because in some way they deserved to be. Though we often tend to think of Darwin's theory as anti-religion or even anti-the established society, it is apparent that some people did see the forest for the trees. Upon hearing the postulates at a scientific congress, one attender is reported to have said, "Sir, you are preaching scientific Calvinism with biological determinism replacing religious predestination."

Instead of a fixity of the universe, of hierarchical relations promulgated by God, we now had a universe fixed by scientific laws. As judged by the political, social, and legal implementations of such theorizing, many more people seemed willing to act upon it though they might not acknowledge it directly. Thus it would be our contention that much of science and later medical science in its notion of progress had a particular kind of progress at least latently in mind.

With the bacteriological revolution and the Flexner report in the U.S., medicine wedded itself not only to science but became the great incorporator of knowledge.

Thus long before it claimed to be the truth, it began to garner to its bosom any form of knowledge (admittedly some more grudgingly than others) that might be relevant to its ends. From biology to physics to economics to psychology to engineering to philosophy to ethics, all found a place in the medical curriculum. And once in no piece of knowledge seemed ever to be dropped and so the scope of medical training continued to expand and lengthen. While this apparently may be the source of much consternation to curriculum committees it did give medicine the claim of being involved in more aspects of life than any other discipline or institution and place it in a central position to be a codifier of the meaning of life in the 20th century.

Medicine also wedded itself to an important 'geist' of the times - the new wave of 'humanism'. For while medicine was still concerned with the more traditional issues of authority and truth (see previous lecture), it brought to preeminence something else - the notion of service (Bittner) the idea of helping others directly.

Something else was happening broadly speaking on the social level - the standard of living, eating, and housing were on the rise and mortality of due to all causes in the decline.
(A phenomenon essentially unrelated to medicine - see Dubos, The Mirage of Health.) At very least this gave medicine another kind of relevance vis-a-vis religion. It may seem reaching but it does not strike me as inconsistent that religion and notions of the hereafter are especially relevant when 'the here' is so lousy and so short. But when 'the here' increases dramatically - when man live to 50, 60 or 70 and get diseases he never dreamed of, then this life and its most concrete embodiment, the human body, becomes of greater interest and concern.

These are all long-term kinds of trends.
The full sway of medicine-health seems to date from the end of World War II. It seems almost as if a self-conscious (and perhaps political) decision was made at least in the United States. Putting all our techniques to destruction we won a war, maybe we can put the same tools and new ones to the preservation of life. And so the National Institutes of Health expanded almost a hundred fold, Foundations got into the health business, and medically-related occupations became the fastest growing category of employment.

Now we turn to the final 'why' - why medicine rather than some other institution or complex of values. One point which we have probably not stressed sufficiently in our emphasis on medicine's replacing religion and law is that its success was and is dependent not on its being different from medicine and law but rather appearing to be different while carrying on many of the old functions. (An aside devoted to stating that this takeover of medicine is in process, that religion and law are still important, that the concern with health has not permeated the entire society. On the other hand, what such a society might look like when illness is so great a deviation as to be considered a crime is described in a book written over a 100 years ago (Samuel Buttler's Erewhon).
It is worth noting that scientists of the eighteenth century were interested in emphasizing the ties rather than the differences between science and religion. Thus, as Hill claims (Reformation to Industrial Revolution, p. 167).

> "Writers about science from Bacon to Locke slowly brought about an intellectual climate in which scientific laws, the laws of nature, were equated with laws of God, immutable rational precepts and also with an equally immutable moral law."

Some felt it necessary to reason as follows:

> "There is no man or woman needs go to Rome nor hell below ground.....to find the....power of darkness; neither to go up into heaven above the skies to find Christ the word of life. For both these powers are to be felt within man, fighting against each other..... And this is that day and night, the light and darkness, winter and summer, heat and cold, moon and sun, that is typed out by the fabric of the great world; for within these two powers is the mystery of all divine workings wrapped up....to know the secrets of nature is to know the works of God."
> (Gerrard Winstanley, in C. Hill, Reformation to Industrial Revolution, p. 162.)

Interesting enough it was not merely à la balileo etc. that some scientific ideas had 'religious implications'.
That such a rapprochement might have been necessary was seen even by scientists themselves for quite a different reason. For Joseph Priestly, one of the first historians of science not only never conceived of the creation of the role of a full-time professional scientist but considered such full time pursuit of science 'immoral'.

> "Hastly let it be remembered, that a taste for science, pleasing and even honorable as it is, is not one of the highest passions of our nature, that the pleasures it furnishes are even but one degree above those of sense, and therefore that temperance is requisite in all scientifical pursuits.
> Besides the duties of every man's proper station in life, which ought ever to be held sacred and inviolate, the calls of piety, common friendship, and many other avocations ought generally to be heard before that of study. It is therefore only a small share of their leisure, that most men can be justified in giving to the pursuit of science; though this share is more or less, in proportion to a man's situation in life, his natural abilities, and the opportunity he has for conducting his inquiries." (History of Electricity, Vol. I, p. XXV.)

Medicine itself seems not unaware of the benefits of some close association - directly or functionally with religion. Both are posessors of an esoteric knowledge, and techniques, wear strange garb, speak (and write) often in a foreign if not garbled tongue. Both rely on faith as one of their major tools of the track. And both are concerned with life and death issues though L.J. Henderson notes that it was not until about 1900 that the physician's concern had much positive advantage to the patient. As he put until then a random patient meeting a random physician had about a 50-50 chance of benefitting from the encounter. Our point is really a simple one that from our vantage point there was simply no viable competitor to medical science.

Though I cannot at this point articulate the principles involved let me talk about a major 'competitor' one might have made it once and still might (education).

Education did not make it for it seems that at least for the last couple of hundred years education was either so tied up with society (and so bad so real independent being) or so removed from it as to be completely irrelevant to life. The former we see as when it was openly teaching the tools of the trade - reading, writing, arithmetic and the latter when either education itself was merely for the compleat man or the subjects tought because they were always tought - with little justification. Education does, however, have the potentiality for following in the footsteps of medicine, law, and religion if in focussing as they do on the individual that virtue, legal, and health is replaced by something called self-awareness, personal growth. Then too all forms of knowledge and experience will be valued and evaluated in this light. There are times when this seems almost to be breaking through. There was a time in the 1920's and '30's in the U.S. when life adjustment was the organizing rationale in many educational programs. Moreover the general popularity of the encounter movement, the human growth potential movement and its incorporation into the curriculum of many colleges and universities is not without consequence. When it does come full blown you can also be sure that it will draw heavily on its predecessors. The most dramatic example of this is the LSD flung in the mid 1960's. For before the legal and medical roof caved in, this was a road to greater self-awareness, self-knowledge, beauty, creativity, even religious experience all aided and abetted by a drug invented by medical science. This is still a self-awareness phenomenon rather limited yet it could grow particularly in the light of certain irrefutable social facts. The age span is getting longer but people are working less. Not only do they work for a shorter period during their lifetime (beginning later, returning earlier) but the working day is also decreasing. Finally work as physical labor is getting less demanding and exhousting. In short, man has more 'free time' and leisure instead of being a small part of life becomes the greater part. What we spent so much time learning (i.e. necessary skills) becomes relevant to a smaller part of life. With so much time on one's hands, it is not unreasonable to not only wonder how to fill it but also to wonder more deeply what life is all about. Enter the concern with greater self-knowledge, personal growth, self-awareness.

There is still another level of why which I would like to mention but postpone discussion on until we have more data - that is the political implications of focussing attention on the individual level rather than on some other level of analysis and intervention, something which medicine does better than any other institution.
What this all leads up to is my contention that indeed the physician is a MORAL ENTREPRENEUR

- in the sense that he not only creates new labels or codes for morality;
- and in the sense that he imputes these to acts, behaviors, and people.

This means that I must demonstrate to you that labels 'health' and 'illness' whatever else they are still contain many of the connotations evil, sinful, bad, immoral, undesirable. This is the task of the next session.

MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL

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III THE MORALIZING ENTERPRISE OF MEDICINE

Today's session is essentially devoted to two themes: the power of the doctor in his daily practice to make important social judgements and that much of these social judgements are shrouded in moral terms. More specifically we mean that the label "illness" carries with it connotations of dirty, evil, undesirable even immoral and that despite all the rhetoric, medicine still leaves man accountable and responsible for being sick.

To begin with, being sick is not - at least in the 20th century merely having - possessing some physical-organic impairment, pathological condition. As Freidson notes:

> ". . . when a veterinarian diagnoses a cow's condition as an illness, he does not merely by diagnosis change the cow's behavior: to the cow illness remains an experienced biophysical state no more. But when a physician diagnoses a human condition as illness, he changes the man's behavior by diagnosis: a social state is added to a biophysical state . . . (p. 223)

What we mean is that being ill in modern industrial society involves and has social consequences. Through the years many have tried to delineate these consequences. The most sophisticated articulation is found in the work of Talcott Parsons. For he felt there was a sufficient coherence in these consequences to conceptualize it as "the sick role". One of the key elements in this role was that any incapacity resulting from disease-injury is regarded as grounds for exemption from normal obligations. In other words, if you are sick, there are things you no longer have to do. But there are according to Parsons two important qualifications to be met, for this exemption is not unconditional. First the sufferer has to recognize that to be ill is <u>undesirable</u> in the eyes of society and he/she is under an obligation to get rid of or at least deal with the problem. And secondly in modern industrial society, the obligation is further elaborated to mean "competent help" (usually defined as a physician, clinic etc.) and to cooperate with attempts to get him well. Unless these conditions are reasonably met the legitimation is withdrawn. Pragmatically this means that if we should claim to be sick and as a result wish to be excused

from school, work of some other social obligation we can only do so on a very short term basis. For rules exist, formally and informally, in businesses and in families, as to how long one will be "excused" without "the problem" being certified by some competent recognized medical authority. For our purposes it means that the physician in his daily tasks in modern society has at least two important functions: a technical one dealing with the whys and wherefores of diagnosis, treatment, rehabilitation and a social one where he explains, accedes, allows, legitimizes certain consequences of these diagnoses, treatment etc.

Most physicians will admit that such a social function does take place. Yet the feeling is that the basis for its exercise is so straightforward and objective that little judgement is involved. Freidson states this operating assumption quite clearly when he contrasts medicine, law and religion:

> p. 204 ". . . medicine is kept apart from religion and law because, unlike them, it is believed to rest on an objective scientific foundation that eschews moral evaluation. Illness is thought to involve viruses and molecules and thust constitute a physical reality independent of time, space, and changeable moral evaluation. Thus, from the bones of men long dead, who spoke long forgotten tongues and practiced now wholly obscure customs, we can independently of their culture draw evidence of fractures, arthritis, rickets and the like. It is because it is believed to be independent of human culture (though human culture may influence its prevalence and treatment) that illness is felt to be different, more "objective" and stable than such clearly social forms of deviance as crime. In this view illness is biological rather than social deviance, subject to the same biophysical law in man as in mouse, rabbit, or monkey. Whether we evaluate it or not, it is always "there", independent of us. In the same sense it is independent of medicine, hardly created by it.

Yet think carefully about this statement. For to me, it brings to mind the age old statistical distinction between reliability and validity. For this "independence of human culture" means I think that if we could be concrete enough we could describe a special set of signs or symptoms or give some agreed upon tools of measurement (e.g. a thermometer, blood test) to a Buddhist or a Bantu, a Korean or an Algerian, a Spaniard or an Englishman in the year 1972 A.D. or 2072 B.C., they would all agree that it exists, it's real. But whether or not this state would be given any special significance, treated as an "illness" or by a "medical person" was and is essentially a sociohistorical phenomenon. Where these groups both in time and space are likely to differ is in what they would do

about it. A broken bone is a broken bone, but it may call forth a bonesetter or an orthopedist as well as difference in priorities between propitiating the gods and looking for splints. Moreover, where a "medically pathological" condition is almost omnipresent in a society, it may be regarded as an everyday condition of life. Thus even while it may be recognized as a suffering or inconvenience, it may not necessarily be called an illness or even more important, "something" that could or should be treated (Zola, "Culture and Symptoms for many examples). In short, there has been a continuing evolution of what is deemed illness and appropriate to medical purview. We will give more attention to some specific forms of this in the next session, for now we wish merely to note that the physician has always had wide and changing discretion on what is commonly thought to be illness.

It is to the major consequence of imputing illness the legitimating function to which we wish to turn now. Here I would probably hypothesize that the power of this function has expanded. When the illness and problems coming before the physician were of the acute infectious variety - the plagues, epidemics, revers, one probably did not need a highly skilled diagnostician to determine that a person was ill or more importantly that he was unfit to carry on certain social obligations. He looked and acted sick, his symptoms and their functional consequences were pretty obvious. Histories of this period indicate that the physician was called after the diagnosis was made to hopefully do something about it or prevent it from spreading. Even here, however, the physician still might have functioned to legitimize the length of convalescence or certain of the long term consequences such as the "real" nature of certain "residuals" (i.e. the age old problem of "malingering").

Today both the physician's discretionary power (what is or is not illness) and his legitimating function seem to have expanded. We can see the latter in two ways - statistical and clinical. The first is seen in the recent Office of Home Economics Bulletin on "absenteeism", which noted that while in 1968 3 million work days were lost through industrial strikes, 300 million work days were lost through illness. The clinical expansion is evidenced in the intensive examination of doctor's practices. It is first of all clear, that few patients are coming at their physically sickest

and that regardless of the reality of their problems, few constitute medical emergencies or even medical attention while it is true that these patients want help, several investigators (Balint, Zola) have claimed that a large number with "real illnesses" are seeking escape from some uncomfortable social-psychological situation - an escape for which they, however, seek legitimation or medical ground.

But perhaps the greatest difference between yesterday and today is in the discrepancy in the patient's and doctor's ability to diagnose disease and the consequence of this in the greater discretionary power allocated to the doctor. Most of todays's "modern" diseases do not "show". We cannot see the damaged heart, the mestasasis, the tumor, the spreading infection, the inflamed nerve and the insufferable pain. Even when we are allowed occasionally to view the evidence on X-rays or slides, through the microscope or on a tape, we find that without the long-term sensitization we simply cannot "see" the important shadings skapes etc. In short, we are forced to accept the testimony of the physician on faith. I do not mean that our belief and acceptance is without empirical foundation but rather that most of us have never seen a filterable virus or bacteria nor know the differences between various agents of disease. If indeed the doctor tells us that we have a virus or an infection or a particular disease we for the most part accept it without calling upon him to prove it. (Exemple cited of an even more extreme situation where trained researchers who use statistics every day of their work lives have to accept the validity and derivation of their statistical tools because the mathematics underlying them were simply too complex for them to comprehend. The Mosteller case where this eminent statistics professor after spending an hour and covering several blackboards with figures discovered with exasperation that somewhere along he'd made an error. Turning to his audience of trained researchers, he stated that "you will just have to believe me that it works out" and to a man and woman they did). Moreover, there are at least two factors which inhibit the patient's further questioning of the doctor's opinion. First, depending on the patient's geographic and social position, there may simply be physical and financial barriers.

Secondly, at lest in the United States, there is a kind of informal taboo against "shopping around" for other medical opinions.

The great judgmental power of the physician is seen perhaps best in a couple of examples. For even where there no biological evidence is available - a situation where if the physician were asked to show the organic pathology, he could not - still his opinion holds sway. During a series of studies carried out at Massachusetts General Hospital, I was able to observe this phenomenon at first hand. A number of diagnoses placed on respondents in my research were simply not in my Merck Manval. Particularly frequent were: Vitreous Opacities and Tinnitus. In each of these the patient suffered from some difficulty - from seeing spots in front of his eyes to a ringing in his ears, but in no case was any organic pathology found. The terms wer simply a descriptive name for the complaint when asked why such a "diagnosis" was given rather than a designation such as "nothing found on tests" etc., the physician (mostly opthalmologists and otolaryngologists) replied that they were not certain that no organic disease or damage existed but rather with the tests they had available, they have <u>not yet</u> been able to find it and perhaps at some later date . . . . Though I had some suspicion that such diagnoses were not randomly distributed, I had no data. Soon, however, I did. Toward the end of my research, I noticed that proportionately more Italian patients received "psychological diagnoses". This was somewhat surprising since I had independent evidence that there were no differences in "psychological disturbance" or "socio-environmental problems" between the Italians and any other ethnic group in my study. Trying to figure out what was going on, I hypothesized, that when in an ambiguous situation and since the name of the game in the U.S. is differential diagnosis i.e. a pressure on the doctor to make a specific medical determination, if at all possible; the physician may (unwittingly) rely on other than medical cues to make a diagnosis. I thus took all the cases in my study where no organic pathology was found (but not including the previously mentioned vitreous opacities and tinnitus) and tried to see how the diagnoses were distributed. Because the number of males which fit

this criteria were too small for statistical comparisons, the hypothesis was only tested on a subsample of Italian, Irish, and Anglo-Saxon women. When the previously mentioned ratings of "psychological disturbance" and socioenvironmental problems were applied to these three groups, no statistically significant differences were found. I divided the diagnosis into two categories - psychogenesis implied and no psychogenesis implied. The first category included three diagnoses: tension headache, functional - , and some psychological term (e.g. depressed, anxiety state, personality problem). The second category included only those where the terms "no pathology" or their equivalent was the primary diagnosis. The results are seen in the following table.

Table 3

Physician Diagnosis of Female Patients with no Organic Basis for Symptoms (Zola, I., Journal of Med. Education, Vol 38, Oct. '63 pp 829-838).

	Italian	Irish	Anglo-Saxon
Psychogenesis Implied	11	2	2
No Psychogenesis Implied	1	9	4
	12	11	6

It is worth noting that the two "psychogenesis" cases of the Anglo-Saxons had the most obvious psychopathology in the entire sample and thus required little exercise of clinical judgment. One of these presented herself as being "mentally ill" and had been referred by the local Mental Health Association. The second entered the interview reeling and unsteady, accompanied by the distinct aroma of liquor and was subsequently diagnosed by her physician as "alcoholic".

From the larger study an explanation of this diagnostic bias is available. For the Italians in marked contrast to both the Irish and the Anglo-Saxons not only reported more symptoms and stated more often that the symptoms made them irritable and difficult to get along with but that in describing the specific circumstances in bringing them to a doctor more often felt that their symptoms interfered with social and personal relations, or mentioned the presence of an interpersonal crisis. In another study of Italians, Zborowski felt that their "uninhibited display of reactions" to pain and their overinvolvement with their symptoms would tend to provoke

distrust in the doctors treating them. In our study this "distrust" or displeasure was translated we feel into a "disapproving" diagnosis - one which the patient carried with him as long as he was a patient in the hospital. Looking back over our cases we then began to realize that diagnoses like vitreous opacities and tinnitus which were attributed primarily to Anglo-Saxon and Irish patients might have conversely an "over protective" function. For in at least one case it was noted by me but not the examining physician that in addition to hearing rings, humming, buzzing etc. the patient also heard voices with quite distinct commands etc. (A question was asked if the doctors ethnic, religious background effected his diagnosis. The answer was no and that perhaps the important socializing experiences of medical education "wiped" out certain background influences (Beckerstal, Boys in White).

Our general point so far has been simply to demonstrate the enormous and almost unquestioned power of the contemporary physician to confer the label illness and that these labels have very important social consequences and that there are certain factors which may influence their use.

Our second general theme is that the label "illness" is enveloped with moral connotations. We can see this in several wars. First of all it is rather explicit in some of the general rhetoric about illness, when campaigns are mounted to eradicate a disease. Again in America, this metaphor is no doubt more popular. For it is very clear that illness is an undesirable state and the disease is the enmemy. And thus we have "wars" against heart disease, measles, polio, birthdeformities, cancer, with armies banded together engaged in a battle where only unconditional surrender will be accepted. (The same trend of warring elements was also noted in much advertising of medical products.) Secondly, whatever else medicine is, it is not neutral in its operational attitude toward disease.

> "Moral neutrality exists only when a person is allowed to be or do what he will without remark or question. Positive moral approval, of course, exists where a person is urged to be what he may not wish to be. Clearly the physician neither approves of disease nor is neutral to it." (Freidson, p.253)

A person does not in many ways have the right to be sick or remain untreated. (The not unrelated debate over whether or not an individual has the right to determine when or how he might die was cited.) Aside from compulsory vaccination, quarantine and other forms of legal exclusion,

certain new restrictions are appearing. In many jurisdiction legislation has already been passed or introduced which restrict the rights of parents over their children. Of particular interest are laws making it illegal for a parent to refuse vaccination, blood transfusion, and even operations to an underage child, when life or permanent injury is at stake. In other instances, laws are not necessary. For a patient's refusal to partake of a specific treatment may be interpreted as part of his illness. Thus because he is "ill", he is in no condition to judge what is or is not in his best interests (the rationale behind involuntary hospitalization for mental illness).

But most important, I do not think medicine has ever shaken the moral shackles it was supposed to replace. For despite long educational campaigns the public attitude toward many diseases still seem to be shot through with connotations of repulsion, disgust, notions of personal weakness and inadequacy. Thus venereal disease carries with it rather explicit condemnations. And though they have been around for a couple of hundred years, epilepsy, leprosy, mental retardation, and mental illness still evoke feeling of fear and repulsion. Even that most modern of diseases Cancer, interestingly referred to as "the wasting disease" and often magically called only by its initials, CA, does not escape. No doubt this reflects that attitudes toward disease are influenced by what organs or physical functions are involved. Attitudes toward colostomy seem to surmount national barriers as seen in the similarities of patients in the Soviet Union and in the United States.

> "Whatever you say there's cancer and cancer", Shulubin declared, looking straight ahead of him instead of at Oleg. "There's one kind of cancer beats all the others. However miserable one is, there's always someone worse off. Mine's the sort of case you can't even discuss with other people, you can't ask their advice bout it."
> "Mine's the same, I think."
> "No, mine's worse, whichever way you look at it. My disease is something specially humiliating, specially offensive. The consequences are terrible. If I live - and it's a very big if - simply standing or sitting near me like you are now, for instance, will be unplesant. Everyone will do their best to keep two steps away. Even if anyone moves closer I'll still be thinking to myself, 'you see, he can hardly stand it, he's cursing me'. It means I'll lose the company of human beings". (Solhenitsyn, Cancer Ward, pp 431-432)

> "When I smelled an odor on the bus or subway before the colostomy, I used to feel very annoyed. I'd think that the people were awful, that they didn't take a bath or that they should have gone to the bathroom before traveling. I used to think that they might have

> an odor from what they are, I used to be terribly annoyed; to me it seemed that they were filthy, dirty. Of course, at the least opportunity I used to change my seat and if I couldn't it used to go against my grain. So naturally, I believe that the young people feel the same way about me if I smell". (case cited in Orbach, p. 165)

Regardless of what disease one has, there seems to be considerable condemnation attached to what one does about it. This is seen in an admittedly phenomenological analysis of the vast literature of "troublesome patients". For without seeming ludicrous if one listed the traits of people who break appointments, fail to follow treatment regimen, or even delay in seeking medical aid, one finds a long list of "personal flaws". Such people seem to be ever ignorant of the consequences of certain diseases, inaccurate as to symptomatology, unable to plan ahead or find time, burdened with shame, guilt, neurotic tendencies, haunted with fear of doctors, hospitals, needles, traumatic medical experiences or members of some lower status minority group, religious, ethnic, racial or socioeconomic. In short they appear to be a sorely troubled if not disreputable group of people. I believe a similar trend is found in our general attitude toward people with chronic diseases and physical handicaps. Not without reason has Goffman written a critical book about such people entitled 'Stigma - Notes on the Management of Spoiled Identity'. Whatever else he is claiming, using the terms introduced at the beginning of this session I would say that there is literally no unconditional legitimation for having a chronic condition. For no matter what the disease there seems to be a value not in showing it, being comfortable with it but rather in hiding it. One of the nicest compliments one can give is 'I did not even know he had . . .'. Goffman and others have thus concluded that the "best" way for a person with a chronic illness or permanent handicap to act is to be as inobtrusive as possible, to organize his life and his actions to cause the least embarassment to others. (A Boston psychiatrist recently reported that one group having severely burned facial disfigurements may have been so successful that several "Burn Institutes" report no follow-up data on their patients and have speculated that they seemed to have disappeared off the face of the earth.) That there must be something "bad" about these people is at least perpetuated in the United States where children are continually admonished (supposedly so as not to hurt the "afflicted"'s feelings), that "it is not nice" to stare at or talk about such things. In short

they are taught almost to deny it as well as the person's existence.

The issue of morality is seen most clearly in what the medical model is supposed "to buy" for both the individual and his condition, namely, treatment instead of punishment absolution instead of blame. Here again Parsons offers the best exposition. Ironically enough, however, he thinks he is describing what <u>is</u>, while I think he is describing what was wished.

As parsons has pointed out, in our time the term "illness" when used to give meaning to perceived deviance, implies that what is thought to be deviant does not arise through the deliberate, knowing choice of the actor and that it is essentially beyond his control - that is, it is unmotivated. Furthermore it implies that what is wrong with him is determinable by rational knowledge, and is likely to be known to and manageable by a special class of practitioners holding such knowledge. One does not therefore "judge" a sick person, for he is not to be held responsible for himself. Rather, he should put himself, or be put, into the hands of one of a number of specialists who have the knowledge and skill to help him return to as normal a state as possible. The help of those specialists usually takes the form of education and training or treatment and manipulation: economic or physical punishment is not considered to be an effective or moral method or management.

Turning first to the issue of punishment, if there is one insight into human behaviour that the 20th century should have firmly implanted, it is that punishment cannot be seen in merely physical terms nor only from the perspective of the giver. Granted that capital offenses are on the decrease, that whipping and torture seem to be disappearing as is the use of chains and other physical restraints, yet our ability if not willingness to inflict human anguish on one another does not similarly seem on the wane. The most effective forms of brain washing deign any physical contact and the concept of relativism tells much about the psychological costs of even relative deprivation of tangible and intangible wants. Thus, when an individual because of his "disease" and its treatment is forbidden to have intercourse with fellow human beings (like children separated from parents), confined until cured, forced to undergo certain medical procedures for his own good, perhaps deprived forever of the right to have sexual relations and/or produce children <u>then</u> it is difficult for that patient <u>not</u> to view what is happening to him as punishment. This does not mean that medicine is the latest form

of the 20th century torture, but merely that pain and suffering take many forms, and that the removal of a despicable inhumane procedure by current standards does not necessarily mean that its replacement will be all that beneficial. (In part, the satisfaction in seeing the chains cast off by Pinel may have allowed us for far too long to neglect examining with what they had been replaced.)

The association between punishment and treatment is seen in other respects. How often as children have we not heard about medicines as well as disciplinary actions, that this is being done for "our own good". It is only a recent change, something that owes much more to mass marketing than humane impulses, that medicines need no longer be distasteful, malodurous, difficult to administer or awful to behold for them to be regarded as "real" and effective. And what of all the barriers - financial, geographic, visiting and office hours - which seem to make it more difficult rather than easy to seek medical help. Blue-collar workers seldom get recompensed for time spent waiting for medical care. Many hospitals and clinics have long admission forms and waiting periods - so long in fact that many patients "give up" and leave. And all too often I have heard the medical personnel quip "Well he could not have been that sick . . . ". In psychiatry as well as other medical specialties, the imposition of fees is even regarded by some as an essential ingredient of the treatment - a sign of commitment. (A similar rationale was heard about the importance of fees in the mid 1960's during the Medicare debate in the U.S.) Thus if not punishment, at least there seems to be in a great deal of medical treatment, the necessity for a form of suffering and sacrifice which shows the patient's "good faith".

It is the issue of accountability which requires more attention. For it is not clear that the issue of morality and individual responsibility have been fully banished from the etiological scene itself. For at the same time that the label "illness" is used to attribute "diminished responsibility" to a whole host of phenomena, the issue of "personal responsibility" seems to be reemerging within medicine itself. Regardless of the truth and insights of the concepts of stress and the perspective of psychosomatics, whatever else they do, they bring man <u>not</u> bacteria, to center stage and lead therby to a reexamination of the individual's role in his own demise, disability and even recovery.

The case, however, need not be confined to professional concepts

and their degree of acceptance, for we can look at the beliefs of the man in the street. As most surveys have reported when an individual is asked what caused his diabetes, heart disease, upper respiratory infection etc., we may be comforted by the scientific terminology if not the accuracy of his answers. Yet if we follow this questioning with but the probe - either, "Why did you get X now?" or "Of all the people in your community, family etc. who were exposed to X why did you get it?", then the rational scientific veneer is pierced and the concern with personal and moral responsibility emerges quite strikingly. Indeed the issue "why me" becomes of great concern and is expressed in generally quite moral terms of what they did wrong. On the other hand, it is possible to go argue that here we are seeing a residue and that it will surely be different in the new generation. A recent experiment I conducted should cast some doubt even on this. I asked a class of forty undergraduates, mostly 17, 18, and 19, to recall the last time they were sick, disabled or hurt and to then record how they did or would have communicated this experience to a child under the age of five. The purpose of the assignment had nothing to do with the issue of responsibility and it is worth noting that there was no difference in the nature of the responses between those who had or had not actually encountered children during their "illness". The responses speak for themselves. The opening words of the sick, injured, person to the query of the child were

"I feel bad"

"I feel bad all over"

"I have a bad leg"

"I have a bad eye"

"I have a bad stomach ache"

"I have a bad pain"

"I have a bad cold"

The reply of the child was inevitable "What did you do wrong?" The "Ill person" in no case corrected the child's perspective but rather joined it at that level.

On bacteria

"There are good germs and bad germs and sometimes the bad germs . .".

On catching a cold

"Well you know sometimes when your mother says, 'Wrap up or be careful or you'll catch a cold, well I . . .".

On an eye sore

"When you use certain kinds of things (mascara) near your eye you must be very careful and I was not . . .".

On a leg injury

"You've always got to watch where you're going and I did not".

Finally to the treatment phase,

On how drugs work

"You take this medicine and it attacks the bad parts . . .".

On how wounds are healed

"Within our body there are good forces and bad ones and when there is an injury, all the good ones . . .".

On pus

"That's the way the body gets rid of all its bad things . . .".

On general recovery

"If you are good and do all the things the Dr. and your mother tell you, you will get better."

In short, on nearly every level from getting sick to recovering, a moral battle raged. This seems more than the mere anthropromorphizing of a phenomenon to communicate it more simply to children. Frankly it seems hard to believe that the English language is so poor that a moral rhetoric is needed to describe a supposedly amoral phenomenon-illness.

In short, despite hopes to the contrary, the rhetoric of illness by itself seems to provide no absolution from individual responsibility, accountability, and moral judgment. In fact, one occasionally wonders if it was ever supposed to.

MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL

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IV THE MEDICALIZING OF SOCIETY

Today we add another building block in our case about the role of medicine in contemporary society. To date we have argued on a general level about medicine's relationship to the more traditional institutions of social control - religion and law, about the close ties of professions in general and medicine as an example, to the goals of the State, about why medicine has come to the forefront in the 20th century and how because of its position of strength, the label 'illness' has assumed great social consequences, and how this label rather than being 'objective' is still enveloped in notions of morality. Now we wish to extend our observations to the every day practice of medicine. Today we wish to examine as concretely as possible the means by which medicine is becoming an institution of social control - the insidious and undramatic process by which medicine has become ever more involved in our social life.

Freidson has stated a major aspect of the process most succinctly:

> "The medical profession has first claim to jurisdiction over the label of illness and <u>anything</u> to which it may be attached, irrespective of its capacity to deal with it effectively."

For illustrative purposes this 'attaching' process may be categorized in four concrete ways:

1. Through the expansion of what in life is deemed relevant to the good practice of medicine.
2. Through the retention of <u>absolute</u> control over certain technical procedures.
3. Through the retention of near absolute access to certain "taboo" areas.
4. Through the expansion of what in medicine is deemed relevant to the good practice of life.

1. The expansion of what in life is deemed relevant to the good practice of medicine.

Western medicine is not the same as it was at the turn of the century. At least three interrelated changes are relevant to today's discussion: a shift from concern with acute infectious diseases and epidemics to chronic debilitating disorders; a change of commitment from an etiological model of disease which emphasized specific causal agents and specific disease states to a more complex multi-causal model; and the increasing acceptance of the concepts and principles of 'comprehensive medicine', psychiatry and psychosomatics. Together and separately these have enormously expanded the data which is or can be relevant to the understanding, treatment, rehabilitation and even prevention of an individual patient's disorder. Thus it is no longer necessary for the patient merely to divulge the symptoms of his body but also the symptoms of daily living, his habits and his worries.

The medical work-up once was confined to past diseases and operations, cause of death of parents and close relatives, drug-reactions and the development of the present complaint. Today the work-up may include everything from living-arrangements to dietetic preferences, from work to sexual satisfaction, from problems resulting from the present complaint to "other problems that might be bothering you." More and more, particularly at large scale institutions, a good deal of such data is routinely collected regardless of the 'presenting complaint' of the patient and before any physician is seen. At one such center a prospective patient was given two psychological tests, one work-satisfaction questionnairre, a personal and social inventory, was measured 'anthropometrically' - all in addittion to countless laboratory tests and physical measurements. I have no idea how widespread it is but recently in attending a dentist I had to fill out a questionnairre about past medical experiences as well as about my general fears and feelings about dentists.

Such collection of data is no longer an isolated effort but is now advocated as almost a national goal.

> "...patient assessment techniques are prequisite to the proper selection of health care services for patients. If the health care resources of this country are to be used most effectively and with maximum economy of funds and personnel, the development of such techniques is essential." (Ryder et al. p. 923).

Moreover it is claimed to have benefits to the patient, to the community and to the profession. (Rijder et al. p. 924.)

> With respect to the patient—
> To identify the care needs of patients and to ascertain the adequacy of available care
> To develop a treatment plan for care of the patient
> To aid in patient care evaluation and utilization review
>
> With respect to an individual resource—
> To facilitate effective utilization of the individual health resource
> To aid in program evaluation of the facility or service
> To assist in identifying restrictive policies and procedures that block the provision of care
> To provide a source of data useful in orientation and training of all health personnel
>
> With respect to the community—
> To facilitate the development of an efficient system of health care
> To assist in determining overall community needs for additional or new services
> To assist in establishing priorities for health planning purposes
>
> With respect to research—
> To assist in identifying care needs in populations
> To facilitate epidemiologic comparisons of groups of patients

Such goals are translated into specifics. And thus they recommend the following "Proposed Items for Inclusion in Standard Patient Assessment."

('Patient Assessment, An Essential Tool in Placement and Planning of Care' by Claire F. Ryder, William F. Elkin, Dana Doten)

Proposed Items for Inclusion in Standard Patient Assessment

I. **Identifying data**
   1. Name
   2. Address including phone
   3. Person to notify in emergency
   4. Source of referral
   5. Physician responsible
   6. Year of birth
   7. Sex
   8. Race
   9. Ethnic group
   10. Religion
   11. Education
   12. Marital status
   13. Significant employment history
   14. Amount and source of income
   15. Sources of payment
   16. Type of dwelling
   17. Household composition
   18. Significant relatives outside household.

II. **Medical data**
   1. Present illness
      a. Diagnosis
      b. Course
      c. Prognosis
      d. Present status
      e. All prescribed medications
      f. Appliances
   2. Other diagnoses
   3. Goals and overall prognosis
   4. Impairments (all systems)

III. **Physical function**
   1. Personal care
      a. Present performance
      b. Present ability to perform
      c. Potential ability to perform
   2. Ability to move about
      a. Present performance
      b. Present ability to perform
      c. Potential ability to perform
   3. Other essential ADL (as applicable)
      a. Present performance
      b. Present ability to perform
      c. Potential ability to perform

IV. **Personal adjustment**
   1. Mental functioning (ability to understand care needs and participate in planning and decision making)
   2. Behavior patterns
   3. Impact of illness (attitudes, behavior, feelings, goals)
   4. Adjustment to illness (attitudes, behavior, feelings, goals)
   5. Social adjustment (interpersonal relationships)
      a. Patient—family members
      b. Patient—household (most important person)
      c. Patient—others (significant persons)

V. **Family adjustment**
   1. Impact of patient's illness on family
   2. Adjustment to patient's illness
   3. Characteristics of family members (interpersonal relationships)
   4. Characteristics of caretaker
   5. Goals of family
      a. For patient
      b. For family situation

VI. **Physical environment**
   1. Present housing and living arrangements
   2. Possible modifications, if indicated

VII. **Services from community agencies**
   1. Services currently received by patient and/or family
   2. Significant services previously received by patient and/or family

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P. 930 HSMHA Health Reports, October 1971, Vol. 86, no 10 p. 923-932.

Part of this data explosion is greatly facilitated in the 'age of the computer'. For what might be too embarassing, or take too long, or be inefficient in a face to face encounter can now be asked and analyzed impersonally by the machine, and moreover be done before the patient ever sees the physician. With the advent of the computer a certain

guarantee of privacy is necessarily lost, for while many physicians might have probed similar issues, the only place the data was stored was in the mind of the doctor and only rarely in the medical record. The computer, on the other hand, has a retrievable, transmittable and almost inexhaustible memory. Perhaps not without relevance is the fact that in the U.S. there is a movement afoot to codify, computerize and microfilm medical records so that such information could be more easily transmitted and shared to keep up with the highly mobile U.S. population.

It is not merely the nature of the data needed to make more accurate diagnoses and treatments which is at issue but the perspective which accompanies it - a perspective which pushes the physician far beyond his office and the exercise of technical skills - a perspective most clearly seen in the increasing emphasis on the rehabilitative and preventitive functions of the general practitioner. Now whether it be the enormous demographic increase in the aged portion of our population or the increased tempo of modern living whereby more and more persons are becoming disabled by accidents in the home or the highway, the post World War II years have heard rehabilitation referred to as a national challenge. In a rhetoric echoing that of the early pioneers of social medicine, it was acclaimed that:

p. 232 "An examination or the problem of the crippled and the disabled has revealed their importance in our national economy. The number of the disabled, however estimated, is so large that it demands our urgent attention. I believe that at least twenty-five percent of the world is physically handicapped. When we consider the extent of disability in the United States, and add to it the countless millions in other countries who have been disabled by war or famine or both, the figure appears conservative. This desparate situation requires more than our attention. It cries out for organized action.

... We have seen too, that a large source of man power has been wasted because of the false beliefs concerning the relationship between outward appearance and the ability to work. We cannot afford to waste these powers any longer. Profligacy is not only a sin, it is national suicide." (H. Kessler, Rehabilitation of the Physically Handicapped, 1953.)

This challenge was further translated into practical implications.

"Each time the surgeon saves the life of a person having such extensive and seriously crippling injuries and each time the medical practitioner prevents the death of an extensively paralyzed patient, a triumph over death is achieved; but at the same time these physicians have created for themselves

> a new problem in management of chronic disability and in providing facilities for the rehabilitation of a living, but extensively disabled, chronically ill and often aged patient. One of the major responsibilities of the modern physician is to restore such persons to self-respecting citizenship." (F.H. Krusen, F.J. Kolke, P.E. Ellwood, eds. Handbook of Physical Medicine and Rehabilitation, 1965)

And Howard Rusk made this implication a part of the physicians duty: (Howard Rusk, Preventive Medicine, Curative Medicine - then Rehabilitation. New Physician, Vol. 13: 165-167, 1964.)

> "Rehabilitation of the chronically ill and the chronically disabled is not just a series of restorative techniques. It is a philosophy of medical responsibility. Failure to assume this responsibility means to guarantee the continued deterioration of many less-severely disabled persons until they, too, reach the severely disabled and to tally dependent category. The neglect of disability in its early stages is far more costly than an early aggressive program of rehabilitation which will restore the individual to the highest level of physical, economic social, and emotional self-sufficiency."

Realizing the limitations of rehabilitation, the textbook referred to earlier defines its aim in still broader humanitarian terms:

> "Increasing support of the rapidly expanding number of centers of physical medicine and rehabilitation for the restoration of the chronically ill and seriously disabled to self-sufficiency is a triumphant affirmation of our society's belief in the intrinsic dignity and worth of the individual. The person's right to such services is not measured by his potential ability to bear arms for the state or to fill his established production quota or to become a useful servant of the community according to purely utilitarian standards. These programs in physical medicine and rehabilitation seek to restore the patient to his maximal degree of self-sufficiency even if this means that he will merely be able to lift a fork to his lips, hoist himself from his bed into a wheel-chair or write with a pencil clutched in a clawlike device. The fact that he is a human being in need is sufficient justification for exerting every effort to help him use whatever abilities remain, however slight they may be. It is our hope that this handbook will aid physicians and other health workers concerned with the handicapped and the disabled to understand their problems, to learn how to evaluate their disabilities and to provide the modern techniques of management so that they can achieve the fullest degree of self-sufficiency, productivity, and happiness of which they are capable (Krusen et al. p. 10)

The resemblance of this rhetoric to the global of definitions of health as postulated by WHO is not accidental. It is part of the same movement. Thus to rehabilitate or at least alleviate many of the ravages

of chronic disease. It has become increasingly necessary to become concerned with the total life situation of the patient.

In many ways, the perspective underlying preventive medicine has undergone a similar change. For recent textbooks decry the traditional emphasis on vaccination and mere detection of disease and define its goals more broadly as "the science and art of preventing disease, prolonging life, and promoting physical and mental health and efficiency." Morever, preventive medicine is not merely to be carried on in the public realm on mass population instead,

> "Every general practitioner is an indispensable wheel in the complex machinery of health work. Almost every one of his patients furnishes him with the opportunity for performing work in the field of preventive medicine."

It might well be argued that in prevention, the 'extension into life' becomes even deeper, since the very idea of primary prevention means getting there before the disease process starts. The physician must not only seek out his clientele but once found must often convince them that they must do something now and perhaps at a time when the potential patient feels well or not especially troubled. If this in itself does not get the prevention-oriented physician involved in the workings of society then the nature of 'effective' mechanisms for intervention surely does, as illustrated by these two quotes of physicians trying to deal with health problems in the ghetto

> "Any effort to improve the health of ghetto residents cannot be separated from equal and simultaneous efforts to remove the multiple social, political, and economic restraints currently imposed on inner city residents."

or even more broadly

> "Inevitably, medicine must concern itself with the larger field of social welfare and develop a holistic concept of the community's health, if it is to prevent disease and maintain health and thereby enhance the quality of life and contribute to the national welfare."

Certain forms of social intervention and control emerge even when medicine comes to grips with some of its more traditional problems like heart disease and cancer. An increasing number of physicians feel that a change in diet may be the most effective deterrent to a number of cardiovascular complications. They are, however, so perplexed at how to get the general population to follow their recom-

mendations that an article, in a national magazine was entitled 'To Save the Heart: Diet by Decree. (The precedent for this in 'legalized additives to food was cited)

It is obvious that there is an increasing pressure for more explicit sanctions against the tobacco companies and against high users to force both to desist. And what will be the implications of even stronger evidence which link age at parity, frequency of sexual intercourse, or the lack of male circumcision to the incidence of cervical cancer, can be left to our imagination!

2. Through the retention of absolute control over certain technical procedures.

In particular this refers to skills which in certain jurisdictions are the very operational and legal definition of the practice of medicine - the right to do surgery and prescribe drugs. Both of these take medicine far beyond concern with ordinary organic disease.

In surgery this is seen in several different sub-specialities. The plactic surgeron has at least participated in, if not helped perpetuate, certain aesthetic standards. What once was a practice confined to restoration has now expanded beyond the correction of certain traumatic or even congenital deformities to the creation of new physical properties from size of nose to size of breast. Though it probably did not need it, a recent court case gave credence to this position (Judge Shepperd's instruction to the jury in the Cora Galenti case).

> "You are instructed that the treatment or removal of any ailment, blemish, deformity, disfigurement, disorder by surgical means constitutes the practice of medicine. I further charge you that the use of chemical means to produce the same end results constitutes the practice of medicine."

Again and again it seems as if medicine is trying to prove Ortega Y Gassett's statement that man has no nature only a history. Thus many of the accompaniments of formerly considered 'natural processes' come under medical purview - as in ageing. Now failing sight, hearing, teeth become of greater medical concern and chemical and surgical interventions to deal with wrinkless, sagging and hair loss become more common. Dr. Joseph W. Goldzieher of the Southwest Foundation for Research and Education in San Antonio went so far as to describe the menopause as "one of nature's mistakes". And Ilya Ilyich Mechnikov one of the pioneers in 'anti-ageing' research has applied the final 'necessary corrective'.

> "It is doubtless an error to consider aging a physiological phenomenon. It can be considered normal because everyone ages, but only to the extent that one might consider normal the pains of childbirth that an anesthetic might relieve; on the contrary, aging is a chronic sickness for which it is much more difficult to find a remedy."

Alterations in sexual and reproductive functioning have long been a medical concern. Yet today the frequency of hysterectomics seem not so highly correlated as one might think with the presence of organic disease. What avenues the very possibility of sex change will open is anyone's guess. Though here too we are reminded of medicine's responsibility.

> "The surgical treatment of the conditions of hermaphroidism and pseudohermaphroidism to correct nature's mistakes, that the sexual identy and function of such persons may be established, has long been accepted as a contribution or medical science to suffering mankind." (New England Journal of Medicine, Russel, p. 535, 1968).

Transplantations despite their still relative infrequency have had a tremendous effect on our very nations of death and dying. And at the other end of life's continuum, since abortion is still essentially a surgical procedure it is to the physician-surgeron that society is turning (and the physician-surgeron accepting) for criteria and guideliness.

In the exclusive right to prescribe and thus pronounce on and regulate drugs the power of the physician is even more awesome. Forgetting for the moment our obsession with youth's "illegal" use of drugs, any observer can see, judging by sales alone, that the greatest increase in drugs over the last ten years has not been in the realm of treating any organic disease but in treating a large number of psycho-social states. Thus we have drugs for nearly every mood:

> to help us sleep or keep us awake
> to enhance our appetite or decrease it
> to tone down our energy level or to increase it
> to relieve our depression or stimulate our interests

And perhaps frighteningly Balint and his colleagues report that nearly 20 % of the patients in a series of general practioners practices received a repeat prescription (of predominantly psychotropic) and little else.

Recently the newspapers and more popular magazines, including some medical and scientific ones, have carried articles about drugs which may be an effective peace pill or anti-agression tablet, enhance our memory,

our perception, our intelligence and our vision (spiritually or otherwise). This led to the easy prediction:

> "We will see new drugs, more targeted more specific and more potent than anything we have .... And many of these would be for people we would call healthy."

This statement incidentally was made not by a visionary science fiction writer but by the former commissioner of the United States Food and Drug Administration.

3. Through the retention of near absolute access to certain "taboo" areas.

These "taboo" areas refer to medicine's almost exclusice licence to examine and treat, that most personal of individual possessions - the inner workings of our bodies and minds. My contention is that if anything can be shown in some way to effect the workings of the body and to a lesser extent in the mind, then it can be labelled an "illness" itself or jurisdictionally "a medical problem". This jurisdictional extention is worth comment. At one time a debate might have been carried on as to whether a particular phenomenon was really a disease. Today this no longer seems necessary. For if a phenomena can be shown to be either 'caused' by some recognized disease agent or to result in some medical condition, or to lend itself to prevention or treatment by some medical intervention, then it comes under medical purview and control. In a sheer statistical sense the import of this is especially great if we look at only three such problems - ageing
alcoholism
pregnancy
The first and last were once regarded as normal natural processes and the middle one as a human foible and weakness. Now this has changed and to some extent medical specialties have emerged to meet these new needs. Numerically it expands medicine's involvement not only in a longer span of human existence but opens the possibility of its services to millions if not billions of people.

Ageing again provides an interesting example - not only in the creation of new specialties called geriatrics, gerontology but more 'extensively' in the new interest in death and dying. No one dies anymore of old age or natural causes. Now one dies of some disease or disorder. Medicine has helped prolong not only the process of dying. The sum total is that people no longer die at home but in hospitals, no longer among

their familiars, but amongst strangers, no longer quickly but increasingly over a long period of time, and perhaps because of the decreasing viability of religion no longer do they turn primarily to the priest and minister for solace, comfort and even reflections on the meaning of life but to the doctor. In at least partial recognition of this as well as the traditional medical emphasis on heroic measures "to maintain a flicker of life in people so old or ravaged as to be beyond carring, Dr. William Poe, a professor of Community Medicine at Duke University, not only takes issue with the "winning psychology" of most medical specialties but suggests the creation of a new discipline, the practitioners of which would be willing losers. Poe calls this new specialty "marantology" (from the breek marantos meaning withered or wasted).

Marantologists would care for those whom no one else wants: the old, the incontinent and the incurable, those who have "committed the sin of remaining alive but not yielding to our manipulations." Those specialists, says Poe, would be taught to see their patients slip away without experiencing feelings of guilt or personal failure.

In the United States at least, the implication of declaring alcoholism a disease (the possible import of a pending Supreme Court decision as well as laws currently being introduced into several state legislatives) would reduce arrests, in many jurisdictions by 10 to 50 % and transfer such 'offenders' when 'discovered' directly to a medical facility.

It is pregnancy, however, which produces the most illuminating illustration. For again in the U.S. it was barely 70 years ago when virtually all births and its concommittants occurred outside the hospital as well as outside medical supervision. Now the process is completely reversed with well over 90 % of all births occurring in hospitals under medical supervision. We shall turn to some of latent consequences of this phenomenon on subsequent sessions.

The general physician is also increasingly becoming the choice of help for many with personal and social problems. Partly this is through the foothold that medical personnel already hold in 'the taboo'. For it seems as reported in many studies that access to the body opens up access to other intimate areas as well (Zola and Croog, Social Science and Medicine, 1968). Thus Freidson (Specialties without Roots, Human Organization, 1959) reports that patients explain their preference for a nurse over a social worker in help with emotional problems because of the former's greater 'familiarity' with their situation. One of his

cases illustrates this aptly.

> "You know, you like to go to someone who knows something about you and I don't know the social worker. I know she took my social history and that we always say hello, but I did not know her and I didn't think she really knew much about us and our family. Where the nurse knew about us, she would be the logical one to go to." (p. 115)

The medical profession's growing 'popularity' in this area is also due to the simple reduction of other resources.
Religion and its practitioners has seemed decreasingly 'relevant' to the problems of daily living, though there is now a new emphasis on various forms of counseling. Modern living arrangements has also contributed. For whether we look at the suburban spread or the concrete cylinders called 'modern urban communities', there seems to be an absence of informal and comfortable places to gather and talk and thus a further reduction in 'informal networks of help'. Thus people must of necessity turn to more formal institutions. And they do in increasing numbers. A recent British study (Dunnell and Cartwright, 1972) reported that within a five-year period there had been a notable rise (from 25 % to 41 %) in the proportion of the population willing to consult the physician with a personal problem.

4. Through the expansion of what in medicine is deemed relevant to the good practice of life.

Though in some ways the most powerful of all 'the medicalizing of society' processes, the point can be simply made. Here we refer to the use of medical rhetoric and evidence in the arguments to advance any cause. Let us listen again to the words of Lady Barbara Wooton:

> "Without question.....in the contemporary attitude towards antisocial behavior, psychiatry and humanitarianism have marched hand in hand. Just because it is so much in keeping with the mental atmosphere of a scientifically-minded age, the medical treatment of social deviants has been a most powerful, perhaps even the most powerful, reinforcement of humanitarian impulses; for today the prestige of humane proposals is immensely enhanced if these are expressed in the idiom of medical science".

What Wooton attributed to psychiatry is no less true of medicine and applies to any proposal. To say that many who use such labels are not professionals only begs the issue. For the public is only taking their cues from professionals who increasingly have been extending their expertise into the social sphere or call for such an extension.

(Alinsky, 1967, Wedge, 1967). A look at the New York Times in a recent year yielded medical and psychiatric commentaries on such diverse phenomena as hippies, race riots, black power, juvenile dilinquency. The use of heroin, marihuana and LSD, college dropouts, recialand religious intermarriage, disrespectfull children, civilrights workers, divorces, war protesters,non-voters, draft resisters, and female liberationists. The other day, our documentalist handed me an article entitled "Some Continuing Health Problems of School Children and Young People and their Implications for a Child and Youth Health Service" (Public Health Lond, 1971, 85,. 58-66). It was by Dr. P. Henderson and was his Presidential address to the British School Health Service Group of the British Society.

His article is a listing and a call for action on the following 'health problems':

Poverty and slum or new slum housing
Behavior and emotional difficulties
Maladjustment
Juvenile Delinquency
Drug taking
Suicide
Children in care
Venereal Diseases
Teenage illegitimate pregnancies
Abortion

To these which he singles out for special attention, he adds the more traditional problems of children with visual, hearing, physical handicaps, those with speech and and language difficulties the epileptic, the diabetici, the asthmatics, the dyslexics, the emotionally, the educationally, and intellectually retarded. One wonders who or what is left out!

The rhetoric extends even more broadly into the policical sphere. One hears of the healthy or unhealthy economy or the state. More concretely the physical and mental health of U.S. presidential candidates has been an issue in the four last elections and a recent book claimed to link faulty political decisions with faulty health (H.L. Etang, The Pathology of Leadership, 1970).

I would like to conclude with an example which seems particularly appropriate in light of our continual concern as to whether the medicalizing of society's problem has relevance beyond the shores of America. While I cannot argue yet about its acceptance, it is now clearly up for export. In the January 1972 issue of the American Journal of Public Health, Dr. Lee M. Howard, Director of the Office of Health, Technical Assistance Bureau of the Agency for International Development wrote about the rele-

vance of health and medicine to international development. I can do no better than quote kim directly and extensively. His opening words are as follows:

Figure 1

"The former official seal of the American Public Health Association (Figure 1) depicts the figure of a woman kneeling, hands outstretched, beneath a tree. Upon the seal, these words are inscribed, "And the leaves of the tree were for the healing of nations."[1] Whatever the intended symbolism, the seal suggests a relevance between public health and the healing of nations. Does the symbolism imply a fragile hope or a real possibility? A dream or a dilemma?

If we define the health of nations in the broad WHO terms of physical and social well-being, and if we take a simultaneous look at the state of the world's well-being as reported in the daily newspapers, one might ask the extent to which the focus and impact of traditional international health activities actually serve to improve the well-being of nations, much less heal them.

In the 98 years since the APHA was founded, has the Middle East become a healthier place to live? Have the prospects for social well-being in Southeast Asia improved or decreased? In America, have traditional health efforts been relevant to the growing social unrest in many segments of our nation?

If the leaves of the public health tree are indeed to be used for the healing of nations, what is it that we are

> trying to heal? What is it that the nations of the earth are seeking?
>
> During the past year, the Technical Assistance Bureau of the Agency for International Development has been attempting to probe these questions with the purpose of identifying key health obstacles to national development goals among the low-income countries with which the Agency cooperates overseas. National development goals serve as one means of expressing a nation's search for its own well-being.[1]

Several pages later he elaborated the relationship between health and modernization.

> The concept of health is subject to as much confusion as the concept of disease. Health is not a term synonymous with death control. It is the state of man's adjustment to his environment—a measure of man's fulfillment, not of his survival. As a development activity, health is that sector of the modernization process which assists man himself to make a maximum physical and psychological adjustment to his internal and external environment consistent with available resources. This view coincides with the World Health Organization definition of health as a state of "physical, mental and social well-being and not merely the absence of disease or infirmity." This positive view of well-being, in a very real sense, is the ultimate objective of modernization. It refers to the quality of man himself. The well-being of mankind is what development is all about.
>
> The healing of nations, considering the aspirations and dreams of the developing world, requires a multidisciplinary approach far beyond the current limitations we place upon our own traditional health roles. The healing of nations cannot be less than a social process which corrects a whole range of adverse social factors which perpetuate or accentuate maladjustment to man's environment—his poverty, food shortages, poor education, rapid population growth, insecurity, and, not least, his attitudes towards his neighbors and the world in which he lives.
>
> It does not follow that modification in population quantity alone will automatically lead to improved population quality. The production of a ton of grain by itself is no guarantee of the improved well-being of the man that produced the grain.
>
> The health of man or of nations is a concept which requires recognition that well-being depends upon attention to all the key social, political and economic variables that affect the lives of men. [4]

So ends my general discussion of how medicine in contemporary society has become more relevant and 'intrusive' in the social life we lead.

MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL

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V THE MIRAGE OF HEALTH REVISITED - ON THE OMNIPRESENCE OF ILLNESS

A. Historical Background.

In the mid 1950's three medical scientists began a critique of the American and Western way of medicine. They were Hans Selye, Thomas Szasz and Rene Dubos. The respective titles of their work indicates both their concern and their tone: The Stress of Life (Selye), The Myth of Mental Illness (Szasz) and The Mirage of Health (Dubos). They were not necessarily the first to make their particular critique but they were certainly the most articulate. Perhaps because of their eminent positions or their very persistence (each has been 'accused' of making the same point since in many different ways), they were also the first to command a wide hearing.

Each in his own way, was criticizing the implications of a medical model which conceived of illness as an objective, limited and finite entity. In pointing out the restrictiveness of our notions of clinical entity, Selye noted that labelling and diagnosis is based on a very small amount of characteristics peculiar to that disease and no other, and that by far the largest number of signs and symptoms of any disease are shared with a wide variety of disorders and physiological malfunctioning. Furthermore, because of the limited success that this notion has had with a few infectious diseases, this has led to a focussing on disease causation as "invasion from the outside" and to a neglect of the "breakdown" in adaption which takes place within the host, a more generally diffuse phenomenon and which he argues is what disease is "really" all about. Szasz was concerned that the supposed 'objectivity of illness and its practioners' has allowed it to be applied to a whole host of phenomena he called "problems in living". In a long series of books, he has gone on to show not only the social implications of the label 'mental illness' but the political motivations that seem to be associated with its use and acceptance. Perhaps the most eloquent of all, Rene Dubos

has criticized our static notion of disease and pointed out that such notions of fixity and finiteness have given us a misplaced and false hope in our attempts to cope with illness. Over the next hill lays no Utopia. After the conquest of cancer or heart disorder lays no world without disease or suffering. Quite the contrary, he contends:

> "Organized species such as ants have established a satisfactory equilibrium with their environment and suffer no great waves of diseases or changes in their social structure. But man is essentially dynamic, his way of life constantly in flux from century to century. He experiments with synthetic products and changes his diet; he builds cities that breed rats and infection; he builds automobiles and factories which pollute the air; and he constructs radioactive bombs.
> As life becomes more comfortable and technology more complicated, new factors introduce new dangers; the ingredients for Utopia are the agents of new disease."

And thus he coined the expression, "the mirage of health".
All these names and their viewpoints are increasingly well-known to American audiences - even on a certain popular level. Dubos recently won a Pulitzer Prize and Szasz has been making the rounds of the U.S. TV "talk" shows.
Yet I would contend that 15 years after they first offered their messages - while widely quoted and even lampooned - they have made little headway where it operationally counts - in medical practice and education, expenditures and research priorities. Perhaps it <u>is</u> coming, but I think we can safely agree that it is <u>not yet here</u> and thus at very least this lack provides the rationale for my lecture today.

B. <u>The Cognitive Map of "Illness"</u>.

As we proceed to illustrate the omnipresence of disease, you will probably note an interesting irony. For the very same researchers who are providing me with my data on the prevalence of illness, at the same time continue on their traditional research directions unimpeded by the implications of their own remarks. At very least this shows the power of models, concepts and what Gouldner calls 'domain assumptions' and how data <u>per se</u> is insufficient to change the commitments, beliefs and orientations of even scientists.

As Dubos, Selye, and Szasz pointed out the notion of illness as a discrete, fixed, infrequent entity goes deep. In fact it goes so deep that it has become part of our cognitive map, built into not only our thinking but our very tools - namely the way we count and tabulate and

record the presence of disease. I take as typical the reports of 'health statistics' regularly reported by most governments. For we count such things as days of disability, doctor visits, and specifically diagnosed conditions and when we do we are confirmed in our belief that illness is a relatively infrequent phenomenon. Taking the most available compendium of 'vital statistics' I noted that in the United States in 1967

Measures of disability

days out of work	5.6 days per year
days out of school	4.5 days per year
bed disability	4.5 days per year

Doctor visits over 15

males	3.8 visits per year
females	4.8 visits per year

And when we tabulate separate specifically diagnosed conditions the rates are so small that they are usually computed in numbers per thousand. None of these is particularly high and since cross tabulations are rarely if ever made except in very select populations (i.e. to demonstrate the existence of multiproblem families), we never get any total picture. When a realization intrudes on an investigator that people indeed are 'sicker' than he was led to believe, he does not change his orientation but may regard it as an interesting methodological problem. This was illustrated quite vividly in a study of coping reactions to a first myocardial infarct. The sample was quite large, in the hundreds, but the investigator was perplexed when he discovered that in the vast majority of cases, a myocardial infarct was not the only major medical medical problem of his patients. He thus spent most of the next several months in designing way of 'controlling' this fact out of existence. To me, he was doing more, he was controlling reality. For by trying to ignore the fact that a myocardial infarct was just one of many medical and other problems with which his patients had to cope, he was altering their reality and compromising more than he realized any practical utility of his findings.

The operation of assumptions about 'frequency' and 'fixity' are more pervasive than a single example and is reflected in how much of sociomedical research was formulated at least through the late 1960's. To heighten this phenomenon, we might contrast some research trends in 'mental' versus 'physical' illness.

	Mental Illness	Physical Illness
	The Data Examined or Questions Asked	
The problem		
The state or amount of illness in a society	Epidemiological - studies or attempts to measure the untreated, often assuming that most or a significant portion do not get into treatment and a concern with the issue of what is a case	Epidemiological - based on treated cases - on the implicit assumption that the vast majority eventually get into treatment and are thus counted, or stated another way, that those untreated do not represent a significantly different population. A clear definition of what a case is
What is Illness (Laity view)	The studies of attitudes toward and perception and definition of mental illness	Measures of the accuracy of knowledge about certain physical disorders (CA, Heart Disease, Arthritis, Diabetes, etc.)
Doctor Usage	The single instance - why do you come now	Utilization - how often does one go
Decision to seek aid	Why he comes? (motivation for treatment?)	Why he delays? (barriers against treatment)

(Examples given how the fingings of such research orientations are then translated into programs of health education and the organization of medical services.)

Together these assumptions create an interesting if misleading picture of illness and the way it is handled. Rarely do we try to understand how or why a patient goes to the doctor, for the decision itself is thought to be an obvious one. We postulate a time when the patient is asymptomatic or unaware that he has symptoms, then suddenly some clear objective symptoms appear: then perhaps he goes through a period of self-treatment and when either this treatment is unsuccessful or the symptoms in some way too difficult to withstand, he decides to go to some health practitioner (usually, we hope, a physician).

C. A 'Truer' Emperical View of Illness.

Now if you will indulge me let me piece together what I think is the 'real' emperical picture of disorder. We can start with mental illness where there is a long tradition of case finding in the community. In the 1930's data began to be reported indicating that for

every individual hospitalized for mental illness, there was one or more 'ambulatory' in the community who perhaps should not be. Gradually, more sophisticated measurements and surveys were created resulting in the two

Leo Srole et al: Mental Health in the Metropolis - The Mid Town Manhattan Study, New York, McGraw-Hill, 1962.

Table 8-3, Home Survey Sample (Age 20-59) Respondents' Distribution on Symptom-Formation Classification of Mental Health.

Well	18,5	7
Mild symptom formation	36,3	
Moderale symptom formation	21.8	
Marked symptom formation	13.2	
Severe symptom formation	7.5	
Incapacitated	2.7	
Impaired (Moderate, Severe and Incapacitated combined)		23.4
N = 100 %	(1.660)	

Dorothea C. Leighton: The Character of Danger - Psychiatric Symptoms in Selected Communities (The Stirling County Study of Psychiatric Disorder and Sociocultural Environment - Vol. III) New York: Basic Books, 1963 (p. 142).

Table V-1, (Adapted by IKZ). Ratings of Need for Psychiatric Attention Based on Bristol Health Survey and Family Life Survey.

Typology of need for psychiatric attention	BHS	FLS
Probably well	11	17
Doubtful	14	26
Probable Psychiatric Disorder	36	37
Psychiatric Disorder with Significant Impairement	38	17
Most Abnormal	1	3
Total N	(140)	(1010)

best known studies. The midtown Manhattan Study and the Stirling County Study. Both were published in the early 1960's and both documented a

rather high level of psychosocial disturbance. As you can see by the tables, scarcely 20 % at best seems to be free from distress. In a separate substudy of the Midtown Manhattan investigation the finding that seventy-five percent of the total sample manifested "significant symptoms of anxiety" led them to the conclusion that:

> "anxiety is not only highly prevalent in our population but given that it is completely independent of so important a factor as socio-economic status, it must be regarded as a highly generalized psychological phenomenon as well." (T. Rennie et al: "Urban Life and Mental Health", American Journal of Psychiatry, Vol. 113, 1957, p. 831-836).

The reactions to such claims has been mixed. They have been criticized on methodologival grounds, taken as further proof that the concept 'mental illness' is too amorphous a one and that psychiatrists seem to see illness everywhere. Surely it is claimed this does not apply to what we know as 'physical illness' and surely not to the perspectives of medical practitioners.

Well, it all depends on where you look for your data. For in a most unlikely place, figures on a similarly high prevalence of physical illness has been accumulating. The repositories I refer to are journals of industrial and occupational medicine and the myriad health reports which businesses and large scale institutions publish and the data is from their 'periodic health examinations'. From business executives to union members from college students to college professors, the reports note that at the time of their anual check-up, there was scarcely an individual who did not possess some symptom, some clinical entity worthy of treatment. The figures range from 50 to 90 % of all 'examinees' and remember these statistics are on a supposedly healthy population - employed and financially secure (Gordon S. Siegel, Periodic Health Examinations - Abstracts from the Literature, Public Health Service, Publication no. 1010, Washington D.C.: U.S. Government Printing Office, 1963; J.W. Meigs, "Occupational Medicine", New England Journal of Medicine, Vol. 264, April 1961, p. 861-867).

My favorite illustration of this point, mostly because of its detailed reasoning, is a rather old study - The Peckham Experiment. (I.H. Pearse and L.H. Crocker, The Peckham Experiment, London: George Allen and Urwin, Ltd. 1949; ————, Biologists in Search of Material, Interim Repory on the Work of the Pioneer Health Center, Peckham; London: Faber and Faber, Ltd., 1938). In the late thirties there were in

London, England, a group of men, physicians specializing in preventive medicine who were very concerned with the problem of how people stay healthy. They did not want to study the problem of ailments; they wanted to learn how to institute good public health, preventive medicine programs. They created a center in Peckham, England, which is a little bit outside of London. They chose this area because all the statistics on morbidity and mortality, juvenile delinquency and other social problems were relatively low in that area. The people were of 'good working class stock', 'good lower middle class', clerical and white collar. They were neither the very poor nor the very rich. The physicians organized a kind of recreational center where people could congregate. Since the researchers were interested in how this population maintained their good health, they required that everyone coming to the center had to submit to a physical examination once or twice a year, and that in addition to this examination, medical care would generally be available for them. The researchers' aim here was to gain a baseline measure of the general health of the people, from which they could later note change. They were very strict about their criteria. They started off with an assumption:

> "Biology is concerned with the function of the living organism and any deviation from this function that is observable is worthy of note."

Then they gave the following definitions:

a. "In this survey we have dealt only with those conditions which are universally recognized as clinical entities, symptoms such as constipation, headaches, rheumatism or the milder forms of dysmenorrhea, our knowledge of which dependend only on the testimony of the member have not been included in this list.

b. Again conditions such as the milder catarrhs, bronchitis, sinusitis, vaginitis, though accompanied by some visible manifestation have been excluded.

c. Moreover where an appendix has been removed, a hernia repaired, teeth stopped, the repaired lesion does not count.

d. Neither is any mention made of the various psychological conditions or social maladjustments.

e. Eye conditions are also omitted.

The schedule of diseased given here is thus to be read in the straightforward clinical sense. It represents active or progressive lesions of one kind or another of a definite clinical nature. It is not a list of

biological shortcomings measured by any theoretical standard."

Two further definitions were used: Disorder was the presence of clinical entities, as determined by a professional diagnostician, while disease was the subjective state of discomfort verbalized by the individual. With all these qualifications, the results of the examination of this supposedly healthy population were as follows:

	Males		Females	
	No.	%	No.	%
I Disorder accompanied by disease	165	21	163	21
II Disorder without disease	484	63	568	75
III Without disorder	123	16	33	4

In the total sample of 3911 people of all ages, 3553 or 91 % were diagnosed upon complete examination as having some physiological defect or aberration. Taking a closer look at their 9 per cent of the population that had no problem, they noted two qualifications - an over representation of children under the age of five and people in good general condition under normal circumstances but not necessarily under certain unexpected emergency conditions (e.g. Person who had been given a 'clean bill of health' dying soon after of a heart attack). Thus an enormous amount of symptoms and conditions occurred in this population, conditions which doctors would doubtedlessly label sickness, if they appeared in patients seeking aid.

D. Does What is 'missed' Matter.

Before leaving this data it is necessary to deal with some obvious criticisms. The first is that the bulk of this high prevalence figure is made up of relatively minor problems. While this is true it is worth noting that minor does not mean insignificant for many such as obesity are regarded by the medical profession as the potential precursors of much more serious conditions. Moreover, studies of doctors' practices reveal that the bulk of the problems they daily confront are of such 'minor' variety. Thus doctors have been able to argue that while they miss many such conditions, that what they miss is unimportant is 'not serious'. As Pinsett claimed, "for practical purposes it can be assumed that the general practitioner sees, during the course of a year, virtually all the significant illnesses in his practices." But does he?

In the above mentioned Peckham study, every type and seriousness of disorder was found in the class of individuals who are unaware of or disregard their disorders, everything from multiple sclerosis to cancer to tuberculosis, to various forms of heart disease.
J. Morris (Uses of Epidemiology, 1967, p. 122) put this into statistical terms. From available epidemiological data and clinical surveys he estimated that "in an average British general practice of 2.250 persons, for every 8 in one year he sees, there are 69 with "latent" diabetes.....and for every 5 he sees with ischeamic heart disease there are 15 more undetected.

The final 'fall back position' is representativeness.
All right perhaps the physician misses some cases and perhaps he even misses some serious ones, well at least those he does see, the treated, are representative of the universe of such cases. Well aren't they? And now even this most unquestioned of assumptions, and thus uninvestigated, is being called into doubt. All studies must deal with questions of those who are not in their sample - the non respondents and often go to great lengths to show that the missing are just like or at least "not significantly different" from the included. In medicine, because of many of the assumptions we have already delineated this was never thought necessary. But now there exists data which shows that those individuals who did go into treatment were unrepresentative of all those who had the disease and thus in certain important ways their diseases were unrepresentative. Let's look at some examples and their implications.

Sometimes this unrepresentativeness may lead to an over or undestination of its extent and seriousness. In terms of the latter, May Clarke's, Trouble With Feet (Occasional Papers on Social Administration no. 29, London: G. Bell and Sons Ltd., 1969) is instructive.
For there she noted that between 55 and 90 per cent (patient report versus chiropodist examination) of her sample of 1.100 adults had something the matter with their feet. The conditions ranged from corns to skin infections, from ingrown toenails to hammer toes.
Yet only 17 per cent of these problems had ever been treated. For the vast majority of these respondents it is not that such condition are not painful and inconvenient - ironically for the aged, though clinically not 'serious' they are often functionally crippling - but that they have come to be regarded as an ordinary consequence of life and worthy only of 'self-treatment' (for many similar examples - I.K. Zola,

"Culture and Symptoms, American Sociological Review, Vol. 31, October 1966, p. 615-630). Thus it seems likely that simply through not seeing such problems we have no idea as to the extent, type, treatability and preventability of such foot disorders and this neglect is perpetuated. In a similar vein, scarlet fever was thought to be a relatively mild disease without serious complications because the early reporters like Sydenham primarily had contact with well off rather than well patients (George Rosen, "People, Disease, and Emotion: Some Newer Problems for Research in Medical History, Bulletin of the History of Medicine XLI, 1967, p. 9-10). A case of overestimation of seriouseness is histoplasmosis. For until the late 1940's it "was thought to be a rare tropical disease, with a uniform, fatal outcome. Recently, however, it was discovered that is is widely prevalent, and with fatal outcome or impairment extremely rare. (J. Schwartz and G.L. Baum, "The History of Histoplasmosis", New England Journal of Medicine CCLVI, 1957, p. 253-258).

Sometimes the lack of representativeness is reflected in leading to incorrective causative pathways or interpretations. Thus it was formerly believed that Buerger's disease was prevalent in Eastern European Jews. Later it was discovered that this evidence was due not so much to the nature of the disease as to the fact that Dr. Buerger made his observations at Mount Sinai Hospital in New York City - an institution which served predominantly Jewish patients (Melitta Schmideberg, Social Factors Affecting Diagnostic Concepts", International Journal of Social Psychiatry, Vol. 7, Fall 1961, p. 222-230). A recent study by Cobb has shed doubt on the traditional emphasis on arthritis as being a predominantly female disease. When all the employed males in a factory were surveyed for prodromal arthritic symptoms, their rates were as high as any of those traditionally reported for women (S. Cobb, "Epidemiology of Rheumatoid Arthritis." Academy of Medicine of New Yersey, Vol. 9, 1963, p. 52-60). It thus seems that the oft reported sexual difference in arthritis was due more to a greater tendency for women to seek aid for arthritic-type symptoms and, thus, to appear in morbidity statistics.

A final example is seen in a study of peptic ulcer. For in studying the rates of peptic ulcer among African tribal groups Raper first confirmed the stereotype that it was relatively infrequent among such groups and therefore that it was associated (as many had claimed) with the stresses and strains of modern living. Yet when he relied not on

reported diagnosis but on autopsy data, he found that the scars of peptic ulcer were no less common than in Britain (A.B. Raper, "The Incidence of Peptic Ulceration on Some African Tribal Groups", Transactions of the Royal Society of Tropical Medicine and Hygiene, Vol. 152, November 1958, p. 535-546).

Occasionally, the lack of representativeness may lead to a questioning of the very conceptualization and measurement of the disease entity. Thus in the case of high blood pressure it was discovered with some surprise that a fair proportion of the general population outside the consulting room manifests the signs without any apparent complaint or ill effects (cited in E. Freidson, Profession of Medicine, New York, Dodd, Mead and Co., 1971, p. 270). Finally, a community study of undetected diabetic revealed so many cases which by clinical standards should have resulted in much more serious impairment if not in a comatuse condition, that Butterfield wondered if the very clinical criteria of diabetes, bases as they are on treated cases, might need to be changed (W.J.H. Butterfield, Priorities in Medicine, The Nuffield Provincial Hospitals Trust, 1968, especially Chapters 3 and 4).

So much for some of the criticisms of our claim that instead of illness being a relatively infrequent or abnormal phenomenon, the empirical reality may be that illness, defined as the presence of clinically serious symptoms, is the statistical norm (What is particularly striking about this line of reasoning is that the statistical notions underlying many "social" pathologies are similarly being questioned. A number of social scientists have noted that the basic acts or deviations, such as law-breaking, addictive behaviors, sexual "perversions" or mental illness, occur so frequently in the population that were one to tabulate all the deviations that people possess or engage in, virtually no one could escape the label of "deviant" - See such references as:

Fred J. Murphy, Mary M. Shirley, and Helen L. Witmer, "The Incidence of Hidden Delinquency," *American Journal of Orthopsychiatry,* 16 (October, 1946), pp. 686-696; Austin L. Porterfield, *Youth in Trouble,* Fort Worth: Leo Potishman Foundation, 1949; James F. Short and F. Ivan Nye, "Extent of Unrecorded Delinquency," *Journal of Criminal Law, Criminology, and Police Science,* 49 (December, 1958), pp. 296-302; James S. Wallerstein and Clement J. Wyle, "Our Law-abiding Lawbreakers," *Probation,* 25 (April, 1947), pp. 107-112; Alfred C. Kinsey, Wardell B. Pomeroy, and Clyde C. Martin, *Sexual Behavior in the Human Male,* Philadelphia: W. B. Saunders, 1953; Stanton Wheeler, "Sex Offenses: A Sociological Critique," *Law and Contemporary Problems,* 25 (Spring, 1960), pp. 258-278; Leo Srole, Thomas S. Langer, Stanley T. Michael, Marvin K. Opler, and Thomas A. C. Rennie, *Mental Health in the Metropolis,* New York: McGraw-Hill, 1962; Dorothea C. Leighton, John S. Harding, David B. Macklin, Allister M. MacMillan and Alexander H. Leighton, *The Character of Danger,* New York: Basic Books, Inc., 1963

E. The Operation of The Clinical Perspective.

Assuming then this prevalence is 'real', how did it come to be. At very least we are dealing with an interplay of the clinical perspective and a new population awareness. We will turn to the what Freidson has called "The professional construction of illness" first.

Metaphorically put while the priest in his confessional operates on the assumption, that none of you are without sin, so the physician in his office operates on the assumption that none of you are without disease. Operationally put, while in a U.S. courtroom the defendant is assumed to be innocent until proven guilty, in a doctor's office, the patient is assumed to be sick until proven healthy. Thomas Scheff argues that members of professions such as medicine are frequently confronted with uncertainty in the course of their routine duties. In these circumstances, informal norms have developed for handling uncertainty so that paralyzing hesitation is avoided. These norms are based on assumptions that some errors are more to be avoided than others. In medicine, he claims, this 'decision rule' takes the form that judging a sick person well is more to be avoided than judging a well person sick. At least one of the consequences of this is labelling patients as sick who ought not to be.

What then is the evidence for such a bias.
At least one example was seen in a previous session when I cited the case of physicians when confronted with ambiguity and under pressure to make a diagnosis relied on external non-medical clues. (I.K. Zola, Problems of

Communication op. cit.). Disagreement over diagnoses is commonly reported but what we are concerned with is the 'directionality' of such disagreement. Thus on X - ray readings for tuberculosis. L.H. Garland ("Studies on the Accuracy of Diagnostic Procedures, American Journal of Roentgenology, Radium Therapy, and Nuclear Medicine, LXXXII, 1959, p. 25-38) reports that out of 14.867 films 1.216 were interpreted as providing positive indication of TB that were subsequently interpreted as nagative (fake positive) while only 24 of those interpreted as negative were later declared positive (defined as false negatives). But perhaps the most illuminating is a report by Harry Bakwin ("Pseudodoxia Pediatrica", New England Journal of Medicine, CCXXXII, 1945, p. 691-697) of a:

> "1934 survey of American Child Health Association of doctor's judgements of the advisability of toncillectomy for 1.000 school-children of 1.000 children, "some 611 had already had their tonsils removed. The remaining 389 were then examined by other physicians and 174 were selected for tonsillectomy. This left 215 children whose tonsils were apparently normal. Another group of doctors was put to work examining these 215 children and 99 of them were adjudged in need of tonsillectomy. Still another group of doctors was then employed to examine the remaining children, and nearly one half were recommended for operation."

As Freidson notes in America "this very much reflects the thrust toward active intervention that is inherent in clinical practice as such. While the physician's job is to make decisions, including the decision not to do anything, the fact seems to be that the everyday practitioner feels impelled to do something if only to satisfy patients who urge him to do something when they are in distress" (Freidson, op. cit. p. 258). In this light he cites two studies. The first is the report of a survey finding that a prime reason why physicians prescribe is the reported fear of not doing anything (Harry F. Dowling, "How Do Practicing Physicians Use New Drugs?", Journal of the American Medical Association, CLXXXV, 1963, p. 233-236). The second is a study of surgical decision where Peterson, Barsamian, Eden, note that (A Study of Diagnostic Performance: A Preliminary Report, Journal of Medical Education, XLI (1966), p. 797-803) when de Stein-Leventhal syndrome is diagnosed, it is almost always in error. That mistaken diagnosis is so popular because the syndrome refers to the only type of infertility that can be benefited by surgery. By making the diagnosis the doctor can do something and encourage the patient to feel that everything is being done in order to help.

A more serious outcome of this clinical perspective is seen in a study which takes place beyond the borders of the United States. It seems worth discussing in some detail.

Sigrid Lichtner and Manfred Pflanz (Appendectomy in the Federal Republic of Germany: Epidemiology and Medical Care Patterns, Medical Care, Vol. 9, July-August 1971, p. 311-330) decided to focus on the epidemiology of appendectomy because it represented such a well defined disease entity. Noting first that the death rate for appendicitis was three to four times higher in German speaking countries (Federal Republic of Germany, German Democratic Republic, West Berlin, Austria) than in all other countries, they noted a similar trend confining themselves only to appendicitis with the Federal Republic of Germany having a rate 2 to 3 times higher than other countries. Finally restricting themselves only to Hannover, the trend remained the same, enabling them to make the following comparison between Oxford, England and Hannover, West Germany: In Oxford, 12.7 % of all males and 12.1 % of all females will undergo an appendectomy prior to their 75th year while in Hannover the per cent will be 33.7 for males and 46.2 for females. And so they naturally ask what is going on?
Nothing they know leads them to think this reflects any 'true incidence' of the disease. Local findings bear out this negative conclusion. For on the basis of pathological-anatomical findings:

> "acute appendicitis led to surgery in only one out of three men and in one out of five women. The biggest fraction is accounted for by 'recurrent scarced appendicitis' which practically represents a normal status. It may assumed further that the terms 'neurogenic appendicitis' and 'chronic appendicitis' stand for more or less normal findings. Thus there has been no strict indication in almost two thirds of the operations performed." (p. 322).

In Hannover it seems also to have a non-organically explainable demographic distribution - namely it is a disease which hardly occurs on weekends and which occurs three times more often in white collar workers than it does in blue collar workers. Their own explanation for what is going on is multiple. They mention the possibility of certain psychosomatic conflicts, perhaps 'favored' more among Germanic peoples which may result in pains in that area of the body and a pressure for surgery. Somehow, however, one feels that they place little credence in this explanation. In terms of the space they devote to it and the lack of qualifying remarks, they most strongly suspect something in

the orientation of the physician.

> "In face of the lack of characteristic symptoms in uncomplicated acute appendicitis, it would not be surprising if fashion trends played a great part especially in this disease. There is only one sound reason why surgeons in the Federal Republic should perform appendectomies voluntarily for their own interest, e.e. if in order to obtain the certificate as a specialist of surgery. The applicant is required to perform a non-specified but relatively large nummer of appendectomies. According to some word of mouth communications, 40 to 60 appendectomies are the absolute minimum but many applicants can boast more than 200 cases." (p. 327).

In light of the fact that:

> "The consequences of the high rate of appendectomy are the high mortality from appendicitis, diseases tending to develop later (ileus, carcinoma of the colon, Hodgkin's disease) as well as considerable additional costs for unnecessary hospitalization." (p. 329).

They conclude with a plea that:

> "It is hoped that the rates of appendectomy and, as a consequence, the number of deaths from appendicitis (approximately 2.000 cases in 1966) will decrease in the Federal Republic of Germany within the next 10 years." (p. 329).

In the light of this general orientation, one physician went so far as to claborate on the notion of "non-disease" (C.K. Meador, "The Art and Science of Non-disease", New England Journal of Medicine, CCLXXII, 1965, p. 92-95). This is a diagnostic label that is established after a man is incorrectly diagnosed as ill of a particular disease and then after closer investigation is found not to have that disease. For example, a man with heavy pigmentation and low blood pressure could be suspected of having Addison's disease. Such would be duly recorded in the medical record perhaps as 'suspected' Addisons's Disease, further tests necessary. When after further examination his skin color stems from a Cherokee (American Indian) grandfather and that his adrenal function is within normal limits, however, his doctor may declare that, like a number of people at the lower limit of normal blood pressure, he does not have Addison's disease - he has non-Addison's disease. He is specifically healthy in the sense that Addison's disease is one specific thing he surely does not have. Those of you familiar with recent American History may recall the direct relevance of this kind of thinking

to the discussion of the health of President John F. Kennedy in the 1960's, i.e. whether he did or did not have Addison's Disease and the nature of adrenal difficulty he did have.

All false positives that have been investigated and subsequently found to be false become potentially non-diseases. Superficially, it would seem that having a non-disease is hardly more serious than the cost, the temporary worry, and the annoyance incurred in the space of time between the initial (false positive diagnosis) and the final outcome. Medicine has, illustrated by our many previous examples, argued that it is more serious to miss a disease by carelessness, ignorance, or accident, than to temporarily diagnose one - even apparently if the 'temporary diagnosis' results in surgery. But as Freidson notes what is continually forgotten is that the label "illness" has other implications, not all of which is supplied or controlled by the diagnosing physician. Some 'illnesses' may not be undone and may never become non-diseases in the world of the patient or his social world. For all too many diseases just having been suspected if a particular illness if enough. This does not merely apply to mental illness - where all too often the questions on medical inquiries ask whether or not you have even consulted a psychiatrist or been in a mental hospital and not you final diagnosis or treatment. It applies equally well to the benign tumors which were not caught, the vitreous opacities which did not indicate neurological damage, the all too many condition described as low or high as the case may be but "within normal limits" and all those signs and bodily states which "one should keep an eye on though they are nothing to be alarmed or worried about." 'Don't worry' as transmitted by a physician must be among the most ineffectual messages in the English language. Thus J.V. Warren and J. Walter ("Symptoms and Diseases Induced by the physician", General Practitioner, Vol. 9, 1954, p. 77-84) conclude:

> "The physician, by calling attention to a murmur or some cardiovascular abnormality, even though functionally insignificant, may precipitate (symptoms of heart disease). The experience of the work classification units of cardiac - in - industry programs, where patients with cardiovascular disease are evaluated as to work capacity, gives impressive evidence regarding the high incidence of such functional manifestations in persons with the diagnosis of cardiac lesion." (p. 78).

F. Some implications for Sociomedical research.

This seeems as good a place as any to reiterate a point made several times in these sessions, that where medicine leads others often too willingly follow. In this regard I wish to note briefly the unwitting acceptance of much of the clinical perspective on the part of socio-medical researchers and some of the consequences of this for what we do not know and what we have for too long ignored. This is seen most ironically when such investigators justified their broader focus on psychological, social, economic, ecological etc. factors in the utilization or decision to seek medical aid. In doing so they often cited data to emphasize that not all the organically ill were under medical care. Thus as one example, Kerr White et. al. (The Ecology of Medical Acre", New England Journal of Medicine, Vol. 265, Nov. 1961, pp. 885-892) reported.

> "Data from medical-care studies in the United States and Great Britain suggest that in a population of 1,000 adults (sixteen years of age and over) in an average month 750 will experience an apisode of illness and 250 of these will consult a physician ...."

Despite his noting that the physician has no medical contact with two out of three illness episodes, within several years he was the principal investigator of the largest international study of utilization ever undertaken - a study with hundreds of questions about those episodes which do get to an offical source and relatively few about those which do not. Even, an investigator, who reviewed explicitly much of the literature on 'untreated illness' concluded

> "We can now restate a more realistic empirical picture of illness episodes. Virtually every day of our lives we are subject to a vast array of bodily discomforts. Only an infinitesimal amount of these get to a physician. Neither the mere presence nor obviousness of symptome, neither their medical seriousness nor objective discomfort seems to differantiate those episodes which do and do not get professional treatment. In short, what then does convert a person to a patient? This then became a significant question and the search for an answer began." (Zola - "Pathways to the Doctor", Forthcoming in Social Science and Medicine)

And when answers indeed started to come in, the data was used to delineate how and who got stuck, delayed, perhaps even ignored or passed in their seeking of help. When the data was sufficiently detailed, stages of seeking of help were documented. Yet somehow these stages - though it was

empirically obvious, that the majority of all people and illness episodes never reached the end - point i.e. the doctor - were viewed as way stations, and inappropriate ones at that. Put another way it was usage of the doctor we were trying to understand and in some sense improve. For when we divide a population along the criteria of high or low doctor utilization we are implicitly saying there is some 'correct' utilization consists of seeing a doctor. To paraphrase another professional credo, there seems to have been the acceptance that "he who has himself (or a friend, or a chiropractor or once an osteopath) for a physician has a fool for a doctor". In this light it is not surprising that there have been few published studies of self-medication, (Jefferys, M., J.H.F. Brotherston, A. Cartwright, "Consumption of Medicines on a Working-Class Housing Estate", Britisch Journal of Preventive and Social Medicine, 14 (1960), pp. 64-76; Kessel, N., M. Shepherd, "The Health and Attitudes of People Who Seldon Consult a Doctor", Medical Care, 3 (1965), pp. 6-10; Knapp, D.A., D.E. Knapp, J.F. Engle, "The Public, the Pharmacist, and Self-Medication", Journal of American Pharmaceutical Association, N S 6 (Sept. 1966), pp. 460-462; Knapp, D.A., "Self-Medication and Community Health", College of Pharmacy, Ohio State University, Columbus, Ohio, 1968) virtually none of the utilization of non-orthodox practitioners (Bender, M., "Pathways to Chiropractic Utilization". Health Research and Training Program, Columbia University School of Public Health and Administrative Medicine, Sept. 1965; Cassee, E.Th., "Deviant illness Behaviour: Patients of Mesmerists", Social Science and Medicine, 3 (Jan. 1970) pp. 389-396) and the merest beginnings of how illness is managed without resort to medicine (Alpert, J., J. Kosa, R. Haggerty, "A month of Illness and Health Care Among Low-Income Families", Public Health Reports 82 (August 1969) pp. 705-713). There is a history of looking at these issues not in Western industrial settings but amongst more 'backward','underdeveloped' nations (Cunningham, C., "Thai Injection Doctors" Social Science and Medicine, 4 (July 1970), pp. 1-24; Harley, G.W., Native African Medicine, Cambridge: Harvard University Press, 1941; Huges, Ch.C., "Ethnomedicine" in International Encyclopedia of the Social Sciences, New York: Mac Millan, 1968, Section I, pp. 87-93; Kirv, S., Curanderismo, New York: Free Press, 1968). Further implying to me, that the practices themselves are perceived to be 'backward' and 'underdeveloped'.

G. The Public's Perception

It is not merely professionals who may hold somewhat inconsistent attitudes re the prevalence of illness. For while public opinion surveys report most people as feeling they are healthy, they at the same time report that within a fairly recent interval - the studies used to ask within the last year, now they ask within the last two weeks or even the last 24 hours - fairly substantial numbers from 50 to 75% have experienced some medical difficulty. The most recent study I read was an English one - published in 1971 (M.E.J. Wadsworth, W.J.H. Butterfield and R. Blaney, Health and Sickness - The Choice of Treatment, Tavistock 1971) that of 2,153 adults, only 5% had no complaints during the fourteen days before the interview. Even this does not give a clear picture of what is going on for it perceives and reports the illness that occured as a one time event.

A clearer picture of such statistical omnipresence can be illustrated by the following computation of Hinkle et. al. They noted that the average lower-middle-class male between the ages of 20 and 45 experiences over a 20-year period approximately 1 life-endangering illness, 20 disabling illnesses, 200 non-disabling illnesses and 1000 "symptomatic" episodes. Totalling this data gives 1221 episodes over 7300 days or one new episode every six days. This figure, however, takes no account of the duration of a particular condition, nor does it consider any disorder of which the respondent may be unaware. In short, even among a supposedly "healthy" population scarcely a day goes by wherein they would not be able to report a "symptomatic experience".(Lawrence E. Hinkle, Jr., Ruth Redmont, Norman Plummer, and Harold G. Wolff, "An Examination of the Ralation Between Symptoms, Disability, and Serious Illness in Two Homogenous Groups of Men and Women," American Journal of Public Health, 50 (Sept. 1969) pp. 1327-1336.)

A study by Kosa et. al. (J. Kosa, J. Alpert, R. Pickering, R.J. Hoggerty, "Crisis and Family Life". The Wisconsin Sociologist 4, Summer 1965) pp. 11-19.) makes this even more vivid. Seventy-eight families who kept a health calender on the average for 25,9 days, reported 834 medical symptoms, 136 upsetting events, 12 chronic stress situations and 11 crises. And some recent data culled by myself indicates that even this may be an underestimate. For when I had a group of college students, supposedly one of the most healthy of population samples, keep a health calendar of their bodily discomforts, I found that the more structured was my questioning (i.e. making them record at the end of the day versus

recording at specific time intervals), the more symptoms were elicited. Thus there was virtually no one who did not experience one or more bodily discomforts a day, severe enough for them to notice and reguire some behavioral response. Though used in another context a statement by Leighton (op. cit) provides an apt summary.

> "From this broad perspective there is no point in asking whether over the span of his adult life, a particular individual should or should not be considered a medical case. Everyone is a medical case. The significant questions become, How severe a case? What kind of case?"

We used to rationalize that this high level of prevalence did not, however, translate itself into action since not only are rates of medical utilization not astonishingly high but they also have not gone up appreciably. Some recent studies, however, indicate that we may have been looking in the wrong place for this medical action. It has been noted in the U.S. and U.K. that within a given 24-36 hour period from 50 to 80% of the adult population has taken one or more 'medical' drugs (K. Dunnell and A. Cartwright, Medicine Takers, Prescribers, and Hoarders. In Press and K. White et. al. 1967 op. cit.)

Quite frankly I think we are just seeing the beginning. For the public is like a sleeping giant awakening to more and more bodily awareness. As I noted previously part of this is a long term trend related to a rising standard of living and a consequent decline in mortality. For when 'the here and now' begins to expand, when man and woman can live to 50, 60 or 70 and get diseases he never dreamed of, then this life and its most concrete embodiment, the human body, becomes of increasing interest and concern. This need not take merely a negative emphasis such as the belief of how 'unhealthy' we really are but as my colleague Egon Bittner pointed out it may take a more positive orientation - such as how much can be done to make one feel, look, or function better. In this light several different social movements in the United States have some relevance: The health food movement which has emphasized not only our previously ill-nourished state but how we "literally are what we eat" and how our health can be improved with better attention to purer foods. Yoga and similar phenomena emphasize the oneness of mind and body, and the necessity to get back in touch with our deepest inner thoughts and bodily states. And finally the human growth potential movement as well as women's liberation continually emphasize how repressive our culture has been in our potential

experiencing our own bodies (e.g. from bodily sensations to bodily contacts). If any of these should come to pass, it can only lead to greater and greater bodily attention of all sorts - pleasure as well as pain, sensations as well as symptoms.

From still another, though certainly not independent source, the third estate, comes a further focussing on the human body, particularly what is negatively happening to it. For in reading the scientific, pharmacological, and medical literature, one finds a growing litany of indictments of 'unhealthy' life activity. From sex to food, from aspirins to clothes, from driving your car to riding the surf, it seems that under certain conditions, or in combination with certain other substances or activities, or if done too much or too little, virtually anything can lead to certain medical problems. In short, I at least have finally been convinced that living is injurious to health. This remark is not meant as facetiously as it may sound. But rather that every aspect of our daily life has in it elements of risk to health.

H. Overview

The most simple and general point of today's session was that believing in the fixity, finiteness and infrequency of illness allows us to think of it as handleable, objective, and not of great enough importance to be very concerned about. In other words it does not happen very often and when it does it is handled straight forwardly and neutrally. On the other hand by viewing illness as fluid, infinite and very frequent (by whatever clinical standards are currently practiced) opens us to the awareness of its lack of objectivity as well as its pervasiveness. It is, thus something that potentially is experienced by all of us all of the time. As such when the diagnosis and treatment has been restricted to a certain group this gives that group great possibilities for intervention in our lives. And when health and illness become of great importance, this group, perhaps unwittingly, is in a position to exercise control and influence about what we should and should not do to atlain that "paramount value". Next time we ask the question how much all this matters - is medicine on anyone's side?

The rest of the material presented today can be understood as 'anticipated' answers to many of your recurring questions. Does all this unseen and untreated illness matter? And so the material on seriousness and representativeness. Why does this view and continual search for disease persist and what are its consequences? Thus the material on the

conceptual tools of medicine and its clinical perspective. And finally is it only medicine that sees the world this way? Thus the material on the acceptance and consequences of the medical perspective for socio-medical research and the general public.

ADDENDA

Question:

Why has socio-medical research in general and social science or medical sociology in particular so readily 'bought' medicine's point of view and perspective?

Tentative answer:

In large part this is a historical phenomenon dealing with how and why social science became interested in medicine in the first place. Most seem to have come to medicine precisely because of the attraction of the medical model.

Occupational sociology foccussed on medicine because it was felt to represent the prototype of all professions. Thus by studying it, much light could be shed on the occupational structure of modern Society.

Sociologists, in fact their very discipline, is at base concerned with problems of social order and social organization (Robert Nisbet, The Sociological Tradition). There scarcely exists an organization so hierarchically organized and yet so readily observable (contrasted to say the Church and the Military) which also possesses such rigidly defined regulations and ritual contact between varying statuses (e.g. between doctors, nurses, and patients and even subgroups within these). The 'recruitment' to all the roles in this organization - from doctors to nurses to patients - also provides an excellent opportunity to study the process of socialization.

What medicine dealt with also had its appeals - namely desease.

Many certainly of the earliest social scientists were at heart social reformers, thus disease represented another evil like delingvency to which they could bring their tools and talents to its study, in the hope of alleviating human suffering. For many, it had a latent benefit of prestige by association. Mingling with doctors was infinitely more glamorous in their own eyes as well as that of the general public than mingling with the police, the prostituted, the poor, the powerless.

For the 'scientifically inclined', illness provided at last a 'hard variable' to predict to, something against which they could test all sorts of social, psychological, and behavioral correlates.

It was only much later that social scientists came to study medicine because it was viewed as a place in society where power was abused,

where evil might be promulgated rather than alleviated. Here I refer to men like Erving Goffman (Asylums) who is much more popular among students than his professional colleagues. It is not accidental that one of the early major contributors to medical sociology is Talcott Parsons, a man now recognized as not only America's foremost and dominant sociological theoretician but also the promulgator of the most conservative and status quo approach to the study of society (Alvin Gouldner, The Coming Crisis in Western Sociology).

5-4-72.

MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL

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VI. IN THE NAME OF HEALTH AND ILLNESS: ON THE SOCIAL AND POLITICAL CONCEQUENCES OF MEDICAL INFLUENCE

A. Introduction

Several years ago in the United States, a popular satirist, himself a physical scientist, wrote a song dedicated to our rocket experts.

> "Once they are up who cares where they come down:
> 'Thats's not my department', says Werner von Braun."

It is a statement with implications far beyond rocketry. It is 'not my department' provided for all too long a shield for scientists in general and medical scientists in particular - a defense against the uses to which their techniques and discoveries might be used. Moreover, the statement that we must do something because we can do it is as Dubos notes "operationally and ethically meaningless ..... tantamount to an intellectual abdication". Dubos as a result calls for science to exercise value judgements, to set priorities. While I agree that new priorities have to be set, my concern is not that medical science should now exercise values but that for all too long it has been making value judgements in the name of health and illness. An unless we become aware of this and explicate the nature of these judgements no corrective is really possible.

Today I wish to trace the implications of medical influence - first concretely and then analytically. Freidson sets the terms of our initial description.

> "Medicine is not merely neutral .... As applied work it is either deliberately amoral - which is to say, guided by someone else's morality - or it is actively moral by its selective intervention."

This broadly speaking are the two categories of examples I will present - first where medicine is used and perhaps abused and second where medicine seems to be more actively moral by taking sides based either on implicit assumption of their profession or values latent

in the background of its practitioners.

B. The 'Amoral' Uses of Medicine.

In previous sessions, we pointed out the uses of medicine and its rhetoric in the pushing of humane causes. There is, however, nothing inherent in medical science which places it on the side of the angels. So now we shall point out, in a kind of escalating scale of seriousness, some of the other kinds of causes that medicine can be used to support.

Noise in the urban environment has finally turned out to be what we hoped it would - namely detrimental to health as well as offensive. Among the kinds of noise offensive for many reasons to middle-class and older ears is 'rock-music' and the blaring and glaring of light and sound' shows. Recently a group of audiologists noted that constant exposure to such 'abrasive sounds' could lead to subsequent hearing difficulty.

Smoking has long-been considered by many to be a sinful habit and as such not to be indulged in by the young. Smoking in the last two decades has also been indicted as detrimental to health. Recently there occurred a 'marriage of convenience' in a local U.S. school district. There, as students all over the world, they were demanding certain rights - among them - a private unsupervised smoking room. The embattled administrator found a way out. As much as he personally was in favor of student rights he could not yield on this issue: for restrictions on smoking were necessary for reasons of health.

For a very long time, there has been a debate over whether or not alcoholism is a disease. In a move welcomed by many the United States Army took a forward step. On March 8, 1971 (International Herald Tribune of that date) the Pentagon announced a change in attitude. Alcoholism was now a treatable disease Dr. Richard S. Wilbur, the assistant secretary of defense for health and environment, in announcing a new rehabilitation program, stated, "Until now we took a punitive approach toward treatment including denial of promotion, loss of security classification and expulsion from the service". Later on in the release, it was also noted "Under the Pentagon's new policy an alcoholic is not to be considered physically unfit for military service on the basis of his alcoholism provided the individual undergoes treatment and makes progress". Is it me alone that wonders about the problems of reenlistment and recruitment in the most unpopular war the U.S. has

ever engaged in and how psychiatric disqualification including alcoholism was one of the most popular ways that people used either to prevent getting in or to help get them out. What other conditions or diseases will soon be recognized as treatable or at least not so disqualifying?

A look at the uses of a new technical medical advance also may prove instructive. I refer to Automatic Multiphasic Testing. It has been a procedure hailed as a boon to aid the doctor if not replace him. While some have questioned the real efficiency and validity of all those test-results and still others fear that it will lead to 2nd class medicine for already underpriviledged populations, it is apparent that its major use to date and in the future may be not in promoting health or detecting desease to prevent it. Thus three large institutions are now or are planning to make use of this method not to treat people but to "deselect" them. The armed services use it to weed out physically and mentally unfit, insurance companies to reject "uninsurables" and large industrial firms to point out "high risks". At a recent conference representatives of these same institutions were asked what responsibility they did or would recognize to whose whom they have just informed that they have been 'rejected' because of some physical or mental anomaly. They calmy and universally stated none-- neither to provide them any appropriate aid nor even to ensure that they get or be put in touch with any help. It is also worth noting, that the results of periodic health examinations are not as private a concern as once thought. It is now being used as a way of controlling executives- "If you do not lose weight, take care of your ulcer....." Medical data is now being used in retirement policies. I have seen recent contracts of older professors eliminating age which is thought to be discriminatory and substituting health which is thought to be objective as a criteria. But what disease is detrimental to being a professor and who decides?

And what about medicine's uses in that most political arenas -war. That medical personnel should do their best to save lives and treat the wounded - the civil population, our side and their side is fairly clear but after this the road gets murky. The study of medicine in wartime ofter reveals that the physician is put in the position of choosing between the best goals of treatment and rehabilitation and the "war effort". While many new techniques were created under these circumstances, it is clear that their practitioners were aware that they might be sacrificing the long term health of their patients to the short term goal of the army commander. (In a novel, Leo Rosten details this dilemma

for a psychiatrist - Captain Newman, M.D.). Recently there was a cause celebre when a physician felt he was being asked to step over the line. I refer to the case of Dr. Howard Levy - subsequently courtmartialed and imprisoned because he refused to train Green Berets in first aid and other medical treatments. He claimed that such training had primarily a political aim, to gain the confidence and help of the local population in tracking down Viet Cong. And what lastly about direct contributions to the war. With so much made of medicine's commitment to the preservation of life and health, how do we justify social-psychiatric help in undermining a population's will to fight, or in interrogating prisoners and what about biomedical efforts in bacteriological warfare? Is medicine always or even inevitably on the side of good? I guess it depends on whose side you are on.

We can see the issue of sides a bit more clearly, if not uncomfortably, when we look at the label "illness" as used on a more personal level. In a previous lecture, we noted how the label "illness" could exempt an individual from certain responsibilities and even declare him not responsuble for his desease as well certain actions. The word 'responsible' cuts two ways, however, for it can be used both to discredit as well as exempt.

Kenneth Burke (Attitudes Toward History, 1959) stated:

> "Call a man a villain and you have the choice of either attacking or avenging. Call him mistaken and you invite yourself to attempt to set him right."

I would add, "Call him sick or crazy", and all his behaviour becomes dismissable. Because a man has been labelled ill, all his activity and beliefs, past, present and future become related to, and explainable in terms of, his illness. Once this occurs we can then deny the validity of anything which he might say, do, or stand for.

The generalizing implications of such labelling is further seen when it is applied to a discussion of a controversial social issue. Today the best weapon is to label the other side as mentally ill. (Though being 'physically ill' does not lag far behind) In such a situation the separate evaluations of badness and madness and wrongness become unnecessarily and unfortunately intertwined. A very old joke illustrates this principle:

> A man was changing a flat tire outside a mental hospital, when the bolts from his wheel roll down a nearby sewer. Distraught, he is confronted by a patient watching him who suggests, "Why don't you take one bolt off each of the other wheels and place it on the spare?" Surprised when it works,

> the driver says, "How come you of all people would think of that?" Replied the patient, "I may be crazy, but I'm not stupid".

This anecdote demonstrates the association between thinking that a person is mad and therefore believing him to be stupid or incapable of being right or insightful about anything. Thus today if something is felt to be bad, the most effective discreditation is that it is mad, for if mad, then it is "naturally" wrong. In fact, if madness can be demonstrated, then it may be unnecessary to argue the other steps, particularly its wrongness. The sound advice of Thomas Hobbes (1651) applies as much today as three hundred years ago when he wrote:

> "Seeing then that truth consists in the right ordering of names in our affirmations, a man that seeks precise truth has need to remember what every name he uses stands for; and to place it accordingly; or else he will find himself entangled in words as a bird in lime twigs; the more he struggles the more belimed".

There are, of course, many places where illness considerations are relevant in the debate over social issues, but their importance as a key datum or cornerstone in the argument has been vastly overplayed. Furthermore, such considerations can be utilized by both sides in the argument to the ultimate confusion of the major issue. Two examples illustrate this. For years there have been attempts to discredit, by reference to their emotional instability, those who have either defected to the Communist world or been extremely critical of our own (Almond, G. The Appeals of Communism, Princeton, New Jersey: Princeton University Press, 1954, T. Szasz, Law, Liberty and Psychiatry, New York: Macmillan, 1963). On the other hand, the words and criticisms of Communist defectors are readily accepted as little short of the revealed truth. As a report in the New York Times 'February 25, 1968) showed, it was only a matter of time before the Soviet Union responded in kind.

> "Recently there has been a great deal of slander in the Western Press against several of our writers whose works played into the hands of our enemies. The campaign by the Western Press in defense of (Valery) Tarsis (author of Ward 7) ceased only when he want to the West where it became evident that he was not in his right mind.
>
> At the moment (Aleksandr) Solzhenitsyn (author of "One day in the Life of Ivan Denisovitch") occupies an important place in the propaganda of capitalistic governments. He is also a psychologically unbalanced person, a schizophrenic. Formerly he was a prisoner and justly or unjustly was subsequently subjected to repressions. Now he takes his revenge against

> the government through his literary works. The only topic he is able to write about is life in a concentration camp. This topic has become an obsession with him....." (Excerpts from remarks made during a private meeting with Soviet journalists last October in Leningrad by M.V. Zimyanin, editor- in-chief of Pravda, which were made available from sources in the West and reprinted in the column "Another Opinion", Section IV, p. 13, of the New York Times, Sunday, February 25, 1968)

Closer to home there has been a similar turnabout with reference to the involuntary segregation of Negroes. In many discussions, a key datum was the presumed negative effect of segregation on the mental health of the Negro. In other words, segregation was argued to be wrong because it impaired the Negro psyche. A prominent psychoanalyst has, however, argued that, given the long history of negro-white relations in the South, the negro in his subservient, defeated role has become essential to the precarious mental health of the "poor White" Southerner. A similar situation is seen in the case where findings about low Negro IQ are used to demonstrate either congenital inferiority or environmental deprivation. The issue surfaced again recently in Joseph Alsop's ruminations on a selective review of studies of Negro intelligence. (Arthur R. Jensen, "How much can we boost IQ and scholastic achievement", Harvard Educational Review, 391, 1-123 (1969). His syndicated column was carried in many dailies early March 1969 and the counter-articles and letters to the editor are still appearing. With clever adversaries, mental health-illness considerations may thus only confuse the basic moral or social issue. Thus, there is no necessary and incontrovertible association between being right and being sane or being wrong and being crazy, no matter how much we would like it to be so.[x)]

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x)

While we contend that the general use of 'medical labels' to discredit is a product of our times, apparently its possibilities were recognized well over a hundred years ago. Thus the Athenaeum of 23, March, 1850 carried the following commentary on the '1848 democrats'

> "In Berlin, a curious subject for a thesis has been found by a student in medicine, the son of M. Groddeck, the deputy, seeking his degree. M. Groddeck has discovered a new form of epidemic, whose virus has of late circulated throughout the continental nations with a rapidity contrasting strongly with the solemn and stately march of cholera. Its development, indeed, has been all but simultaneous in the great European Capitals, but we know not that it has before occurred to anyone to treat it medically. M. Groddeck's thesis publicly maintained is entitled "De morbo democratico, nova insaniae Forma" (On the democratic desease, a new form of insanity).

> The Faculty of Medicine, with the usual dislike of Faculties of Medicine to new discoveries, refused admission, it appears to this dissertation, but the Senate of the University, on M. Groddeck's reversed their decicion - Reported in "A New Form of Insanity", American Journal of Insanity 8: 195, 1851."

C. The 'Moral' Interventions of Medicine.

Here I wish to cite some cases where it is not a question of medicine being used but rather more actively taking sides. The first example is short, the last rather lengthy.

The issue of drug safety should seem straightforward but both words in that phrase apparently can have some interesting flexibility - namely what is a drug and what is safe. During Prohibition in the U.S. alcohol was medically regarded as a drug and was often prescribed as a medicine. Yet in recent years, when the issue of dangerous substances and drugs has come up for discussion in medical circles, alcohol has been officially excluded from the debate. Another more uncomfortable matter of definition was heard before the U.N. Commission on Biological and Chemical weapons in 1969. For there medical testimony was solicited in the attempt to classify bacteriological toxins as chemicals, thus exempting them from a passible ban on biological weapons (Health Pac Bulletin 1970). As for safety, many have applauded the AMA's judicious position in declaring the need for much more extensive, longitudinal research on marihuana and their unwillingness to back legalization until more data is in. This applause might be muted if the public read the 1970 Food and Drug Administration 'Blue Ribbon' Committee Report on the safety, quality, and efficacy of all medical drugs commercially and legally on the market since 1938. Though appalled at the lack and quality of evidence of any sort, few recommendations were made for the withdrawal of drugs from the market. Moreover, there are no cases of anyone dying from an overdose or of extensive adverse side effects from marihuana use, but the literature on adverse effects of a whole host of 'medical drugs' on the market today is legion.

Our second example is more pervasive in its influence. For generations, medicine has been exalted, praised, or feared because it held within its hands the power of life and death. For most of medical history this was more fantasy than truth. It was not until the turn of the century that the hospital was more than a final resting place and that the major

way of departure changed from horizontal to vertical. And it was not until that time that in the oft-quoted phrase of Henderson: That a random patient with a random disease meeting a random physician had more than a 50-50 chance of benefiting from the encounter. I am not trying to denigrate medicine's contribution - to be sure physicians saved many lives, my point is that it is not until our time that the oft-attributed power of medicine over life and death has become real. For it is really only now that physicians are in the position of actually being able to make conscious decisions about life and dealth. It is to the exercise of this decision-making power that we now turn.

With expanded 'life span', the population at least in Western industrial nations now has an increasing range of 'death possibilities'. For better or worse, we are now subject to a whole host of lingering, degenerative, and wasting diseases. At the same time medical technology is so advanced that we can keep people alive who ordinarily would die. Apparently, however, due to limits of time and personnel, not everyone benefits equally from these advances. Thus about three years ago, a tremendous row occurred in one of the London hospitals when a practice that probably existed covertly for a long time was made public. A notice was posted that if a patient over the age of sixty-five suffered a cardiac arrest no special efforts were to be made at resuscitation. (A similar situation was noted in the U.S. by David Sudnow in his book Passing On.) The idea of saving all lives is not so rigidly held as one might be led to believe - some lives are more worth saving than others. This issue becomes even more depressing where medical resources are indeed limited and likely to be so for years to come. In particular, those in need of kidney dialysis where the supply of the mechines are small, the financial coasts enormous, and the amount of patients able to be serviced by each machine far less than those medically eligible- It is obvious that purely medical criteria loom small in determining the benefactors - who will decide and on what basis?

Still more dramatically, a new right is being argued about - the right to die. For many patients - no one knows how many for the issue has not systematically been studied - would like to have some ability to exercise this right, particularly if they are faced with the possibility of a long life of pain, marked loss of function, or great physical and psychological dependency. Some physicians may go along with the passive side of euthanasia letting a patient die at a certain point but relatively few will admit to more active participation. (In many

jurisdictions participants in this would be subject to criminal charges of manslaughter). Here is one of several instances we will cite where the medical commitment to a particular model of life and practice is at odds with a significant segment of the public will. How large a discrepancy exists we can only guess. Looking at an analogous issue is suggestive. Traditionally the doctor has been the sole judge of when, if at all, to inform a patient of impending of possible death. Yet a recent study shows that while 80% of a sample of doctors were opposed to telling patient, 80% of a sample of patients wanted to know. Other data indicate that this stance on the part of the doctor is not merely to spare the feeling and ease the suffering of the patient and his family but that doctors if not all allied professions, are ill-equipped and often unwilling to deal with the social and emotional problems generated by a dying person. (The implications of only some people knowing and the patient having no one to speak to were delineated in the discussion.)

We turn now to the other end of the age continuum - where the issue is not when life should end but whether it should be allowed to begin. Here we have several factors effecting what the physician does - the clinical perspective as well as certain background factors such as his social class, religion and sex. In birth control, there was experimention with various methods of contraception long before medicine came into the field. Today, however, it is not only medicine which has been 'perfecting' the method but which has the exclusive right to dispense these methods where women are concerned. Moreover there is not equal access to either information or methods. The higher educated, higher socio-economic seem to have no difficulty in getting such data but not so the less educated and less socio-economically privileged. To be sure, in many cases, the clientele do not directly ask. On the other hand, the physician advises on a large range of preventive measures which he thinks important <u>without</u> the patient asking, why not this one? I am not necessarily saying that he advise the patient to use contraception but he can at least inform them of availability. It is also obvious that the physician in this role of dispensing birth control information, often functions in a moral capacity. Here being a college professor and advisor to many undergraduates has put me in a position to observe this. For I have seen too many cases where yound single women have been lectured, chastized, made fun of, embarassed, and in many cases refused help when they approached a physician for the 'pill', IVD, or a diaphragm. The documented cases of gynecologist - young women encounters would I feel drive many men as well as women to the

banners of "female liberation".

It is in abortion that values come most clearly into play. In Hordern's excellent history of the fight for legal abortion in England (A. Hordern, Legal Abortion: The English Experience, Oxford: Pergamon 1971), it is clear that the most consistent opposition came from the medical sector with British gynecologists in the lead. Professor Norman Morris points out, some of the dilemmas facing most gynecologists.

> found terminating a pregnancy very disturbing, since technically it was a "bloody, miserable and thoroughly unpleasant procedure". Operators could not escape the obvious conclusion that they were destroying life, albeit in an early form of development; and as they became older they found that destruction of life became progressively more repulsive. Receiving little assistance from his colleagues, the gynaecologist frequently found himself in the invidious position of being both judge and executioner. This was especially repugnant, Professor Morris[4] later observed, since most gynaecologists functioned also as obstetricians, and in this role had usually spent years studying and discussing ways of improving the environment of the foetus *in utero*. They were dedicated to the progressive reduction of perinatal death and, like most doctors, had an obsessive desire to prolong and preserve life. Deliberate abortion, a "haemorrhagic exercise in destruction", was thus especially odious and was not even technically satisfying since, though the operation had some hazards, it demanded only limited manual dexterity and was the most unpleasant and unsatisfactory procedure they were called on to perform."
>
> (Hordern, p. 18)

Hern, himself a physician-gynecologist is a little less charitable with aspects of the clinical perspective particularly with the concept of a 'normal' pregnancy which he feels is also male-dominated view as to where women should be.

> The use of the term 'normal pregnancy' in obstetrical practice, then, is the extension of the broader cultural influence into the professional setting. The term is useful, in a specialized sense, to distinguish pregnancies which are complicated from those which are routine. Unfortunately, its continued use by physicians is carried back to the nonprofessional context and reinforces the folk idea that pregnancy is more 'normal' than the nonpregnant state. Its use within the medical profession results in certain awkward dilemmas, particularly when the pregnancy is unwanted.
>
> (W.M. Hern, "Is Pregnancy Really Normal", Family Planning Perspectives, vol. 3 January 1971, pp. 5-10.)

> This reaches to the core of our current difficulties and controversy about abortion, since pregnancy has traditionally been defined in Western culture as 'normal', and the desire to terminate the pregnancy therefore, as, 'pathological'. It follows that every woman who wants an abortion must need to have her head examined, and that is exactly what has happened. Liberalized abortion laws in several states have resulted in a situation in which psychiatric consultation is mandatory for women seeking a legal hospital abortion; and hospital boards and the medical community still maintain this ritual in some places where there are no legal reasons for its maintenance.

Some physicians went so far as to feel that abortion reform was treatening to the very doctor-patient relationship, Nachsen.

> pointed out that often in a perfectly healthy young woman, with no history of mental disorder, the general practitioner was being asked to agree to a termination of pregnancy on which the woman had already decided. Frequently she would not accept the general practitioner's opinion that termination was not advisable, and if the gynaecologist to whom he sent her concurred, she would frequently seek out privately a more liberal practitioner whose views approximated to her own, and would obtain a legal abortion under the terms of the Act. In these circumstances, the opinion of the family doctor was of little value; and he had either to let the matter rest or agree to well-nigh any request that came his way. Nachshen concluded: "The Abortion Act is destroying the conventional and time-honoured relationship between patient and doctor, wherein the doctor advises his patient as to what he considers to be the correct means of alleviating complaints and medical conditions. . . . Ultimately we shall lose our capacity for objective clinical judgement, and, with it, our self-respect."
>
> (p. 117, Hordern)

To one who lived through the medicare debate in the United States the last words are especially discomforting for virtually the same effect was guaranteed when a patient did not pay a doctor for all his services. Listening to medical testimony rather than written articlesone also finds some rather disconcerting views on "such healthy young women" who seek abortion

- mention of its encouraging promiscuity by rewarding certain missteps.
- mention that mothers are always filled with joy at a child's birth and thus the physician must "support the woman through her pregnancy until her courage returned".
- or the chastisement of such women "whose only objection to their pregnancy is on grounds of inconvenience".

Because of the "conscience clause" in the British law and general opposition elsewhere, it is clear wittingly or unwittingly there is also a class bias against lower socio-economic women getting an abortion. Forthough theoretically it is available in many places, it takes money to get there. The 'conscience clause' has another latent benefit for it allows physicians to get other opinions. In general patients when informed of the necessity of an operation are oft pushed to do it right away. No pushing of the physician is available here in the one operation where it is universally true that even a short delay changes the condition of the patient and the nature of the operation. In the United States the effect of background variables is even clearer. As many of you know the U.S. is not particularly liberal by European standards on the issue of abortion. Moreover it is outside federal jurisdiction and varies from state to state. The AMA has taken a relatively liberal stand but one regarded as far too liberal by many physicians. And so the stage was set for a major political battle in the Spring of 1971 when the AMA convention was held in Boston. Since that is my home base I had a ring-side seat. Boston is many things and one is its great concentration of Catholics and consequently Catholic doctors. A highly organized move took place. The arguments were hardly medical-emphasizing the sacredness of life and of the many great men who were seventh sons of seventh soms. But Boston is also America's academic medical mecca with 3 medical schools, dozens of teaching hospitals and universities and thus also one of the greatest concentrations of liberal physicians in the U. S. The liberal forces were massed, the conservatives beaten back and the original 1967 resolution supported - a hardly radical statement which called abortion a decision between patient and her doctor without stating any grounds.

The whole issue of abortion is a value one and not a medical scientific one - though there are medical scientific considerations (e.g. in the attendant 'medical risk at different stages) none of them will tell when life begins or whether the taking of it any stage of development is justified. Frankly, given my own values I regard all current positions on abortion as relatively conservative and a reversal of at least my priorities. For instead of listing some two or twenty reasons when an abortion is permissible, I would reverse the issue and say an abortion is justified <u>unless</u> there are counterindications. It should not be up to the women to plead that she should have an

abortion but for others to defend why she should not.

But perhaps the greatest impact of medicine as well as the values underlying its perspective and its practitioners is in the issue of whether conception should even be allowed to take place - the whole idea of genetic counseling. The concern with genetics intrudes upon us from many directions. As Dubos points out:

> "The potential ability of mankind to survive the treats arising from new technologies and new ways of life constitutes but a limited aspect of the problem of adaptation. Many seemingly fully adaptive biological and social changes desirable today will have to be paid for in the future at a cruel price in terms of human values. A threateming consequence of medical and technological progress is the accumulation in our communities of hereditary defectives, people who today survive into reproductive age and in the past would have died without progeny. Modern ways of life are thus interfering with natural elimination of undesirable genes and are probably creating some measure of genetic hazard. Eventually this wide-spread impairment of genetic quality will express itself in overt disease or at least in reduced vitality." Dubos, Medicine and Environment, p. 110.

Concern with genetics goes beyond this for when population size for whatever reason becomes more limited then inevitably will follow the attempt to improve the quality of that population which will be produced. Here again Dubos points out how this may come about and some of the eventual value decisions which will have to be faced (p. 138 - Man, Medicine + Environment).

> "Family planning, however, is likely to create new biological problems which are little if at all understood. Once infant mortality has been reduced to levels as low as those prevailing in prosperous contries, an average of three children per family is far too high for population control. Surprising as it may be, this family size results in a doubling of the population within a very few decades. The population can be stabilized only if the average number of children born per couple does not exceed 2,3. Such low birth rates would leave little room for the operation of the selective forces that have maintained the genetic characteristics of the human race in the past."

> "The fear that genetic self-correction may no longer operate is creating a renewal of scientific and popular interest in the problems of eugenics. Some geneticists claim that man can avoid genetic deterioration only if that approximate 20 percent of the population who are heavily laden with genetic defects either fail to live until maturity or fail to reproduce. Increasingly, the proponents of eugenics go beyond advocating methods for preventing genetic deterioration. They claim that man could be positively improved physically and mentally if

> society were willing to favor the selective reproduction of the human gene types representing desirable qualities
>
> ..... Opinion about the world and men change and this necessarily complicates the selection of semen donors. No one disagrees with eliminating the gross physical and mental defects which afflict the human race, although even this limited approach poses problems of judgement and of execution far more complex than usually realized. The choice of the positive attributes to be fostered raises questions of a more subtle nature.
>
> Our present ways of life may soon be antiquated, and the future may demand qualities undreamed of at the present time. For all we know, resistance to radiation, noise, crowding, intense light, and to the repetition of boring activities may be essential for biological success in future civilizations. Who knows furthermore, whether mankind is better served by persons who prize, above all, individuality and self realization, or by those who regard service to the collective society as the highest form of life? One of the fundamental difficulties standing in the way of formulating eugenic programs is that no one knows what men want to become. (Dubos, Man Medicine and Environment, p. 139-140)

I recognize, of course, that values are at stake here. What I am concerned with is whose values will be the dominant ones and that values will be masked behind a scientific orientation. I would like to demonstrate the subtlety of this with one further example.

At a recent conference on the more limited concern of what to do when there is a documented probabiliy of the offspring of certain unions being damaged a position taken was that it was not necessary to pass laws or bar marriages that might produce such offspring. Recognizing the power and influence of medicine and the doctor, one of those present argued:

> "There is no reason why sensible people could not be dissuaded from marrying if they know that one out of four of their children is likely to inherit a disease."

There are in this statement certain values on marriage and what it is or could be, that perhaps while popular, are not necessarily shared by all. Thus in addition to presenting the argument against marriage, it would seem that the doctor should - if he were to engage in the issue at all - present at the same time some other alternatives:

1. Some 'parents' could be willing to live with the risk that out of 4 children, 3 may turn out fine.
2. Depending on the diagnostic procedures available they could take the risk and if indications were negative abort.

3. If this risk were too great but the desire to bear children were there, and depending on the type of problem, artificial insemination might be a possibility.
4. Barring all these and not wanting to rake any risk, they could adopt children.
5. Finally, there is the option of being married without having any children.

With a foothold in birthing and related aspects I guess it is natural to expect medicine to extend its lack of expertise into related activities - such as sex and counseling about it. For while still a sensitive topic in many parts of the world, one of the places where it seems more legitimate to talk about it is in the doctor's consulting room. If my tone sounds sarcastic, it is meant to be. For I cannot think of a subject on which the physician is more willing to expound and less equipped to do so. Most of you have been spared America's top ranking TV program - Marcus Welby, M.D. and his discoursing on premarital intercourse, venereal disease. Only time prevents me from illustrating that the scripts belong more in the Victorian Age than the atomic one. Why do I think medicine is ill prepared on this subject? First of all learning about the body as a machine, and an overwhelming emphasis on pathology rather than variation seems not ideal preparation for dealing with the complexities of love, diverse sexual strivings, and the ever changing relations between man and woman, as well as man-man and woman-woman. It is evident in what medical students are taught.

> "It is hardly surprising that the long-standing disinclination of the medical profession to involve itself in problems of sexuality and contraception was carried over into the teaching curricula of British medical schools, even though the recent unprecedented accumulation of knowledge in these areas could and should have been imparted to medical students. Thus the results of a survey of 1167 undergraduates with more than 20 months of clinical experience showed that whilst all but 3 per cent had had teaching in infertility, only between one-fifth and three-fifths had had teaching on normal psycho-sexual development, marital adjustment, and sexual difficulties, and less than three-fifths felt that their knowledge was adequate in any of these fields. One student commented, "The only teaching we have here on sex, marital adjustment, etc., is one lecture on the mating habits of cats", whilst another remarked, "It is ridiculous that the study of venereal disease is compulsory when the study of sexual relations is ignored"." (p. 44 Hordern)

This probably compares favorably with what is available in the U.S. where it is regarded as not worth talking or teaching about since it only involves "doing what comes naturally". Yet if there is one thing that Freud and Kinsey taught us is that what is natural has considerable

variation in time, space, and frequency. Kinsey seemed to document that what some people think is unnatural occurs with uncommon frequency. Moreover as Masters and Johnson have so painstakingly and dully documented, it is not so natural to do for most of us as we would like to believe. Female liberation has also shown that what is claimed to be natural for men is not necessarily so for women and that in fact a male and medical bias has for years totally distorted if not oppressed many aspects of female sexuality. (The case of Nancy Shaw's observations on what is taught nursing students was cited) Despite such blissful ignorance, the medical and allied professions do not seem loathe to give advice though on what they base their information might make one shudder. For we probably have childhood experience conditioned by social class and religious factors reified into clinical knowledge.

D. The location of the Source of Difficulty.

Analytically, there is something very important about where we locate the source of any trouble. It is locating the source of trouble as well as the place of treatment in individuals and making the etiology of the trouble either completely impersonal (e.g. virulent bacteria) or in something the individual did that gives the medical model much of its contemporary appeal. Lost in a commitment to action, western society and particularly the United States is "supremely cause-conscious" (F.Kluckhohn and F. Strodtbeck, Variations in Value Orientations, Evanston, Illinois: Row, Peterson, 1961.) Thus, there exists the conviction that if we search hard enough we will find some knowable, specifiable, delimited (and ultimately changeable and correctable) motive or reason in every human action. Nowhere is this more evident than when confronted with behaviors, incidents, or phenomena which are felt to be threatening or unsettling. Immediately a search begings for what specifically went wrong and the means to charge it. Bell and Spiegel (1966) gave an illustration of this process.

> "It is easy enough to ascribe the current popularity of social psychiatry to the typical American attitude: "Dont't stand there numbling; do something!" Even if we do not know to do there is the national assumption that some action is better than none at all. Once an idea has been identified as both new and scientific, there is an insatiable demand that something be done about it. And if the new, scientific idea also promises amelioration of such vast public problems as mental illness, crime, delinquency, alcoholism, and a good many others, then the demand reaches a programmatic intensity cooresponding to

> So, too, we may be able to change the form of a problem to make it less offensive. In one study of delinquency (McCord et al.) it was found that the "best" disciplinary insurance against delinquency was consistent physical punishment in response to the least little deviation. Delinquents, these boys did not become but hardly "healthy" in other senses.

With this kind of framework in mind we can now examine in particular what happens when we look to understand a series of problems - their etiology and the intervention - in individuals.

We can start with some of the research that many auto accidents are due to death wishes, "accident proneness" or the consumption of alcohol; or that cigarette smoking (in the case of cancer victims) is due to the need to gratify one's oral-dependency. That in both these examples the individual may have a role in his demise is doubtless true. It is also not accidental that such research is often heavily funded by the tobacco and auto industry. Yet at least to me it is hard to see why even if true this should absolute the auto and cigarette manufacturers from 'legal' accountability' as it has in a couple of recent court cases. Or why it should absolve them from making their products safer for human consumption and without the absolute necessity of passing the increased financial cost onto the consumer.

Sometimes the process of concentrating on the individual is helped by the professions themselves often with a certain poignancy. A case presented at a conference on the care of the elderly in homes for the aged illustrates this. A social worker described the following paranoid delusion of an elderly dying man,

> "This 81 year old man claimed that he was being systematically robbed of all his possessions - money, clothes, mementos, everything. And when everything was gone, he would die. His murderer, however, would never be caught because there would be no evidence that he (the elderly man) had ever lived."

The entire discussion following this case presentation focussed on the mental difficulties and impediments of ageing and the therapies available to deal with them. There is little doubt that this man was by current psychiatric standards clinically paranoid, but was the reality of his growing old (and perhaps ageing itself) and the feeling of loss, neglect, abandonment as depicted in his fantasy any less true? No one at the conference including myself who was also caught up in the psychiatric perspective seemed capable of seeing this issue (see M. Baizerman and D.L. Ellison "A Social Role Analysis of Senility", The gerontologist, 2, 1971, pp. 163-170) for one analysis of this problem).

Sometimes, the focussing not only indirectly effects public policy as it would in programs for the ages emanating from the above conference but can do so directly as seen in the words of an administrator, reflecting upon the poor and disavantaged:

> "The next push in public welfare should be the development of a high quality of professional program dealing with the problems of social and emotional adjustment to economic dependency." (A. Kruse, "Implications for Voluntary Agencies", The Social Welfare Forum, National Conference on Social Welfare, New York: Columbia University Press, 1957, p. 109.

Economic dependency, here, is assumed; the social and emotional problems from it are the target for change. Such a view could put a sealer on the basic problem of economic dependency, by ignoring its causes and exploring, or treating, only its consequences. Most cynically put, it could mean being satisfied with having millions of unemployed and then exploring how we can make these people less of a problem.

What is operative in all these examples is a "go-no-further effect" and one largely due to that aspect of the medical model which locates the source of trouble (the disease) and treatment primarily in individuals. While this may have a pragmatic basis in the handling of a specific organic ailment, when a social problem is located primarily in the individual or his immediate circle, it has the additional function of blinding us to larger and discomfiting truths. Slater talks about this as the "Toilet assumption".

> "Our ideas about institutionalizing the aged, psychotic, retarded and infirm are based on a pattern of thought that we might call The Toilet Assumption - The notion that unwanted matter, unwanted difficulties, unwanted complexities and obstacles will disappear if they are removed from our immediate field or vision .... Our approach to social problems is to decrease their visibility: out of sight, out of mind ... The result of our social efforts has been to remove the underying problems of our society farther and farther from daily experience and daily consciousness, and hence to decrease in the mass of the population, the knowledge, skill, resources, and motivation necessary to deal with them" (Philip Slater, The Pursuit of Loneliness Boston: Beacon Press, 1971, p. 15)

The specifying of many problems as individual diseases is but a variation on this theme. As a disease it is by definition not social and at the same time the most ordinary level of intervention is also not social. If it has to be handled anywhere or if anyone is to blame it is individuals - usually the carriers of the problem - and certainly not the rest of us, or society at large. It is quite naturally far less overwhelming to blame the concentration camps and genocide or World War II upon the

madness of a few men, than upon the banal complicity of millions (G. Gilbert, The Psychology of Dictatorship, New York: Ronald Press, 1950 versus H. Arendt, Eichmann in Israel, 1963). For individuals are theoretically, manageable units. What a Pandora's box would be opened if poverty, delinquency, addiction, etc. were considered indicative of something wrong in the basic structure of the society at large rather than (or as well as) in the basic structure of a relatively small collection of individual psyches.[x)]

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x)

"Interesting enough almost the same issue seems to be at the heart of the controversy re accepting expanded notions of the causality of mental illness itself. Thus, J.S. Bockoven in Moral Treatment in American Psychiatry, New York: Springer, 1963, p. 100 concludes; "The modern concept that mental illness is a reaction to the past and present relationship with other people is understandably repugnant to our society, since such a view implies that our society itself is the ultimate cause. It means that we actually do "drive" our close associates insane - something we admit only in jest. Furthermore, modern concepts of treatment which hold that mental illness is curable through relationships with other people place the responsibility to provide such relationships squarely upon our shoulders. We become even more uncomfortable when faced with the proposition that sanity and insanity are not a matter of black and white, but a relative affair depending on the adjustment of individuals to each other. Such a proposition raises the question of our mental health. Indeed the whole issue of mental illness becomes so unsavory at this point that we would rather put it out in mind altogether."

Halleck in a most cogent book, The Politics of Therapy (1971) directly indicts the practicing psychiatrist for his complicity in this process.

> " In dealing with the individual patient, the psychiatrist usually emphasizes that person's internal problems. Psychiatric treatment that focuses upon internal conflict encourages the patient and those who influence him to believe that his social environment is not contributing to his misery and that the environment is therefore adequate. But the patient is part of a social system. So long as treatment does not encourage the patient to examine or to confront his environment and so long as treatment protects those who have adversely affected that patient from considering their own behavior, the net effect of treatment is to strengthen the status quo. The psychiatrist, however, has alternative courses of action. If he elects to emphasize the oppressiveness of the patient's external environment or if he actually tries to show the patient how that environment might be changed, the psychiatrist will help to change the status quo. It is apparent that whatever the psychiatrist does, he will either encourage the patient to accept the existing distributions of power in his world or encourage the patient to change them. *There is no way in which the psychiatrist can deal with behavior that is partly generated by a social system without either strengthening or altering that system. Every encounter with a psychiatrist, therefore, has political implications.* There is a strange and unfortunate tendency among psychiatrists to believe that professional activities designed to change the status quo are political and activities tending to strengthen the status quo are medical or neutral. This kind of thinking is illogical. By reinforcing the position of those who hold power, the psychiatrist is committing a political act whether he intends to or not. Once this fact is appreciated, the psychiatrist's search for political neutrality begins to appear illusory.

One begins to wonder about the analogies to the practice of general medicine. When we deal with problems resulting from ageing but not ageing itself, cure malnutrition but not its source, recognize that bronchitis and emphysema are part of the costs of industrial progress but accept that progress as inevitable. And always the rationalization 'That's not my department. I'm too busy' as if his daily activities are unrelated to the problem and may unwittingly help perpetuate it.

Still a final function of the medical model is worth noting. In a previous session, we mentioned the positive effects for the individual of the diagnosis "illness", of its temporary exemption for individuals from certain responsibilities as well as certain stresses. A number of social scientists have pointed out that the sick role also has positive functions for a social system - providing in many institutions and

situations a safety value - a place where people could be 'cooled off' or more cynically put 'cooled out'. To give but one recent example Judith Shuval ("The Sick Role in a Setting of Comprehensive Medical Care", Medical Care, January-February 1972, Vol. X, pp. 50-59) noted that "illness may serve a functional role in a society characterized by a large proportion of immigrants by contributing to their integration in the social system". Talcott Parsons has stated in analytic terms how the sick role is "integrative"

> The sick role is analytically significant because it constitudes a form of deviance that is caught up in a process of social control that at once seals the deviant off from non-deviants and prevents him from becoming permanently alienated. It insulates the sick person from the well, depriving the former of unconditional legitimacy and reinforcing the latter's motivation not to fall ill, while at the same time pushing the former into professional institutions where he becomes dependent on those who are not sick ...
>
> The sick role is ... a mechanism which ... channels deviance so that the two most dangerous potentialities, namely, group formation and succesful establishment of the claim to legitimacy, are avoided. The sick are tied up, not with other deviants to form a 'subculture' of the sick, but each with a group of non-sick, his personal circle and, above all, physicians. The sick thus become a statistical status class and are deprived of the possibility of forming a solidary collectivity. Furthermore, to be sick is by definition to be in an undesirable state, so that it simply does not 'make sense' to assert a claim that the way to deal with the frustrating aspects of the social system is 'for everybody to get sick'.

Aside from its more obvious political effects this has had a very important effect within medicine itself. For it has protected and insulated the physician from his most potential and powerful source of criticism - the revolt of his clientele. For based on my long observations of self-help group there is no greater reason to account for the fact that it has taken so long - really not till the sixties - for any kind of systematic and organized and widespread self-help movement to emerge (see I.K. Zola, "The Problems and Prospects of Mutual Aid Groups", forthcoming in Psychological Aspects of Disability.)

E. The Moral Neutrality of the Medical Model.

There are many reasons why the medical model has been widely used to understand, diagnose, and treat "society's ills". Not the least of these reasons as we have pointed out before is the assumed moral neutrality of such a model. Herein, however, lies the greatest

potentiality for abrogating and obfuscating moral issues. Illness, from the medical model assumes something painful and undesirable, and thereby something that can and should be eliminated. It is because of the latter element that great caution must be exercised in the equating of social problems or unpleasant social phenomena with illness. Drug addiction and homo-sexuality provide examples of this process. Both are behaviors considered by many to be morally reprehensible. In many parts of the world to engage in either is a criminal offense. Now with our modern enlightenment, the situation is changing. They are less often regarded as crimes and more as signs of illness, if not ipso facto illnesses themselves. While this may be more humanitarian and therapeutic, it provides no answer to the underlying ethical and moral issues. It is a particular society which calls them illnesses or regards them negatively. There is no universal agreement in this evaluation and there are many places where such behavior is considered appropiate or at least tolerable (E. Schur, Crimes Without Victims, Englewood Cliffs, New Jersey: Prentice Hall, 1965, C. Ford and F. Beach, Patterns of Sexual Behavior, New York: Ace Books, 1951). Thus the fact there are significant medical psychological and even physiological differences between homosexuals and non-homosexuals, and between drug users and non-drug users is no demonstration that homosexuality and drug addiction are primarily medico-psychological problems. Nor is the fact that homosexuals or drug users can be treated or changed any argument that they should be forced to change. Yet this is done continually in the context of the medical model. Popular articles have even begun to use such reasoning as an argument against homosexuality and at least one citing evidence on "improvement" of homosexuals through psychotherapy, concluded that therefore the homosexuals have no excuse for not undergoing treatment. Within this framework, such questions as the homosexual's or addict's wish for change, his satisfaction with the situation, and his right to dispose of his body in his way if he does not harm others (American Civil Liberties Union Conference on Control of One's Own Body, June 3-7, 1970), will not even be asked. A social illness, like an individual one, is by definition to be eliminated, regardless of the wish of the individual.

The word "regardless" is a key element. In the process of labelling a social problem an illness, there is a power imbalance of tremendous import. For all illness, as we have mentioned previously is only to be diagnosed and treated by certain specified licensed and mandated

officials - primarily M.D.'s. In such a situation, the potential patient has little right of appeal to the label-diagnosis. In fact when a patient-client does object to what is being done for him, the social rhetoric once again may obscure the issue, i.e. since he is sick, he does not really know what is good for him. The treater-diagnosticians, of course, do since there is nothing "in it" for them, the experts who made the diagnosis. The very expertise, being socially legitimated, makes the above approach seem morally neutral. It is in such reasoning that there is the greatest deception. Even granting that the illness diagnostician and his tools may be morally neutral (something which we have doubted in the previous papers in this series) for society to decide that any particular social problem is relevant to his province is not without moral consequences. This decision is not morally neutral precisely because in establishing its relevance as a dimension, the moral issue is prevented from being squarely faced and occasionally even from being raised. By the very acceptance of a specific behavior as an illness and the definition of illness as an undesirable state the issue becomes not <u>whether</u> to deal with a particular problem but <u>how</u> and <u>when</u>. Thus the dabate over homosexuality, drugs, abortion become focussed on the degree of sickness attached the phenomenenon in question or the extent of a health risk is involved. And the more principled, more perplexing, or even moral issue of <u>what</u> freedom should an individual have over his/her body is shunted aside.

It seems also worth mentioning that within medicine itself a few lonely voices are beginning to question the universal acceptance of illness, its signs and symptoms as by definition 'undesirable' and 'therefore to betreated or eliminated'. Theodosis Dobzhansky of The Rockefeller Institute has wondered about our general notations of mutation and has coined the expression 'heterosis' to account for situations where mutations may produce stronger rather than necessarily weaker individuals. Other have begun to note instances where exposure to one disease may protect the individual from other more serious ones. Ratner (Herbert Ratner, "Medicine", an interview by D. McDonald, one of a series on American Character, sponsored by the Center for the Study of Democratic Institutions and published by the Fund for the Republic, 1962) among others has thus begun to question our zeal in immunization and Jones has speculated in a similar vein about the so-called diseases of civilization, wondering if they represent a kind of "... balanced polymorphism: (since) such conditions as

obesity, diabetes, hypocholesterolaemia and ischaemic heart disease are so frequent - and so often associated -- because they represent the survival of genes that could withstand famine, and other privation, from times when such genes were advantageous to age and affluence (to times) when manifestly they are not." (H.B. Jones, "The Relation of Human Health to Age, Place and Time", in J.E. Birren, Editor Handbook of Ageing and the Individual Chicago: University of Chicago Press, 1960, pp. 336-360). There is also some limited evidence that at least in the psychic realm such symptoms as anxiety are not necessarily all 'bad', related as it may be to certain kinds of achievement and adaptational as it is under certain situations of acute crisis (I. Janis, Psychological Stress: Psychoanalytic and Behavioral Studies of Surgical Patients, New York: Wiley, 1955). Perhaps in many senses of the word, "to be ill" may at times be positively functional for the continued long-run good "health" and performance of the group but also for the individual. It may ironically be "treating" certain phenomena as basic disorders rather than ephemeral or adaptive episodes which leads to their maladaptive and dysfunctional for the individual and society.

Conclusion

This series of papers has been many things and one is a warning note on the perils of the wholesale transfer of the medical model to the understanding of social problems. The many illustrations have tried to show the social and political and hardly neutral ends which can be served by labelling a person-problem 'illness' and trying to understand it and handle it within a medical framework, basically the contention is that the increasing use of illness as a lever in the understanding of social problems represents no dramatic shift from a moral or legal view to a neutral one but merely to an alternative conceptual scheme or strategy for securing desired social change. This has been vividly in a commentary on the revival of witchery on college campusus by the Dean of a Catholic University. (New York Times 1969).

> "We've really become progressive around here. A couple of hundred years ago we would have burned them. Twenty-five years ago I would have expelled them. Now we simply send them all to psychiatrists."

Thus the shift in the handing such social problems is primarily in who will undertake the change (psychiatry and other medical specialties) and where the change will take place (in the individual's psyche and

body). The problem being scrutinized and the person being charged is no less immoral for all the medical rhetoric. It or he is still a "problem" though the rhetoric may convince us that he and not the society is responsible, and he not the society should be changed. Even the moral imperatives remain, in the idea that if such a problem-person can be medically treated-changed, it-he should be. Here, however, is no imperialistic takeover by medicine and psychiatry of the minds and judgements of our society, but rather an insidious and diffuse phenomenon almost mundane in its exercise and nature. My concern is that society in its search for cure-alls to its problems keeps seeking advice from scientific experts - in this case the medicine-man, and that medicine seems all too willing (perhaps unwittingly) to involve itself in social problems. The primary danger is that both sides too often appear unaware of what they are really doing - namely hiding the continuing and inevitable moral (as well as socio-political) nature of social problems.

As stated in the very beginning this 'medicalizing of society' is as much a result of medicine's potential as it is of society's wish for medicine to use that potential. Why then the focus more on the medical potential than the social desire. In part it's a function of space but also of political expediency. For the time may rapidly be approaching when recourse to the populace's wishes may be impossible. Let me illustrate with the statements of two medical scientists who if listening to my remarks today would probably dismiss all my fears as groundless. The first was by one commenting on the ethical, moral, and legal procedures of the sex change operation.

> "Physicians generally consider it unethical to destroy or alter tissue except in the presence of disease or deformity. The interference with a person's natural procreative function entails definite moral tenets, by which not only physicians but also the general public are influenced. The administration of physical harm as treatment for mental or behavioral problems - as corporal punishment, lobotomy for unmanageable psychotics and sterilization of criminals - is abhorrent in our society" (D. Russell, The Sex-Conversion Controversy, New England Journal of Medicine, vol. 279, 1968, p. 536)

Here he states as almost an absolute condition of human nature, spmething which is at best a recent phenomenon. He seems to forget that there were laws promulgating just such procedures through much of the 20th century, that within the past few years at least one California jurist ordered the sterilization of an unwed mother as a condition of

probation, and that such procedures were done by Nazi scientists and physicians as part of a series of medical experiments. More recently, there is the misguided patriotism of the cancer researchers under contract to the United States Department of Defense who allowed their dying patients to be exposed to massive doses of radiation to analyse the psychological and physical results of simulated nuclear fall-out. True the experiments were stopped but not until they'd been going on for eleven years.

The second statement is by Sir Frances Crick at a conference on the implications of certain genetic findings:

> "Some of the wild genetic proposals will never be adopted because the people will simply not stand for them." (Time Magazine, April 14, 1971)

Note where his emphasis is, on the people not the scientist. In order, however, for the people to be concerned to act and to protest, they must first be aware of what is going on. Yet in the very privatized nature of medical practice plus the continued emphasis that certain expert judgments must be free from public scrutiny there are certain processes which will prevent the public from ever knowing what has taken place and thus from doing something about it. Let me cite two examples

> Recently in a European country, I overheard the following conversation in a kidney dialysis unit. The chief was being questioned about whether or not there were self-help groups among his patients. 'No' he almost shouted 'that is the last thing we want. Already the patients are sharing too much knowledge while they sit in the waiting room thus making our task increasingly difficult. We are working now on a procedure to prevent then from ever meeting with another'.

The second example removes certain information even further from public view.

> The issue of fluoridation in the U.S. has been for many years a hot political one. It was in the political arena because in order to fluoridate local water supplies, the decision in many jurisdictions had to be put to a popular referendum. And when it was, it was often defeated. A solution was found and a series of state laws were passed to make fluoridation a public health decision and to be treated, as all other public health decisions, namely by the medical officers best qualified to decide questions of such a technical, scientific, and medical nature.

thus the issue at base here is the question of what factors are actually of a solely technical, scientific and medical nature!

To return to our opening caution this paper is no attack on medicine as much as a situation in which we find ourselves in the latter part of the 20th century. What I am convinced of is that the medical area is the arena or the example par excellence of today's identity crisis - what is or will become of man. It is the battle-ground not because there are visible threats and oppressors but because they are almost invisible, not because the perspective, tools, and practitioners of medicine and the other helping professions are evil but because they are not. It is so frightening because there are elements here of the banality of evil so uncomfortably written about by Hannah Arendt. But here the danger is greater for not only is the process masked as a technical, scientific objective one but one done for our own good. A few years ago a physician speculated on what, based on current knowledge, would be the composite picture of an individual with a low risk of developing atherosclerosis or coronary-artery disease. He would be:

> "... an effeminate municipal worker or embalmer completely lacking in physical or mental alertness and without drive, ambition, or competitive spirit; who has never attempted to meet a deadline of any kind; a man with poor appetite, subsisting on fruits and vegetables laced with corn and whale oil, detesting tobacco, spurning ownership of radio, television, or motorcar; with full head of hair but scrawny and unathletic appearance, yet constantly straining his puny muscles by exercise. Low in income, blood pressure, blood sugar, uric acid and cholesterol, he has been taking nicotinic acid, pyridoxine, and long term anti-coagulant therapy ever since his prophylactic castration". (G. Myers quoted in L. Lasagna Life, Death and the Doctor, New York: Alfred Knopf, 1968, pp. 215-216)

Thus I fear with Freidson (Profession of Medicine, New York: Dodd, Mead, 1970, p. 354)

> "A profession and a society which are so concerned with physical and functional wellbeing as to sacrifie civil liberty and moral integrity must inevitably press for a 'scientific' environment similar to that provided laying hens on progressive chicken forms - hens who produce eggs industriously and have no disease or other cares."

Nor does it really matter that if instead of the above depressing picture, we were guaranteed six more years of life, drugs to expand our potentialities and potencies. We should still be able to ask: what do six more inches matter? In what kind of environment will the thirty additional years be spent? Who will decide what potentialities and potencies will be expanded and what curbed?

Freidson (The Profession of Medicine) has very cogently analyzed why the expert in general and the medical expert in particular should be granted a certain autonomy in his researches, his diagnoses and his recommended treatments. On the other hand, when it comes to constraining or directing human behaviour because of the data of his researches, diagnoses, and treatment, a different situation obtains. For in these kinds of decisions it seems that too often the physician is guided not by his technical knowledge but by this values, or values latent in his very technique. Thus there are measures which can and must be done now. I am sure with thought and I hope with renewed concern you will create even more pertinent and viable measures.

- a greater "spreading" of medical education to include ever wider segments, ethnically, racially, sexually of the population.
- a continuing examination of the very premises under which medicine and all experts function.
  - in other words, it is time for all of us experts to defend as well as articulate our working assumptions.
- an open debate on the viability certain "rights" - what we do to our bodies and mind, the right to live as well as the right to die.
- a spreading of medical responsibility and techniques to many many paramedicals so that at very least the term 'care' in medical care will have meaning.
- reexamination of all experts prerogatives from what treatments he alone should administer to how he and on whose behalf he organizes his work time and services.
- the founding of patient's rights organization independent of medical services, for no matter how noble or with good intentions only an advocacy system will quarantee that a group's interests will be clearly and systematically in the forefront. There are frankly some things and perspectives one cannot take without having been there. (I.K. Zola, Problems and Prospects of Mutual Aid Groups)
- The need to guard against one of the greatest sins of experts - the sin of presumptiousness of knowing what is best for someone else. Thus lets start with the opposite assumption of sharing decision and information until this becomes patently unworkable.

None of this will be easy. The otherday one of you was drawing an analogy to the fact that social change and demands always seem ill-timed. Colonial peoples always want their power and everything too soon. Without going into the reasons why such people are often if not always ill-prepared, let me argue that that sadly is one of the cost of many social changes. In fact it is one of the reason that we talk of change and not some other concept. Thus the otherday I picked up a newspaper article which reported a psychiatric study of women. The finding indicated that 'female patients are sicker today than they were ten years ago'. They conclude that "the change in sexual and social role expectations during the past decade (what some have labelled the thrust toward liberation) seem to be greater and somewhat more ambiguous for women than for men". Even if true, this then is one of the costs of freedom and independence.

Finally I must also confess that given the road down which so much expertise has taken us, I am willing to live with some of the frustrations and even mistakes that will follow when the authority for many decisions becomes shared with those whose lives and activities are involved. For I am convinced that patients have much to teach their doctors as do students their professors and children their parents.

MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL

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VII A SELECTIVE ANNOTATED BIBLIOGRAPHY ON "MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL

The following bibliography is not meant to be exhaustive. Several of the papers usually where studies are cited or individuals quoted are already heavily footnoted and no useful purpose would be served in repeating those references here. This bibliography is by definition evaluative. It does not include everything that conceivably might be relevant. It is meant to provide a general background and a series of entree points for the interested reader.

Balint, Michael
The Doctor, His patient and the Illness
New York: International Universities Press, 1957

A very articulate and in depth description of the doctor-patient relationship as it occurs in daily general practice. Based on the reports of general practitioners, it presents not only the subconscious elements in this relationship but also the many psychosocial factors which bring the patient to the physician and the varied kinds of help he 'truly' seeks.

Becker, Ernest
The Structure of Evil. An Essay on the Unification of the Science of Man
New York: George Braziller, 1968

This book is the latest in a series to create a unified science of man. Whether he succeeds is problematic. Yet in the process he takes the reader through a fascinating historical journey from the decline of medieval cosmology, through the decisive break form the 'old order'

in the French Enlightenment to the 19th c. attempt to unify science and value. Again and again he illustrates the forces at work to 'dethrone' man from the center of study.

Becker, Howard S. et al
Boys in White-Student Culture in Medical School
Chicago: University of Chicago Press, 1961

A participant observation study of a medical school which focusses primarily on the student culture as a socializing influence. It traces the 'fate of idealism' and the development of the many perspectives which become part of the future medical researcher and clinician.

Bittner, Egon
"The Structure of Psychiatric Influence"
Mental Hygiene Vol. 52 July 1968 pp 423-430

A most provocative article which sketches the crises of the Christian Ministry and of jurisprudence setting the stage for the emergence of Psychiatry as a 20th c. answer to man's problems. It also suggests not only what psychiatry offers that religion and law ceased to, but also why it, rather than some other intellectual tradition rose to fill the gap.

Bittner, Egon
"Comprehensive Medical Care and the Psychiatric Consultation Social Institutions and Medical Care"
Psychosomatics Vol. VIII, May-June 1967, pp 126-130

An analysis of the features of modern family life which have generated problems for which outside help must be sought and why physicians were the group which answered 'the call'.

Burgess, Anthony
The Wanting Seed

A novel once regarded as pure science fiction about the end the state might go to often with medical help to control the population explosion.

Burrow, James,G.
AMA Voice of American Medicin Baltimore: Johns Hopkins University Press 1963

A good solid history of the American Medical Association from its early beginnings in avowed self-interest and preservation to its later extension into public policy.

Butler, Samuel
Erewhon
New York: Signet 1961

A novel written a hundred years ago depicting man's struggle against technology. A fascinating chapter delineating what happens when it becomes 'illegal' to be 'sick'.

Davis, Kingstey
"Mental Hygiene and The Class Structure"
Psychiatry, Vol. 1, February 1938, pp 55-65

An oft-cited predecessor to the current criticisms of psychiatry. Here he traces the similarity between the "world philosophy" of the U.S. middle class and the supposed objective aims of the mental hygiene movement.

Dubos, Rene
Man Adapting
New Haven: Yale University Press 1965

A direct follow-up to Mirage of Health. An extensive documentation of man's ability to adapt to the most 'unhealthy' of human and environmental situations.

Dubos, Rene
Man, Medicine and Environment
New York: New American Library 1968

An attempt at synthesizing many of the findings of biology, anthropology, psychology, and sociology. He points out not only the dangers in man's almost infinite 'adaptability' but also some of the ethical dilemmas now facing modern

medical science. A perhaps unjustified optimism of medicine's powers of 'self correction'

Dubos, Rene
Mirage of Health
New York: Anchor 1961

His earliest and most provocative work setting the stage for his later messages. A sobering view of the contributions of medicine past and future and the false hope and unreality of any 'life without disease'.

Dubos, Rene
So Human an Animal
New York: Charles Scribner's Sons 1968

His Pulitzer Prize-Winning and most optimistic book. On the one hand a warning about the continued dehumanizing of man in this technological society, a call to redress the aims of science and the hope that a new reoriented bio-medical science will lead to a better future.

Eckstein, H.
Pressure Group Politics: The Case of the British Medical Association
Stanford, California: Stanford University Press 1960

A good historical as well as political analysis of the relationship between the British Medical Association and the eventual policies and admistration of the National Health Service as run by the Ministry of Health.

Eiseley, Loren
Darwin's Century-Evolution and the men who discovered it: New York: Anchor 1961

A history of the precursors of Darwinian Theory not only in terms of the discoveries which preceded it but of the social age which made its acceptance possible. For acceptance was key as Eiseley traces the many other previously rejected theories of 'evalution', the struggle in Darwin's own time-the challenges reputations, and neo-Darwinian developments.

Foucault, Michel
Madness and Civilization: A History of Insanity in The Age of Reason
New York: Pantheon Books, 1965.

A brilliant if occasionally unreadable analysis of the 'rise of insanity' as a concept and a social tool, the intertwining and similarity of handling of mental illness with other societal problems as well as a history of the changing

notions of reason and unreason.

Freidson, Eliot
Professional Dominance: The Social Structure of Medical Care
New York: Atherton, 1970.

In a series of separate essays, he first traces research in medical sociology and shows how it has failed to provide a critical perspective because of its wholesale acceptance of many medical assumptions. He then argues that many of the current problems in providing health services stem more from the professional dominance of medicine-particularly its unbridled autonomy-than from any bureaucratic failings of the health care institutions per se.

Freidson, Eliot
Profession of Medicine - A study of the sociology of applied knowledge
New York: Dodd, Mead. 1971.

If there is a single book to read this is it. It is certainly the most extensive description of a professional institution in modern society. It is primarily a socio-political analysis of not only how medicine came to its dominant position but also the chief tactic in its maintenance-the professional organization of work and its stress on autonomy. The book also traces the many elements which support this situation e.g. The socialization and training of physicians, the clinical perspective, the lay views of illness, and also provides the basic data for analyzing the role of medicine as a 20th centrury institution of social control.

Goffman, Erving
Asylums-Essays on the Social Situation of Mental Patients and other inmates
New York: Anchor 1961

The first provocative sociological account of what it means to be treated for mental illness. It is an indictment of the power of such institutions as mental hospitals to make one 'sick', if one was not before and of the power for social manipulation a facet artfully convexed in a chapter subtitle, "notes on the vicissitudes of the tinkering trades." It also describes the techniques available to the patient to fend off the staff and the institution.

Goffman, Erving
Stigma: Notes on the Management of Spoiled Identity
Englewood Cliffs, New Jersey: Prentice-Hall, 1963

In a certain way a segual to Asylums. Here the setting instead of a men-

tal hospital, the focus is on the situation of all people who are unable to conform to standards which society calls 'normal'.
The physically and mentally defective, the drug addict,the deformed etc.
In response to the daily confrontations with society and its institutions, Goffman delineates the techniques by which these 'stigmatized' individuals maintain their 'precarious social idehtities'.

Gouldner, Alvin
The Coming Crisis in Western Sociology
New York: Basic Books 1970

A masterful and highly original analysis of the historical and social roots of sociological theory with Talcott Parsons taken as his in depth example. He also tells how sociology has been influenced by political forces of the right and left as well as the structure of academia itself. Though a work showing the shaping of one intellectual tradition in Western Society, it has inplications for understanding many of the ideas now current in our society.

Gouldner, A.
"The Sociologist as Partisan: Sociology and the Welfare State"
American Sociologist 1968 pp 103-116

A very provocative if unbalanced and often personal attack on the misplaced emphasis of many social scientists attempts to understand current social problems. In particular he analyzes the implications of their unarticulated value assumptions, their focus of study and their sources of funding.

Grob, Gerald
The State and the Mentally Ill. A History of Worcester State Hospital in Massachusetts, 1830-1920.
Chapel Hill: University of North Carolina Press, 1966.

Though focussing on but one institution,he is nevertheless able to trace the changes in the conception,treatment, and clientele in relation to the changing social scene in America.

Health Pac Bulletin
Published monthly by the Health Policy Advisory Center, Inc. 17 Murray St. New York, N.Y. 10007.

The most consistently critical and avowedly polemical reportage of all medicine's foibles. Always fiery, occasionally overstated, but usually well-written and documented often citing sources of date and observations generally

unavailbale to both the professional and lay public.

Hern,Warren M.
"Is Pregnancy Really Normal"
Family Planning Perspectives Vol.3, January 1971 pp.5-10

A brilliant, ironic often witty essay on the many political, social, and medical implications of handling pregnancy within a tradtional Medical framework.

Hobsbawm, E.J.
The Age of Revolution, Europe 1789-1848
London: Weidenfeld & Nicobon 1962

A general treatise on the impact of the dual revolutions-the French and the industrial. Indispensible for knowing the general context within which medical science began to emerge as an answer to many of man's problems.

Hofstadter, Richard
Social Darwinism in American Thought
Beacon: Boston Revised Edition 1955

A lucidly written history of perhaps the most socially important of 19th c. scientific 'discoveries' evolution.
Illustrated by the lives and works of its promulgators and antagonists, this book traces the effect of Darwinism,its uses and abuses,on American Social Thinking, and why though England gave Darwin to the world, it was in the United States that he received sympathy and achieved preeminence.

Hordern: Anthony
Legal Abortion: The English Experience
Oxford: Pergamon Press 1971.

A virtually indispensable work for one who wishes to trace the active role that medicine can take in social policy. From a brief history of abortion before 1965, he describes the attitudes of the public, general practitioners, psychiatrists, and gynaecologists. He outline the abortion act in detail and the aftermath in attitudes and behavior of public and physicians. All is amply documented with empirical studies, observations, hearings, newspaper and committee reports.

Horowitz, Irving Louis, Editor
The Rise and Fall of Operation Camelot: Studies in the Relationship between Social Science and Practical Politics, Cambridge Mass - MIT press 1967

In December 1964 Project Camelot was officially described as a study whose objective was to determine the feasibility of developing a model which would make it possible to predict and influence politically significant aspects of social change in developing countries. It was financed by the U.S.,Department of the Army, and after a public outcry, was terminated. This book is a collection of papers by social scientists and statesmen involved in the project.
It not only poses the question of the degree to which social sciences should get involved in military and political matters but aptly illustrates how disciplinary perspectives often have a force of their own which get them involved in such enterprises.

Hughes, EverettH.C.
Men and Their Work
New York: Freepress of Glencoe, 1958

An important series of essays in the sociology of work and occupations, where he delineates the concepts of license and mandate so important to the conduct of a profession.

Hyde, D.R. et.al.
"The American Medical Association: Power, Purpose and Politics in Organized Medicine".
Yale Law Journal LXIII 1954, pp. 938-1022

A very cogent analysis of medicine's involvement in public policy with many examples.

Jones, Kathleen
Lunacy, Law and Conscience (1744-1845)
The Social History of the Care of the Insane
London: Routledge & Kegan Paul Ltd 1955

History of 1st legislative mention of the 'insane' to Shaftesbury's Lunatics Act which set up a national set of standards for care. It not only emphasizes the great struggle necessary but also the dubious humane motives which spurred these changes.

Jones Kathleen
Mental Health and Social Policy 1845-1959
London: Routledge & Kegan Paul,1960

While good in tracing the legal and social processes leading to the Mental Health Act of 1959, it is overoptimistic on what this means for the professional and public attitudes toward the mentally ill.

Korn, Richard
"The Private Citizen, the Social Expert and the Social Problem: An Excursion Through an Unacknowledged Utopia
In B. Rosenberg, I. Gerver, F.W. Howton (Editors)
Mass Society in Crisis
New York: Macmillan 1966, pp. 576-593

A most enlightening argument against the role of the expert, be he medical or social, as social problem solver.

Luhn, Thomas S.
The Structure of Scientific Revolutions
Chicago: University of Chicago Press 1970 Rev. Ed.

A tremendously heuristic analysis of scientific discoveries-how they are hardly inevitable and the importance of paradigms, models and cognitive maps to both elucidate and blind the investigator to the 'new truth'.

Leifer, Ronald
In the Name of Mental Health
New York: Science House 1969.

A description of the growing influence of psychiatry in contemporary life with particular reference to the community mental health movement, involuntary hospitalization, the handling of political devients, and in criminal proceedings.

McGrady, Patrick M. Jr.
The Youth Doctors
New York: Ace 1969

A popularly written and informative account of the great research and interest, popular and scientific in the process of regeneration or'age-retardation'.

Merton, R.K., Redder, G. and Kendall, P.L. (Eds).
The Student Physician: Introductory Studies in The Sociology of Medical Education
Cambridge: Harvard University Press, 1957.

Study of medical students often contrasted with Boys in White because of its difference in method (more on questionnaires and surveys) and interpretation placing great importance on the professor and practicing clinician as 'socializing influences'

Mills, C.W.
The Professional Ideology of Social Pathologists
American Journal of Sociology, Vol. 49, September 1942, pp. 165-180

An early and oft cited study of the effect of social background on what the popular social problem text book writers chose to emphasize as the cause and solution of America's social problems.

Parsons, Talcott
"Definitions of Health and Illness in the Light of American Values on Social Structure"
In E.G. Jaco, Editor, Patients, Physicians and Illness. Glencoe, Illinois: Free Press, 1955, pp.165-157

Just what the title says: the current conceptions of illness analyzed and elucidated in the light of dominant American values-a classic.

Parsons, Talcott
The Social System
Glencoe, Illinois: The Free Press 1951

It is chapter 10: Social Structure and Dynamic Process:
The Case of Modern Medical Practice which deserves special attention because of his classic delineation of the sick role and the physician role, along with the strains inherent in these roles.

Rosebury, Theodor
Life on Man
New York: Vinking Press, 1969

A charming, witty and instructive excursion into man's inevitable and oft necessary coexistence with microbes. He not only discourses on man's attitude

toward these microbes and the bodily parts and functions in which they are lodged, but also speculates on some of social-psychological-cultural roots of man's aversion.
An interesting parallel can be drawn to medicine's own attitude toward diseases and problems related to excretory functions.

Rosen, George
A History of Public Health
New York: MD Publications 1958

The best available social history of the development of public health, noting its social context, the influence of scientific discoveries, and its excursions into other spheres of influence.

Rosen, George
Madness in Society Chapters in the Historical Sociology of Mental Illnes
Harper Torch Books: New York 1969

A social and documentary history, far better than most, of the presence of madness and its handling from the ancient world to the present. Some interesting material on psychic epidemics, dance frenzies, and an especially good chapter in "Public Health and Mental Health: Converging trend and emerging issues".

Rosen, George
"The Evolution of Social Medicine"
In H.E. Freeman, S. Levine, L.G. Reeder (Editors) Handbook of Medical Sociology
Englewood Cliffs, New Jersey: Prentice Hall 1913 pp. 17-61

An excellent history providing much data for analyzing the emergence of social medicine in response to the social conditions in Europe.

Scheff, Thomas
Being Mentally Ill
Chicago: Aldine, 1966

A delineation of the assumptions and contingencies which determine whether a particular individual will be designated as mentally ill. In particular he emphasizes the clinical perspective which often leads to a decision rule wherein the physician feels it is more appropriate to judge an individual as "ill" rather than "healthy".

Schur, Edwin, M.
Crimes Without Victims: Deviant Behavior and Public Policy
Englewood Cliffs, New Jersey: 1965

A historical and social examination of the implications in making illegal such problems as abortion, homosexuality, and narcotics addiction, problems where there is technically no complaining victim.

Selye, Hans
The Stress of Life
New York: Mc Graw Hill, 1956

After reviewing much of the previous work on stress, Selye outlines his own theory of stress as well as disease, postulating the existence of a "General Adaptation Syndrome" in which disease results as much from the internal adaptative mechanisms of the host as from any external 'invasion' or trauma.

Shryock, Richard H.
American Medical Research: Past and Present
New York: Commonwealth Fund, 1947

A historical portrayal of Medical research in America with attention to the social background and values which influence its choice of problems and development.

Shryock, Richard H.
The development of Modern Medicine
An Interpretation of the Social and Scientific
Factors Involved
New York: Knopf 1947

The best available social history of medicine from 1600 onward.

Slater, Philip E.
The Pursuit of loneliness: American Culture at the Breaking Point
Boston: Beacon Press 1970

A stimulating, well-written, and all too vivid analysis of the relationship between America's self-imposed subservience to technology and the quality of life which inevitably results.

Szasz, Thomas S.
Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man
New York: Anchor 1970

A collection of essays elaborating points in his previous books-insanity pleas, involuntary hospitalization, mental health services in schools and universities.

Szasz, Thomas S.
The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement
New York: Harper and Row, 1970

This is his latest attempt to show the need for reform in psychiatry. He argues that people do not recognize mental illness as a behavioral condition but infer it instead from the association of the subject with the stigmatizing officials. And thus he states "that just as the ordinary man in the Middle Ages had no way of knowing who was a witch, and recognized her only from her identification by inquisitors,so, in our day, the ordinary man has no way of knowing who is a madman, and recognizes him only from his identification by mental health workers".

Walker, Nigel
Crime and Insanity in England
Edinburgh: Edinburgh University Press 1968

A very detailed and comprehensive account of the development of the English approach to the mentally disordered offender. From pre-Norman times to the Mental Health Act of 1969, he not only details what prompted varying changes,but also presents statistical material to evaluate such shifts

Wooton, Barbara
Social Science and Social Pathology
London: George Allen & Unwin 1959

One of the first and most articulate dissections of the assumptions underlying many current theories of mental, illness, delinquency, and maternal deprivation.

Szasz, Thomas S.
Law, Liberty and Psychiatry
New York, Macmillan, 1963

Mostly a series of case studies of the handling of political and other deviants through 'psychiatric classification and manipulation'.

Szasz, Thomas S.
The Myth of Mental Illness Foundations of a Theory of Personal Conduct
New York: Harper and Row 1961

His first booklength statement of a myth dominating psychiatry and America. Much of the problem, he claims, is in psychiatry's distortion of medicine's assumptions. He points out the gradual contamination of phychiatric classification with social purposes. In the second part of this book, he offers a theory of personal behavior-latent in all subsequent works-an attempt to reinstate freewill to the conception of man.