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## 5

# A Tale of Two States

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*Victor R. Fuchs*

In the western United States there are two contiguous states that enjoy about the same levels of income and medical care and are alike in many other respects, but their levels of health differ enormously. The inhabitants of Utah are among the healthiest individuals in the United States, while the residents of Nevada are at opposite end of the spectrum. Comparing death rates of white residents in the two states, for example, we find that infant mortality is about 40 percent higher in Nevada. And lest the reader think that the higher

rate in Nevada is attributable to the "sinful" atmosphere of Reno and Las Vegas, we should note that infant mortality in the rest of the state is almost exactly the same as it is in these two cities. Rather, . . . infant death rates depend critically upon the physical and emotional condition of the mother.

The excess mortality in Nevada drops appreciably for children because, as shall be argued below, differences in life-style account for differences in death rates, and these do not fully emerge until the

Table 5-1. Excess of Death Rates in Nevada Compared with Utah, Average for 1959-61 and 1966-68

Age group	Males	Females
< 1	42%	35%
1-19	16%	26%
20-29	44%	42%
30-39	37%	42%
40-49	54%	69%
50-59	38%	28%
60-69	26%	17%
70-79	20%	6%

adult years. As [Table 5-1] indicates, the differential for adult men and women is in the range of 40 to 50 percent until old age, at which point the differential naturally decreases.

The two states are very much alike with respect to income, schooling, degree of urbanization, climate, and many other variables that are frequently thought to be the cause of variations in mortality. (In fact, average family income is actually higher in Nevada than in Utah.) The numbers of physicians and of hospital beds per capita are also similar in the two states.

What, then, explains these huge differences in death rates? The answer almost surely lies in the different life-styles of the residents of the two states. Utah is inhabited primarily by Mormons, whose influence is strong throughout the state. Devout Mormons do not use tobacco or alcohol and in general lead stable, quiet lives. Nevada, on the other hand, is a state with high rates of cigarette and alcohol consumption and very high indexes of marital and geographical instability. The contrast with Utah in these respects is extraordinary.

In 1970, 63 percent of Utah's residents 20 years of age and over had been born in the state; in Nevada the comparable figure was only 10 percent; for persons 35-64 the figures were 64 percent in Utah and 8 percent in Nevada. Not only were more than nine out of ten Nevadans of middle age born elsewhere, but more than 60 percent were not even born in the West.

The contrast in stability is also evident in the response to the 1970 census question about changes in residence. In Nevada only 36 percent

Table 5-2. Excess of Death Rates in Nevada Compared with Utah for Cirrhosis of the Liver and Malignant Neoplasms of the Respiratory System, Average for 1966-68

Age	Males	Females
30-39	590%	443%
40-49	111%	296%
50-59	206%	205%
60-69	117%	227%

of persons 5 years of age and over were then living in the same residence as they had been in 1965; in Utah the comparable figure was 54 percent.

The differences in marital status between the two states are also significant in view of the association between marital status and mortality discussed in the previous section. More than 20 percent of Nevada's males aged 35-64 are single, widowed, divorced, or not living with their spouses. Of those who are married with spouse present, more than one-third had been previously widowed or divorced. In Utah the comparable figures are only half as large.

The impact of alcohol and tobacco can be readily seen in [Table 5-2 in] the comparison of death rates from cirrhosis of the liver and malignant neoplasms of the respiratory system. For both sexes the excess of death rates from these causes in Nevada is very large.

The populations of these two states are, to a considerable extent, self-selected extremes from the continuum of life-styles found in the United States. Nevadans, as has been shown, are predominantly recent immigrants from other areas, many of whom were attracted by the state's permissive mores. The inhabitants of Utah, on the other hand, are evidently willing to remain in a more restricted society. Persons born in Utah who do not find these restrictions acceptable tend to move out of the state.

### Summary

This dramatic illustration of large health differentials that are unrelated to income or availability of medical care helps to highlight the [following] themes . . .

1. From the middle of the eighteenth century to the middle of the twentieth century rising incomes resulted in unprecedented improvements in health in the United States and other developing countries.
2. During most of this period medical care (as distinct from public health measures) played an insignificant role in health, but, beginning in the mid-1930s, major therapeutic discoveries made significant contributions independently of the rise in real income.
3. As a result of the changing nature of health problems, rising income is no longer significantly associated with better health, except in the case of infant mortality (primarily post-neonatal mortality)—and even here the relationship is weaker than it used to be.
4. As a result of the wide diffusion of effective medical care, its marginal contribution to health is again small (over the observed range of variation). There is no reason to believe that the major health problems of the average American would be significantly alleviated by increases in the number of hospitals or physicians. This conclusion might be altered, however, as the result of new scientific discoveries. Alternatively, the *marginal* contribu-

tion of medical care might become even smaller as a result of such advances.

5. The greatest current potential for improving the health of the American people is to be found in what they do and don't do to and for themselves. Individual decisions about diet, exercise, and smoking are of critical importance, and collective decisions affecting pollution and other aspects of the environment are also relevant.

These conclusions notwithstanding, the demand for medical care is very great and growing rapidly. As René Dubos has acutely observed, "To ward off disease or recover health, men as a rule find it easier to depend on the healers than to attempt the more difficult task of living wisely."<sup>1</sup>

#### NOTE

1. René Dubos, *The Mirage of Health* (New York: Harper, 1959), p. 110.

## Medicine as an Institution of Social Control

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*Irving Kenneth Zola*

The theme of this essay 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 is largely an insidious 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.<sup>1</sup> 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 that profession. Nor is this extension 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. If we search for the "why" of this phenomenon, we will see instead 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.<sup>2</sup>

Quite frankly, what is presented in the follow-

ing pages is not a definitive argument but rather a case in progress. As such it draws heavily on observations made in the United States, though similar murmurings have long been echoed elsewhere.<sup>3</sup>

### An Historical Perspective

The involvement of medicine in the management of society is not new. It did not appear full-blown one day in the mid-twentieth century. As Sigerist<sup>4</sup> has aptly claimed, medicine at base was always not only a social science but an occupation whose very practice was inextricably interwoven into society. This interdependence is perhaps best seen in two branches of medicine which have had a built-in social emphasis from the very start—psychiatry<sup>5</sup> and public health/preventive medicine.<sup>6</sup> Public health was always committed to changing social aspects of life—from sanitary to housing to working conditions—and 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 lay in the objection that witches ought not to 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 proceed-

ings, 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 concomitant removal of certain rights and privileges).

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 occur 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. with gunshot wounds, attempted suicide, drug use and what is now called child abuse). 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 members—and really all ancillary health professions—were accused of practicing social control (the term used by the accusers was genocide) in first, *whom* they have traditionally treated with *what*—giving *better* treatment to more favored clientele; and secondly, *what* they have treated—a more subtle form of discrimination in that, with limited resources, by focusing on some diseases others are neglected. Here the accusation was that medicine has focused 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.

### The Myth of Accountability

Even if we acknowledge such a growing medical involvement, it is easy to regard it as primarily a "good" one—which involves the steady destigmatization of many human and social problems. Thus Barbara Wootton was able to conclude:

Without question . . . in the contemporary attitude toward antisocial behaviour, 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.<sup>7</sup>

The assumption is thus readily made that such medical involvement in social problems leads to their removal from religious and legal scrutiny and thus from moral and punitive consequences. In turn the problems are placed under medical scientific scrutiny and thus in objective and therapeutic circumstances.

The fact that we cling to such a hope is at least partly due to two cultural-historical blindspots—one regarding our notion of punishment and the other our notion of moral responsibility. Regarding the first, if there is one insight into human behavior that the twentieth 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 seem similarly on the wane. The most effective forms of brain-washing deny 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, is confined until cured, is forced to undergo certain medical procedures for his own good, perhaps deprived forever of the right to have sexual relations and/or produce children, *then* it is difficult for the patient *not* to view what is happening to him as punishment. This does not mean that medicine is the latest form of twentieth 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.

It is the second issue, that of responsibility, which requires more elaboration, for it is argued here that the medical model has had its greatest impact in the lifting of moral condemnation from the individual. While some sceptics note that while the individual is no longer condemned his disease still *is*, they do not go far enough. Most analysts have tried to make a distinction between illness and crime on the issue of personal responsibility.<sup>8</sup> The criminal is thought to be responsible and therefore accountable (or punishable) for his act, while the sick person is not. While the distinction does exist, it seems to be more a quantitative one rather than a qualitative one, with moral judgments but a pinprick below the surface. For instance, while it is probably true that individuals are no longer directly condemned for being sick, it does seem that much of this condemnation is merely displaced. Though his immoral character is not demonstrated in his having a disease, it becomes evident in what he does about it. 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 traumatic medical experiences or members of some lower status minority group—religious, ethnic, racial or socio-economic. In short, they appear to be a sorely troubled if not disreputable group of people.

The argument need not rest at this level of analysis, for it is not clear that the issues of morality and individual responsibility have been fully banished from the etiological scene itself. At the same time as the label "illness" is being used to attribute "diminished responsibility" to a whole host of phenomena, the issue of "personal responsibility" seems to be re-emerging 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, *not* bacteria to the center of the

stage and lead thereby to a re-examination 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 the probe: "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 . . . ?", 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 generally expressed in quite moral terms of what they did wrong. It is possible to 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 on this. I asked a class of forty undergraduates, mostly aged seventeen, eighteen and nineteen, to recall the last time they were sick, disabled, or hurt and then to 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 response 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 your're going and I . . ."

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 doctor 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 anthropomorphising 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.

### The Medicalizing of Society

Perhaps it is possible that medicine is not devoid of potential for moralizing and social control. The first question becomes: "what means are available to exercise it?" 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 *anything* to which it

may be attached, irrespective of its capacity to deal with it effectively.<sup>9</sup>

For illustrative purposes this "attaching" process may be categorized in four concrete ways: first, through the expansion of what in life is deemed relevant to the good practice of medicine; secondly, through the retention of absolute control over certain technical procedures; thirdly, through the retention of near absolute access to certain "taboo" areas; and finally, 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

The change of medicine's commitment from a specific etiological model of disease to a multi-causal one and the greater acceptance of the concepts of comprehensive medicine, psychosomatics, etc., have enormously expanded that which is or can be relevant to the understanding, treatment and even prevention of disease. 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. Part of this is greatly facilitated in the "age of the computer," for what might be too embarrassing, 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 where the data were 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.

It is not merely, however, the nature of the data needed to make more accurate diagnoses and treatments, but the perspective which accompanies it—a perspective which pushes the physician far beyond his office and the exercise of technical skills. To rehabilitate or at least alleviate many of the ravages of chronic disease, it has become increasingly necessary to intervene to

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change permanently the habits of a patient's lifetime—be it of working, sleeping, playing or eating. 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 the statement of a physician 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.<sup>10</sup>

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 as to how to get the general population to follow their recommendations that a leading article in a national magazine was entitled "To Save the Heart: Diet by Decree?"<sup>11</sup> 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 links 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-specialties. The plastic surgeon 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, as well as dealing with certain phenomena—wrinkles, sagging, etc.—formerly associated with the "natural" process of aging. Alterations in sexual and reproductive functioning have long been a medical concern. Yet today the frequency of hysterectomies seems 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.) Transplantations, despite their still relative infrequency, have had a tremendous effect on our very notions 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-surgeon that society is turning (and the physician-surgeon accepting) for criteria and guidelines.

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 drug use over the last ten years has not been in the realm of treating any organic disease but in treating a large number of psychosocial 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 interest.

Recently the newspapers and more popular magazines, including some medical and scientific ones, have carried articles about drugs which may be effective peace pills or anti-aggression tablets, 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.<sup>12</sup>

This statement incidentally was made not by a visionary science fiction writer but by a 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 exclusive license 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 affect the workings of the body and to a lesser extent the mind, then it can be labelled an "illness" itself or jurisdictionally "a medical problem." In a sheer statistical sense the import of this is especially great if we look at only four such problems—aging, drug addiction, alcoholism and pregnancy. The first and last were once regarded as normal natural processes and the middle two as human foibles and weaknesses. Now this has changed and to some extent medical specialties have emerged to meet these new needs. Numerically this expands medicine's involvement not only in a longer span of human existence, but it opens the possibility of medicine's services to millions if not billions of people. 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 legislatures) would reduce arrests in many jurisdictions by 10 to 50 percent 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 United States, it was barely seventy years ago that virtually all births and the concomitants of birth occurred outside the hospital as well as outside medical supervision. I do not frankly have a documentary history, but as this medical claim was solidified, so too was medicine's claim to a whole host of

related processes: not only to birth but to prenatal, postnatal, and pediatric care; not only to conception but to infertility; not only to the process of reproduction but to the process and problems of sexual activity itself; not only when life begins (in the issue of abortion) but whether it should be allowed to begin at all (e.g. in genetic counselling).

Partly through this foothold in the "taboo" areas and partly through the simple reduction of other resources, the physician is increasingly becoming the choice for help for many with personal and social problems. Thus a recent British study reported that within a five year period there had been a notable increase (from 25 to 41 percent) in the proportion of the population willing to consult the physician with a personal problem.<sup>13</sup>

### 4. *Through the Expansion of What in Medicine Is Deemed Relevant to the Good Practice of Life*

Though in some ways this is the most powerful of all "the medicalizing of society" processes, the point can be made simply. Here we refer to the use of medical rhetoric and evidence in the arguments to advance any cause. For what Wootton attributed to psychiatry is no less true of medicine. To paraphrase her, today the prestige of *any* proposal is immensely enhanced, if not justified, when it is expressed in the idiom of medical science. To say that many who use such labels are not professionals only begs the issue, for the public is only taking its cues from professionals who increasingly have been extending their expertise into the social sphere or have called for such an extension.<sup>14</sup> In politics one hears of the healthy or unhealthy economy or state. More concretely, the physical and mental health of American presidential candidates has been an issue in the last four elections and a recent book claimed to link faulty political decisions with faulty health.<sup>15</sup> For years we knew that the environment was unattractive, polluted, noisy and in certain ways dying, but now we learn that its death may not be unrelated to our own demise. To end with a rather mundane if depressing example, there has always been a

constant battle between school authorities and their charges on the basis of dress and such habits as smoking, but recently the issue was happily resolved for a local school administration when they declared that such restrictions were necessary for reasons of health.

### The Potential and Consequences of Medical Control

The list of daily activities to which health can be related is ever growing and with the current operating perspective of medicine it seems infinitely expandable. The reasons are manifold. It is not merely that medicine has extended its jurisdiction to cover new problems,<sup>16</sup> or that doctors are professionally committed to finding disease,<sup>17</sup> nor even that society keeps creating disease.<sup>18</sup> For if none of these obtained today we would still find medicine exerting an enormous influence on society. The most powerful empirical stimulus for this is the realization of how much everyone has or believes he has something organically wrong with him, or put more positively, how much can be done to make one feel, look or function better.

The rates of "clinical entities" found on surveys or by periodic health examinations range upwards from 50 to 80 percent of the population studied.<sup>19</sup> The Peckham study found that only 9 percent of their study group were free from clinical disorder. Moreover, they were even wary of this figure and noted in a footnote that, first, some of these 9 percent had subsequently died of a heart attack, and, secondly, that the majority of those without disorder were under the age of five.<sup>20</sup> 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 United States and the United Kingdom that within a given twenty-four to thirty-six hour period, from 50 to 80 percent of the adult population have taken one or more "medical" drugs.<sup>21</sup>

The belief in the omnipresence of disorder is

further enhanced by a reading of the scientific, pharmacological and medical literature, for there one finds a growing litany of indictments of "unhealthy" life activities. 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 every aspect of our daily life has in it elements of risk to health.

These facts take on particular importance not only when health becomes a paramount value in society, but also a phenomenon whose diagnosis and treatment has been restricted to a certain group. For this means that that group, perhaps unwittingly, is in a position to exercise great control and influence about what we should and should not do to attain that "paramount value."

Freidson in his recent book *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 diagnosis and his recommended treatments.<sup>22</sup> On the other hand, when it comes to constraining or directing human behavior because of the data of his researches, diagnosis 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 his values, or values latent in his very techniques.

Perhaps this issue of values can be clarified by reference to some not so randomly chosen medical problems: drug safety, genetic counseling and automated multiphasic testing.

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 United States 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. As for safety, many have applauded

the A.M.A.'s judicious position in declaring the need for much more extensive, longitudinal research on marihuana and their unwillingness to back legalization until much more data are in. This applause might be muted if the public read the 1970 Food and Drug Administration's "Blue Ribbon" Committee Report on the safety, quality and efficacy of *all* medical drugs commercially and legally on the market since 1938.<sup>23</sup> 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 recorded cases of anyone dying from an overdose or of extensive adverse side effects from marihuana use, but the literature on the adverse effects of a whole host of "medical drugs" on the market today is legion.

It would seem that the value positions of those on both sides of the abortion issue needs little documenting, but let us pause briefly at a field where "harder" scientists are at work—genetics. The issue of genetic counselling, or whether life should be allowed to begin at all, can only be an ever increasing one. As we learn more and more about congenital, inherited disorders or predispositions, and as the population size for whatever reason becomes more limited, then, inevitably, there will follow an attempt to improve the quality of the population which shall be produced. At a conference on the more limited concern of what to do when there is a documented probability of the offspring of certain unions being damaged, a position was taken 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.<sup>24</sup>

There are in this statement certain values on marriage and what it is or could be that, while they may be 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 of the other alternatives:

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

If this risk were too great but the desire to bear children was there, and depending on the type of problem, artificial insemination might be a possibility.

Barring all these and not wanting to take any risk, they could adopt children.

Finally, there is the option of being married without having any children.

It is perhaps appropriate to end with a seemingly innocuous and technical advance in medicine, 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 validity of all those test-results and still others fear that it will lead to second class medicine for already underprivileged populations, it is apparent that its major use to date and in the future may not be in promoting health or detecting disease but 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 the 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 those whom they have just informed that they have been "rejected" because of some physical or mental anomaly. They calmly and universally stated: none—neither to provide them with any appropriate aid nor even to ensure that they get or be put in touch with any help.

## Conclusion

C. S. Lewis warned us more than a quarter of a century ago that "man's power over Nature is really the power of some men over other men, with Nature as their instrument." The same

could be said regarding man's power over health and illness, for the labels health and illness are remarkable "depoliticizers" of an issue. By locating the source and the treatment of problems in an individual, other levels of intervention are effectively closed. By the very acceptance of a specific behavior as an "illness" and the definition of illness as an undesirable state, the issue becomes not whether to deal with a particular problem, but *how* and *when*.<sup>25</sup> Thus the debate over homosexuality, drugs or abortion becomes focused on the degree of sickness attached to the phenomenon in question or the extent of the health risk involved. And the more principled, more perplexing, or even moral issue, of *what* freedom should an individual have over his or her own body is shunted aside.

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 has the focus been more on the medical potential than on the social desire? In part it is a function of space, but also of political expediency. For the time rapidly may be approaching when recourse to the populace's wishes may be impossible. Let me illustrate this with the statements of two medical scientists who, if they read this essay, would probably dismiss all my fears as groundless. The first was 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 pro-creative 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.<sup>26</sup>

Here he states, as almost an absolute condition of human nature, something which is at best a recent phenomenon. He seems to forget that there were laws promulgating just such procedures through much of the twentieth century, that within the past few years at least one Californian 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 analyze the psychological and physical results of simulated nuclear fall-out. True, the experiments were stopped, but not until they had been going on for *eleven* years.

The second statement is by Francis 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.<sup>27</sup>

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 them from even meeting with one 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

series of state laws were passed to make fluoridation a public health decision and to be treated, as all other public health decisions, 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 not an attack on medicine so much as on a situation in which we find ourselves in the latter part of the twentieth century; for 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 battleground, 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.<sup>28</sup> 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 antocoagulant therapy ever since his prophylactic castration.<sup>29</sup>

Thus I fear with Freidson:

A profession and a society which are so concerned with physical and functional wellbeing as to sacri-

fice civil liberty and moral integrity must inevitably press for a "scientific" environment similar to that provided laying hens on progressive chicken farms—hens who produce eggs industriously and have no disease or other cares.<sup>30</sup>

Nor does it really matter that if, instead of the above depressing picture, we were guaranteed six more inches in height, thirty more years of life, or 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, or who will decide what potentialities and potencies will be expanded and what curbed.

I must 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 so much to teach to their doctors as do students their professors and children their parents.

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## The Medicalization and Demedicalization of American Society

*Renée C. Fox*

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Along with progressive medicalization, a process of demedicalization seems also to be taking place in the society. To some extent the signs of demedicalization are reactions to what is felt by various individuals and groups to be a state of "over-medicalization." One of the most significant manifestations of this counter-trend is the mounting concern over implications that have arisen from the continuously expanding conception of "sickness" in the society. Commentators on this process would not necessarily agree with Peter Sedgwick that it will continue to "the point where everybody has become so luxuriantly ill" that perhaps sickness will no longer be "in" and a "backlash" will be set in motion;<sup>1</sup> they may not envision such an engulfing state of societally defined illness. But many observers from diverse professional backgrounds have published works in which they express concern about the "coercive" aspects of the "label" illness and the treatment of illness by medical professionals in medical institutions.<sup>2</sup> The admonitory perspectives on the enlarged domain of illness and medicine that these works of social science and social criticism represent appear to have gained the attention of young physicians- and nurses-in-training interested in change, and various consumer and civil-rights groups interested in health care.

This emerging view emphasizes the degree to which what is defined as health and illness, normality and abnormality, sanity and insanity

varies from one society, culture, and historical period to another. Thus, it is contended, medical diagnostic categories such as "sick," "abnormal," and "insane" are not universal, objective, or necessarily reliable. Rather, they are culture-, class-, and time-bound, often ethnocentric, and as much artifacts of the preconceptions of socially biased observers as they are valid summaries of the characteristics of the observed. In this view, illness (especially mental illness) is largely a mythical construct, created and enforced by the society. The hospitals to which seriously ill persons are confined are portrayed as "total institutions": segregated, encompassing, depersonalizing organizations, "dominated" by physicians who are disinclined to convey information to patients about their conditions, or to encourage paramedical personnel to do so. These "oppressive" and "counter-therapeutic" attributes of the hospital environment are seen as emanating from the professional ideology of physicians and the kind of hierarchial relationships that they establish with patients and other medical professionals partly as a consequence of this ideology, as well as from the bureaucratic and technological features of the hospital itself. Whatever their source, the argument continues, the characteristics of the hospital and of the doctor-patient relationship increase the "powerlessness" of the sick person, "maintain his uncertainty," and systematically "mortify" and "curtail" the "self" with which he enters the sick role and arrives at the hospital door.

This critical perspective links the labeling of illness, the "imperialist" outlook and capitalist behavior of physicians, the "stigmatizing" and "dehumanizing" experiences of patients, and the problems of the health-care system more generally to imperfections and injustices in the society as a whole. Thus, for example, the various forms of social inequality, prejudice, discrimination, and acquisitive self-interest that persist in capitalistic American society are held responsible for causing illness, as well as for contributing to the undesirable attitudes and actions of physicians and other medical professionals. Casting persons in the sick role is regarded as a powerful, latent way for the society to exact conformity and maintain the status quo. For it allows a semi-approved form of deviance to occur which siphons off potential for insurgent protest and which can be controlled through the supervision or, in some cases, the "enforced therapy" of the medical profession. Thus, however permissive and merciful it may be to expand the category of illness, these observers point out, there is always the danger that the society will become a "therapeutic state" that excessively restricts the "right to be different" and the right to dissent. They feel that this danger may already have reached serious proportions in this society through its progressive medicalization.

The criticism of medicalization and the advocacy of demedicalization have not been confined to rhetoric. Concrete steps have been taken to declassify certain conditions as illness. Most notable among these is the American Psychiatric Association's decision to remove homosexuality from its official catalogue ("Nomenclature") of mental disorders. In addition, serious efforts have been made to heighten physicians' awareness of the fact because they share certain prejudiced, often unconscious assumptions about women, they tend to over-attribute psychological conditions to their female patients. Thus, for example, distinguished medical publications such as the *New England Journal of Medicine* have featured articles and editorials on the excessive readiness with which medical specialists and textbook authors accept the undocumented belief that dysmenorrhea, nausea of pregnancy, pain in labor, and infantile colic are all psychogenic disorders, caused or aggravated by women's emotional problems. Another related develop-

ment is feminist protest against what is felt to be a too great tendency to define pregnancy as an illness, and childbirth as a "technologized" medical-surgical event, prevailed over by the obstetrician-gynecologist. These sentiments have contributed to the preference that many middle-class couples have shown for natural childbirth in recent years, and to the revival of midwifery. The last example also illustrates an allied movement, namely a growing tendency to shift some responsibility for medical care and authority over it from the physician, the medical team, and hospital to the patient, the family, and the home.

A number of attempts to "destratify" the doctor's relationships with patients and with other medical professionals and to make them more open and egalitarian have developed. "Patients' rights" are being asserted and codified, and, in some states, drafted into law. Greater emphasis is being placed, for example, on the patient's "right to treatment," right to information (relevant to diagnosis, therapy, prognosis, or to the giving of knowledgeable consent for any procedure), right to privacy and confidentiality, and right to be "allowed to die," rather than being "kept alive by artificial means or heroic measures . . . if the situation should arise in which there is no reasonable expectation of . . . recovery from physical or mental disability."<sup>3</sup>

In some medical milieux (for example, community health centers and health maintenance organizations), and in critical and self-consciously progressive writings about medicine, the term "client" or "consumer" is being substituted for "patient." This change in terminology is intended to underline the importance of preventing illness while stressing the desirability of a non-supine, non-subordinate relationship for those who seek care to those who provide it. The emergence of nurse-practitioners and physician's assistants on the American scene is perhaps the most significant sign that some blurring of the physician's supremacy vis-à-vis other medical professionals may also be taking place. For some of the responsibilities for diagnosis, treatment, and patient management that were formerly prerogatives of physicians have been incorporated into these new, essentially marginal roles.<sup>4</sup>

Enjoiners to patients to care for themselves rather than to rely so heavily on the services of

medical professionals and institutions are more frequently heard. Much attention is being given to studies such as the one conducted by Lester Breslow and his colleagues at the University of California at Los Angeles which suggest that good health and longevity are as much related to a self-enforced regimen of sufficient sleep, regular, well-balanced meals, moderate exercise and weight, no smoking, and little or no drinking, as they are to professionally administered medical care. Groups such as those involved in the Women's Liberation Movement are advocating the social and psychic as well as the medical value of knowing, examining, and caring for one's own body. Self-therapy techniques and programs have been developed for conditions as complicated and grave as terminal renal disease and hemophilia A and B. Proponents of such regimens affirm that many aspects of managing even serious chronic illnesses can be handled safely at home by the patient and his family, who will, in turn, benefit both financially and emotionally. In addition, they claim that in many cases the biomedical results obtained seem superior to those of the traditional physician-administered, health-care-delivery system.

The underlying assumption in these instances is that, if self-care is collectivized and reinforced by mutual aid, not only will persons with a medical problem be freed from some of the exigencies of the sick role, but both personal and public health will thereby improve, all with considerable savings in cost. This point of view is based on the moral supposition that greater autonomy from the medical profession coupled with greater responsibility for self and others in the realm of health and illness is an ethically and societally superior state.

We have the medicine we deserve. We freely choose to live the way we do. We choose to live recklessly, to abuse our bodies with what we consume, to expose ourselves to environmental insults, to rush frantically from place to place, and to sit on our spreading bottoms and watch paid professionals exercise for us. . . . Today few patients have the confidence to care for themselves. The inexorable professionalization of medicine, together with reverence for the scientific method, have invested practitioners with sacrosanct powers, and correspondingly vitiated the responsibility of the

rest of us for health. . . . What is tragic is not what has happened to the revered professions, but what has happened to us as a result of professional dominance. In times of inordinate complexity and stress we have been made a profoundly dependent people. Most of us have lost the ability to care for ourselves. . . . I have tried to demonstrate three propositions. First, medical care has less impact on health than is generally assumed. Second, medical care has less impact on health than have social and environmental factors. And third, given the way in which society is evolving and the evolutionary imperatives of the medical care system, medical care in the future will have even less impact on health than it has now. . . . We have not understood what health is. . . . But in the next few decades our understanding will deepen. The pursuit of health and of well-being will then be possible, but only if our environment is made safe for us to live in and our social order is transformed to foster health, rather than suppress joy. If not, we shall remain a sick and dependent people. . . . The end of medicine is not the end of health but the beginning. . . .<sup>5</sup>

The foregoing passage (excerpted from Rick Carlson's book, *The End of Medicine*) touches upon many of the demedicalization themes that have been discussed. It proclaims the desirability of demedicalizing American society, predicting that, if we do so, we can overcome the "harm" that excessive medicalization has brought in its wake and progress beyond the "limits" that it has set. Like most critics of medicalization on the American scene, Carlson inveighs against the way that medical care is currently organized and implemented, but he attaches exceptional importance to the health-illness-medical sector of the society. In common with other commentators, he views health, illness, and medicine as inextricably associated with values and beliefs of American tradition that are both critical and desirable. It is primarily for this reason that in spite of the numerous signs that certain *structural* changes in the delivery of care will have occurred by the time we reach the year 2000, American society is not likely to undergo a significant process of *cultural* demedicalization.

Dissatisfaction with the distribution of professional medical care in the United States, its costs, and its accessibility has become sufficiently acute and generalized to make the enactment of a national health-insurance system in the foresee-

able future likely. Exactly what form that system should take still evokes heated debate about free enterprise and socialism, public and private regulation, national and local government, tax rates, deductibles and co-insurance, the right to health care, the equality principle, and the principle of distributive justice. But the institutionalization of a national system that will provide more extensive and equitable health-insurance protection now seems necessary as well as inevitable even to those who do not approve of it.

There is still another change in the health-illness-medicine area of the society that seems to be forthcoming and that, like national health insurance, would alter the structure within which care is delivered. This is the movement toward effecting greater equality, collegiality, and accountability in the relationship of physicians to patients and their families, to other medical professionals, and to the lay public. Attempts to reduce the hierarchical dimension in the physician's role, as well as the increased insistence on patient's rights, self-therapy, mutual medical aid, community medical services and care by non-physician health professionals, and the growth of legislative and judicial participation in health and medicine by both federal and local government are all part of this movement. There is reason to believe that, as a consequence of pressure from both outside and inside the medical profession, the doctor will become less "dominant" and "autonomous," and will be subject to more controls.

This evolution in the direction of greater egalitarianism and regulation notwithstanding, it seems unlikely that all elements of hierarchy and autonomy will, or even can, be eliminated from the physician's role. For that to occur, the medical knowledge, skill, experience, and responsibility of patients and paramedical professionals would have to equal, if not replicate, the physician's. In addition, the social and psychic meaning of health and illness would have to become trivial in order to remove all vestiges of institutionalized charisma from the physician's role. Health, illness, and medicine have never been viewed casually in any society and, as indicated, they seem to be gaining rather than losing importance in American society.

It is significant that often the discussions and developments relevant to the destratification and control of the physician's role and to the enactment of national health insurance are accompanied by reaffirmations of traditional American values: equality, independence, self-reliance, universalism, distributive justice, solidarity, reciprocity, and individual and community responsibility. What seems to be involved here is not so much a change in values as the initiation of action intended to modify certain structural features of American medicine, so that it will more fully realize long-standing societal values.

In contrast, the new emphasis on health as a right, along with the emerging perspective on illness as medically and socially engendered, seems to entail major conceptual rather than structural shifts in the health-illness-medical matrix of the society. These shifts are indicative of a less fatalistic and individualistic attitude toward illness, increased personal and communal espousal of health, and a spreading conviction that health is as much a consequence of the good life and the good society as it is of professional medical care. The strongest impetus for demedicalization comes from this altered point of view. It will probably contribute to the decategorization of certain conditions as illness, greater appreciation and utilization of non-physician medical professionals, the institutionalization of more preventive medicine and personal and public health measures, and, perhaps, to the undertaking of non-medical reforms (such as full employment, improved transportation, or adequate recreation) in the name of the ultimate goal of health.

However, none of these trends implies that what we have called *cultural* demedicalization will take place. The shifts in emphasis from illness to health, from therapeutic to preventive medicine, and from the dominance and autonomy of the doctor to patient's rights and greater control of the medical profession do not alter the fact that health, illness, and medicine are central preoccupations in the society which have diffuse symbolic as well as practical meaning. All signs suggest that they will maintain the social, ethical, and existential significance they have acquired; even though by the year 2000 some structural aspects of the way that medicine and care are

organized and delivered may have changed. In fact, if the issues now being considered under the rubric of bioethics are predictive of what lies ahead, we can expect that in the future, health, illness, and medicine will acquire even greater importance as one of the primary symbolic media through which American society will grapple with fundamental questions of value and belief. What social mechanisms we will develop to come to terms with these "collective conscience" issues, and exactly what role physicians, health professionals, biologists, jurists, politicians, philosophers, theologians, social scientists, and the public at large will play in their resolution remains to be seen. But it is a distinctive characteristic of an advanced modern society like our own that scientific, technical, clinical, social, ethical, and religious concerns should be joined in this way.

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